AHMEDABAD
BHOPAL

BHUBANESHWAR

Health Insurance nov 10

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-008-0746

Sri Ambika Charan Parija

Vrs

Royal Sundaram General Insurance Co. Ltd., Bhubaneswar

Award dated 24th November, 2010

The Complainant had taken a Health Insurance policy . He was treated for hypertension and loss of memory and after discharge lodged a claim with the insurer. The claim was rejected by the company stating non-disclosure of material facts and pre-existing disease.

Hon'ble Ombudsman perused all the documents. The policy was running since 2003 and thus over six years and was claim free. The doctor's prescription was presented by the complainant which shows that the complainant has suffered from HTN since 2 years. Thus on the basis of the documents and the IRDA guidelines regaring the coverage of pre exising disease after four claim free years , the claim was allowed by Ombudsman.

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Health Insurance nov 10

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-002-0744

Sri Sanjay Kumar Dey

Vrs

The New India Assurance Co. Ltd., Choudwar

Award dated 26th November, 2010

The Complainant had taken a Health Insurance policy for himself and his wife. Her wife was diagnosed with primary infertility with fibromyoma uterus with dermoid cyst & had undergone hysterectomy. Insurer rejected the claim stating that the treatment relates to infertility which is an excluded disease.
Hon'ble Ombudsman perused all the documents and observed that the hysterectomy was done and cyst was removed which is in no way connected to the treatment of infertility. Also, the policy was running since four years and hence exclusion of hysterectomy is not applicable. Hence Hon'ble Ombudsman ordered for payment of the claim with 8% interest.

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BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-012-0749

Sri Syama Barad

Vrs

ICICI Lombard Insurance Co. Ltd.

Award dated 24th November, 2010

The Complainant had taken a Health Insurance policy being a member of SKS Micro Finance Co. He was hospitalised in a network hospital after injury of his leg resulting from an accident and incurred an expenditure of Rs.14700/-. The claim was lodged with the insurer but the insured delayed in paying the claim. Hon'ble Ombudsman after perusing the documents and hearing the complainant's representative ordered for payment of the claim for Rs.14,700/-.

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Mediclaim Nov 10

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-002-0736
Smt Rupa Paul Choudhury
Vrs
New India Assurance Co Ltd.
Bhubaneswar

Award dated 26th November 2010

The complainant had taken Mediclaim Insurance Policy with New India Assurance Company for the period from 20.11.2006 to 19.11.2007 and renewed continuously till 19.11.2010. She was admitted to hospital for treatment of menorrhagia with lower abdominal lump and diagnosed with urine leiomyomas, cyst ovary and rt. follicular cyst. On discharge she lodged a claim. Insurance Company repudiated the claim on the ground that the disease was pre existing.

Hon'ble Ombudsman heard the case on 26.11.2010 where both parties were present. Hearing both parties and on perusal of records, held that the policy was under constant renewal since 2006 and the disease can not be taken as pre existing. There fore directed Insurance Company to settle the claim subject to deductions and limits if any.

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Health Policy

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-011-0729

Smt. Radha Rani Sahu
Vrs
Bajaj Allianz General Insurance Co Ltd.
Bhubaneswar

Award dated 19th January 2011

The insured had taken a Health Policy from Bajaj Allianz General Insurance Co Ltd and was hospitalised for acute thigh pain due to herpes infection. She lodged a claim for Rs.3891/- .The insurer rejected the claim relying on the policy exclusion clause no.16

which excludes medical expenses relating to any hospitalisation primarily and specifically for diagnostic, X-ray or laboratory examinations and investigations.

Hon'ble Ombudsman heard the case on 24.12.2010 . The Discharge card of the Hospital shows the diagnosis as Low backache with herpes Simplex for which tablets & ointments were prescribed but no suggestions were made for medical tests or ultra sound. As the hospitalisation was for treatment of herpes & low back pain for which medicines & ointments were prescribed , the claim does not come under exclusion no.16 . However as the diagnostic tests were not advised by the hospital, no expenses incurred towards the same is payable by the insurer.

Hon'ble Ombudsman passed the award for Rs.2989/- taking in to account the cost of the Medicines & ointments purchased by the insured as per advice of the doctor.

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BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-002-0748

Sri Prasant Chandra Pattnaik

Vrs

The New India Assurance Co. Ltd.

Award dated 28th January, 2011

The Complainant had taken a Health Insurance policy from the insurer since 2005 and in the year 2008 underwent angiography. The insurer renewed the policy thereafter excluding heart disease as pre-existing. In the year 2010 , the complainant had a bye – pass surgery and claimed for reimbursement . The claim was rejected by the insurer stating that heart disease has been shown as an excluded disease in the policy.

Hon'ble Ombudsman observed that repudiation of the claim is in order as the complainant had accepted the policy after the exclusion of the heart related disease and renewed thereafter without any objection.

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BHUBANESWAR OMBUDSMAN CENTER

Complaint No.14-009-0735
Sri Samir Kumar
Vrs
Reliance General Insurance Co Ltd.

Award dated 31st January 2011

The insured had taken a Health Policy from Reliance General Insurance Co Ltd and was hospitalised for treatment of Myocardial Infarction in Aditya Care Hospital. The claim was rejected on the ground of pre-existing disease as the patient was suffering from hypertension since 8 years.

Hon'ble Ombudsman heard the case on 24.12.2010 where the insurer did not attend. The insured submitted his mediclaim policy copies taken from United India Insurance Co. Ltd. since 21.04.2004 to 20.4.2007 & from Reliance co. From 21.4.07 to 20.4.10 on yearly basis. The Discharge Card submitted by the insured does not reveal existence of hypertension beforehand. Rather the policy condition of United India Insurance Co. submitted by the insured , reveals that pre-existing diseases are covered if taken continuously from any of the Indian Insurers without break.

As the disease was not proved as pre-existing at the time of taking the policy and the insured was continuously renewing the policy , the repudiation of the claim was not in order . Hence , Ombudsman ordered for payment of the claim.

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BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-004-0753

Sri Ganesh Garg
Vrs
United India Insurance Co. Ltd.

Award dated 3rd February, 2011

The Complainant had taken a Health Insurance policy from the insurer for Rs.50000/- and underwent operation for hernia. The claim was closed by the insurer after some correspondences. The hearing date was fixed where the insurer appeared and submitted that the claim was already settled for the full sum insured of Rs. 50000/-. The complainant also informed about the receipt of the cheque. As such the complaint was dismissed being settled by the insurer.

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BHUBANESWAR OMBUDSMAN CENTER

Complaint No.14-009-0760

Sri Aswini Kumar Mohanty

Vrs

Reliance General Insurance Co. Ltd.

Award dated 16th February, 2011

The Complainant had taken a Health Insurance policy for his family. Two claims were lodged with the insurer for the treatment of fracture of bone of his son which were rejected by the insurer the first one, for delay in submission of the papers and the second one for the sole reason of , rejection of the first claim . Hon'ble Ombudsman perused the Medical papers and observed that in the first claim the treatment was continuing even after the discharge from the Nursing Home and hence it is natural to submit the treatment papers after the complete treatment was over for which prior intimation was given to the company. Hon'ble Ombudsman ordered to pay both the claims .

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Health Care Feb11

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-020-0775
Gagan Bihari Pradhan
Vrs
Universal Sompo General Insurance Co Ltd.
Rourkella

Award dated 22nd February 2011

The complainant being an employee of IOB was covered under IOB Health Care Insurance Policy with Universal Sompo General Insurance Company for the period from 09.12.2009 to 08.12.2010.He was hospitalized for Gall Stone disease. On discharge he lodged a claim for Rs 26,348/-. Insurance Company repudiated the claim on the ground that the disease was excluded in the first year of the policy.

Hon'ble Ombudsman ordered for hearing of the case on 22.02.2011. But before the hearing, Insurance Company settled the claim and complainant informed the forum in writing to withdraw the complaint. Accordingly the complaint was dismissed by Ombudsman in a separate order as above.

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CHANDIGARH

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. GIC/832/REL/11/10

Sanjiv Kumar Jain Vs Reliance General Insurance Co. Ltd.

ORDER DATED: 08TH MARCH, 2011 MEDICLAIM

FACTS: Shri Sanjiv Kumar Jain was having a Reliance Health-wise Policy bearing no. 282510392655 issued by Reliance General Insurance Co. Ltd. for the period 21.02.2009 to 20.02.2010. His son, Aaradyha Jain was admitted to CMC, Ludhiana due to Persistent Diarrhea. He was admitted on 14.04.2009 and discharged on 27.04.2009. The claim was lodged with the insurance company but they repudiated the claim on the ground of pre-existing disease. The doctor clearly mentioned on the discharge summary as well as case summary that the problem is just 15 days old. Further, as required by the insurance company, the doctor again issued a certificate mentioning that the problem is just 15 days old. In spite of that the insurance company repudiated his claim. Parties were called for hearing on 08.03.2011 at Chandigarh.

FINDINGS: The insurer clarified the position by stating that the patient was suffering from Mal Nutrition Grade II and Mild Anemia which goes to show that the patient was suffering from preexisting disease because such disease takes time to develop.

DECISION: Held that company was not justified in repudiating the claim on ground of pre-existing disease because as per doctor's certificate the child was suffering from the disease only for 15 days on the date of admission. The consulting doctor did not say that the patient was suffering from such diseases even prior to taking that policy. No evidence whatsoever placed on record on behalf of company that the patient was under treatment for such diseases even prior to taking the policy. Therefore, the company was not justified in repudiating the claim on ground of pre-existing disease. As per terms and conditions of the policy, the claim is admissible. **Accordingly, an award was passed with the direction to insurance company to make the payment of Rs. 28589/- along with panel interest @8% from the date of repudiation (08.01.2010) till the date of actual payment.**

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. GIC/837/UII/11/10

Brij Mohan Gupta Vs United India Insurance Co. Ltd.

ORDER DATED: 09th March, 2011 **Mediclaim**

FACTS: Sh. Brij Mohan Gupta and his family were covered under a Individual Mediclaim Policy bearing no.201002/48/08/97/00000513 issued by United India Insurance Co. Ltd. for the period 21.10.08 to 20.10.09. His daughter, Divya Gupta was operated on 23.06.2009 at Mirchia Hospital for the treatment of Myopia both eyes. He had incurred expenditure of Rs. 24,612/- on her treatment. She was admitted in the hospital on 23.06.2009 and discharged on 24.06.2009. The claim was reported to Raksha TPA. But the TPA rejected the claim on the ground that the said treatment related to cosmetic surgery and aesthetic and as per policy condition 4.3 the claim is not payable. Parties were called for hearing on 09.03.2011 at Chandigarh

FINDINGS: The insurer replied that the claim was repudiated on the ground of violation of clause 4.3 of the policy. It has been observed from the papers submitted that patient suffered from Myopia and Lasik Laser Treatment was done as the refractive error of the patient is right eye- 3.5 Ds pt 6/6 and left eye- 4.4 spl 6/6. The treatment taken by the patient is to remove spectacles and the treatment comes under Cosmetic and Aesthetic surgery.

DECISION: Held that the company was justified in repudiating the claim because the expenses claimed related to treatment of correction of eye sight and the same falls in the category of cosmetic surgery. The company had given sufficient reasons while repudiating the claim. The same is upheld. The claim is not found payable. **Accordingly, the complaint filed is dismissed.**

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. GIC/814/UII/11/10

Jagdish Bishnoi Vs United India Insurance Co. Ltd.

ORDER DATED: 09TH March 2011 **Mediclaim**

FACTS: Sh. Jagdish Bishnoi had taken a mediclaim policy No. 200100/48/08/97 for the period 28.11.08 to 27.11.09. He has been taking the policy for last 4 years. When on 03.06.09 in the 4th year, he lodged a claim, the company refused to pay the same stating that his disease is a pre-existing disease. He felt cheated as he has been paying the premium regularly for four years and at the time of claiming, the company is making excuses. Parties were called for hearing on 09.03.2011 at Chandigarh.

FINDINGS: The insurer clarified the position by stating that the claim is not payable because of exclusion clause 4.8. The discharge summary clearly stated that he was having alcohol occasionally for the last 20 years and has the history of self-medication like injection Penicillin and tab Trica without prescription. He stated that insured had not supplied the required information as demanded by the TPA. Exclusion Clause 4.1 was also cited as a reason for not accepting the claim by the company.

DECISION: Held that the company was not justified in repudiating the claim because the company could not place on record any evidence to the effect that the insured was under treatment prior to inception of the policy. The company could not support the reasons for repudiation that exclusion clause 4.1 applies. Until and unless evidence is brought on record by the company that the insured was under treatment before the inception of the policy, the argument of pre-existing disease cannot be accepted. The submission as made by the insurer during the course of hearing that insured was taking alcohol is also not acceptable because the treating doctor in the history mentioned that the insured used to take alcohol occasionally. Therefore, the claim is payable. **Accordingly, an award is passed with the direction to insurance company to make the payment of Rs. 57323/- along with the penal interest @8% from the date of repudiation to the date of actual payment.**

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. GIC/840/UII/11/10

Kiran Gupta Vs United India General Insurance Co. Ltd.

ORDER DATED: 09TH March 2011 **Mediclaim**

FACTS: Smt. Kiran Gupta had been having a Mediclaim Insurance Policy bearing no. 201100/48/08/97/00000031 issued by United India General Insurance Co. Ltd. for the period 15.04.2008 to 14.04.2009 for sum insured of Rs. 5,00,000/-. She had been having Mediclaim policy since 1999 and never lodged any claim during this period. In the month of September 2008, she got admitted in Fortis Hospital, Noida for the treatment of pain and swelling in both her knees. She was treated for the ailment and both the knees were transplanted and an expenditure of Rs. 3,80,000/- was incurred towards the treatment. The claim was preferred with the insurance company. The company made payment of Rs. 2,00,000/- only. She made a representation for balance claim of Rs.

1,80,000/- but the insurance company did not reply. Parties were called for hearing on 09.03.2011 at Chandigarh.

FINDINGS: The insurer clarified the position by stating that the age of client is 56 years and she has been covered under Gold Category of Individual Health Insurance Policy. That policy is subject to certain limits in case of major surgeries like knee replacement i.e. 70% of the sum insured subject to maximum Rs. 2,00,000/-. The insured has a sum insured of Rs. 5,00,000/-, 70% which comes to Rs. 3,50,000/- but subject to maximum Rs. 2,00,000/-. The illness, knee replacement falls in major category of surgery and attracts cap limit. The company had paid the claim as per the entitlement of the insured under the policy and nothing is outstanding.

DECISION: Held that the company was justified in restricting to the claim to the payment of Rs. 2.00 lakh, because as per terms and conditions of the policy the complainant was entitled only 70% of the sum insured subject to maximum limit of Rs. 2.00 lakh. The policy was issued to the insured and it was duty of insured to clearly peruse and be aware about the terms and conditions of the policy. The company had already released the claim as per terms and conditions of the policy. The complainant is not entitled to any further relief. **The complaint filed by the complainant is dismissed.**

DELHI

Case No.GI/286/RSA/09
In the matter of Ms. Sonia Dhamija
Vs
Royal Sundaram Alliance Insurance Company Limited

AWARD dated 21.10.2010 - Non- settlement of Mediclaim

1. This is a complaint filed by Ms. Sonia Dhamija (herein after referred to as the complainant) against the decision of Royal Sundaram Alliance Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non- settlement of Mediclaim.

2. Complainant submitted that she had taken a Mediclaim policy bearing no. HJ000014990001014 from M/s. Royal Sundaram Alliance Insurance Co. Ltd. which covered herself, her husband Shri Narinder Dhamija and her son and such policy was effective from 10.07.2004. it is submitted further by her that her husband Late Shri Narinder Dhamija who was leading a normal and active life was assured for hospitalization expenses upto Rs.3 Lacs on payment of premium of Rs.13058/- per annum. The policy was issued by the Insurance Company after satisfying that all the requisite conditions governing the issue of Mediclaim Policy to a person of 59 years of age, including Medical Tests, if required, ascertaining of pre-existing disease. Unfortunately on the night of 22nd /23rd May, 2009, after expiry of more than 59 months from the effective date of insurance her husband developed acute Headache and Restlessness. Immediately family Dr. Col. Dhamija, Sr. Neurologist was contacted who advised to take the patient to Sir Ganga Ram Hospital, New Delhi which is the most professional and reputed hospital of India. The patient was accordingly rushed to Sir Ganga Ram Hospital in the early hours of 23.05.2009. The team of doctors at Sir Ganga Ram Hospital diagnosed the patient as a case of Brain Haemarhage and treatment was started accordingly. Later on the conditions of the patient started deteriorating gradually and died on 04.06.2009 in the hospital. The cost of treatment in the hospital amounting to Rs.3,37,356/- in respect of which claim no. 52593 was filed. It is further submitted by her that her late husband had not suffered from any disease as diagnosed in the hospital. Brain Haemorrahage was a sudden disease relating to brain and it did not have any link with disease earlier occurred.

She had submitted all requisite documents to Royal Sundaram Alliance insurance Co. Ltd., Chennai supporting her Mediclaim but the claim was repudiated vide company's letter dated 11.09.2009 on the ground that patient had history of heart ailment, treatment done seven years earlier to the present date of brain ailment. She again requested the Insurance Company to reconsider its decision of repudiating of the claim on 18.09.2009. However, the Insurance Company did not reconsider its decision and reiterated its decision of repudiation of the claim. She submitted that the Insurance Company is trying to evade the main issue of actual cause of death. She stated that her husband did not die of the disease which he might have suffered earlier because he died on account of Brain Haemorrheage. During the course of hearing the complainant was accompanied by her relative who argued vehemently that the Insurance Company is liable for deficiency in service if it fails to reimburse the hospitalization expenses for the patient who has Mediclaim policy. Disease cannot be called pre-existing nor can the patient be denied his insurance claim even if he had not mentioned the disease as pre-existing. It was held by Mumbai District Consumer Forum as per publication in Times of India dated 23.07.2010. the diagnosis and cause of death as diagnosed by the doctor, who treated the patient throughout the ailment in Sir Ganga Ram Hospital, New Delhi namely Dr. H.N. Aggarwal, MS (Surgery), M.Ch (Neurosurgery), Chairman and Sr. Consultant, Head of Department of Neurosurgery was Craniotomy and Haematona Evacuation with Penumona with ARF with Septic Shock and not Valve replacement. The treatment was also neither for heart ailment nor any pre-existing disease. In this connection column

Nos. 9 and 11 of health sheet claim from annexure VI and column No. 7 of the death certificate- Annexure VII issued by the hospital may kindly be perused. Dr. H.N. Aggarwal has stated in clear and unambiguous terms that the resent ailment is not a complication of pre-existing disease or condition. This fact has also been confirmed by Dr. Arun Kumar Trehan, MBBS stating that the cause of death as certified by Ganga Ram Hospital has not co-relation with any past disease. The cause of death is brain haemorrhage, which was new and sudden disease occurred for the first time after 9 year from curing of earlier disease and 59 months after the date of insurance of the present Mediclaim policy. The view of the company's paid doctors of not disclosing pre-existing nature of heart ailment as intimated by the company for rejecting the claim is not relevant. It is further submitted by the complainant that the approach of the Insurance Company in repudiating the claim was not justified. The Insurance Company is to repudiate the claim on one ground or the other. It is unfortunate and cruel case of repudiation of genuine claim where the well earning, insured had expired after incurring more than Rs.337000/- in treatment in the most reputed hospital.

3. The written submission were placed on record on behalf of the Insurance Company besides verbal submissions made by the representative of the Insurance Company during the course of hearing. It has been submitted on behalf of the insurance company on receipt of the claim, investigator was appointed to investigate the claim of the complainant and the investigator from the internal hospital records and IPD noting found out that Shri Narinder had a history of Mitral Valve Replacement which was done 7 years back i.e. before policy inception and it is submitted that Shri Narinder was regularly having the medication of Acitrom after having the mitral valve replacement for past 7 years. It is submitted that Mitral Valve replacement ailment related with heart ailment was not disclosed to the Insurance Company in the proposal form filled while taking the policy. It is submitted that the Mitral Valve replacement is a material fact which the complainant has not disclosed to the Insurance Company while taking the policy. In fact the complainant i.e. the policy holder herself admitted that her husband was suffering with heart ailment 9 years back. The company had summarized its reasons for repudiating the claim in Para '8' of its letter which I think appropriate to quote:
"We had repudiated the claim of the complainant vide our letter dated 11.09.2009 on the ground non-disclosure of any material fact in the proposal form by the complainant on the true health status of complainant's husband. It is submitted that we have reiterated our stand to the complainant on 20.10.2009 also. It is submitted that the all the contracts of insurance are contracts of utmost good faith and in this instant matter complainant breached the said clause by not disclosing the material fact. In this regard the attention of this forum is drawn to the policy of Insurance vide clause 6, Misdescription, wherein it is stated that in event of any misrepresentation, misdescription or non-disclosure of material facts, the policy of insurance shall be invalid and all premium paid therein shall stand forfeited to the insurer, the relevant clause contained in the Policy of Insurance is reproduced herein for reference:-

"Misdescription

This policy shall be void and all premium paid hereon shall be forfeited to the Company in the event of misrepresentation, misdescription or non-disclosure of any material fact."

It further stated that that the complainant had deliberately concealed relevant facts in the proposal form which have been discovered subsequently. Therefore on this ground alone

the complaint is liable to be dismissed in view of the suppression of material information by the complainant at the time of submitting the proposal form. The gist of the detailed submission of the Insurance Company is that the claim was repudiated on the ground of suppression of material facts relating to health while submitting the proposal for taking the policy.

4. I have very carefully considered the submission of the complainant and I also perused the detailed written reply which is placed on record on behalf of the Insurance Company and also considered verbal argument of the representative of the Insurance Company in the course of hearing. After due consideration of the matter I hold that Insurance Company was not justified in repudiating the claim because it is not a case of suppression of material facts relating to health of the deceased by the policy holder. I fail to understand as to what the policy holder failed to disclose about the death of the deceased i.e. Shri Narinder Dhamija in the proposal form. It is clearly mentioned in the relationship form that the policy holder was required to state only the existing illness of the person covered in the policy and its duration since at the time of taking the policy, Late Shri Narinder Dhamija was not suffering from any disease when the proposal was submitted for taking the policy. Therefore, obvious answer was no and the same has been mentioned. It would be appropriate to quote relationship form:-

Yes! I would like to enroll for Health Shield GoldBC. Details of myself & my family are stated below.

Relationship Form
Family
Name
Date of Birth
(DD/MM/YYYY
Sex
Choose your plan
Annual Amount
(Rs)
Any existing illness
Suffering since
(Month/Year)
Self
(Card Member)
M/F
Plan_____
M/F
Plan_____
Plan_____
M/F
Plan_____
M/F
Plan_____
M/F
Plan_____

The relationship form does not contain any column relating to disease which any of the beneficiary ever suffered. There is no such column where it has been desired to disclose that persons covered in the policy suffered from any disease earlier. Had there been such column indicating disclosure of such information and there was failure on the part of the insured to disclose such information then there would have been a case of suppression of Material facts i.e. to say the policy holder while taking policy was not required as per relationship form to disclose the fact that her late husband Shri Narinder Dhamija got MVR earlier in 2001. As regards the argument that Late Shri Narinder Dhamija was taking Acitrom, it is a medicine which is taken only as precautionary measure which has the effect of reducing the thickness of the blood. This is not a medicine for treatment of any disease, since late Shri Narinder Dhamija was not suffering from any disease at the time of taking policy, the policy holder was not under obligation to disclose any earlier disease which he might have suffered and got treatment. Therefore, it is not correct to say that while taking the policy and while filling the proposal , Material facts were suppressed relating to the health of late Shri Narinder Dhamija. As per terms and conditions of the policy the claim is very much payable and the Insurance Company was not justified at all in repudiating the claim. Accordingly, Award is passed with the direction to the Insurance Company to make the payment of Rs.3,37,356/- along with interest @ 8% from the date of repudiation till the date of actual payment.

5. Copies of the Award to both the parties.

Case No.GI/21/Reliance/10
In the matter of Dr. Nikhil Bansal
Vs
Reliance General Insurance Company Limited

AWARD dated 22.10.2010 - Repudiation of Mediclaim

1. This is a complaint filed by Dr. Nikhil Bansal (herein after referred to as the complainant) against the decision of Reliance General Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for repudiation of Mediclaim.

2. Complainant submitted that he had been harassed and cheated by the Insurance Company. Insurance Company had deprived him of lawful right to the claim. It is stated that his family met with an accident whereby he along with his wife and other occupants of the car were injured. As a result of injury his wife namely Dr. Seema Bansal underwent hip surgery at Fortis Hospital, Noida. Claim was put up with E-meditek and the claim is still pending. He submitted that multiple reminders were sent besides making phone calls but of no use. Documentation with regard to claim was done. On 01.10.2008 the front office of the E-Meditek company informed him on telephone that his claim has been approved for reimbursement upto the extent of Rs.1.61 Lacs but fact remains that claim was not settled so far. The claim was repudiated on 28.03.2009 vide repudiation letter No. EMSL/REJ/32009/00006037. Insurance Company was required to submit reasons for repudiation. Despite his request to the Insurance Company to give detailed reasons, the Insurance Company had not sent reply to him. E-Meditek Solutions Ltd. Had repudiated the claim on 28.03.2009 and communicated the same to the

complainant. While repudiating the claim, E-Meditek Solutions had assigned the reasons, which I think appropriate to quote:-

"We are in receipt of the claim form & associated documents of Dr. Seema Bansal. On Scrutiny of the same, we observe that he-she was admitted in Fortis Hospital. As per the verification report, the claim cannot be settled as per
Terms and Conditions clause no.- 2 duty of disclosure If any claim is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means is devices are used by the Insured/Insured person or anyone acting on his/her to obtain any benefit under this policy, or if a claim is made and rejected and no court action or suit is commences within twelve months after such rejection or, in case of arbitration taking place as provided therein, within twelve (12) calendar months after the arbitrator or arbitrators have made their award, all benefits under this policy shall be forfeited. Terms &conditions clause no. 15- Fraudulent Claims the policy shall be null & void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis- description or non-disclosure of any material particulars in the proposal form, personal statement, declaration & connected documents. Or any material information having been withheld or a claim being fraudulent or any fraudulent means or device being used by the insured/insured person or any one action on his/her behalf to obtain a benefit under the policy. This regard we wish to inform your that the claim is not payable as per-

In view of the above, we are left with no option but to repudiate your claim.

3. During the course of hearing the representative of the Insurance Company stated that the Mediclaim policy was taken fraudently. Detailed reply dated 18.10.2010 was also placed on record on behalf of the Insurance Company wherein it has been stated that Dr. Nikhil Bansal obtained Reliance Healthwise policy valid from 22.03.2008 to 21.03.2009. On 22.03.2008 Dr. Seema Bansal wife of Dr. Nikhil Bansal got admitted in fortis Hospital as a case of fracture Right Pelvis Bone. She remained there for 7 days from 26.03.2008 to 03.04.2008 for the treatment and preferred a claim of Rs.1,71,059/- under the policy. It was further stated that the date of receipt of the proposal form by the branch office was 27.03.2008 but the insurance cover has been given before the proposal was received i.e. from the date of loss (22.03.2008). Perhaps it was meant that the policy was made effective before the date of acceptance of the proposal in the branch office of the Insurance Company. The policy was made effective from 22.03.2008 from 00:00 hour whereas the proposal for the policy was received in branch on 27.03.2008 that clearly shows that concealment of material facts by the insured. The Healthwise policy is subject to certain exclusions, conditions and explanation which are not covered under the scope of the policy. Reply also referred to clause no. '2' and '15' of the policy terms and conditions. Clause '2' relates to disclosure and clause '15' relates to fraudulent claims. Hence the claim was repudiated by the TPA of the Insurance Company which is just in accordance with terms and conditions of contract of insurance which are envisaged in the policy document.

4. I have very carefully considered the submissions of the complainant. I also perused the reply placed on record on behalf of the Insurance Company. I have also considered the verbal argument made on behalf of the Insurance Company and also perused the letter

of repudiation. After due consideration of the matter I hold that the Insurance Company was not justified in repudiating the claim because it had not placed on record any evidence to the fact that policy was fraudulently taken. It is very much clear from the policy as well as the proposal form that the complainant intended to take the policy w.e.f. 22.03.2008. He handed over the cheque dated 20.03.2008. The policy was issued to the policy holder as per terms and conditions of the policy. Though fact remains that the proposal was received by the Insurance Company only on 27.03.2008, but it has got no value because the policy was issued as per contents of the proposal form. If Insurance Company has a practice of issuing the policy before actual date of receiving the proposal, then nobody can help. It may be the fault with the insurer rather than of the insured. When the Insurance Company had decided to issue the policy w.e.f. date much before the actual date of receiving the proposal, later on Insurance Company cannot take the plea with regard to fraud commitment of the policy holder. It appears a deliberate act on the part of the insurer to issue the policy with effect from the date prior to the actual date of receipt of the proposal form. Unfortunately accident took place during the subsistence of the policy which is effective from 00:00 hours of 22.03.2008 to the midnight of 21.03.2009 and accident took place between 7 am to 8 am on 22.03.2008. Therefore, it is held that Insurance Company is liable to pay the claim to the insured. Accordingly, award is passed with a direction to the Insurance Company to make the payment of Rs.1,71,059/-.

5. Copies of the Award to both the parties.

Case No.GI/33/ICICI Lomb/10
In the matter of Shri Chander Mohan
Vs
ICICI Lombard General Insurance Company Limited

AWARD dated 29.10.2010 - Repudiation of Mediclaim

1. This is a complaint filed by Shri Chander Mohan (herein after referred to as the complainant) against the decision of ICICI Lombard General Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for repudiation of Mediclaim.

2. Complainant submitted that claim was submitted to ICICI Lombard Delhi office on 05.11.2009 who in turn forwarded the same to the TPA i.e. MD India Healthcare Services Pvt. Ltd. The claim was rejected and he came to know about the rejection of the claim after repeated calls to the TPA Delhi Office but no written communication was given to him. Requests was made for re-consideration of the claim and documents sent through DTDC Courier and delivered in Delhi Office on 16.12.2009 but when he was told that documents were not received by courier, he handed over another set and he had to undergo lot of harassment because he travelled all the way from Shahdara to Lajpat Nagar and back and had to spend a sum of Rs.200/- on conveyance. It was submitted by him that the claim was repudiated on the wrong reasons. He submitted that the claim was filed well within the due date of limit because MRI was finally conducted on 01.11.2010 and the claim submitted on 05.11.2009, which is well within the time of 30 days. It is further submitted that Focus Imaging & Research Centre while accepting balance

payment at the time of handing over MRI dated 21.10.2009 had issued computerized receipt of full amount dated 16.09.2009 i.e. the date when advance payment of Rs.1500/- was paid to them due to their inbuilt system in the computer. He argued that claim was submitted in time and the Insurance Company was not justified in repudiating the claim.

3. The Insurance Company informed the complainant, that claim was repudiated only on the ground that claim was filed late.

4. I have considered the submissions of the complainant. I have also perused the reply of the Insurance Company. After due consideration of the matter, I hold that Insurance Company was not justified in repudiating the claim because the claim was filed by the complainant well within the prescribed time because MRI was ultimately done on 21.10.2009. The Insurance Company has repudiated the small claim on flimsy grounds. Accordingly, award is passed with a direction to the Insurance Company to make the payment of Rs.3000/- along with penal interest @ 8% from the date of repudiation to the date of actual payment.

5. Copies of the Award to both the parties.

Case No. GI/06/NIC/10
In the matter of Shri Ved Prakash Arora
Vs
National Insurance Company Limited

AWARD dated 19.10.2010 - Repudiation of mediclaim

1. This is a complaint filed by Shri Ved Prakash Arora (herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that due to emergency he got admitted at nearby hospital. He further submitted that the policy is in continuation since 2002 but despite his repeated requests, the insurance company had not understood that it was due to emergency that admission in the nearby hospital was taken and no other reason. The pain was unbearable and could not sleep on that count. He submitted that all relevant papers were submitted in support of the claim. It has been requested by him that his claim be got settled at an early date.

3. Written replies were placed on record on behalf of the company. The insurance company had repudiated the claim only on the ground that treatment was taken in a hospital which was outside the approved list of hospitals provided to the policy holder along with the policy. During the course of hearing, the representative of the insurance company admitted that the claim is payable and it will be paid now. As a matter of fact, he promised to settle the claim within a week.

4. I have very carefully considered the submissions of the complainant and also perused the written replies placed on record on behalf of the insurer. After due consideration of the matter, I found that the insurance company was not justified in repudiating the claim only on the ground that treatment was taken in a hospital which was outside the approved list of hospitals given to the policy holder. The claim is otherwise admissible and payable and the same cannot be repudiated only on technical ground. Accordingly, Award is passed with the direction to the insurer to settle the claim and make the payment of Rs.45701/- along with penal interest @8% from the date of repudiation to the actual date of payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/13/NIC/10
In the matter of Shri Shyam Sunder Jain
Vs
National Insurance Company Limited

AWARD dated 19.10.2010 - Repudiation of mediclaim

1. This is a complaint filed by Shri Shyam Sunder Jain (herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that he got done Cataract surgery of his left eye on 30.05.2009 at Bajaj Eye Centre, Pitam Pura, Delhi registered by Government of Delhi. The claim papers were sent to Alankit Healthcare Private Limited on 03.06.2009. He was informed vide letter dated 08.07.2009 that his claim was repudiated on the ground that Bajaj Eye Centre whereat surgery was done, was outside the approved list of hospitals provided to the policy holder and, therefore, the claim is not payable. The complainant submitted that the company was not justified in repudiating the claim because the hospital where treatment was taken is a registered hospital with Government of Delhi. The complainant submitted that the claim be got settled at an early date.

3. Written replies were placed on record on behalf of the company. The insurance company had repudiated the claim only on the ground that eye surgery was got done in a hospital which was outside the approved list of hospitals provided to the policy holder along with the policy. During the course of hearing, the representative of the insurance company admitted that the claim is payable and it will be paid now. As a matter of fact, he promised to settle the claim within a week.

4. I have very carefully considered the submissions of the complainant and also perused the written replies placed on record on behalf of the insurer. After due consideration of the matter, I found that the insurance company was not justified in repudiating the claim only on the ground that surgery was got done in a hospital which was outside the approved list of hospitals given to the policy holder. The claim is otherwise admissible and payable and the same cannot be repudiated only on technical ground. Accordingly, Award is passed with the direction to the insurer to settle the claim and make the payment of Rs.18300/- along with penal interest @8% from the date of repudiation to the actual date of payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/03/RGI/10
In the matter of Shri Chander Mohan
Vs
Reliance General Insurance Company Limited

AWARD dated 19.10.2010 - Repudiation of mediclaim

1. This is a complaint filed by Shri Chander Mohan (herein after referred to as the complainant) against the decision of the Reliance General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that he filed a claim for his wife's cancer treatment on 06.10.2008 but the TPA M/S.E-Meditek Solution Private Limited, Gurgaon of Reliance General Insurance Company Limited denied the cashless facility stating that the cancer is not covered during the first year of the policy. When it was informed to the TPA that the complainant had taken Reliance Gold Plan mediclaim policy, the reimbursement relating to cancer is admissible in the first year of the policy. He further submitted that during the course of hearing, his wife Smt. Maya Devi was expired on 19.11.2008 even after taking all care. After performing all rituals ceremonies, he submitted all documents to the insurance company on 29.01.2009 at TPA, E-Meditek Solution Private Limited, Gurgaon by hand in person explaining everything. TPA staff first informed him that his claim is repudiated on 20.11.2008 due to late submission of documents under Clause No.3. The complainant submitted that no claim form or any other documents ere submitted to Reliance General Insurance Company Limited or E-Meditek, TPA, Gurgaon till 20.11.2008 then how the claim was repudiated? He explained all facts after the death of his wife and informed TPA's staff that he had submitted the claim today along with the original documents.

However, finally repudiation letter No.EMSL/NC/112008/00004223 dated 09.02.2009 was issued to him on 09.03.2009. He was informed by the coordinator that the case was re-opened on 04.03.2009. He requested the TPA and the insurer company for re-opening and reimbursement of the claim but no favourable reply was given. It is submitted by him that the company does not want to pay the claim which is genuine. It is further stated by the complainant that till 18.01.2009, he was busy with ceremony relating to the death of his wife. He is the only responsible person in the family and attended every job at the home. The claim was filed late due to the fact that he was busy on account of ceremony relating to death of his wife and attended the other important aspects of the family.

3. Written submissions were placed on record on behalf of the company wherein it was stated that the complainant obtained Reliance Healthwise policy valid from 30.11.2007 to 29.11.2008. On 06.10.2008, Smt. Maya Devi got admitted in Sir Ganga Ram Hospital as a case of Carcinoma Gall Bladder with Liver Metastasis. She underwent chemotherapy from 06.10.2008 to 07.11.2008 and preferred a claim of Rs.139119/- under the policy on 29.01.2009 to the TPA and thus the claim was filed beyond 30 days after the discharge from the hospital. The company endorsed the view of the TPA that the claim was rightly repudiated by TPA as the claim was filed beyond prescribed period. However, during the course of hearing, the representative of the company was somewhat considerate and agreed to waive the delay occurred in submission of the claim. Moreover, the representative of the company was also of the view that cancer treatment is also payable in the first year of the policy and thus agreed that the claim is payable despite the fact that there was delay in submission of the claim.

4. I have considered the submissions made by the complainant and have also perused the written replies placed on record on behalf of the company. I have considered the verbal arguments of both the parties. After due consideration of the matter, I hold that the company was not justified in repudiating the claim because delay in filing the claim was with justification. The complainant was busy in ceremonies relating to death of his wife and therefore, such delay cannot be intentional and was with bonafide reasons and can be waived. Moreover, the claim is otherwise admissible and genuine. Accordingly, Award is passed with the direction to the insurance company to make the payment of claim of Rs.1,39,119/- as submitted by the complainant along with penal interest @ 8% from the date of repudiation to the date of actual payment.
5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Vs
Reliance General Insurance Company Limited

AWARD dated 19.10.2010 - Repudiation of mediclaim

1. This is a complaint filed by Ms.Savita Bhasin (herein after referred to as the complainant) against the decision of the Reliance General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that she had taken comprehensive motor policy bearing cover Note No. 1306782334005878 in respect of her vehicle No. RJ 14 GB 6688 from Reliance General Insurance Company Limited. This vehicle met with an accident and the claim was lodged with the insurer. All required formalities were completed as desired by the Insurance Company but the company repudiated the claim mentioning the reason as under:

   > "On careful perusal of the surveyor report and other documents on record, it has been observed that Shri Salim was driving the vehicle at the time for accident and his driving license found to be fake after getting the same verified from concern authority."

3. She further stated that on receipt of repudiation letter, she immediately contacted RTO, Agra for verification of the license of Shri Salim. RTO, Agra confirmed that license is valid and in order. A copy of the verification report received from RTO, Agra has been placed on record. She again approached the insurance company along with verification report received from RTO, Agra for reconsideration of the claim. She sent reminders also but the insurance company was not interested to reconsider the case which has been closed on the invalid ground. She requested to this forum to instruct the insurance company to settle the legitimate claim.

4. Written submissions were placed on record on behalf of the company. During the course of hearing also, representative of the company argued that the license of Shri Salim who is driving the vehicle at the time of accident was found fake on verification. In fact, this was the only reason given by the company for repudiating the claim of the policy holder. The report received by the company from RTO, Agra is also placed on record. It has been stated in the reply that as per the Motor Vehicle Act and as per the terms and conditions of the policy, the claim cannot be admitted as the driving license of the driver who was driving at the time of accident is fake as per records.

5. I have considered the submissions of the complainant very carefully and have also perused the written submissions of the company placed on record particularly the record it had received from RTO, Agra on the basis of which the claim has been repudiated. I have also perused the records placed on record by the policy holders with regard to the certification of driving license of Shri Salim by RTO, Agra. After due consideration of the matter, I hold that the insurance company was not

justified in repudiating the claim because Shri Salim who was driving the vehicle at the time of accident was having valid license. The complainant had placed on record the certification of RTO, Agra with regard to the genuineness of the driving license of the driver. I find that the report placed on record by the company with regard to the driving license of the driver was incomplete. **In view of the fact that the RTO, Agra certified that the driving license of Shri Salim was issued by them and is valid, the company was not justified in repudiating the claim. The claim is otherwise admissible. The vehicle met with an accident and all formalities have been complied with by the policy holder. I, therefore, pass the Award with the direction to the insurance company to make the payment of Rs.60797/- less applicable policy clause and less salvage, if any, as assessed by the surveyor.**

6. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

7. Copies of the Award to both the parties.

Case No. GI/08/NIA/10
In the matter of Ms. Poonam Gupta
Vs
New India Assurance Company Limited

AWARD dated 19.10.2010 - Repudiation of the mediclaim

1. This is a complaint filed by Shri Manoj Gupta husband of the insured (herein after referred to as the complainant) against the New India Assurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of the mediclaim.

2. The complainant submitted that he had lodged a claim with Raksha TPA for the treatment of his wife but the claim was repudiated. It was further stated that she was admitted for pain in her stomach in Metro Hospital. She was treated there and discharged after 3 days. It has been stated further that there was no treatment for stone for which the claim was repudiated. During the course of hearing, the complainant vehemently argued that his wife was not treated for the stone. As a matter of fact, as per diagnosis conducted at AIIMS, no stone was found in the body. Since she was not treated for the stone in her body, the insurance company was not justified in repudiating the claim on that ground.

3. Written reply was given on behalf of the insurance company which is placed on record. M/S. Raksha TPA informed that the claim has been made non-tenable as the patient was admitted and diagnosed as a case of acute cholecystitis chocelithiasis and left lower zone peritonitis while as per policy terms and conditions this claims falls under two year exclusion clause 4.3(ix) as well as 4.1 – pre-existing as per history of patient and thus, the claim was not admissible. Even during the course of hearing, the representative of the company argued that since the claim has been made in the first year of the policy, the same is not

admissible as it has two years waiting period. He further argued that as per discharge certificate issued by the hospital, the complainant was diagnosed as a case of cholecystitis chocelithiasis and the reimbursement relating to treatment of stone in gall bladder is admissible only after two years of the policy. He also placed on record copy of the bill which has been submitted by the complainant to the insurance company.

4. I have considered the submissions of the complainant very carefully and have also perused the replies placed on record on behalf of the insurer. After due consideration of the matter, I hold that the insurance company was not justified in repudiating the claim because the policy holder did not lodge the claim with regard to the treatment of stone in gall bladder. The complainant might have been diagnosed as a case of stone in gall bladder but was not treated for the same. This fact was very much clear from the details of the expenses which are placed on record. Most of the expenses relate to investigations. Therefore, there is merit in the argument of the complainant during the course of hearing that since his wife was not treated for Stone in Gall bladder, nevertheless, she was treated in the hospital and various investigations were conducted, the company was not justified in repudiating the claim on the ground that reimbursement of the expenses relating to stone in gall bladder has two years waiting period in the policy. The claim was repudiated only on that ground. From the details of the claim, it is clear that she was not treated for the stone in gall-bladder. **Therefore, in my view, the claim is admissible and payable by the company. Accordingly, Award is passed with the direction to the company to make the payment of Rs.20739/- less Rs.501/-towards the cost of consumables = Rs.Rs.20238/-.**

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/20/RGI/10
In the matter of Shri Amit Gupta
Vs
Reliance General Insurance Company Limited

AWARD dated 25.10.2010 - Repudiation of mediclaim

1. This is a complaint filed by Shri Amit Gupta (herein after referred to as the complainant) against the decision of the Reliance General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that he was admitted in Pentamed Hospital on 10.11.2008 and discharged on 15.11.2008. On 11.11.2008, the hospital sent the fax to TPA, E-Meditek Solutions Ltd. But they could not receive it because there

was some fault in the fax machine. The complaint submitted that it was not his fault. He submitted further that he submitted all relevant documents to TPA and receipt was confirmed by the TPA and issued a letter dated 29.12.2008 asking for reasons for delay in submission of the documents. He sent hospital certificate and letter explaining the delay in submission of the documents. On 06.03.2009, he along with his father met the Branch Manager on 4.30 p.m. After listening to their problem, the Branch Manager instructed some Shri Nitin Thakur to clear their claim. They met Shri Nitin Thakur again on 23.03.2009 who promised to take up the matter. In fact, he was made to belief that cheque will be issued within a week. However on 06.07.2009, he received a letter from TPA stating that the claim is not payable as per terms and conditions of the policy Clause No.15 – "Fraudulent Claim".

3. Written detailed reply is placed on record received on behalf of the company wherein it has been stated that the complainant Shri Amit Gupta obtained Reliance Healthwise policy valid from 17.01.2008 to 16.01.2009. On 10.11.2008, Shri Amit Gupta got admitted in Pentamed Hospital as a case of enteric Fever with Dehydration. He remained there for 5 days from 10.11.2008 to 15.11.2008 for the treatment and preferred a claim of Rs.24765/- under the policy. On verification of the claim, it was found that there was gross variation between documents and patient statement, regarding the type of symptoms, duration of symptoms and the time of admission and furthermore there were no evidence of any treatment during the pre-hospitalization period. Moreover, there is no advice for admission in the hospital which clearly shows mis-representation of material fact from the hospital and the insured. The claim was repudiated by the TPA which is just and in accordance with the terms and conditions of the policy. It is stated that the complaint may be dismissed on the ground mentioned above.

4. I have considered the submissions of the complainant and have also perused the reply given by the company and also the reasons given for repudiation of the claim. After due consideration of the matter I hold that the company was not justified in repudiating the claim because the company had not established by any evidence that there was mis-representation of the material facts from the hospital and the insured. The claim has been repudiated on flimsy ground. All conditions for admission of the claim are fulfilled by the complainant. The late submission of the documents has already been waived by the company. The company had not given valid reasons for repudiating the claim. In my considered view, the claim is considerable and payable. Accordingly Award is passed with the direction to the insurer to make the payment of Rs.24765/- along with penal interest from the date of repudiation to the date of actual payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

In the matter of Shri Deepak Bansal
Vs
Oriental Insurance Company Limited

AWARD dated 25.10.2010 - Delay in settlement of Mediclaim

1. This is a complaint filed by Shri Deepak Bansal (herein after referred to as the complainant) against the Oriental Insurance Company Limited (herein after referred to as respondent insurance company) in respect of delay in settlement of Mediclaim.

2. The complainant submitted that he is having one mediclaim Policy No.215402/48/2009/3218 in the name of Jyoti Bansal and family. He had lodged a claim in the month of April,2009. After submission of all documents, he was informed in the month of July, 2009 that a cheque has been prepared and shall be sent to him in a day or two. However, inspite of many calls to the office of Alankit Healthcare TPA, he did not receive the payment. He also had a talk with Shri Chanderbhan who informed that cheque has been sent but the same was not received by him. However, it was also not confirmed that cheque has been encashed. He continued to make efforts for getting the payment. Ultimately he got the claim of Rs.48445/- in the month of January, 2010. He request that he be compensated for late receipt of the payment.

3. It has been stated on behalf of the company that the insured claim was already settled in the month of July, 2009. The cheque was also dispa5tched to him but in the month of January, 2010, a fresh cheque was issued in lieu of his earlier cheque which had become stale. His fresh cheque for Rs.48445/- was personally delivered to insured's husband Shri Deepak Bansal at his residence and he confirmed its receipt on mobile to the company's officer.

4. I have considered the submissions of the complainant and have also perused the reply as placed on record on behalf of the company and also verbal submissions made by the representative of the company. After due consideration of the matter, I find that there is delay in making payment of Rs.48445/- to the insured. The delay appears to be deliberate. The company had not placed on record any evidence of having dispatched the cheuqe as stated in the month of July, 2009. The company stated that a fresh cheque was issued in the month of January, 2010 in place of stale cheque. Thus, it is held that the company withheld the genuine payment of the insured and the insured needs to be compensated for the late receipt of payment. **Accordingly, Award is passed with the direction to the company to make the payment of penal interest @ 8% from 01.09.2009 to January, 2010.**

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/17/NIC/10
In the matter of Shri Mridul Kumar Agarwal
Vs
National Insurance Company Limited

AWARD dated 25.10.2010 - Repudiation of mediclaim

1. This is a complaint filed by Shri Mridul Kumar Agarwal (herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that his mediclaim policy is renewed with effect from 02.06.2009 to 01.06.2010. On 01.07.2009, he suffered severe pain in abdomen, urinary problem, high grade fever and vomiting and as Aastha Hospital located at nearby to his residence, he was rushed to this hospital for treatment. There the concerned doctor Dr.S.K.Jain examined him and diagnosed the ailment as UTI C MOD.DEHYDRATION C PRE-RENAL AZOTEMIA. He was admitted in the hospital for further treatment the same day. He was discharged from the hospital on 05.07.2009 and filed his claim for Rs.22807/- and Rs.2157/- on 16.07.2009 and on 11.09.2009 respectively to M/S. Alankit Health Care Ltd. The above claims were repudiated by TPA with the remarks that the treating hospital (Aastha Hospital), New Delhi which is outside the approval list of Delhi Hospital provided by DRO-II. Hence the claim is not payable. He submitted that he got the treatment in the hospital as it was near to his residence and there is an emergency for his admittance in that hospital. He submitted that there is no provision in the contract that the claim can be reimbursed only if the treatment is taken in a particular hospital. The procedure for payment of claim for treatment in approved hospital is a part of cashless treatment which is administered by TPA. The company was not justified in repudiating his claim. The decision of the company is baseless and unjustified. He requested this forum to get his claim settled.

3. Written reply is placed on record on behalf of the company. The company was represented at the time of hearing. During the course of hearing, it was argued by the representative of the company that the claim was not payable because treatment was not taken in a hospital which is approved by it. That is to say, the claim was repudiated only because the treatment was taken in a hospital other than the approved hospitals as per list.

4. I have very carefully considered the submissions of the complainant and also perused the written replies placed on record on behalf of the insurer. After due consideration of the matter, I found that the insurance company was not justified in repudiating the claim only on the ground that treatment was taken in a hospital which was outside the approved list of hospitals given to the policy holder. The

claim is otherwise admissible and payable and the same cannot be repudiated only on technical ground. **Accordingly, Award is passed with the direction to the insurer to settle the claim and make the payment of Rs.24964/- along with penal interest @8% from 11.09.2009 to the actual date of payment.**

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/35/NIC/10
In the matter of Shri Rajesh Gupta
Vs
National Insurance Company Limited

AWARD dated 27.10.2010 - Repudiation of mediclaim

1. This is a complaint filed by Shri Rajesh Gupta (herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that he has taken mediclaim policy No.360501/48/08/8500004048 from National Insurance Company Limited covering self, his father and mother along with his four children. He submitted that his policy is in force since 03.01.1999 without any gap. On 27.03.2009 his mother was hospitalized and operated for cataract at Kesar Hospital, Shalimar Bagh, Delhi which is not on panel for cashless facility. He filed a claim for reimbursement on 13.04.2009 with the Alankit Healthcare Limited, TPA. M/S.Alankit Healthcare Limited vide its letter 30.05.2009 stated that the claim is not payable as Kesar Hospital is not on panel for cashless and reimbursement. The complainant further stated that he had sent written complaint to Grievance Redressal Officer of the company on 17.06.2009 but there was no reply from that side. He requested this forum to get his claim settled.

3. Written replies were placed on record on behalf of the company. The insurance company had repudiated the claim only on the ground that treatment was taken in a hospital which was outside the approved list of hospitals provided to the policy holder along with the policy. During the course of hearing, it was argued by the representative of the company that the claim was not payable because treatment was not taken in a hospital which is approved by it. That is to say, the claim was repudiated only because the treatment was taken in a hospital other than the approved hospitals as per list.

4. I have very carefully considered the submissions of the complainant and also perused the written replies placed on record on behalf of the insurer. After due consideration of the matter, I found that the insurance company was not justified in repudiating the claim only on the ground that treatment was taken in a hospital which was outside the approved list of hospitals given to the policy holder. The

claim is otherwise admissible and payable and the same cannot be repudiated only on technical ground. **Accordingly, Award is passed with the direction to the insurer to settle the claim and make the payment of Rs.20654/- along with penal interest @8% from 03.06.2009 to the actual date of payment.**

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/24/NIA/10
In the matter of Shri Chander Kant Khandelwal
Vs
New India Assurance Company Limited

AWARD dated 25.10.2010 - Repudiation of mediclaim

1. This is a complaint filed by Shri Chander Kant Khandelwal (herein after referred to as the complainant) against the decision of the New India Assurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that he had approached this forum because M/S.Raksha TPA had repudiated his wife's claim though he had already submitted complete papers related to the claim. He submitted further that he filed all original papers/receipts relating to payment of Rs.1,77,000/-. Despite submitting original bills and receipt on demand, he had personally handed over the duplicate bills of various dates, break up of original bills to Dr.Anil vide Raksha TPA receipt dated 11.09.2009 but the claim has not been settled so far. It is a deliberate case of harassment. He requested that his claim be got settled at an early date. During the hearing also, it was found that original bills had been submitted to the TPA.

3. However, on behalf of the company, it has been stated that original bills have not been submitted and only duplicate bills have been submitted and, therefore, claim is not payable. The company informed the complainant on 30.10.2009 that it was informed to the complainant by the TPA that original documents with regard to the payment of hospital bill of Rs.1,77,000/- and original break up of main hospital bills are required for settling the claim.

   During the course of hearing, representative of the company was apprised of the fact that original bills/receipts were already placed on record in the file of the company and if so, then it was not proper to request the complainant to submit the original bills/receipt. But the representative of the company continued to argue that original bills and receipts have not furnished and the receipts furnished were duplicate and that is the reason the claim has not been settled so far.

4. I have considered the submissions of the complainant and have also perused the file fo the company and also considered verbal arguments of the representative of the company. After due consideration of the matter, I hold that the company was not justified in not settling he claim of the policy holder so far. Original bills and receipts were made available to the company by the insured. Even on demand duplicate bills and receipt were given to the company but the claim was not settled. The duplicate bills are as authentic as the original bills, therefore, even for arguments sake that original bills and receipts were not made available by the insured, the company ought to have settled the claim on the basis of duplicate bills/receipts because they were original and duplicate only due to the fact that original were issued earlier and subsequently duplicate bills were issued. In my view the company has not settled the claim of the complainant only on flimsy ground. I find the claim is genuine and is admissible. Accordingly, Award is passed with the direction to the insurance company to make the payment of Rs.1,77,000/- along with penal interest @ 8% from 13.10.2009 to the date actual payment is made.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/68/NIC/10
In the matter of Shri Sanjay Tyagi
Vs
National Insurance Company Limited

AWARD dated 15.11.2010 - Non-settlement of mediclaim

1. This is a complaint filed by Shri Sanjay Tyagi (herein after referred to as the complainant) against the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of non-settlement of mediclaim.

2. The complainant submitted that he was informed by the company vide letter No.360803/Med/09 dated 04.11.2009 that the company was unable to make the payment of mediclaim due to reason that the hospital where the treatment was taken by the complainant of his daughter was not in the approved list of hospitals. He requested that the company be directed to settle the claim. During the course of hearing the complainant stated that he had already been paid a sum of Rs.6758/- out of a total claim of Rs.10223/-. It has been stated by him that the company was not justified in making him reduced payment particularly the diagnostic charges of Rs.2660/- because such diagnosis related to the disease and moreover tests were conducted as per the direction of the treating doctor.

3. The representative of the company stated that the claim of the complainant was settled for a sum of Rs.6758/- which was already paid vide cheque No.883623 dated 22.04.2010 on account of treatment of Ms.Nupur Tyagi, daughter of the policy holder. As regards reduction out of the claimed amount, it has been stated that the diagnostic charges did not relate to the disease and the complainant had made excessive claim with regard to the room rent and the complainant is not entitled to Misc. charges Rs.40/- and also registration charges of Rs.50/-.

4. I have considered the submissions of the complainant and have also considered the verbal arguments of the representative of the company. After due consideration of the matter, I hold that the insurer was not justified in not making payment with regard to Misc. charges, registration fee and also expenses related to diagnostic charges because the same are payable. The diagnostic charges related to the disease and such tests were conducted at the instance of the treating doctor. Therefore, the same are payable by the company. **Accordingly, Award is passed with the direction to the company to make the payment of Rs.2660/- being lab. charges along with the penal interest @ 8% from 22.04.2010 till the time the payment is made and further interest @ 8% on Rs.9418/- with effect from 04.11.2009 to 22.04.2010.**

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/57/NIC/10
In the matter of Shri Vikas
Vs
National Insurance Company Limited

AWARD dated 15.11.2010 - Repudiation of mediclaim

1. This is a complaint filed by Shri Vikas (herein after referred to as the complainant) against the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant stated that his son was admitted in Kesar Nusing Home, Delhi which is approved by Delhi State Government on 22.07.2009 at 8.00 p.m. in emergency condition and discharged on 25.07.2009 at 10.00 a.m. The total expenditure incurred on treatment amounting to Rs.8558/-. He had claimed the reimbursement but his claim was not settled by the TPA on the ground that the hospital at which treatment was taken was not authorized for cashless facility and also for reimbursement of the claim. The complainant submitted that the claim is payable and he was not provided the list of hospitals where treatment is to be taken. Moreover, the hospital at which the treatment was taken is approved and is

a registered hospital by the Delhi State Government. The company was not justified in repudiating the claim.

3. The company's TPA has treated the case as no claim mainly because the hospital at which treatment was taken was not listed as per the list of the hospitals by the insurance company. During the hearing, the representative of the company also stated the same reasons for repudiating the claim.

4. I have very carefully considered the submissions of the complainant and also perused the written replies placed on record on behalf of the insurer. After due consideration of the matter, I find that the insurance company was not justified in repudiating the claim only on the ground that treatment was taken in a hospital which was outside the approved list of hospitals given to the policy holder. The claim is otherwise admissible and payable and the same cannot be repudiated only on technical ground. **Accordingly, Award is passed with the direction to the insurer to settle the claim and make the payment of Rs.8558/- along with penal interest @8% from the date of repudiation to the actual date of payment.**

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/301/ICICI Lombard/09
In the matter of Shri Sanjay Chadha
Vs
ICICI Lombard General Insurance Company Limited

AWARD dated 03.11.2010 - Non-settlement of mediclaim

1. This is a complaint filed by Shri Sanjay Chadha (herein after referred to as the complainant) against the ICICI Lombard General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of non-settlement of mediclaim.

2. The complainant submitted that on 27.11.2008, patient was down with fever and was prescribed medicine by family doctor Shri Subhash Arora. On 29.11.2008, patient suffered shivering at night. On 30.11.2008, family doctor advised some tests like Hematology, platelet count, SGPT, Widal, Urine) which were done at Delhi Diagnostic Centre and urine infection was diagnosed and medicine started. On 03.12.2008, patient was taken to Fortis/Escorts Faridabad and shown to Dr.Kesar/Dr.Thakuria in OPD. OPD doctors who advised immediate admission in hospital. Patient was admitted in the hospital where tests were done and doctors took four-five days to ascertain Acute Renal Failure disease due to Urine Tract Infection, DM and Dengue Fever and Bronchial Asthma. On 07.12.2008,

first dialysis was done as treatment and thereafter recovery started and patient was discharged on 12.12.2008. Last dialysis was done on 19.12.2008. On 23.01.2009, all documents and hospital bills as requested by Raksha TPA were submitted. Some more documents were required for settling the claim which were given but the claim has not been settled so far.

3. Written submissions were placed on record on behalf of the company. Its representative also attended the hearing and submitted that the claim of the complainant is under consideration. It has been stated that the complainant and his wife were covered under the group health insurance policy No.4015/0001070/02 issued to Apex Medical System Private Limited. The complainant's wife was hospitalized on 03.12.2008 and got discharged on 12.12.2008 and the claim was filed with Raksha TPA Pvt. Ltd. The said claim was closed by the TPA for the requirements of Certificate of treating doctor mentioning when the disease was diagnosed with OPD prescription and investigation reports. It has been submitted in the reply that the requisite documents were not made available to the insurer by the insured. On receipt of the documents, the claim will be settled by the TPA.

4. I have considered the submissions of the complainant very carefully and have also perused the replies placed on record on behalf of the company. I have also considered the verbal arguments of the representative of the company who stated during the course of hearing that the claim will be settled within 20 days. After due consideration of the matter, I hold that the company was not justified in not settling the claim so far. The claim is payable and the company ought to have settled the claim much earlier. **Accordingly, Award is passed with the direction to the company to make the payment of Rs.71291/-. The company is further directed to consider the claim of post-hospitalization expenses incurred by the insured as and when the same is put up before it.**

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/83/NIA/10
In the matter of Shri Ravi Shankar Sharma
Vs
New India Assurance Company Limited

AWARD dated 29.11.2010 - Repudiation of the mediclaim

1. This is a complaint filed by Shri Ravi Shankar Sharma (herein after referred to as the complainant) against the New India Assurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of the mediclaim.

2. The complainant submitted that the company had vindictive attitude while dealing with the claim of the policy holders. The company is deliberately repudiating the claim without citing proper reasons for the same. It has been submitted by him that he had taken mediclaim policy which is still continued after renewal for the last two years. He fell in the bathroom on 18.06.2009 and sustained injuries CLW scalp, 3 inches long and bleeded profusely. He was taken to hospital and was discharged on 18.06.2009 after symptomatic treatment and nine stitches on his scalp. He submitted relevant papers to the insurance company but the company had repudiated the claim on flimsy grounds stating that his injury was minor surgery. The company was in haste in repudiating his claim, the universal Medi-aid services Limited has issued him a repudiation letter dated 25.07.2009 citing observation "Not Admissible" He states that the claim has wrongly been repudiated by the insurance company. The TPA has shown a casual approach in this regard. He requested this forum to get his claim settled.

3. No written reply was given by the insurance company. However, during the course of hearing, the representative of the insurance company was present.

4. I have considered the submissions of the complainant and have also heard the representative of the company during the course of hearing. After due consideration of the matter, I hold that the company was not justified in repudiating the claim because the policy holder had taken the treatment on account of injury sustained by him due to fall in the bathroom for which hospitalization for 24 hours is not required. The claim was repudiated for wrong reasons. The claim is admissible and payable. Accordingly, Award is passed with the direction to the insurance company to make payment of Rs.5728/- along with penal interest @ 8% from 25.07.2009 to the date of actual payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/79/NIA/10
In the matter of Shri Rajendra Kumar Gupta
Vs
New India Assurance Company Limited

AWARD dated 29.11.2010 - Repudiation of the mediclaim

1. This is a complaint filed by Shri Rajendra Kumar Gupta (herein after referred to as the complainant) against the New India Assurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of the mediclaim.

2. The complainant submitted that the company was not justified in repudiating the mediclaim as the claim is admissible. It has been stated by him that the policy

holder had paid a sum of Rs.15600/- towards premium for a policy No.1250034093800000015 with effect from 01.08.2009 to 31.07.2010. He submitted that wife of the policy holder Smt. Garima Gupta who is covered in the policy became seriously ill on 18.08.2009 with sudden onset of pain in the right arm and shoulder accompanied with dizziness, vomiting, and numbness and sweating. She was rushed to Indraprastha Apollo Hospital, New Delhi and consulted a doctor who carefully examined her and prescribed certain medicines and asked the patient to strict bed rest. She had taken 2nd opinion of the doctor. Thereafter MRI was done. She was admitted in the hospital on 19.08.2009 under the supervision of Dr.M.S.Chaudhury of Appollo Hospital and was discharged on 22.08.2009. Claim was filed with the TPA on 28.08.2009 for Rs.71936/-. The claim was repudiated on 07.10.2009 stating therein that the treatment can be done on an OPD basis.

3. The company had not submitted any reply. However, the representative of the company attended the hearing who stated that the claim is payable and it appears to have been rejected on the wrong ground.

4. I have considered the submissions of the complainant and have also perused the reasons as given by the company for repudiating the claim. After due consideration of the matter, I hold that the company was not justified in repudiating the claim because it is for the treating doctor to decide as to whether treatment is to be taken in the hospital after admission or not. The insurance company does not have any role in this regard. The patient was admitted in the hospital and treated as per the advice of treating doctor. The claim is otherwise admissible and payable as has been admitted by the representative of the insurance company. Accordingly Award is passed with the direction to the insurance company to make payment of Rs.60386/- along with penal interest @ 8% from the date of repudiation, that is, 07.10.2009 to the date of actual payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/101/RGI/10
In the matter of Shri Sanjeev Kumar
Vs
Reliance General Insurance Company Limited

AWARD dated 29.11.2010 - repudiation of mediclaim

1. This is a complaint filed by Shri Sanjeev Kumar (herein after referred to as the complainant) against the decision of the Reliance General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant stated that he is 39 years old and is having two children and dependent parents. He had undergone bye pass surgery on 02.07.2009. He is insured since 2000 from National Insurance Company Limited and from 2007 to till date with Reliance General Insurance Company Limited. His policy No.28251040 7079 was issued for a sum assured of Rs.5.00,000/- under gold plan for the period 17.03.2009 to 16.03.2010. It was 3rd year renewal without break from Reliance General Insurance Company Limited itself. He had given details of the insurance with effect from 2000-01 to 2010-2011. He was insured up to 2007 with the National Insurance Company Limited. Thereafter he had taken insurance from the present insurer. The policy was without any break. The terms and conditions of the policy of Reliance General Insurance Company Limited also state that in the 3rd year of continuous renewal, pre-existing diseases are also covered. The claim falls in the 3rd year of the policy with the present insurer though he was insured since 2000 with the National Insurance Company Limited. His request for cashless facility was rejected without any valid reasons. He had submitted the claim with requisite documents on 14.07.2009. His claim has been repudiated by the TPA, Medi Assist India Pvt. Ltd. On 18.02.2010 which is neither signed nor stamped by any officer and the same is rejected on pre-existing ground. He stated that he never suffered from any disease since the inception of the policy with Reliance General Insurance Company Limited. When he was first seen in causality at Saroj Hospital and doctor on duty asked him about his past medical history, he told him that once in 2005 his blood pressure was high, which was mis-interpreted by another doctor, Dr.Dheeraj Malik, to whom he had never consulted as the case of hypertension since 2005. He had not taken any medicine whatsoever. The policy has been again renewed after his bye-pass surgery by Reliance General Insurance Company Limited of the same assured with extra premium without paying any claim. The complainant also produced a certificate dated 03.07.2009 which states that the policy holder was suffering from Hypertension only since 2005 and he is not suffering from CAD & DM. The complainant requested that his claim be got settled at an early date.

3. Written submissions are placed on record on behalf of the company wherein it has been stated that the complainant was admitted in Batra Hospital and remained there for two days and was discharged on 29.06.2009. During the treatment the claimed amount came at as Rs.3, 11,194/-. It was further submitted that the complainant complained of heaviness in chest since 26.06.2009 and diagnosed as a case of hypertension CAD-TVD for which CAG was done, which revealed triple vessel disease for which he was treated and was discharged on 29.06.2009. The complainant was again admitted on 29.06.2009 in Escorts Heart Institute and research centre for the treatment of TVD and CABG and discharged on 10.07.2009. The complainant denied of having any illness in the proposal form and also refused to confirm the exact duration of the history of HTN. The company stated that as per certificate dated 03.07.2009 issued by Shri Dhiraj Malik of Batra Hospital; it is clearly mentioned that complainant had a past history of hypertension since 2005. The claim of the complainant was repudiated under Condition No.2 and exclusion Clause No.1. In the repudiation letter, it has been stated that on the basis of the above mentioned fact and evidence, there was violation of policy condition No.2 “duty of disclosure” and present ailment found

to be pre-existing prior to the inception of the policy. Hence, it has been stated that the claim is repudiated.

4. I have considered the submissions of the complainant and have also perused the written reply as placed on record on behalf of the company. I have also perused the letter of the representative of the insurance company. After due consideration of the matter, I hold that the company was not justified in repudiating the claim on the ground of pre-existing and non-disclosure of facts because the policy holder was insured since 2000. He was insured with the National Insurance Company Limited from 2000-2001 to 2006-07 and thereafter from 2007-08 to 2010-2011 with the present insurer without any break. Therefore, there is no justification to state that the complainant was suffering from pre-existing disease. There is no evidence to this effect that the policy holder was suffering from this disease prior to 2000. Since policy is continued without any break, the policy holder is to be given the benefit of continuance of the policy. As a matter of fact, policy holder deserves to be given the benefit of continued insurance of the past years by earlier insurer. Accordingly it is held that the claim of the policy holder is admissible and allowable. **Accordingly, award is passed with the direction to the insurance company to make the payment of Rs.3,08,095/- along with penal interest @ 8% from the date of repudiation to the date of actual payment.**

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/80/RGI/10
In the matter of Shri Gabbar Singh
Vs
Reliance General Insurance Company Limited

AWARD dated 29.11.2010 - Non-settlement of mediclaim

1. This is a complaint filed by Shri Gabbar Singh (herein after referred to as the complainant) against the decision of the Reliance General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of non-settlement of mediclaim.

2. The complainant stated that he was suffering from chronic liver disease (Hepatitis B+)for the last 4 years. Doctor opined that the disease was untreated to Jaundice. He was admitted in the month of February, 2008 in Sukhmani Hospital for treatment of Chronic liver disorder. He had under gone treatment for 4 days from 11.02.2008 to 15.02.2008 and again admitted in Akash Hospital for four days from 21.02.2008 to 25.02.2008. he had incurred an expenditure of Rs.48473/-. He submitted claim to the insurance company two years back. He had sent reminders from time to time but every time objection were raised which were irrelevant and unjustified. He is class IV employee with heavy responsibilities

and having continuous pressure from the persons from whom he had borrowed money for his treatment and paying interest on the money. He requested that his claim be got settled at an early date.

3. Written submissions were placed on record on behalf of the company. It has been stated therein that the complainant has taken a Reliance Healthwise policy for the period 27.07.2007 to 26.07.2008. The complainant was admitted in Sukhmani Hospital from 11.02.2008 to 15.02.2008 and again on 21.02.2008 to 25.02.2008 in Aakash Hospital and claimed an amount of Rs.45563/-. It was further submitted that the patient is a known case of Cirrhosis of Liver with portal HTN with ascites with history of alcohol intake. The claim was repudiated under Clause 1 and 10 of the policy exclusion and under Condition No.15. It has been submitted on behalf of the company that the claim was repudiated as the complainant was a known case of Cirrhosis of Liver disease and on account of pre-existing disease and also the complainant was taking alcohol.

4. I have considered the submissions of the complainant and also perused the written replies as given by the insurance company which is placed on record. I have also considered the verbal submissions made by the representative of the insurance company. After due consideration of the matter, I hold that the company was not justified in repudiating the claim as the allegation of pre-existing disease and taking of alcohol at the time of taking the policy were not proved. As per discharge summary, complainant is not a case of pre-existing disease. As regards intake of liquor, the complainant stated before the doctor that he used to take liquor but he stopped consuming liquor. Therefore, it is not a case of pre-existing disease also and use of liquor. **Therefore, in my considered view, the claim of the policy holder is payable. Accordingly, award is passed with the direction to the insurance company to make the payment of Rs.45563/- to the complainant.**

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/197/UII/09
In the matter of Shri Sushil Narayan
Vs
United India Insurance Company Limited

AWARD dated 16.12.2010 - Inadequate settlement of Mediclaim

1. This is a complaint filed by Shri Sushil Narain (herein after referred to as the complainant) against the decision of United India Insurance Co. Ltd (herein after referred to as respondent Insurance Company) for inadequate settlement of Mediclaim.

2. Complainant stated that he had taken a policy bearing no. 221500/48/07/97/0000796 on 18.09.2007. He stated that while travelling to Panchgani Maharashtra on 08.06.2008 he and his family met with an accident and the passers took them to Bel Air Hospital at Panchgani. Due to non availability of CT Scan machine, there, they were transferred from Bell Air Hospital, Panchgani to Grant Medical Foundation Ruby Hall Clinic, Pune. They informed the TPA through the hospital but there was no response from the TPA. The Insurance Company was also informed orally. Since cash was not available, his brother came from Delhi to Pune by air since it was an emergency and after two days his wife and son were discharged from the Hospital, but since he got major head injury with Scalp Defect and required operation, his brother had taken him to Delhi and got operated at Ganga Ram Hospital. After recovery from the illness, after the operation, he submitted his claim to United India Insurance Co. Ltd. With all bills, X-ray, CT Scans and reports in original for a total claim of Rs.1,39,690.77/-. He had to present the claim with the TPA and he had got a sum of Rs.60962/- but could not get the balance amount so far. He stated that the entire amount was spent from their own pocket. This amount of Rs.60962/- was also received by way of cheques, are dated 04.02.2009 for an amount of Rs.52,892/-, another dated 31.01.2009 for an amount of Rs.8,070/-. He submitted further that he was not so far given the balance amount. TPA was causing mental harassment and he was suffering the financial loss. He requested that his claim may kindly be got settled at early date and he be given interest also.

3. During the course of hearing, the Insurance Company's representative stated that whatever amount was admissible to the complainant, the same was given and the Insurance Company had given explanation with regard to balance amount. It has been stated in the reply that Insurance Company had given reasons for not reimbursing various items such as Rs.3000/- related to Bel Air Hospital are not payable. Further, no breakup of hospital charges for a sum of Rs.8855/- were given and hence not payable. Mouth wash was not payable, Pharmacy breakup worth Rs.1205.36/- not available, Pharmacy Breakup worth Rs.1587/- and OT consumables breakup worth Rs.3480/- was not payable. Breakup worth Rs.13500/- was not satisfactory. There is no prescription for Rs.1000/- and hence not payable. Further, representative could not stated the reasons for not paying the balance amount of Rs.60,962/-. The Insurance Company had given explanation only with regard to Rs.37775/- but not with respect to remaining amount of Rs.40957/-.

4. I have considered the submissions of the complainant very carefully. I have also considered the verbal submissions of the representative of the Insurance Company and also the written reply placed on record on behalf of the Insurance Company. After due consideration of the matter, I hold that Insurance Company was not justified in not making the payment with regard to balance amount of Rs.78732/-. The complainant had submitted the claim for an amount of rs.139690/-, but it had paid only a sum of Rs.60962/-. It had not given worthwhile reasons for not making payment in respect of remaining amount of Rs.78732/-. The complainant had paid entire amount of treatment himself. Accordingly, in my considered view, the Insurance Company is under obligation to make full amount of the claim to the policy holder. Accordingly, Award is passed with a direction to the Insurance Company to make the payment of Rs.78732/- along with penal interest @ 8% from the date of payment of Rs.60962/- to the date of actual payment of balance amount.

5. Copies of the Award to both the parties.

Case No.GI/84/NIA/10
In the matter of Shri Narinder Kumar
Vs
The New India Assurance Company Limited

AWARD dated 10.12.2010 - Repudiation of Mediclaim

1. This is a complaint filed by Shri Narinder Kumar (herein after referred to as the complainant) against the decision of The New India Assurance Co. Ltd (herein after referred to as respondent Insurance Company) for Repudiation of Mediclaim.

2. Complainant stated that he had submitted his claim to the Insurance Company M/s. New India Assurance Co. Ltd.. He had taken a policy bearing no. 310600/34/08/11/00003673. He had submitted all requisite documents along with claim but the claim has not been settled so far. He requested that his claim be got settled at an early date. He had sought relief amounting to Rs.28207/-. The complainant stated that he had taken insurance since 1999 from Oriental Insurance Co. Ltd and had shifted to New India Assurance Co. Ltd from 2009-10 and since the insurance is continued since 1999 the claim is admissible and he deserved to be given benefit of continuity of the policy.

3. The Insurance Company had informed the insured vide its letter dated 03.02.2010 that it regrets to inform that since the Insurance was shifted from Oriental Insurance Co. and this was the first year of Insurance with the New India Assurance Co. Ltd the claim of cataract is rightly repudiated by M/s. Raksha TPA as it falls under exclusion clause no. 4.3 whereby certain disease/ailments/conditions have a waiting period of 2 to 4 years. Since the claim falls within 2 years of taking the policy from New India Assurance Co. Ltd the claim is not tenable.

4. I have considered the submissions of the complainant. I have also perused the letter of the Insurance Company informing the complainant about the non admissibility of the claim. After due consideration of the matter, I hold that the Insurance Company was not justified in not admitting the liability of the insured because the terms and conditions of the earlier insurer are same as that of the present insurer.Therefore, in my considered view, policy holder deserved to be given the benefit of continuity of the policy of earlier years by earlier insurer. Present insurer had given Cumulative Bonus to the insured. In my view, the claim is admissible. Accordingly, award is passed with a direction to the Insurance Company to make the payment of Rs.28207/- along with penal interest @ 8% from the date of repudiation to the date of actual payment.

5. Copies of the Award to both the parties.

Case No.GI/140/UII/10
In the matter of Shri Vijay Jain
Vs
United India Insurance Company Limited

AWARD dated 27.12.2010 - Repudiation of Mediclaim

1. This is a complaint filed by Shri Vijay Jain (herein after referred to as the complainant) against the decision of United India Insurance Co. Ltd (herein after referred to as respondent Insurance Company) for Repudiation of Mediclaim.

2. Complainant stated that he had taken a Mediclaim policy w.e.f. 26.02.2009 to 25.02.2009 from United India Insurance Co. Ltd. He had gone to Tirupati Balaji on 30.12.2009 and fell ill. First he got treatment at Ahmadabad and thereafter in Pune in Jahangir Hospital. East West TPA was informed about his illness and he was informed that in Jahangir Hospital, Pune had no cashless facility but there was another hospital in the Pune in the same premises namely N.M. Wadia hospital where cashless facility was available but the patient could not be admitted therein on account of doctors advice. After treatment all documents including, original bills were submitted to East West TPA. It had processed the claim but ultimately the claim was made as no claim and he was informed vide letter dated 20.03.2010. He submitted that he was not ill earlier except that in October 2009 he felt some giddiness due to sugar and he had taken treatment for 2 days and became alright. He had spent about 300000/- on treatment and he requested that his claim be settled and Insurance Company be instructed to make the payment of Rs.310000/- along with interest @18%.

3. Insurance Company had stated in his letter dated 21.04.2010 that patient Mr. Jain was admitted in Jehangir Hospital, Pune on 30.12.2009 and was discharged on 30.01.2010. His disease was diagnosed as (Lt) MCA Infarct with Hemorrhage, which is not covered in the 1st year of Mediclaim policy. Therefore, the claim was denied vide letter dated 23.02.2010 and the same was communicated to Mr. Jain. During the course of hearing also the representative of the Insurance Stated that claim is not payable because the disease is not covered in the first year of the policy.

4. I have considered the submissions of the complainant. I have also perused the Insurance Company's letter dated 21.04.2010 which is placed on record and also verbal arguments of the representative of the Insurance Company. After due consideration of the matter I hold that Insurance Company was not justified in repudiating the claim because the disease with which the patient was suffering is not a disease for which any waiting period is provided in the policy. The expenses relating to treatment of disease with which the patient suffered is payable and there is no waiting period. In my considered view, the claim of the complainant is admissible. Requisite documents for admissibility of the claim had been furnished on behalf of the policy holder. The claim had been repudiated on the basis of wrong reasons. Accordingly, Award is passed with a direction to the Insurance Company to make the payment of Rs.3,00,000/-.

5. Copies of the Award to both the parties.

Case No.GI/117/NIC/10
In the matter of Shri Nirala Shankar Aggarwal
Vs
National Insurance Company Limited

AWARD dated 16.12.2010 - Repudiation of Mediclaim

1. This is a complaint filed by Shri Nirala Shankar (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd (herein after referred to as respondent Insurance Company) for Repudiation of Mediclaim.

2. The complainant stated that his claim has not been settled merely because treatment was not taken from the hospital which had been approved by the Insurance Company. He had requested to get his claim settled at an early date. He submitted that Insurance Company was not justified to repudiate the claim only because the treatment was not taken in the hospital approved by it.

3. Written submissions are placed on record on behalf of the Insurance Company wherein it has been submitted that the treatment has been taken by the insured at Nirmal Hospital, New Delhi, which is outside the approved list of Delhi Hospitals as provided to the insured by the DRO-II and that is why the claim is not admissible under the policy imposed clause. Since on the basis of Mediclaim policy clause, the claim is admissible as per terms and conditions the same has been informed to the insured about the fact of the claim.

4. I have considered the submissions of the complainant. I have also perused the written submissions as placed on record on behalf of the Insurance Company which stated therein the reasons for inadmissibility of the claim. After due consideration of the matter I hold that the Insurance Company was not justified in repudiating the claim only on the ground that treatment was taken in the hospital which was not approved by it. The hospital at which treatment was taken fulfills the requisite conditions for admissibility of the claim. Therefore, in my considered view the claim is payable. Accordingly, award is passed with a direction to the Insurance Company to make the payment of Rs.36223/- along with penal interest @8% from the date of repudiation to the date of actual payment.

5. Copies of the Award to both the parties.

Case No.GI/86/NIC/10
In the matter of Shri Rama Nand Sharma
Vs
National Insurance Company Limited

AWARD dated 10.12.2010 - Repudiation of Mediclaim

1. This is a complaint filed by Shri Rama Nand Sharma (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd (herein after referred to as respondent Insurance Company) for repudiation of Mediclaim.

2. Complainant stated that all requisite documents have been submitted to Alankit Health Care Ltd. i.e. TPA. He had also approached the Grievance Cell of the Insurance Company but the claim has not been settled. He had approached many times to the TPA but all in vain. Therefore it has been requested by him to this forum to get his claim

settled at an early date. As per Insurance Company rule cashless, reimbursement both facilities are available in the policy.

3. The Insurance Company had submitted written submissions dated 29.03.2010 wherein it has been submitted that the Insurance Company had issued policy to the insured bearing no. 360304/48/08/8500001572 in favour of the insured for period of 1 year i.e. from 21.11.2008 to 20.11.2009. The insured had preferred the claim directly to the TPA i.e. M/s. Alankit Health care Limited which repudiated the claim vide their letter dated 28.10.2009 on the ground that the hospital where the treatment was taken is outside the list of approved hospital in Delhi. The claim was reconsidered and it was observed that the Hospital i.e. Avantika Hospital, Rohini was approved for 7 beds as per the Registration Certificate. As per policy condition the hospital should have atleast 15 patient beds whereas in this case the hospital was approved for 7 beds thus the claim was rightly repudiated by the TPA.

4. I have considered the submissions of the complainant. I also perused the written submissions which are placed on record. After due consideration of the matter I hold that the Insurance Company was not justified in repudiating the claim because the hospital at which treatment was taken admittedly is registered with State Government, therefore there is no requirement of 15 beds where the hospital is registered. The Hospital must be either registered or atleast have 15 beds and the hospital falls under the condition no. 1. In my considered view the claim is admissible and payable. The claim which is payable and admissible cannot be rejected merely on technical grounds that treatment was not taken in approved list of hospital. Accordingly, Award is passed with a direction to the Insurance Company to make the payment of Rs.23986/-.

5. Copies of the Award to both the parties.

Case No.GI/105/NIC/10
In the matter of Shri Om Prakash
Vs
National Insurance Company Limited

AWARD dated 16.12.2010 - Repudiation of Mediclaim

1. This is a complaint filed by Shri Om Prakash through Shri M. Malhotra his employer (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd (herein after referred to as respondent Insurance Company) for repudiation of Mediclaim.

2. Complainant stated that it has Mediclaim group policy bearing no. 361001/46/08/8500000255 taken by M/s. Forest Fern Hospitality Pvt. Ltd. For the period 15.01.2009 to 14.01.2010. Under this group policy one of the employee Shri Om Prakash Malhotra is insured along with his son Shri Anil Kumar for this period. On 21.02.2009 insured Shri Anil Kumar son of the complainant admitted in emergency conditions in the Khandelwal Hospital & Urology Centre at B-16, East Krishna Nagar, Delhi on account of pain in whole abdomen specially in both flanks with vomiting. He

got discharged from the hospital on 27.02.2009. After the discharge of Shri Anil Kumar, Shri Om Prakash had claimed amount of Rs.33786/- from National Insurance Company Ltd on 20.03.2009 with medical bills, medical reports, X-ray film, Discharge summary, ECG etc. After some days of filling of the claim for payment, the insured received a letter that his claim was denied by TPA M/s. Genins India TPA Ltd. Of National Insurance Company Ltd on the ground that the said hospital is not included in the panel list of hospitals for National Insurance Co. Ltd Delhi. He further submitted that Insurance Company is intentionally denying the claim of the insured because the said hospital is very much in the list of the National Insurance Co. Ltd. And the therefore, the insured is entitled to be reimbursed the amount. He requested that his claim be got settled at an early date.

3. The Insurance Company was represented by its official on the date of hearing but stated that the claim is not payable because the treatment was not taken in a hospital which is listed in the panel of hospitals for Delhi.

4. I have considered the submissions of the complainant. I also considered the verbal arguments of the representative of the Company. After due consideration of the matter I hold that Insurance Company was not justified in repudiating the claim on the ground that the treatment was taken in a hospital which is not listed in the panel for treatment. The representative of the Insurance Company had not given any other reason for not allowing the claim. In my considered view the claim is payable as the treatment was taken in a hospital which was registered and the claim is payable and admissible. Accordingly, Award is passed with a direction to the Insurance Company to make the payment of Rs.33786/- along with penal interest @8% from the date of repudiation i.e. 26.04.2009 to the actual date of payment.

5. Copies of the Award to both the parties.

Case No.GI/94/NIC/10
In the matter of Shri Rajesh Aggarwal
Vs
National Insurance Company Limited

AWARD dated 16.12.2010 - Repudiation of Mediclaim

1. This is a complaint filed by Shri Rajesh Aggarwal (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd (herein after referred to as respondent Insurance Company) for repudiation of Mediclaim.

2. Complainant stated that his claim was repudiated only because the treatment was taken in a hospital which is not listed in the approved list of hospitals of Delhi.

3. Insurance Company had submitted written submissions which are placed on record wherein it has been stated that while scrutinizing the claim documents it was observed that the expenses incurred during the hospitalization pertains to Nav Jeevan Hospital, New Delhi which is outside the approved list of Hospitals as provided by the Insurance Company and that is why the claim was repudiated.

4. I have considered the submissions of the complainant. I have also perused the reply of the Insurance Company stating therein the reasons for not admitting the claim. After due consideration of the matter I hold that the Insurance Company was not justified in denying the claim of the complainant only on the technical ground. The hospital at which treatment was taken is registered one and the claim is reimbursable for the treatment even if the same is not listed in the panel of hospitals. The claim otherwise admissible and payable cannot be denied on technical grounds. Accordingly, Award is passed with a direction to the Insurance Company to make the payment of Rs.21598/- along with penal interest @8% from the date of repudiation to the actual date of payment.

5. Copies of the Award to both the parties.

Case No.GI/81/Reliance/10
In the matter of Shri Pawan Kumar
Vs
Reliance General Insurance Company Limited

AWARD dated 16.12.2010 - Rrepudiation of Mediclaim

1. This is a complaint filed by Shri Pawan Kumar (herein after referred to as the complainant) against the decision of Reliance General Insurance Co. Ltd (herein after referred to as respondent Insurance Company) for repudiation of Mediclaim.

2. Complainant stated that he was hospitalized from 04.04.2008 to 08.04.2008 in North Delhi Nursing Home for the treatment. At that time he was not able to take action for Mediclaim and his family members were not well versed with the policy that is why he could not inform the Insurance Company in time i.e. within the time as stipulated in the policy and policy terms and conditions. When he recovered from the illness he told his wife about the policy and then she met with the agent on 20.04.2008 and she was told by the agent that the claim is reimbursable therefore after that Insurance Company was informed of the claim. He submitted the file for reimbursement on 05.07.2007 but the TPA states that claim was not intimated late and therefore the claim is not payable. He also submitted complaint to the Grievance Cell but no reply was received from the Grievance redressal cell also. He requested to get the claim settled at an early date.

3. The Insurance Company informed vide its letter dated 01.08.2008 to the insured that the claim was made late, no timely information was given to the Insurance Company. Documents were also received late i.e. to say the claim was not timely made and therefore the claim is not payable. Insurance Company also placed on record written submissions wherein it has been submitted that the complainant had obtained Reliance Healthwise policy bearing 282550003892 from period 28.07.2007 to 27.07.2008. The complainant was admitted in the hospital on 04.04.2008 for DM, UTI, Lft Kidney Atrophy and was discharged on 08.04.2008 from North Delhi Nusrsing Home. The claim was submitted for an amount of Rs.26,977/-. The complainant had submitted documents on 07.07.2008 i.e. there was delay of about 3 months. It has been submitted further that the policy is with respect to certain terms and conditions and the complainant is required to intimate the Insurance Company within 7 days from the date of admissions as stated under claim procedure clause 1 and the documents for the same are supposed to be

submitted within 30 days from the date of discharge. The gist of the argument of the Insurance Company is that the complainant had intimated the Insurance Company late and also submitted documents late by 3 months and therefore claim is not payable.

4. I have considered the submissions of the complainant. I have also perused the reply as given by the Insurance Company. I have also gone through the repudiation letter. After due consideration of the matter I hold that the Insurance Company was not justified in repudiating the claim only on account of technicalities. The complainant had narrated the circumstances under which claim was filed late. The insured had taken policy since 2004 to December 2007 with New India Assurance Co. Ltd. And renewed the policy w.e.f. 28.07.2007 to 27.07.2008 with Reliance General Insurance Co. Ltd. In my considered view the claim is payable as the policy is continued for the last 5 years. The continuity benefits are to be allowed by the present insurer because there is no break in the policy since its inception. Accordingly, Award is passed with the direction of the Insurance Company to make the payment of Rs.26977/- along with penal interest @ 8% from the date of repudiation (01.08.2008) to the actual date of payment.

5. Copies of the Award to both the parties.

Case No. GI/53/NIC/10
In the matter of Shri Arun Parti
Vs
National Insurance Company Limited

AWARD dated 01.12.2010 - Repudiation of mediclaim

1. This is a complaint filed by Shri Arun Parti (herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that he was admitted in Kesar Nursing Home approved by Delhi Government on 30.05.2009 at 12.50 p.m. in emergency condition and discharged on 03.06.2009 at 10 a.m. Total expenses of hospital was Rs.20751/-. He made written representation to the Grievance Redressal Officer of the insurance company but had not received any reply. On admission, he had informed the Alankit Healthcare (TPA) on customer care. He was informed that though the hospital was on their panel but the same was not authorized for cashless facility and he was advised that bills may be submitted for reimbursement after discharge from the hospital. He submitted all document in original with Alankit Healthcare (TPA) after discharge from hospital. He could not get satisfactory reply in spite of repeated telephonic requests with the TPA as well as with the National Insurance Company. However, on 06.10.2009, he received a letter from the Insurance Company stating that his claim is closed by putting false and baseless allegations. He is having Parivar mediclaim policy from the National Insurance Company for the last 5 years without any break. As per guidelines of the insurance company for mediclaim, they are entitled for the cashless treatment in the network hospital and reimbursement in any registered

hospital. Therefore, denial by the insurance company is totally baseless and irrational.

3. The insurance company repudiated the claim as treatment was not taken in the network hospital. During the course of hearing also, it was stated by the representative of the insurance company that since treatment was not taken in the approved hospital, the claim was denied.

4. I have very carefully considered the submissions of the complainant and also perused the written replies placed on record on behalf of the insurer. After due consideration of the matter, I found that the insurance company was not justified in repudiating the claim only on the ground that treatment was taken in a hospital which was outside the approved list of hospitals given to the policy holder. The claim is otherwise admissible and payable and the same cannot be repudiated only on technical ground. Accordingly, Award is passed with the direction to the insurer to settle the claim and make the payment of Rs.20751/-- along with penal interest @8% from the date of repudiation to the actual date of payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/54/NIC/10
In the matter of Shri Rakesh Kumar Jain
Vs
National Insurance Company Limited

AWARD dated 01.12.2010 - Repudiation of mediclaim

1. This is a complaint filed by Shri Rakesh Kumar Jain (herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that he had not taken a single claim under the policy. The claim is only for Rs.10750/- which was incurred for his cataract surgery performed on 03.09.2008. He paid the bill to the hospital and claimed reimbursement from the insurance company. The insurance company replied vide its letter dated 25.11.2008 stating that this claim is not being entertained, since the hospital where this surgery was performed is not empanelled with the insurance company as the panel hospital for cashless treatment. He further stated that he is not asking for cashless treatment but is asking for reimbursement of the expenses incurred.

3. Written replies were placed on record on behalf of the company. The insurance company had repudiated the claim only on the ground that treatment was taken in

a hospital which was outside the approved list of hospitals provided to the policy holder along with the policy.

4. I have very carefully considered the submissions of the complainant and also perused the written replies placed on record on behalf of the insurer. After due consideration of the matter, I found that the insurance company was not justified in repudiating the claim only on the ground that treatment was taken in a hospital which was outside the approved list of hospitals given to the policy holder. The claim is otherwise admissible and payable and the same cannot be repudiated only on technical ground. Accordingly, Award is passed with the direction to the insurer to settle the claim and make the payment of Rs.10750/- along with penal interest @8% from the date of repudiation to the actual date of payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/52/NIC/10
In the matter of Smt. Summa Suresh
Vs
National Insurance Company Limited

AWARD dated 01.12.2010 - Repudiation of mediclaim

1. This is a complaint filed by Smt. Summa Suresh (herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that her son admitted in Kesar Nursing Home approved by Delhi Government on 11.05.2009 at 6.40 a.m. in emergency condition and discharged on 13.05.2009 at 2 p.m. Total expenses of hospital was Rs.21918/-. She made written representation to the Grievance Redressal Officer of the insurance company but had not received any reply. On admission, she had informed the Alankit Healthcare (TPA) on customer care. She was informed that though the hospital was on their panel but the same was not authorized for cashless facility and she was advised that bills may be submitted for reimbursement after discharge from the hospital. She submitted all documents in original with Alankit Healthcare (TPA) after discharge from hospital. She could not get satisfactory reply in spite of repeated telephone requests with the TPA as well as with the National Insurance Company. She further submitted that as per guideline of Insurance Company for mediclaim, we are entitled for the cashless treatment in the network hospital and for reimbursement in any registered hospital/Nursing home which should have at least 15 indoor beds. Therefore, the

denial by the Insurance Company is totally baseless and irrational. She requested this forum to get her claim settled.

3. The insurance company had repudiated the claim only on the ground that treatment was taken in a hospital which was outside the approved list of hospitals provided to the policy holder along with the policy.

4. I have very carefully considered the submissions of the complainant and also perused the written replies placed on record on behalf of the insurer. After due consideration of the matter, I found that the insurance company was not justified in repudiating the claim only on the ground that treatment was taken in a hospital which was outside the approved list of hospitals given to the policy holder. The claim is otherwise admissible and payable and the same cannot be repudiated only on technical ground. Accordingly, Award is passed with the direction to the insurer to settle the claim and make the payment of Rs.21918/- along with penal interest @8% from the date of repudiation to the actual date of payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/56/NIC/10
In the matter of Shri Pinku Shah
Vs
National Insurance Company Limited

AWARD dated 01.12.2010 - Repudiation of mediclaim

1. This is a complaint filed by Shri Pinku Shah (herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that he was admitted in Kesar Nursing Home approved by Delhi Government on 03.06.2009 at 9 a.m. in emergency condition and discharged on 06.06.2009 at 10 a.m. Total expenses of hospital was Rs.28491/-. On admission, he had informed the Alankit Healthcare (TPA) on customer care. He was informed that though the hospital was on their panel but the same was not authorized for cashless facility and he was advised that bills may be submitted for reimbursement after discharge from the hospital. He submitted all documents in original with Alankit Healthcare (TPA) after discharge from hospital. He could not get satisfactory reply in spite of repeated telephonic requests from the TPA as well as from the National Insurance Company. As per guidelines of the insurance company for mediclaim, he was entitled for the cashless treatment in the network hospital and for reimbursement in any

registered hospital. Therefore, denial by the insurance company is totally baseless and irrational.

3. The insurance company repudiated the claim as treatment was not taken in the network hospital. During the course of hearing also, it was stated by the representative of the insurance company that since treatment was not taken in the approved hospital, the claim was denied.

4. I have very carefully considered the submissions of the complainant and also perused the written replies placed on record on behalf of the insurer. After due consideration of the matter, I found that the insurance company was not justified in repudiating the claim only on the ground that treatment was taken in a hospital which was outside the approved list of hospitals given to the policy holder. The claim is otherwise admissible and payable and the same cannot be repudiated only on technical ground. Accordingly, Award is passed with the direction to the insurer to settle the claim and make the payment of Rs.28491/-- along with penal interest @8% from the date of repudiation to the actual date of payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/15/RGI/10
In the matter of Shri Rajat Kumar Mathur
Vs
Reliance General Insurance Company Limited

AWARD dated 01.12.2010 - Rrepudiation of mediclaim

1. This is a complaint filed by Shri Rajat Kumar Mathur (herein after referred to as the complainant) against the decision of the Reliance General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that he had taken a mediclaim policy from Reliance General Insurance Company Limited on 28.03.2009(Policy No.282510409113). He submitted further that his last policy was from National Insurance Company Limited. The risk date started from 08.04.2008 till 07.04.2009. His son Vihaan Mathur was admitted to Narinder Mohan Hospital on 12.04.2009. The hospital accepted the policy and started treatment and matter was then referred to TPA and TPA had asked for ID-proof, photograph, last medical policy details etc. TPA rejected the claim compelling him to make cash payment at the hospital. It is submitted by him that since the treatment was done during the currency of the policy, the company should have made the payment. He was informed that the claim is not payable as the policy has not completed 30 days. He had submitted documents thrice but his claim was not settled.

3. Written submissions are placed on record on behalf of the insurance company wherein it has been stated that complainant Shri Rajat Kumar Mathur obtained Reliance Health wise Silver policy valid from 28.03.2009 to 27.03.2010 covering himself along with spouse and son. On 12.04.2009, his son Master Vihaan Mathur got admitted in Narinder Mohan Hospital and Research Centre, Ghaziabad as a follow up case of tuberculosis with Acute Gastroenteritis with some dehydration. He remained there for the treatment and discharged on 14.04.2009. To ascertain the admissibility of the claim, the complainant was asked to submit certain documents. During the course of hearing, representative of the company stated that the claim was rejected for want of submission of certain documents. That is to say, requisite documents have not been made available and, therefore, the claim was rejected. In case documents are submitted, claim may be examined on merits. Moreover, the company has submitted its vague reply. However, policy holder stated that all original documents were already submitted for admissibility of the claim. The representative of the company was required to submit the report after w week. It is to mention here that the date of hearing was 22.10.2010 but the company did not submit any report further in this matter.

4. I have considered the submissions of the complainant very carefully and have also perused the written reply submitted on behalf of the company as placed on record till 21.10.2010 and also noted the fact that the company had not submitted its reply within a week as promised by its representative on the date of hearing. After due consideration of the matter, I hold that the claim is admissible and the company is liable to make the payment. The complainant had already submitted requisite documents as had been stated by him in presence of the representative of the insurance company. Accordingly, Award is passed with the direction to the insurance company to make the payment of Rs.8268/- along with penal interest @ 8% from 09.10.2009 to the date of actual payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/49/RGI/10
In the matter of Shri Vijay Priya
Vs
Reliance General Insurance Company Limited

AWARD dated 01.12.2010 - Repudiation of mediclaim

1. This is a complaint filed by Shri Vijay Priya (herein after referred to as the complainant) against the decision of the Reliance General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that he had lodged the claim with reference to Reliance Health wise Policy which he had taken from Reliance General Insurance Company Limited. He further submitted that he had lodged the claims on 14.08.2008, 18.10.2008 and 10.11.2008. The claims were lodged for Brain surgical treatment of his wife Smt. Seema in Dr.Ram Manohar Lohia Hospital at New Delhi. The claims were lodged for a total sum of Rs.56318/- along with all documents. He approached the company's TPA for early settlement of the claim. He also visited personally on 18.10.2008, 10.11.2008 and on 20.12.2008 to the TPA office at Gurgaon and lodged complaints in writing. However, all of a sudden on 22.11.2008, he got 4 letters in one envelope all dated 13.12.2008 wherein he was required to submit all post policy documents. He made the compliance on 29.12.2008. He again pursued the matter but of no use. However, the claim was repudiated stating that "She was admitted in the hospital for the treatment of rt.petrous hemangioma where pt. has h/o symptoms from feb.2007 (as per reply sent by him) whereas reliance policy starts from 20.03.2007 which makes it pre-existing disease. Previous policies cannot be considered in case of pre-existing disease. Therefore, claim is not payable."

   The complainant further submitted that his wife first consulted the doctor on 22.06.2008 in Shastri Hospital, Shakur Pur, Delhi. She felt dizziness and fell on the bed. Immediately after sipping a glass of water with glucose she felt all right. He requested that his claim be got paid at an early date.

3. Written submissions were placed on record on behalf of the company dated 04.11.2010 wherein it was stated that the complainant had obtained Reliance Healthwise policy valid from 20.03.2008 to 19.03.2009 covering himself along with his spouse and two children. On 22.06.2008, Smt. Seema wife of the complainant got admitted in Shastri Hospital as a case of right side petrous meningioma. She remained there for 3 days from 22.06.2008 to 25.06.2008 for the treatment and preferred a claim of Rs.18,561/- under the policy. It was found that the patient had symptoms since February, 2007, that is, prior to the inception of the policy which shows that the disease was pre-existing. It has quoted clause (1) of the policy with regards to the pre-existing disease. Hence the claim was repudiated by the TPA which is just and in accordance with the terms and conditions of the policy.

4. I have considered the submissions of the complainant very carefully and have also perused the written submissions as placed on record on behalf of the company. After due consideration of the matter, I hold that the company was not justified in repudiating the claim because the complainant had taken policy since 2004. He had taken the policy with effect from 21.03.2004 to 20.03.2007 from the National Insurance Company Limited and from 21.03.2007 to 20.03.2009 from Reliance General Insurance Company Limited. Therefore, arguments of the company for repudiation of claim that it was a case of pre-existing disease are not correct. Since policy is continued since 21.03.2004, the claim cannot be rejected on the ground of pre-existing disease, even if, she was suffering from the disease since February, 2007. In my considered view, claim is admissible and insurance

company is under obligation to bear the liability. **Accordingly, Award is passed with the direction to the insurance company to make payment of Rs.56318/- along with penal interest @ 8% from January, 2009 to the date of actual payment.**

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/48/NIA/10
In the matter of Shri Surindar Kumar Sikri
Vs
New India Assurance Company Limited

AWARD dated 02.12.2010 - Non-settlement of the mediclaim

1. This is a complaint filed by Shri Surindar Kumar Sikri (herein after referred to as the complainant) against the New India Assurance Company Limited (herein after referred to as respondent insurance company) in respect of non-settlement of the mediclaim.

2. The complainant submitted that in the morning of 30.12.2008, he was returning by bus from Faridabad to Janak Puri, New Delhi. On the way to his residence, he felt uneasy and uncomfortable with sudden blurring of his vision. He had rushed to Dr.Shashi Mohan who checked him up and advised him the admission in hospital as early as possible. Accordingly, he got himself admitted in Max Heart Hospital on 30.12.2008 from where he was discharged on 31.12.2008. He was never hospitalized before 30.12.2008 in his life. After getting discharged from the hospital and after getting subsequent consultation from the doctor, he submitted mediclaim papers on 16.01.2009. He was required to submit further documents though he had submitted original papers earlier. He had received an amount of Rs.1500/- through cheque dated 31.03.2009 out of total claim of Rs.22204/-. After his verbal requests and letters, the company did not tell him how his claim was reduced to Rs.1500/-. He requested the company to reconsider his claim. He had requested this Forum to get his balance amount of Rs.20704/- paid. It is further submitted that after the patient is admitted in the hospital, it is the doctor who is to advise what tests to be done and the patient had no say in the doctor's prescription.

3. The company had submitted that investigations carried out by it and found that hospitalization was not necessary. It is found that the patient was hospitalized only for investigation purposes. Accordingly, it was opined that since hospitalization was not necessary, such claims are outside of LIC staff mediclaim policy purview vide exclusion clause 4.10.1. Hence the claim for hospitalization

only for investigation purposes is not admissible. However, Rs.1500/- may be paid for ultrasound as per clause 0.5.17 out of total claim of Rs.22204/-.

4. I have considered the submissions of the complainant and have also perused the written replies as placed on record on behalf of the company. After due consideration of the matter, I hold that the company was not justified in restricting the claim of the complainant to Rs.1500/- out of the total claim of Rs.22204/- because under the circumstances narrated by the complainant of his admission in the hospital, it was just and fair. He was advised by the doctor to get admission in the hospital. Since he was admitted in the hospital by the advice of the doctor and the hospitalization was more than 24 hours, the company is under obligation to make the payment and to meet the liability, that is, expenses incurred by the policy holder. **Accordingly, Award is passed with the direction to the insurance company to make the payment of Rs.20704/- along with penal interest @ 8% from 31.03.2009 to the date of actual payment.**

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/01/RGI/10
In the matter of Shri Onkar Singh
Vs
Reliance General Insurance Company Limited

AWARD dated 03.12.2010 - Non-settlement of mediclaim

1. This is a complaint filed by Shri Onkar Singh (herein after referred to as the complainant) against the decision of the Reliance General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of non-settlement of mediclaim.

2. The complainant submitted that he had taken mediclaim policy No.282560000905 from Reliance General Insurance Company Limited for Rs.3,00,000/- with effect from 30.03.2008 to 29.03.2009. He had sudden pain in his chest on 16.05.2008 and he consulted the doctor who advised him to consult heart specialist. Accordingly, he got himself examined on 16.05.2008 at G.B.Pant Hospital, Delhi and got treatment. The expenses for the treatment amounted to Rs.1,78,800/-. He had submitted requisite documents to TPA E-Meditek Solutions Ltd. He was further advised to submit the documents which were already submitted. He submitted all requisite documents but the company had not settled the claim so far. He requested that his claim be got settled at an early date as he had borrowed money for getting his treatment.

3. The company received the claim papers on 26.05.2008. The company vide its letter dated 31.05.2008 had repudiated the claim on the ground that necessary documents were not submitted by the complainant. During the course of hearing

on 18.10.2010, the representative of the company further argued that the claim could be examined in case documents are provided. It was also required by the representative of the company that if the policy holder submitted evidence for insurance of earlier period, it could settle the claim of the complainant.

The policy holder was directed to submit evidence for insurance of earlier period within the short time. As a matter of fact, the policy holder submitted evidence of insurance of earlier period on 30.10.2010 but the representative of the company could not submit the report as promised by him on the date of hearing on 18.10.2010 to submit report after a month. Accordingly the complaint is being disposed of after considering the entire facts on record. The policy holder also submitted evidence of insurance of earlier period in this office also which shows that the insurance has been taken with effect from 30.03.2000 to 29.03.2008 without any break.

4. I have considered the submissions of the complainant very carefully and have also perused the representation letter of the company. After due consideration of the matter, I hold that the company was not justified in repudiating the claim of the complainant. There is no reason for me not to believe on the submissions of the complainant that he had submitted all requisite documents for settling the claim to the TPA of the insurance company. The company had not submitted its reply despite the assurance given by the representative of the company during the course of hearing. The claim is payable and the company had rejected the claim only on technical ground that requisite documents were not submitted. The claim is admissible and payable. Accordingly, Award is passed with the direction to the company to make the payment of Rs.1,78,800/- along with penal interest @ 8% from 31.12.2008 to the date of actual payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

7.

Case No. GI/100/RGI/10
In the matter of Shri Kewal Issar
Vs
Reliance General Insurance Company Limited

AWARD dated 03.12.2010 - Partial settlement of mediclaim

1. This is a complaint filed by Shri Kewal Issar (herein after referred to as the complainant) against the decision of the Reliance General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of partial settlement of mediclaim.

2. The complainant submitted that he had undergone medical treatment and submitted all relevant bills, documents and requested the reimbursement of the amount. However, after continuous persuasion, the insurance company had paid him part payment but still an amount of Rs.6540/- is outstanding and the same has not been paid despite his repeated requests. The complainant requested to intervene in the matter and to get the claim settled. He further stated that he had got medical treatment and submitted a bill of Rs.14207/-. He had requested for release of the entire amount as he had submitted bills in support of such amount. After hectic chase, he was paid but an amount of Rs.6540/- was not paid and the company had denied the payment of this amount. He submitted that he had mentioned in his reminder to E-Meditek that he had underwent dental and nose treatment which was timely diagnosed and prescribed, relevant in his case of accident that took place on 02.10.2008. He had authenticated the evidence to prove his claim. During the course of hearing, he stated that besides getting heart problem, he was injured also after a fall. Doctor first advised him to get the treatment of the heart and thereafter treatment of the injury caused to his nose and teeth due to the accident. As per doctor's advice, he was first treated for heart ailment and thereafter for his teeth and nose. He further submitted that the company was not justified not to make payment relating to dental and nose treatment.

3. Written submissions were placed on record on behalf of the company wherein it has been submitted that the main claim and pre and post hospitalization was settled as per policy terms and conditions. However a sum of Rs.3250/- was not paid and the same was deducted by the TPA. The company had stated that the TPA was justified in doing so as per terms and conditions of the policy.

4. I have considered the submissions of the complainant and have also perused the reply which is placed on record on behalf of the insurance company. After due consideration of the matter, I hold that the company was not justified in making deduction of Rs.6250/- out of the total claim submitted by the complainant because this amount related to the treatment of teeth and nose as the complainant also suffered by way of accident in his teeth and nose and as per doctor's advice he was first treated for heart ailment and thereafter for his mouth and nose. It is to be mentioned that dental and nose injury was sustained to him due to accident. Therefore, expenses related to such treatment are also payable by the company. Accordingly Award is passed with the direction to the insurance company to make payment of outstanding balance of Rs.6250/- along with penal interest @ 8% from the date of part payment to the date of actual payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Vs
New India Assurance Company Limited

AWARD dated 27.12.2010 - Non-settlement of the mediclaim

1. This is a complaint filed by Shri Manmohan Kumar Malik (herein after referred to as the complainant) against the New India Assurance Company Limited (herein after referred to as respondent insurance company) in respect of non-settlement of the mediclaim.

2. The complainant stated that he had been subscribing to mediclaim policy of New India Assurance Company Limited since 11.01.2002. He was operated for left eye at Shroff Eye Centre, Kailash Colony, New Delhi on 27.04.2009. M/S. Universal Med-Aid Services Limited, TPA had issued pre-authorization of Rs.25000/- against final bill of Rs.35350/-. At the time of discharge from the hospital, he was billed for Rs.35350/-. Balance amount of Rs.10350/- was paid by him. He had submitted the insurer supplementary claim of Rs.10350/- plus bills towards cost of medicines for use before and after surgery for reimbursement. The case was pending with the TPA for a long time. He further submitted that Shroff Eye Centre is a duly recognized hospital; therefore, the entire expenditure incurred by him is reimbursable to him. He had reminded the TPA but he had not received any response. The complainant further stated that his wife was also operated for cataract of her left eye at the same hospital on 22.04.2009. The TPA had issued pre-authorization of Rs.25000/- in her case also against final bill of Rs.35100/- and the balance amount of Rs.10100/- was paid by him from his pocket. Even the insurance company also wrote to its TPA to release the outstanding payment but of no avail. He is a senior citizen and is being put to a lot of inconvenience and harassment. He requested that their claims be got settled at an early date.

3. The company had placed on record the written submissions. It had given reasons for deductions that the balance amount is not payable as per Clause 2 of the policy. The representative of the company who attended the hearing supported the reasons for deductions out of the claims of the complainant as given in the written submissions.

4. I have considered the submissions of the complainant and have also perused the written submissions placed on record on behalf of the company. I have also considered the final submissions made by both the parties during the course of hearing. After due consideration of the matter, I hold that the company was not justified in making deductions out of the claims filed by the complainant. The complainant as well as his wife were operated for cataract in a hospital which is no doubt registered one. Clause 2 of the policy as relied upon by the company for doing deductions has been perused and it is found that it gives the details as to which expenses are reimbursable. It does not restrict any expenditure except room rent and ICU. In my considered view, the company had wrongly deducted the amounts out of the claimed amounts. The company is under obligation to reimburse entire amount of the bills. Deductions as done are not as per policy

terms and conditions. The payments which were made by the complainant are fully reimbursable. **Accordingly, Award is passed with the direction to the company to pay an amount of Rs.25025/- in respect of both the claims as detailed above.**

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/119/NIC/10
In the matter of Shri Krishan Kumar
Vs
National Insurance Company Limited
AWARD dated 16.12.2010 - Repudiation of mediclaim

1. This is a complaint filed by Shri Krishan Kumar (herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant stated that the claim was rejected by M/S. Genins India TPA Ltd. of the insurance company on the ground that M/S. Bhati Hospital is not in the panel list. He submitted that the hospital was nearest to him and it was an emergency to treat him immediately, therefore, he had taken the services. He had also approached the Grievance Redressal Officer of the Insurance Company but of no avail. He submitted that poor services had been provided to him by the insurance company and its TPA. He requested that his claim be got settled at an early date.

3. The company vide its letter dated 31.12.2009 informed the complainant that the company had gone through the claim in details. The claim pertains to Shri Krishan Kumar covered under Group Individual Parivar Policy No.850000001529 for the expenses incurred for medical treatment of Infective Hepatitis with Jaundice at Bhati Hospital, Futa Road, Dayalpur, Delhi. As per the hospital list provided by National Insurance Company Limited, the above said hospital is not included in the hospital panel list. Hence, the claim is recommended for repudiation. During the course of hearing, the representative of the company reiterated the reasons of repudiation and stated that the claim was not payable because hospital at which treatment was taken was not included in the panel list of the insurance company. Otherwise the claim is payable.

4. I have very carefully considered the submissions of the complainant and also perused the written replies placed on record on behalf of the insurer. After due consideration of the matter, I hold that the insurance company was not justified in

repudiating the claim only on the ground that treatment was taken in a hospital which was outside the approved list of hospitals given to the policy holder. The claim is otherwise admissible and payable and the same cannot be repudiated only on technical ground. Accordingly, Award is passed with the direction to the insurer to settle the claim and make the payment of Rs.24158/- along with penal interest @8% from the date of repudiation to the actual date of payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/126/NIC/10
In the matter of Ms. Meenakshi Bhatia
Vs
National Insurance Company Limited

AWARD dated 17.12.2010 - Repudiation of mediclaim

1. This is a complaint filed by Ms. Meenakshi Bhatia (herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant stated that she got insured with the National Insurance Company Limited under policy No.360700/48/09/8500001618 with effect from 13.08.2009 to 12.08.2010. On 20.08.2009, she felt severe stomach pain and consulted a gynecologist and got treatment. After some days, she was down with high fever and was not able to swallow the medicine. Therefore, the physician recommended her to go to nearby hospital, that is, MKW Charitable Hospital where on the advice of Dr. Seema (Gyane) different tests were conducted and injected antibiotics. She was discharged from the hospital next day. She preferred the claim with the insurance company. She was told that the claim is admitted and was advised to bring the latest policy documents. The complainant further submitted that on 28.10.2009, she felt severe pain in upper abdomen along with high temperature. The pain was unbearable and she went to MKW hospital on the recommendation of her physician Dr.Daddu.

   As the condition was worsening, she immediately rushed to the nearest MKW hospital. She was admitted on the advice of the doctor who advised her to go for operation. On 30.10.2009, Laproscopy was conducted. However, after removal of Gall Bladder, serious complications developed and an open surgery Laprotomy was done on 31.10.2009. She had deposited a sum of Rs.99165/- to the hospital authorities for the treatment. After filing the claim with the insurance company, she was informed that her claim has been rejected on the ground that the treatment was taken from the MKW hospital which is not in the approved list of the

insurance company. The complainant requested this office to get her claims settled.

3. Written replies were placed on record on behalf of the company. The insurance company had repudiated both the claims only on the ground that treatment was taken in a hospital which was outside the approved list of hospitals provided to the policy holder along with the policy. Moreover, the claims were not intimated to it within 7 days from the date of injury/accident/treatment as per condition 5(3) of the policy. Therefore, the claims had been repudiated.

4. I have very carefully considered the submissions of the complainant and also perused the written replies placed on record on behalf of the insurer. After due consideration of the matter, I found that the insurance company was not justified in repudiating the claim only on the ground that treatment/operation was got done in a hospital which was outside the approved list of hospitals given to the policy holder. The claim is otherwise admissible and payable and the same cannot be repudiated only on technical ground. Accordingly, Award is passed with the direction to the insurer to settle both the claims and make the payment of Rs.1,22,459/- along with penal interest @8% from the date of repudiation to the actual date of payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/88/IFFCO/10
In the matter of Shri Ram Kishan Gupta
Vs
IFFCO Tokio General Insurance Company Limited

AWARD dated 02.12.2010 - Repudiation of mediclaim

1. This is a complaint filed by Shri Ram Kishan Gupta (herein after referred to as the complainant) against the decision of the Iffco Tokio General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that he made complaint regarding non-settlement of claim against his mediclaim policy No. 52059787 & 52103259 issued by Iffco Tokio General Insurance Company Limited on 04.12.2009. He had also approached the Grievance Redressal Officer of the insurance company on 23.12.2009 but he had not received any reply from the insurance company. He requested that his claim be got settled at an early date. However he further stated the company had paid his claim on 07.06.2010 after a delay of 19 months and 17 months from filing his claim and therefore, the company is under obligation to

make payment of interest for 19 months on claimed amount of Rs.42399/- and for 17 months in respect of claimed amount of Rs.4916/-. He also requested that he be reimbursed the conveyance expenses etc. too.

3. The company had placed on record written submissions where in it has been submitted that the complainant had submitted claims and the same were processed and were denied under general condition 6 of the policy. Thereafter, the claims were further reviewed and settled. A sum of Rs.4986/- was paid vide cheque dated 05.05.2010 and a sum of Rs.42399/- was paid vide cheque dated 05.05.2010.

4. I have considered the submissions of the complainant and have also perused the written replies as placed on record on behalf of the insurance company. I have also perused the payment details provided by the company. After due consideration of the matter, I hold that the company was not justified in settling the claims late. There has been a delay in settling the claims of the complainant and accordingly, there appears to be justification for penal interest to be paid by the insurance company. Accordingly, Award is passed with the direction to the insurance company to make payment of penal interest @ 8% from January, 2009 to the date of actual payment on amounts already paid to him.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/197/UII/09
In the matter of Shri Sushil Narayan
Vs
United India Insurance Company Limited

AWARD dated 16.12.2010 - Inadequate settlement of Mediclaim

1. This is a complaint filed by Shri Sushil Narain (herein after referred to as the complainant) against the decision of United India Insurance Co. Ltd (herein after referred to as respondent Insurance Company) for inadequate settlement of Mediclaim.

2. Complainant stated that he had taken a policy bearing no. 221500/48/07/97/0000796 on 18.09.2007. He stated that while travelling to Panchgani Maharashtra on 08.06.2008 he and his family met with an accident and the passers took them to Bel Air Hospital at Panchgani. Due to non availability of CT Scan machine, there, they were transferred from Bell Air Hospital, Panchgani to Grant Medical Foundation Ruby Hall Clinic, Pune. They informed the TPA through the hospital but there was no response from the TPA. The Insurance Company was also informed orally. Since cash was not available, his brother came from Delhi to Pune by air since it was an emergency and after two days his wife and son were discharged from the Hospital, but since he got major head injury with

Scalp Defect and required operation, his brother had taken him to Delhi and got operated at Ganga Ram Hospital. After recovery from the illness, after the operation, he submitted his claim to United India Insurance Co. Ltd. With all bills, X-ray, CT Scans and reports in original for a total claim of Rs.1,39,690.77/-. He had to present the claim with the TPA and he had got a sum of Rs.60962/- but could not get the balance amount so far. He stated that the entire amount was spent from their own pocket. This amount of Rs.60962/- was also received by way of cheques, are dated 04.02.2009 for an amount of Rs.52,892/-, another dated 31.01.2009 for an amount of Rs.8,070/-. He submitted further that he was not so far given the balance amount. TPA was causing mental harassment and he was suffering the financial loss. He requested that his claim may kindly be got settled at early date and he be given interest also.

3. During the course of hearing, the Insurance Company's representative stated that whatever amount was admissible to the complainant, the same was given and the Insurance Company had given explanation with regard to balance amount. It has been stated in the reply that Insurance Company had given reasons for not reimbursing various items such as Rs.3000/- related to Bel Air Hospital are not payable. Further, no breakup of hospital charges for a sum of Rs.8855/- were given and hence not payable. Mouth wash was not payable, Pharmacy breakup worth Rs.1205.36/- not available, Pharmacy Breakup worth Rs.1587/- and OT consumables breakup worth Rs.3480/- was not payable. Breakup worth Rs.13500/- was not satisfactory. There is no prescription for Rs.1000/- and hence not payable. Further, representative could not stated the reasons for not paying the balance amount of Rs.60,962/-. The Insurance Company had given explanation only with regard to Rs.37775/- but not with respect to remaining amount of Rs.40957/-.

4. I have considered the submissions of the complainant very carefully. I have also considered the verbal submissions of the representative of the Insurance Company and also the written reply placed on record on behalf of the Insurance Company. After due consideration of the matter, I hold that Insurance Company was not justified in not making the payment with regard to balance amount of Rs.78732/-. The complainant had submitted the claim for an amount of rs.139690/-, but it had paid only a sum of Rs.60962/-. It had not given worthwhile reasons for not making payment in respect of remaining amount of Rs.78732/-. The complainant had paid entire amount of treatment himself. Accordingly, in my considered view, the Insurance Company is under obligation to make full amount of the claim to the policy holder. Accordingly, Award is passed with a direction to the Insurance Company to make the payment of Rs.78732/- along with penal interest @ 8% from the date of payment of Rs.60962/- to the date of actual payment of balance amount.

5. Copies of the Award to both the parties.

Case No.GI/84/NIA/10
In the matter of Shri Narinder Kumar
Vs
The New India Assurance Company Limited

AWARD dated 10.12.2010 - Repudiation of Mediclaim

1. This is a complaint filed by Shri Narinder Kumar (herein after referred to as the complainant) against the decision of The New India Assurance Co. Ltd (herein after referred to as respondent Insurance Company) for Repudiation of Mediclaim.

2. Complainant stated that he had submitted his claim to the Insurance Company M/s. New India Assurance Co. Ltd.. He had taken a policy bearing no. 310600/34/08/11/00003673. He had submitted all requisite documents along with claim but the claim has not been settled so far. He requested that his claim be got settled at an early date. He had sought relief amounting to Rs.28207/-. The complainant stated that he had taken insurance since 1999 from Oriental Insurance Co. Ltd and had shifted to New India Assurance Co. Ltd from 2009-10 and since the insurance is continued since 1999 the claim is admissible and he deserved to be given benefit of continuity of the policy.

3. The Insurance Company had informed the insured vide its letter dated 03.02.2010 that it regrets to inform that since the Insurance was shifted from Oriental Insurance Co. and this was the first year of Insurance with the New India Assurance Co. Ltd the claim of cataract is rightly repudiated by M/s. Raksha TPA as it falls under exclusion clause no. 4.3 whereby certain disease/ailments/conditions have a waiting period of 2 to 4 years. Since the claim falls within 2 years of taking the policy from New India Assurance Co. Ltd the claim is not tenable.

4. I have considered the submissions of the complainant. I have also perused the letter of the Insurance Company informing the complainant about the non admissibility of the claim. After due consideration of the matter, I hold that the Insurance Company was not justified in not admitting the liability of the insured because the terms and conditions of the earlier insurer are same as that of the present insurer.Therefore, in my considered view, policy holder deserved to be given the benefit of continuity of the policy of earlier years by earlier insurer. Present insurer had given Cumulative Bonus to the insured. In my view, the claim is admissible. Accordingly, award is passed with a direction to the Insurance Company to make the payment of Rs.28207/- along with penal interest @ 8% from the date of repudiation to the date of actual payment.

5. Copies of the Award to both the parties.

Case No.GI/140/UII/10
In the matter of Shri Vijay Jain
Vs
United India Insurance Company Limited

AWARD dated 27.12.2010 - Repudiation of Mediclaim

1. This is a complaint filed by Shri Vijay Jain (herein after referred to as the complainant) against the decision of United India Insurance Co. Ltd (herein after referred to as respondent Insurance Company) for Repudiation of Mediclaim.

2. Complainant stated that he had taken a Mediclaim policy w.e.f. 26.02.2009 to 25.02.2009 from United India Insurance Co. Ltd. He had gone to Tirupati Balaji on 30.12.2009 and fell ill. First he got treatment at Ahmadabad and thereafter in Pune in Jahangir Hospital. East West TPA was informed about his illness and he was informed that in Jahangir Hospital, Pune had no cashless facility but there was another hospital in the Pune in the same premises namely N.M. Wadia hospital where cashless facility was available but the patient could not be admitted therein on account of doctors advice. After treatment all documents including, original bills were submitted to East West TPA. It had processed the claim but ultimately the claim was made as no claim and he was informed vide letter dated 20.03.2010. He submitted that he was not ill earlier except that in October 2009 he felt some giddiness due to sugar and he had taken treatment for 2 days and became alright. He had spent about 300000/- on treatment and he requested that his claim be settled and Insurance Company be instructed to make the payment of Rs.310000/- along with interest @18%.

3. Insurance Company had stated in his letter dated 21.04.2010 that patient Mr. Jain was admitted in Jehangir Hospital, Pune on 30.12.2009 and was discharged on 30.01.2010. His disease was diagnosed as (Lt) MCA Infarct with Hemorrhage, which is not covered in the 1st year of Mediclaim policy. Therefore, the claim was denied vide letter dated 23.02.2010 and the same was communicated to Mr. Jain. During the course of hearing also the representative of the Insurance Stated that claim is not payable because the disease is not covered in the first year of the policy.

4. I have considered the submissions of the complainant. I have also perused the Insurance Company's letter dated 21.04.2010 which is placed on record and also verbal arguments of the representative of the Insurance Company. After due consideration of the matter I hold that Insurance Company was not justified in repudiating the claim because the disease with which the patient was suffering is not a disease for which any waiting period is provided in the policy. The expenses relating to treatment of disease with which the patient suffered is payable and there is no waiting period. In my considered view, the claim of the complainant is admissible. Requisite documents for admissibility of the claim had been furnished on behalf of the policy holder. The claim had been repudiated on the basis of wrong reasons. Accordingly, Award is passed with a direction to the Insurance Company to make the payment of Rs.3,00,000/-.

5. Copies of the Award to both the parties.

Case No.GI/117/NIC/10
In the matter of Shri Nirala Shankar Aggarwal
Vs
National Insurance Company Limited

AWARD dated 16.12.2010 - Repudiation of Mediclaim

1. This is a complaint filed by Shri Nirala Shankar (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd (herein after referred to as respondent Insurance Company) for Repudiation of Mediclaim.

2. The complainant stated that his claim has not been settled merely because treatment was not taken from the hospital which had been approved by the Insurance Company. He had requested to get his claim settled at an early date. He submitted that Insurance Company was not justified to repudiate the claim only because the treatment was not taken in the hospital approved by it.

3. Written submissions are placed on record on behalf of the Insurance Company wherein it has been submitted that the treatment has been taken by the insured at Nirmal Hospital, New Delhi, which is outside the approved list of Delhi Hospitals as provided to the insured by the DRO-II and that is why the claim is not admissible under the policy imposed clause. Since on the basis of Mediclaim policy clause, the claim is admissible as per terms and conditions the same has been informed to the insured about the fact of the claim.

4. I have considered the submissions of the complainant. I have also perused the written submissions as placed on record on behalf of the Insurance Company which stated therein the reasons for inadmissibility of the claim. After due consideration of the matter I hold that the Insurance Company was not justified in repudiating the claim only on the ground that treatment was taken in the hospital which was not approved by it. The hospital at which treatment was taken fulfills the requisite conditions for admissibility of the claim. Therefore, in my considered view the claim is payable. Accordingly, award is passed with a direction to the Insurance Company to make the payment of Rs.36223/- along with penal interest @8% from the date of repudiation to the date of actual payment.

5. Copies of the Award to both the parties.

Case No.GI/86/NIC/10
In the matter of Shri Rama Nand Sharma
Vs
National Insurance Company Limited

AWARD dated 10.12.2010 - Repudiation of Mediclaim

1. This is a complaint filed by Shri Rama Nand Sharma (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd (herein after referred to as respondent Insurance Company) for repudiation of Mediclaim.

2. Complainant stated that all requisite documents have been submitted to Alankit Health Care Ltd. i.e. TPA. He had also approached the Grievance Cell of the Insurance Company but the claim has not been settled. He had approached many times to the TPA but all in vain. Therefore it has been requested by him to this forum to get his claim settled at an early date. As per Insurance Company rule cashless, reimbursement both facilities are available in the policy.

3. The Insurance Company had submitted written submissions dated 29.03.2010 wherein it has been submitted that the Insurance Company had issued policy to the insured bearing no. 360304/48/08/8500001572 in favour of the insured for period of 1 year i.e.

from 21.11.2008 to 20.11.2009. The insured had preferred the claim directly to the TPA i.e. M/s. Alankit Health care Limited which repudiated the claim vide their letter dated 28.10.2009 on the ground that the hospital where the treatment was taken is outside the list of approved hospital in Delhi. The claim was reconsidered and it was observed that the Hospital i.e. Avantika Hospital, Rohini was approved for 7 beds as per the Registration Certificate. As per policy condition the hospital should have atleast 15 patient beds whereas in this case the hospital was approved for 7 beds thus the claim was rightly repudiated by the TPA.

4. I have considered the submissions of the complainant. I also perused the written submissions which are placed on record. After due consideration of the matter I hold that the Insurance Company was not justified in repudiating the claim because the hospital at which treatment was taken admittedly is registered with State Government, therefore there is no requirement of 15 beds where the hospital is registered. The Hospital must be either registered or atleast have 15 beds and the hospital falls under the condition no. 1. In my considered view the claim is admissible and payable. The claim which is payable and admissible cannot be rejected merely on technical grounds that treatment was not taken in approved list of hospital. Accordingly, Award is passed with a direction to the Insurance Company to make the payment of Rs.23986/-.

5. Copies of the Award to both the parties.

Case No.GI/105/NIC/10
In the matter of Shri Om Prakash
Vs
National Insurance Company Limited

AWARD dated 16.12.2010 - Repudiation of Mediclaim

1. This is a complaint filed by Shri Om Prakash through Shri M. Malhotra his employer (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd (herein after referred to as respondent Insurance Company) for repudiation of Mediclaim.

2. Complainant stated that it has Mediclaim group policy bearing no. 361001/46/08/8500000255 taken by M/s. Forest Fern Hospitality Pvt. Ltd. For the period 15.01.2009 to 14.01.2010. Under this group policy one of the employee Shri Om Prakash Malhotra is insured along with his son Shri Anil Kumar for this period. On 21.02.2009 insured Shri Anil Kumar son of the complainant admitted in emergency conditions in the Khandelwal Hospital & Urology Centre at B-16, East Krishna Nagar, Delhi on account of pain in whole abdomen specially in both flanks with vomiting. He got discharged from the hospital on 27.02.2009. After the discharge of Shri Anil Kumar, Shri Om Prakash had claimed amount of Rs.33786/- from National Insurance Company Ltd on 20.03.2009 with medical bills, medical reports, X-ray film, Discharge summary, ECG etc. After some days of filling of the claim for payment, the insured received a letter that his claim was denied by TPA M/s. Genins India TPA Ltd. Of National Insurance Company Ltd on the ground that the said hospital is not included in the panel list of hospitals for National Insurance Co. Ltd Delhi. He further submitted that

Insurance Company is intentionally denying the claim of the insured because the said hospital is very much in the list of the National Insurance Co. Ltd. And the therefore, the insured is entitled to be reimbursed the amount. He requested that his claim be got settled at an early date.

3. The Insurance Company was represented by its official on the date of hearing but stated that the claim is not payable because the treatment was not taken in a hospital which is listed in the panel of hospitals for Delhi.

4. I have considered the submissions of the complainant. I also considered the verbal arguments of the representative of the Company. After due consideration of the matter I hold that Insurance Company was not justified in repudiating the claim on the ground that the treatment was taken in a hospital which is not listed in the panel for treatment. The representative of the Insurance Company had not given any other reason for not allowing the claim. In my considered view the claim is payable as the treatment was taken in a hospital which was registered and the claim is payable and admissible. Accordingly, Award is passed with a direction to the Insurance Company to make the payment of Rs.33786/- along with penal interest @8% from the date of repudiation i.e. 26.04.2009 to the actual date of payment.

5. Copies of the Award to both the parties.

Case No.GI/94/NIC/10
In the matter of Shri Rajesh Aggarwal
Vs
National Insurance Company Limited

AWARD dated 16.12.2010 - Repudiation of Mediclaim

1. This is a complaint filed by Shri Rajesh Aggarwal (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd (herein after referred to as respondent Insurance Company) for repudiation of Mediclaim.

2. Complainant stated that his claim was repudiated only because the treatment was taken in a hospital which is not listed in the approved list of hospitals of Delhi.

3. Insurance Company had submitted written submissions which are placed on record wherein it has been stated that while scrutinizing the claim documents it was observed that the expenses incurred during the hospitalization pertains to Nav Jeevan Hospital, New Delhi which is outside the approved list of Hospitals as provided by the Insurance Company and that is why the claim was repudiated.

4. I have considered the submissions of the complainant. I have also perused the reply of the Insurance Company stating therein the reasons for not admitting the claim. After due consideration of the matter I hold that the Insurance Company was not justified in denying the claim of the complainant only on the technical ground. The hospital at which treatment was taken is registered one and the claim is reimbursable for the treatment even if the same is not listed in the panel of hospitals. The claim otherwise admissible and

payable cannot be denied on technical grounds. Accordingly, Award is passed with a direction to the Insurance Company to make the payment of Rs.21598/- along with penal interest @8% from the date of repudiation to the actual date of payment.

5. Copies of the Award to both the parties.

Case No.GI/81/Reliance/10
In the matter of Shri Pawan Kumar
Vs
Reliance General Insurance Company Limited

AWARD dated 16.12.2010 - Rrepudiation of Mediclaim

1. This is a complaint filed by Shri Pawan Kumar (herein after referred to as the complainant) against the decision of Reliance General Insurance Co. Ltd (herein after referred to as respondent Insurance Company) for repudiation of Mediclaim.

2. Complainant stated that he was hospitalized from 04.04.2008 to 08.04.2008 in North Delhi Nursing Home for the treatment. At that time he was not able to take action for Mediclaim and his family members were not well versed with the policy that is why he could not inform the Insurance Company in time i.e. within the time as stipulated in the policy and policy terms and conditions. When he recovered from the illness he told his wife about the policy and then she met with the agent on 20.04.2008 and she was told by the agent that the claim is reimbursable therefore after that Insurance Company was informed of the claim. He submitted the file for reimbursement on 05.07.2007 but the TPA states that claim was not intimated late and therefore the claim is not payable. He also submitted complaint to the Grievance Cell but no reply was received from the Grievance redressal cell also. He requested to get the claim settled at an early date.

3. The Insurance Company informed vide its letter dated 01.08.2008 to the insured that the claim was made late, no timely information was given to the Insurance Company. Documents were also received late i.e. to say the claim was not timely made and therefore the claim is not payable. Insurance Company also placed on record written submissions wherein it has been submitted that the complainant had obtained Reliance Healthwise policy bearing 282550003892 from period 28.07.2007 to 27.07.2008. The complainant was admitted in the hospital on 04.04.2008 for DM, UTI, Lft Kidney Atrophy and was discharged on 08.04.2008 from North Delhi Nusrsing Home. The claim was submitted for an amount of Rs.26,977/-. The complainant had submitted documents on 07.07.2008 i.e. there was delay of about 3 months. It has been submitted further that the policy is with respect to certain terms and conditions and the complainant is required to intimate the Insurance Company within 7 days from the date of admissions as stated under claim procedure clause 1 and the documents for the same are supposed to be submitted within 30 days from the date of discharge. The gist of the argument of the Insurance Company is that the complainant had intimated the Insurance Company late and also submitted documents late by 3 months and therefore claim is not payable.

4. I have considered the submissions of the complainant. I have also perused the reply as given by the Insurance Company. I have also gone through the repudiation letter. After

due consideration of the matter I hold that the Insurance Company was not justified in repudiating the claim only on account of technicalities. The complainant had narrated the circumstances under which claim was filed late. The insured had taken policy since 2004 to December 2007 with New India Assurance Co. Ltd. And renewed the policy w.e.f. 28.07.2007 to 27.07.2008 with Reliance General Insurance Co. Ltd. In my considered view the claim is payable as the policy is continued for the last 5 years. The continuity benefits are to be allowed by the present insurer because there is no break in the policy since its inception. Accordingly, Award is passed with the direction of the Insurance Company to make the payment of Rs.26977/- along with penal interest @ 8% from the date of repudiation (01.08.2008) to the actual date of payment.

5. Copies of the Award to both the parties.

Case No. GI/53/NIC/10
In the matter of Shri Arun Parti
Vs
National Insurance Company Limited

AWARD dated 01.12.2010 - Repudiation of mediclaim

1. This is a complaint filed by Shri Arun Parti (herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that he was admitted in Kesar Nursing Home approved by Delhi Government on 30.05.2009 at 12.50 p.m. in emergency condition and discharged on 03.06.2009 at 10 a.m. Total expenses of hospital was Rs.20751/-. He made written representation to the Grievance Redressal Officer of the insurance company but had not received any reply. On admission, he had informed the Alankit Healthcare (TPA) on customer care. He was informed that though the hospital was on their panel but the same was not authorized for cashless facility and he was advised that bills may be submitted for reimbursement after discharge from the hospital. He submitted all document in original with Alankit Healthcare (TPA) after discharge from hospital. He could not get satisfactory reply in spite of repeated telephonic requests with the TPA as well as with the National Insurance Company. However, on 06.10.2009, he received a letter from the Insurance Company stating that his claim is closed by putting false and baseless allegations. He is having Parivar mediclaim policy from the National Insurance Company for the last 5 years without any break. As per guidelines of the insurance company for mediclaim, they are entitled for the cashless treatment in the network hospital and reimbursement in any registered hospital. Therefore, denial by the insurance company is totally baseless and irrational.

3. The insurance company repudiated the claim as treatment was not taken in the network hospital. During the course of hearing also, it was stated by the

representative of the insurance company that since treatment was not taken in the approved hospital, the claim was denied.

4. I have very carefully considered the submissions of the complainant and also perused the written replies placed on record on behalf of the insurer. After due consideration of the matter, I found that the insurance company was not justified in repudiating the claim only on the ground that treatment was taken in a hospital which was outside the approved list of hospitals given to the policy holder. The claim is otherwise admissible and payable and the same cannot be repudiated only on technical ground. Accordingly, Award is passed with the direction to the insurer to settle the claim and make the payment of Rs.20751/-- along with penal interest @8% from the date of repudiation to the actual date of payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/54/NIC/10
In the matter of Shri Rakesh Kumar Jain
Vs
National Insurance Company Limited

AWARD dated 01.12.2010 - Repudiation of mediclaim

1. This is a complaint filed by Shri Rakesh Kumar Jain (herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that he had not taken a single claim under the policy. The claim is only for Rs.10750/- which was incurred for his cataract surgery performed on 03.09.2008. He paid the bill to the hospital and claimed reimbursement from the insurance company. The insurance company replied vide its letter dated 25.11.2008 stating that this claim is not being entertained, since the hospital where this surgery was performed is not empanelled with the insurance company as the panel hospital for cashless treatment. He further stated that he is not asking for cashless treatment but is asking for reimbursement of the expenses incurred.

3. Written replies were placed on record on behalf of the company. The insurance company had repudiated the claim only on the ground that treatment was taken in a hospital which was outside the approved list of hospitals provided to the policy holder along with the policy.

4. I have very carefully considered the submissions of the complainant and also perused the written replies placed on record on behalf of the insurer. After due consideration of the matter, I found that the insurance company was not justified in repudiating the claim only on the ground that treatment was taken in a hospital which was outside the approved list of hospitals given to the policy holder. The claim is otherwise admissible and payable and the same cannot be repudiated only on technical ground. Accordingly, Award is passed with the direction to the insurer to settle the claim and make the payment of Rs.10750/- along with penal interest @8% from the date of repudiation to the actual date of payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/52/NIC/10
In the matter of Smt. Summa Suresh
Vs
National Insurance Company Limited

AWARD dated 01.12.2010 - Repudiation of mediclaim

1. This is a complaint filed by Smt. Summa Suresh (herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that her son admitted in Kesar Nursing Home approved by Delhi Government on 11.05.2009 at 6.40 a.m. in emergency condition and discharged on 13.05.2009 at 2 p.m. Total expenses of hospital was Rs.21918/-. She made written representation to the Grievance Redressal Officer of the insurance company but had not received any reply. On admission, she had informed the Alankit Healthcare (TPA) on customer care. She was informed that though the hospital was on their panel but the same was not authorized for cashless facility and she was advised that bills may be submitted for reimbursement after discharge from the hospital. She submitted all documents in original with Alankit Healthcare (TPA) after discharge from hospital. She could not get satisfactory reply in spite of repeated telephone requests with the TPA as well as with the National Insurance Company. She further submitted that as per guideline of Insurance Company for mediclaim, we are entitled for the cashless treatment in the network hospital and for reimbursement in any registered hospital/Nursing home which should have at least 15 indoor beds. Therefore, the denial by the Insurance Company is totally baseless and irrational. She requested this forum to get her claim settled.

3. The insurance company had repudiated the claim only on the ground that treatment was taken in a hospital which was outside the approved list of hospitals provided to the policy holder along with the policy.

4. I have very carefully considered the submissions of the complainant and also perused the written replies placed on record on behalf of the insurer. After due consideration of the matter, I found that the insurance company was not justified in repudiating the claim only on the ground that treatment was taken in a hospital which was outside the approved list of hospitals given to the policy holder. The claim is otherwise admissible and payable and the same cannot be repudiated only on technical ground. Accordingly, Award is passed with the direction to the insurer to settle the claim and make the payment of Rs.21918/- along with penal interest @8% from the date of repudiation to the actual date of payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/56/NIC/10
In the matter of Shri Pinku Shah
Vs
National Insurance Company Limited

AWARD dated 01.12.2010 - Repudiation of mediclaim

1. This is a complaint filed by Shri Pinku Shah (herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that he was admitted in Kesar Nursing Home approved by Delhi Government on 03.06.2009 at 9 a.m. in emergency condition and discharged on 06.06.2009 at 10 a.m. Total expenses of hospital was Rs.28491/-. On admission, he had informed the Alankit Healthcare (TPA) on customer care. He was informed that though the hospital was on their panel but the same was not authorized for cashless facility and he was advised that bills may be submitted for reimbursement after discharge from the hospital. He submitted all documents in original with Alankit Healthcare (TPA) after discharge from hospital. He could not get satisfactory reply in spite of repeated telephonic requests from the TPA as well as from the National Insurance Company. As per guidelines of the insurance company for mediclaim, he was entitled for the cashless treatment in the network hospital and for reimbursement in any registered hospital. Therefore, denial by the insurance company is totally baseless and irrational.

3. The insurance company repudiated the claim as treatment was not taken in the network hospital. During the course of hearing also, it was stated by the representative of the insurance company that since treatment was not taken in the approved hospital, the claim was denied.

4. I have very carefully considered the submissions of the complainant and also perused the written replies placed on record on behalf of the insurer. After due consideration of the matter, I found that the insurance company was not justified in repudiating the claim only on the ground that treatment was taken in a hospital which was outside the approved list of hospitals given to the policy holder. The claim is otherwise admissible and payable and the same cannot be repudiated only on technical ground. Accordingly, Award is passed with the direction to the insurer to settle the claim and make the payment of Rs.28491/-- along with penal interest @8% from the date of repudiation to the actual date of payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/15/RGI/10
In the matter of Shri Rajat Kumar Mathur
Vs
Reliance General Insurance Company Limited

AWARD dated 01.12.2010 - Rrepudiation of mediclaim

1. This is a complaint filed by Shri Rajat Kumar Mathur (herein after referred to as the complainant) against the decision of the Reliance General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that he had taken a mediclaim policy from Reliance General Insurance Company Limited on 28.03.2009(Policy No.282510409113). He submitted further that his last policy was from National Insurance Company Limited. The risk date started from 08.04.2008 till 07.04.2009. His son Vihaan Mathur was admitted to Narinder Mohan Hospital on 12.04.2009. The hospital accepted the policy and started treatment and matter was then referred to TPA and TPA had asked for ID-proof, photograph, last medical policy details etc. TPA rejected the claim compelling him to make cash payment at the hospital. It is submitted by him that since the treatment was done during the currency of the policy, the company should have made the payment. He was informed that the claim is not payable as the policy has not completed 30 days. He had submitted documents thrice but his claim was not settled.

3. Written submissions are placed on record on behalf of the insurance company wherein it has been stated that complainant Shri Rajat Kumar Mathur obtained

Reliance Health wise Silver policy valid from 28.03.2009 to 27.03.2010 covering himself along with spouse and son. On 12.04.2009, his son Master Vihaan Mathur got admitted in Narinder Mohan Hospital and Research Centre, Ghaziabad as a follow up case of tuberculosis with Acute Gastroenteritis with some dehydration. He remained there for the treatment and discharged on 14.04.2009. To ascertain the admissibility of the claim, the complainant was asked to submit certain documents. During the course of hearing, representative of the company stated that the claim was rejected for want of submission of certain documents. That is to say, requisite documents have not been made available and, therefore, the claim was rejected. In case documents are submitted, claim may be examined on merits. Moreover, the company has submitted its vague reply. However, policy holder stated that all original documents were already submitted for admissibility of the claim. The representative of the company was required to submit the report after w week. It is to mention here that the date of hearing was 22.10.2010 but the company did not submit any report further in this matter.

4. I have considered the submissions of the complainant very carefully and have also perused the written reply submitted on behalf of the company as placed on record till 21.10.2010 and also noted the fact that the company had not submitted its reply within a week as promised by its representative on the date of hearing. After due consideration of the matter, I hold that the claim is admissible and the company is liable to make the payment. The complainant had already submitted requisite documents as had been stated by him in presence of the representative of the insurance company. Accordingly, Award is passed with the direction to the insurance company to make the payment of Rs.8268/- along with penal interest @ 8% from 09.10.2009 to the date of actual payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/49/RGI/10
In the matter of Shri Vijay Priya
Vs
Reliance General Insurance Company Limited

AWARD dated 01.12.2010 - Repudiation of mediclaim

1. This is a complaint filed by Shri Vijay Priya (herein after referred to as the complainant) against the decision of the Reliance General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that he had lodged the claim with reference to Reliance Health wise Policy which he had taken from Reliance General Insurance

Company Limited. He further submitted that he had lodged the claims on 14.08.2008, 18.10.2008 and 10.11.2008. The claims were lodged for Brain surgical treatment of his wife Smt. Seema in Dr.Ram Manohar Lohia Hospital at New Delhi. The claims were lodged for a total sum of Rs.56318/- along with all documents. He approached the company's TPA for early settlement of the claim. He also visited personally on 18.10.2008, 10.11.2008 and on 20.12.2008 to the TPA office at Gurgaon and lodged complaints in writing. However, all of a sudden on 22.11.2008, he got 4 letters in one envelope all dated 13.12.2008 wherein he was required to submit all post policy documents. He made the compliance on 29.12.2008. He again pursued the matter but of no use. However, the claim was repudiated stating that "She was admitted in the hospital for the treatment of rt.petrous hemangioma where pt. has h/o symptoms from feb.2007 (as per reply sent by him) whereas reliance policy starts from 20.03.2007 which makes it pre-existing disease. Previous policies cannot be considered in case of pre-existing disease. Therefore, claim is not payable."

a. The complainant further submitted that his wife first consulted the doctor on 22.06.2008 in Shastri Hospital, Shakur Pur, Delhi. She felt dizziness and fell on the bed. Immediately after sipping a glass of water with glucose she felt all right. He requested that his claim be got paid at an early date.

3. Written submissions were placed on record on behalf of the company dated 04.11.2010 wherein it was stated that the complainant had obtained Reliance Healthwise policy valid from 20.03.2008 to 19.03.2009 covering himself along with his spouse and two children. On 22.06.2008, Smt. Seema wife of the complainant got admitted in Shastri Hospital as a case of right side petrous meningioma. She remained there for 3 days from 22.06.2008 to 25.06.2008 for the treatment and preferred a claim of Rs.18,561/- under the policy. It was found that the patient had symptoms since February, 2007, that is, prior to the inception of the policy which shows that the disease was pre-existing. It has quoted clause (1) of the policy with regards to the pre-existing disease. Hence the claim was repudiated by the TPA which is just and in accordance with the terms and conditions of the policy.

4. I have considered the submissions of the complainant very carefully and have also perused the written submissions as placed on record on behalf of the company. After due consideration of the matter, I hold that the company was not justified in repudiating the claim because the complainant had taken policy since 2004. He had taken the policy with effect from 21.03.2004 to 20.03.2007 from the National Insurance Company Limited and from 21.03.2007 to 20.03.2009 from Reliance General Insurance Company Limited. Therefore, arguments of the company for repudiation of claim that it was a case of pre-existing disease are not correct. Since policy is continued since 21.03.2004, the claim cannot be rejected on the ground of pre-existing disease, even if, she was suffering from the disease since February, 2007. In my considered view, claim is admissible and insurance company is under obligation to bear the liability. **Accordingly, Award is passed with the direction to the insurance company to make payment of Rs.56318/-**

along with penal interest @ 8% from January, 2009 to the date of actual payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/48/NIA/10
In the matter of Shri Surindar Kumar Sikri
Vs
New India Assurance Company Limited

AWARD dated 02.12.2010 - Non-settlement of the mediclaim

1. This is a complaint filed by Shri Surindar Kumar Sikri (herein after referred to as the complainant) against the New India Assurance Company Limited (herein after referred to as respondent insurance company) in respect of non-settlement of the mediclaim.

2. The complainant submitted that in the morning of 30.12.2008, he was returning by bus from Faridabad to Janak Puri, New Delhi. On the way to his residence, he felt uneasy and uncomfortable with sudden blurring of his vision. He had rushed to Dr.Shashi Mohan who checked him up and advised him the admission in hospital as early as possible. Accordingly, he got himself admitted in Max Heart Hospital on 30.12.2008 from where he was discharged on 31.12.2008. He was never hospitalized before 30.12.2008 in his life. After getting discharged from the hospital and after getting subsequent consultation from the doctor, he submitted mediclaim papers on 16.01.2009. He was required to submit further documents though he had submitted original papers earlier. He had received an amount of Rs.1500/- through cheque dated 31.03.2009 out of total claim of Rs.22204/-. After his verbal requests and letters, the company did not tell him how his claim was reduced to Rs.1500/-. He requested the company to reconsider his claim. He had requested this Forum to get his balance amount of Rs.20704/- paid. It is further submitted that after the patient is admitted in the hospital, it is the doctor who is to advise what tests to be done and the patient had no say in the doctor's prescription.

3. The company had submitted that investigations carried out by it and found that hospitalization was not necessary. It is found that the patient was hospitalized only for investigation purposes. Accordingly, it was opined that since hospitalization was not necessary, such claims are outside of LIC staff mediclaim policy purview vide exclusion clause 4.10.1. Hence the claim for hospitalization

only for investigation purposes is not admissible. However, Rs.1500/- may be paid for ultrasound as per clause 0.5.17 out of total claim of Rs.22204/-.

4. I have considered the submissions of the complainant and have also perused the written replies as placed on record on behalf of the company. After due consideration of the matter, I hold that the company was not justified in restricting the claim of the complainant to Rs.1500/- out of the total claim of Rs.22204/- because under the circumstances narrated by the complainant of his admission in the hospital, it was just and fair. He was advised by the doctor to get admission in the hospital. Since he was admitted in the hospital by the advice of the doctor and the hospitalization was more than 24 hours, the company is under obligation to make the payment and to meet the liability, that is, expenses incurred by the policy holder. **Accordingly, Award is passed with the direction to the insurance company to make the payment of Rs.20704/- along with penal interest @ 8% from 31.03.2009 to the date of actual payment.**

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/01/RGI/10
In the matter of Shri Onkar Singh
Vs
Reliance General Insurance Company Limited

AWARD dated 03.12.2010 - Non-settlement of mediclaim

1. This is a complaint filed by Shri Onkar Singh (herein after referred to as the complainant) against the decision of the Reliance General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of non-settlement of mediclaim.

2. The complainant submitted that he had taken mediclaim policy No.282560000905 from Reliance General Insurance Company Limited for Rs.3,00,000/- with effect from 30.03.2008 to 29.03.2009. He had sudden pain in his chest on 16.05.2008 and he consulted the doctor who advised him to consult heart specialist. Accordingly, he got himself examined on 16.05.2008 at G.B.Pant Hospital, Delhi and got treatment. The expenses for the treatment amounted to Rs.1,78,800/-. He had submitted requisite documents to TPA E-Meditek Solutions Ltd. He was further advised to submit the documents which were already submitted. He submitted all requisite documents but the company had not settled the claim so far. He requested that his claim be got settled at an early date as he had borrowed money for getting his treatment.

3. The company received the claim papers on 26.05.2008. The company vide its letter dated 31.05.2008 had repudiated the claim on the ground that necessary documents were not submitted by the complainant. During the course of hearing on 18.10.2010, the representative of the company further argued that the claim could be examined in case documents are provided. It was also required by the representative of the company that if the policy holder submitted evidence for insurance of earlier period, it could settle the claim of the complainant.

    a. The policy holder was directed to submit evidence for insurance of earlier period within the short time. As a matter of fact, the policy holder submitted evidence of insurance of earlier period on 30.10.2010 but the representative of the company could not submit the report as promised by him on the date of hearing on 18.10.2010 to submit report after a month. Accordingly the complaint is being disposed of after considering the entire facts on record. The policy holder also submitted evidence of insurance of earlier period in this office also which shows that the insurance has been taken with effect from 30.03.2000 to 29.03.2008 without any break.

4. I have considered the submissions of the complainant very carefully and have also perused the representation letter of the company. After due consideration of the matter, I hold that the company was not justified in repudiating the claim of the complainant. There is no reason for me not to believe on the submissions of the complainant that he had submitted all requisite documents for settling the claim to the TPA of the insurance company. The company had not submitted its reply despite the assurance given by the representative of the company during the course of hearing. The claim is payable and the company had rejected the claim only on technical ground that requisite documents were not submitted. The claim is admissible and payable. Accordingly, Award is passed with the direction to the company to make the payment of Rs.1,78,800/- along with penal interest @ 8% from 31.12.2008 to the date of actual payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/100/RGI/10
In the matter of Shri Kewal Issar
Vs
Reliance General Insurance Company Limited

AWARD dated 03.12.2010 - Partial settlement of mediclaim

1. This is a complaint filed by Shri Kewal Issar (herein after referred to as the complainant) against the decision of the Reliance General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of partial settlement of mediclaim.

2. The complainant submitted that he had undergone medical treatment and submitted all relevant bills, documents and requested the reimbursement of the amount. However, after continuous persuasion, the insurance company had paid him part payment but still an amount of Rs.6540/- is outstanding and the same has not been paid despite his repeated requests. The complainant requested to intervene in the matter and to get the claim settled. He further stated that he had got medical treatment and submitted a bill of Rs.14207/-. He had requested for release of the entire amount as he had submitted bills in support of such amount. After hectic chase, he was paid but an amount of Rs.6540/- was not paid and the company had denied the payment of this amount. He submitted that he had mentioned in his reminder to E-Meditek that he had underwent dental and nose treatment which was timely diagnosed and prescribed, relevant in his case of accident that took place on 02.10.2008. He had authenticated the evidence to prove his claim. During the course of hearing, he stated that besides getting heart problem, he was injured also after a fall. Doctor first advised him to get the treatment of the heart and thereafter treatment of the injury caused to his nose and teeth due to the accident. As per doctor's advice, he was first treated for heart ailment and thereafter for his teeth and nose. He further submitted that the company was not justified not to make payment relating to dental and nose treatment.

3. Written submissions were placed on record on behalf of the company wherein it has been submitted that the main claim and pre and post hospitalization was settled as per policy terms and conditions. However a sum of Rs.3250/- was not paid and the same was deducted by the TPA. The company had stated that the TPA was justified in doing so as per terms and conditions of the policy.

4. I have considered the submissions of the complainant and have also perused the reply which is placed on record on behalf of the insurance company. After due consideration of the matter, I hold that the company was not justified in making deduction of Rs.6250/- out of the total claim submitted by the complainant because this amount related to the treatment of teeth and nose as the complainant also suffered by way of accident in his teeth and nose and as per doctor's advice he was first treated for heart ailment and thereafter for his mouth and nose. It is to be mentioned that dental and nose injury was sustained to him due to accident. Therefore, expenses related to such treatment are also payable by the company. Accordingly Award is passed with the direction to the insurance company to make payment of outstanding balance of Rs.6250/- along with penal interest @ 8% from the date of part payment to the date of actual payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/139/NIA/10
In the matter of Shri Manmohan Kumar Malik
Vs
New India Assurance Company Limited

AWARD dated 27.12.2010 - Non-settlement of the mediclaim

1. This is a complaint filed by Shri Manmohan Kumar Malik (herein after referred to as the complainant) against the New India Assurance Company Limited (herein after referred to as respondent insurance company) in respect of non-settlement of the mediclaim.

2. The complainant stated that he had been subscribing to mediclaim policy of New India Assurance Company Limited since 11.01.2002. He was operated for left eye at Shroff Eye Centre, Kailash Colony, New Delhi on 27.04.2009. M/S. Universal Med-Aid Services Limited, TPA had issued pre-authorization of Rs.25000/- against final bill of Rs.35350/-. At the time of discharge from the hospital, he was billed for Rs.35350/-. Balance amount of Rs.10350/- was paid by him. He had submitted the insurer supplementary claim of Rs.10350/- plus bills towards cost of medicines for use before and after surgery for reimbursement. The case was pending with the TPA for a long time. He further submitted that Shroff Eye Centre is a duly recognized hospital; therefore, the entire expenditure incurred by him is reimbursable to him. He had reminded the TPA but he had not received any response. The complainant further stated that his wife was also operated for cataract of her left eye at the same hospital on 22.04.2009. The TPA had issued pre-authorization of Rs.25000/- in her case also against final bill of Rs.35100/- and the balance amount of Rs.10100/- was paid by him from his pocket. Even the insurance company also wrote to its TPA to release the outstanding payment but of no avail. He is a senior citizen and is being put to a lot of inconvenience and harassment. He requested that their claims be got settled at an early date.

3. The company had placed on record the written submissions. It had given reasons for deductions that the balance amount is not payable as per Clause 2 of the policy. The representative of the company who attended the hearing supported the reasons for deductions out of the claims of the complainant as given in the written submissions.

4. I have considered the submissions of the complainant and have also perused the written submissions placed on record on behalf of the company. I have also considered the final submissions made by both the parties during the course of

hearing. After due consideration of the matter, I hold that the company was not justified in making deductions out of the claims filed by the complainant. The complainant as well as his wife were operated for cataract in a hospital which is no doubt registered one. Clause 2 of the policy as relied upon by the company for doing deductions has been perused and it is found that it gives the details as to which expenses are reimbursable. It does not restrict any expenditure except room rent and ICU. In my considered view, the company had wrongly deducted the amounts out of the claimed amounts. The company is under obligation to reimburse entire amount of the bills. Deductions as done are not as per policy terms and conditions. The payments which were made by the complainant are fully reimbursable. **Accordingly, Award is passed with the direction to the company to pay an amount of Rs.25025/- in respect of both the claims as detailed above.**

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/119/NIC/10
In the matter of Shri Krishan Kumar
Vs
National Insurance Company Limited

AWARD dated 16.12.2010 - Repudiation of mediclaim

1. This is a complaint filed by Shri Krishan Kumar (herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant stated that the claim was rejected by M/S. Genins India TPA Ltd. of the insurance company on the ground that M/S. Bhati Hospital is not in the panel list. He submitted that the hospital was nearest to him and it was an emergency to treat him immediately, therefore, he had taken the services. He had also approached the Grievance Redressal Officer of the Insurance Company but of no avail. He submitted that poor services had been provided to him by the insurance company and its TPA. He requested that his claim be got settled at an early date.

3. The company vide its letter dated 31.12.2009 informed the complainant that the company had gone through the claim in details. The claim pertains to Shri Krishan Kumar covered under Group Individual Parivar Policy No.850000001529 for the expenses incurred for medical treatment of Infective Hepatitis with Jaundice at Bhati Hospital, Futa Road, Dayalpur, Delhi. As per the hospital list provided by National Insurance Company Limited, the above said hospital is not

included in the hospital panel list. Hence, the claim is recommended for repudiation. During the course of hearing, the representative of the company reiterated the reasons of repudiation and stated that the claim was not payable because hospital at which treatment was taken was not included in the panel list of the insurance company. Otherwise the claim is payable.

4. I have very carefully considered the submissions of the complainant and also perused the written replies placed on record on behalf of the insurer. After due consideration of the matter, I hold that the insurance company was not justified in repudiating the claim only on the ground that treatment was taken in a hospital which was outside the approved list of hospitals given to the policy holder. The claim is otherwise admissible and payable and the same cannot be repudiated only on technical ground. Accordingly, Award is passed with the direction to the insurer to settle the claim and make the payment of Rs.24158/- along with penal interest @8% from the date of repudiation to the actual date of payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/126/NIC/10
In the matter of Ms. Meenakshi Bhatia
Vs
National Insurance Company Limited

AWARD dated 17.12.2010 - Repudiation of mediclaim

1. This is a complaint filed by Ms. Meenakshi Bhatia (herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant stated that she got insured with the National Insurance Company Limited under policy No.360700/48/09/8500001618 with effect from 13.08.2009 to 12.08.2010. On 20.08.2009, she felt severe stomach pain and consulted a gynecologist and got treatment. After some days, she was down with high fever and was not able to swallow the medicine. Therefore, the physician recommended her to go to nearby hospital, that is, MKW Charitable Hospital where on the advice of Dr. Seema (Gyane) different tests were conducted and injected antibiotics. She was discharged from the hospital next day. She preferred the claim with the insurance company. She was told that the claim is admitted and was advised to bring the latest policy documents. The complainant further submitted that on 28.10.2009, she felt severe pain in upper abdomen along with high temperature. The pain was unbearable and she went to MKW hospital on the recommendation of her physician Dr.Daddu.

a. As the condition was worsening, she immediately rushed to the nearest MKW hospital. She was admitted on the advice of the doctor who advised her to go for operation. On 30.10.2009, Laproscopy was conducted. However, after removal of Gall Bladder, serious complications developed and an open surgery Laprotomy was done on 31.10.2009. She had deposited a sum of Rs.99165/- to the hospital authorities for the treatment. After filing the claim with the insurance company, she was informed that her claim has been rejected on the ground that the treatment was taken from the MKW hospital which is not in the approved list of the insurance company. The complainant requested this office to get her claims settled.

3. Written replies were placed on record on behalf of the company. The insurance company had repudiated both the claims only on the ground that treatment was taken in a hospital which was outside the approved list of hospitals provided to the policy holder along with the policy. Moreover, the claims were not intimated to it within 7 days from the date of injury/accident/treatment as per condition 5(3) of the policy. Therefore, the claims had been repudiated.

4. I have very carefully considered the submissions of the complainant and also perused the written replies placed on record on behalf of the insurer. After due consideration of the matter, I found that the insurance company was not justified in repudiating the claim only on the ground that treatment/operation was got done in a hospital which was outside the approved list of hospitals given to the policy holder. The claim is otherwise admissible and payable and the same cannot be repudiated only on technical ground. Accordingly, Award is passed with the direction to the insurer to settle both the claims and make the payment of Rs.1,22,459/- along with penal interest @8% from the date of repudiation to the actual date of payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/122/RSA/10
In the matter of Shri Satpal Agarwal
Vs
Royal Sundaram Alliance Insurance Company Limited

AWARD dated 17.12.2010 - Repudiation of motor claim

1. This is a complaint filed by Shri Satpal Agarwal (herein after referred to as the complainant) against the decision of the Royal Sundaram Alliance Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of motor claim.

2. The complainant stated that his vehicle No.DL-9CG-8332, Toyota Qualis was stolen near his residence. At the time of theft, all documents were kept in the vehicle and they were also stolen along with the vehicle. The information was given to police at 100 number at 10.35 a.m. The company was also contacted on phone but nobody picked up the phone to 2 to 3 days. He further stated that he had gone to Gurgaon many a times and had submitted all requisite documents but he was told by the officers of the company that somebody will come and documents be handed over to that person. On 15.06.2009, a man from the insurance company came and he had taken all the documents. Thereafter, Order 173 was demanded which was also given. It was informed to him that only one key of the vehicle was deposited. The vehicle was old and was purchased and at that time only one key was received from the previous owner. This fact was also given in writing and was also given in writing by the previous owner. The company had repudiated the claim on the ground that intimation was given late. He submitted that he is a semi-literate person and was not in a position to run here and there as he was a kidney patient. The company was contacted on phone but there was no response on behalf of the company. He submitted that his claim be got settled at an early date.

3. The company informed vide letter dated 26.10.2009 to the complainant that no proper steps were taken by him to safeguard the vehicle from loss and thus condition No.4 has been violated. Further intimation of loss was given to the company late by 8 days and to the police by 17 days and thus Condition No.1 has also been violated. The company also had written submissions which are placed on record wherein it has been submitted that letters were written to the insured for submission of the key of the vehicle but the complainant did not produce one key stating that the same was lost. It also referred to the conditions No.1 & 4 of the policy which were breached by the policy holder.

4. I have considered the submissions of the complainant and also perused the written submissions of the company as placed on record. I have also heard the representative of the company and also the policy holder during the course of hearing. After due consideration of the matter, I hold that the company was not justified in repudiating the claim firstly because the complainant had narrated the circumstances under which other key was not deposited. The vehicle was purchased by him from previous owner and he was handed over only one key and the same was deposited to the company. Secondly, insured had intimated the police almost immediately after occurrence of theft on 100 number. Informing police at 100 number is also a way of informing the police. Thirdly, there is no reason for me to disbelief the complainant's submission that information about theft was given to the insurance company immediately on phone but nobody had picked up the phone for 2 to 3 days. There is no denying the fact that the vehicle was stolen and the same was untraced. When theft took place, the vehicle was insured and the same was parked near the residence. Further, the facts of the cases relied upon by the representative of the company are not identical with the facts of the case under reference, therefore, the decision relied upon by the representative of the company are inapplicable in reference to present case though due regards have been given to such observations in the judgments.

In my considered view, keeping in view the above facts, there is no blatant violation or breach of condition No.1 & 4 as mentioned by the company. In my considered view, the claim is payable and insured needs to be compensated for the loss suffered by him by way of theft of the vehicle. Accordingly Award is passed with the direction to the insurance company to make the payment of IDV less policy clause along with penal interest @ 8% from the date of repudiation to the date of actual payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/88/IFFCO/10
In the matter of Shri Ram Kishan Gupta
Vs
IFFCO Tokio General Insurance Company Limited

AWARD dated 02.12.2010 - Repudiation of mediclaim

1. This is a complaint filed by Shri Ram Kishan Gupta (herein after referred to as the complainant) against the decision of the Iffco Tokio General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that he made complaint regarding non-settlement of claim against his mediclaim policy No. 52059787 & 52103259 issued by Iffco Tokio General Insurance Company Limited on 04.12.2009. He had also approached the Grievance Redressal Officer of the insurance company on 23.12.2009 but he had not received any reply from the insurance company. He requested that his claim be got settled at an early date. However he further stated the company had paid his claim on 07.06.2010 after a delay of 19 months and 17 months from filing his claim and therefore, the company is under obligation to make payment of interest for 19 months on claimed amount of Rs.42399/- and for 17 months in respect of claimed amount of Rs.4916/-. He also requested that he be reimbursed the conveyance expenses etc. too.

3. The company had placed on record written submissions where in it has been submitted that the complainant had submitted claims and the same were processed and were denied under general condition 6 of the policy. Thereafter, the claims were further reviewed and settled. A sum of Rs.4986/- was paid vide cheque dated 05.05.2010 and a sum of Rs.42399/- was paid vide cheque dated 05.05.2010.

4. I have considered the submissions of the complainant and have also perused the written replies as placed on record on behalf of the insurance company. I have also perused the payment details provided by the company. After due

consideration of the matter, I hold that the company was not justified in settling the claims late. There has been a delay in settling the claims of the complainant and accordingly, there appears to be justification for penal interest to be paid by the insurance company. Accordingly, Award is passed with the direction to the insurance company to make payment of penal interest @ 8% from January, 2009 to the date of actual payment on amounts already paid to him.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/278/ICICI Lombard/09
In the matter of Shri Naveen Kaul
Vs
ICICI Lombard General Insurance Company Limited

AWARD dated 03.01.2011 - Repudiation of mediclaim

1. This is a complaint filed by Shri Naveen Kaul (herein after referred to as the complainant) against the ICICI Lombard General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant stated that he had covered his father Shri Rattan Lal Kaul for the health insurance cover in December,2008 under company aided parental medical insurance policy. The insurance policy clearly mentioned 'Comprehensive Cover' with no exclusions if the policy was purchased between 01.12.2008 to 20.01.2009. He purchased the policy during such period. The policy was for the period from 01.12.2008 to 30.11.2009. His father fell sick during January, 2009 and needed hospitalization. He was admitted in Sir Ganga Ram Hospital on 19.02.2009. He requested cashless hospitalization claim with the TPA which was denied stating "chronicity of the ailment cannot be ruled out". The TPA appointed their expert panel of Dr.Faizal Mahmood, who was part of the investigation of his father for three full days. On discussions, the attendants and the panel of doctors, Dr. Faizal suggested that he concurs with the opinion of Sir Ganga Ram medical panel doctor and would recommend processing of the claim. His father was discharged from the hospital on 08.03.2009 and he had to clear all the bills. He put the claim with the TPA for processing but the TPA denied and repudiated the claim on the ground that the claim for ailment of CLD with advanced complications within the 2nd month of policy cover indicates the pre-existing liver ailment and hence claim stands repudiated under clause 3(1). He

submitted that he had been providing documents to the effect that there has been no past history and even offered to provide a certificate from the medical experts treating him for last several years, there is no liver related ailments with which he was suffering. The complainant requested that his claim be got settled at an early date.

3. The Insurance company informed through TPA that it confirmed to receive the claim and stated its inability to admit the liability due to the following, "On perusal of the claim documents founds to be, this claim pertains to admission for evaluation of acute on chronic liver disease with presenting complaints of jaundice, ascites and liver de-compensation symptoms since over a month and insured only in the 2nd month of policy cover. Insured is also a known case of CAD status CABG and intrathoracic pseudoaneruysm of graft vessel. Investigations revealed deranged LFT, RFT and raised INR. Acute on chronic disease. The claim for ailment of CLD with advanced complications within the 2nd month of policy cover indicates the pre-existing liver ailment and hence claim stands repudiated under Clause 3(1). During the course of hearing, the representative of the company stated that due to pre-existing disease, the claim is not payable. The representative of the company stated that expert opinion was also taken which opined that disease with which the father of the complainant suffered was a pre-existing disease.

4. I have considered the submissions of the complainant and have also perused the repudiation letter of the company placed on record. After due consideration of the mater, I hold that the company was not justified in repudiating the claim because complainant had taken a policy wherein pre-existing diseases were covered and there was no waiting period and no exclusions were also applicable in the concerned policy which was taken under which the claim has been made. Accordingly, the claim is payable as per terms and conditions of the policy. Therefore, Award is passed with the direction to the company to make the payment of Rs.1,50,000/- being the sum insured under the policy to the complainant.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/46/UII/10
In the matter of Shri O.P. Mittal
Vs
United India Insurance Company Limited

AWARD dated 03.02.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Shri O.P. Mittal (herein after referred to as the complainant) against the decision of United India Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complainant stated that he had approached the grievance cell for redressal of his grievance but the grievance was not settled so far. The details of balance payment of Rs.8444/- was already given to the concerned office vide letter dated 24.12.2009. He requested this forum to get his grievance settled at an early date. complainant stated that Rs.1700/-related to investigation advised by Shri K.C. Memorial Hospital to Nigam Diabetes Centre to control B.P., Diabetes and related problems to undergo intraocular surgery in K.C. Memorial Eye Hospital, Jaipur. Medicines for Rs.6718/- was consumed to control problem. Pre and post hospitalization is advised by K.C. Memorial Hospital. He received discharge voucher for Rs.15526/- against the claim of Rs.23970/- though he received the payment under protest mentioning the same on the Discharge Voucher and balance amount of Rs.8444/- was not paid to him.

3. Insurance Company vide its letter dated 17.09.2010 submitted the reply wherein it has been stated that insured was hospitalized for the period 14.02.2007 to 15.02.2007. Though as per clause 5.4 of the policy, the claim papers must be submitted to TPA within 7 days from the date of discharge but insured submitted the papers after 89 days. The TPA had settled the claim reasonably for an amount of Rs.15526/-. During the course of hearing it was submitted that the papers relating to claim of Rs.8444/- were not submitted.

4. I have considered the submissions of the complainant. I have also perused the written submission of the Insurance Company. After due consideration of the matter I hold that the Insurance Company is under obligation to make the payment of balance amount also of Rs.8444/- because entire claim is payable. Accordingly, award is passed with the direction to the Insurance Company to make the payment of Rs.8444/- as this amount is also payable.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/43/UII/10
In the matter of Shri Anil Gupta
Vs
United India Insurance Company Limited

AWARD dated 03.02.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Shri Anil Gupta (herein after referred to as the complainant) against the decision of United India Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complainant stated that he had submitted Mediclaim for Rs.26252 to Vipul Med Corp. TPA Pvt. Ltd. on 08.08.2009. He further submitted that he had Mediclaim policy no. 140400/48/08/41/0001577 of United India Insurance Co. Ltd. through Bank of Rajasthan under group Insurance covering 1+3 for the period 26.07.2008 to 25.07.2009 which was subsequently renewed upto 25.07.2010. as per plan A of Raj Bank, Arogya Nidhji Plan policy clearly indicates to cover 1+3 under Group Insurance policy. On 13.12.2008 his wife Pooja Gupta gave birth to twins and he intimated this fact through Bank along with Birth certificate and requested to include the name of newly born children within the limit of 1+3 for which no additional premium was chargeable. But unfortunately, the Insurance Company had refused to add the names of the newly born children and stated to include the names in the renewed policy. However, in the renewed policy their names were added. The newly born Master Abhinav Gupta was admitted to hospital on 26.07.2009 and discharged on 02.08.2009. It is submitted that as per terms and conditions of the policy, the new born children also became entitled to the benefit of the policy. Their names were includable in the policy since their birth 13.12.2008 whereas their names were included on 26.07.2009. Accordingly, he requested this forum to direct the Insurance Company to reimburse the claim because claim is payable.

3. The Insurance Company had submitted written reply dated 07.09.2010 wherein it has been stated that the policy no. 140400/48/09/41/000017369 was issued for the period 26.07.2009 to 25.07.2010 under which Shri Anil Gupta, Smt. Pooja were insured along with their twins Master Abhinav and Baby Mahak. On 26.07.2008, Master Abhinav was admitted in the hospital for treatment of fever and cough for 4 days and discharged on 02.08.2009. As per exclusion no. 4.2 of the Mediclaim policy, the expenses for diseased contracted during first 30 days of the policy are not covered hence the claim for treatment of Master Abhinav was repudiated.

4. I have considered the submissions of the complainant. I have also perused the written reply of the Insurance Company. After due consideration of the matter, I hold that the Insurance company was not justified in repudiating the claim because the children of the complainant were entitled to the benefit of the policy w.e.f. 13.03.2009 as informed by the bank as well as by the complainant to the Insurance Company. Since Master Abhinav is entitled to the benefits of the policy w.e.f. 13.03.2009, and has taken treatment from 26.07.2009 to 02.08.2009 clause 4.2 of the Mediclaim policy is not applicable. Thus complainant is entitled to reimbursement of the expenses incurred by him on the treatment of his son Master Abhinav. Accordingly, award is passed with the direction to the Insurance Company to make the payment of Rs.26,256/-.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/381/ICICI Lomb/10
In the matter of Shri Anil Gupta
Vs
ICICI Lombard General Insurance Company Limited

AWARD dated 03.02.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Shri Anil Gupta (herein after referred to as the complainant) against the decision of ICICI Lombard General Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complainant stated that he had approached the grievance cell of the Insurance Company for redressal of his grievance but his grievance has not been settled so far. In his complaint he had given the detailed narration of the grievance and also history of the claim. It has been submitted that on 21.09.2009 OPD consultation was taken at SDMH Hospital and Rs.5000/- was paid to hospital vide their receipt no. 15116889 and 1519780. He had given complete details of the prescription as given by the doctor and thus paid by him. He further stated that as per condition no. 5 of letter no. 4/102/Ins.Sch./NAT/2008dated 11.03.2010 issued by National Trust all existing cases falling due for renewal even before 02.10.2010 can avail the grace period till 02.10.2010. As such all existing cards will remain valid till 01.10.2010 even without renewal subject to stop loss provisions. Complainant stated that his claim was completely in order and therefore he was fully eligible to get reimbursement of medical expenses but the company rejected his claim on baseless grounds and giving contradictory statements. It is further requested to this forum to give necessary directions to the insurance Company to reimburse medical expenses. He further submitted that he had filed the claim on 15.11.2009 for Rs.2555/- but the Insurance Company had rejected the same due to late submission of the claim.

3. Representative of the Insurance Company attended the hearing. He was required to submit the reply within 10 days but no reply was submitted on behalf of the Insurance Company though considerable time had been lapsed. It is presumed that Insurance Company has nothing to say in the matter. The Insurance Company vide its letter dated 27. 07.2010 informed Shri Manu Aggarwal that the National Trust (the insured) had directed them to cancel all the cards issued prior to 02.10.2009 with effect from 01.10.2009. It had also informed that the claims for the treatment upto the date of 01.10.2009 should be paid by the Insurance Company only if such claims are received within 30 days of the date of treatment, in any case no claim was to be paid if received after 31.10.2009.

4. I have considered the submissions of the complainant and also the verbal arguments of the representative of the insurance company as made by him during the course of hearing. After due consideration of the matter I hold that claim of the complainant for an amount of Rs.2555/- cannot be denied merely because the claim was filed late by few days, because the claim is otherwise admissible. Accordingly, award is passed with the direction to the insurance company to make the payment of Rs.2555/-

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/146/RGI/10
In the matter of Shri Umesh Gupta
Vs
Reliance General Insurance Company Limited

AWARD dated 03.02.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Shri Umesh Gupta (herein after referred to as the complainant) against the decision of Reliance General Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complainant stated that the claim of his wife Smt. Reeta Gupta was rejected on the ground of "Internal Tumour". It is stated by the complainant that this exclusion was not mentioned in prospectus given to him. Disease of his wife does not fall under exclusion clause and even the claim has been repudiated, he felt cheated. He further stated that pain started with complaints of Acute Vertigo w.e.f. 25.08.2008 and finally diagnosed through MRI dated 19.11.2008 to be suffering from Brain Tumour (Large Bilateral Anterior Falx Maningiona with Bilateral Discending Transtentorial Hernniation). She was hospitalized on 26.11.2008 to 05.12.2008 for surgery of the brain and all documents along with the claim were filed to the TPA Med assist. He requested that his claim be got settled at an early date. During the course of hearing, he argued that the claim is payable and the tumour with which his wife was suffered was not Benign and it was not treated as benign. Even the test could not specify the exact nature of tumour. Even the discharge summary from the hospital did not specify that it was a Benignal Tumour and it was not benign tumour it was communicated, therefore the claim is payable.

3. Insurance company had submitted written reply dated 29.07.2010 which was placed on record wherein it has been stated that complainant Shri Umesh Gupta obtained Reliance Health wise Gold policy valid from 20.12.2007 to 19.12.2009 covering himself along with spouse. On 26.11.2008 his wife Reeta Gupta was admitted in Paras Hospital as a case of B/L frontal falx meningioma with sup saggital sinus infiltration. She was discharged on 05.12.2008 and preferred a claim of Rs.196175/- under the policy. It was mentioned further that the expenses incurred on treatment of certain disease within one year from the inception of the policy are not payable. It had given details of the disease/illness/ailments wherein claim is not payable in the first year of the policy. According to the insurance company, since the treatment was taken for Benign Tumour, reimbursement of which are not payable in the first year of the policy. Similar reasons were given by the insurance company while repudiating the claim while intimating the decision to the complainant. During the course of hearing the representative of the

insurance company stated that since treatment was taken for Benign Tumour the claim is not admissible.

4. I have considered the submission of the complainant. I have also perused the written reply by the insurance company and also considered the verbal arguments of the representative of the insurance company at the time of hearing. after due consideration of the matter I hold that the insurance company was not justified in repudiating the claim because the patient did not suffer with Benign Tumour but it was the meningioma tumour for which patient was operated. The treatment was taken by the patient on account of Meningioma tumour and not on account of Benign tumour, therefore in my considered view the claim is payable. The discharge certificate nowhere mentioned that it was a Benign Tumour. The nature of tumour which was removed surgically can be termed as malignant. Thus, it is held that the insurance company was not justified in repudiating the claim. Accordingly, award is passed with the direction to the insurance company to make the payment of Rs.196175/- along with penal interest @8% from the date of repudiation i.e. 05.03.2009 till the date of actual payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/149/OIC/10
In the matter of Smt. Madhu Dhal
Vs
The Oriental Insurance Company Limited

AWARD dated 03.02.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Smt. Madhu Dhall (herein after referred to as the complainant) against the decision of Oriental Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complainant stated that she had Mediclaim policy for her and her family for the last few years and no claim has been preferred during such years. Unfortunately she was diagnosed with Kidney Stone during July 2009 and had been under the treatment at R G Stone Urology & Laparoscopy Hospital, Pitampura, Delhi. She informed the hospital about the medical policy and the same was referred to the TPA M/s. Alankit Healthcare TPA Ltd., Jhandewalan, New Delhi for their approval. At the time of discharge from the hospital she was given 2 bills amounting to Rs.47000/-. She was asked by the hospital to pay Rs.15000/- and balance amount of Rs.32000/- will be settled directly from the TPA. at this point she came to know that TPA has authorized a sum of Rs.32000/- to the hospital authorities. She was forced by the hospital to write that the sum of Rs.15000/- being paid by her to the hospital on her free will and that she would not claim this amount from the insurance company. After discharge from the hospital, she submitted her claim for Rs.23053/- with the TPA and TPA had sent him cheque for Rs.8053/- without giving

any reasons for not giving balance amount of Rs.15000/-. She had requested the TPA for giving reasons for not allowing the balance sum of Rs.15000/- but no reply was given. She also approached the grievance cell of the company but she did not receive any reply. She had approached this form with a request to direct the insurance company to make the payment of Rs.15000/- paid by her to the hospital relating to the treatment.

3. During the course of hearing the insurance company was represented by no officer. Nor any written reply was received on behalf of the Insurance Company. In absence of reply on behalf of the Insurance Company, the complaint is to be decided on the basis of the material on record. I find that the complainant was forced to write to the hospital that she would not claim the sum of Rs.15000/- from the insurance company, despite the fact that this amount was charged by the hospital only on account of treatment of the patient. When TPA can authorize the payment of Rs.32000/- it could have also authorized the payment of Rs.47000/-. When the cost of the treatment is Rs.47000/- thus entire cost should have been made by the TPA. In my considered view since cost o the treatment was much more than the amount of Rs.32000/- directly settled by the TPA to the hospital, the insurance company is under obligation to make the balance payment t the insured. Accordingly, award is passed with the direction to the insurance company to make the payment of Rs.15000/- along with penal interest @ 8% from the date of less payment release i.e. 16.10.2009 to the date of actual payment because insured paid Rs.15000/- also to hospital relating to treatment of patient in the hospital.

4. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

5. Copies of the Award to both the parties.

Case No.GI/164/NIC/10
In the matter of Shri Brij Mohan Gupta
Vs
National Insurance Company Limited

AWARD dated 03.02.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Shri Brij Mohan Gupta (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complainant stated that he had taken a Mediclaim policy from National Insurance Co. Ltd. bearing no. 8500002667 valid from 05.11.2008 to 04.11.2009 and premium was paid accordingly. The Mediclaim policy insurance was taken from M/s. National Insurance Co. Ltd. two years ago and the same is continued. The insured was also holding Mediclaim policy from Oriental Insurance Company Limited from the year 2000 to 2007 and thus the complainant remained in insurance covert since 2000 without having any history of ailment. However, the complainant was having problem of breathing and breathlessness while sleeping and it became serious in recent past. Complainant consulted Dr. S.N. Dube for uncontrolled HTN, uncontrolled NIDDM and breathlessness

and on the advice of the doctor the complaint himself was hospitalized for the thorough check-up and remained in the hospital from 05.09.2009 to 07.09.2009 and the complainant had paid a sum of Rs.13600/- vide bill no. 21656. He was advised to avoid future complications and serious ailments, the complainant had to take CPAP machine as per doctor's advice which was purchased for an amount of Rs.78000 and further pulseeoxymeter was also purchased for Rs.6760/- and paid a sum of Rs.12000/- further for Sleep study and thus he has raised the bill for an amount of Rs.113917/- during the valid duration of the policy. He had submitted all requisite documents for settling the claim. Insurance company further cited clause 4.3 and 4.16 to state that remaining amount are not payable. He argued that clauses as mentioned by the insurance company 4.3 and 4.16 ate not applicable in his case and he requested this forum to get the remaining amount released.

3. Insurance company informed that as per terms and conditions of the policy, he is entitled to only a sum of Rs.13490/- and which was paid by way of cheque out of claim amount of Rs.113917/-. It submitted further that Rs.78000/- for CPAP and Rs.6760/- for pulseeoxymeter are not payable as per clause 4.16 of the policy. It also has given the details of other deduction made by it. It further stated that Rs.12000/- deduction for sleep study on account of the fact that proper receipt was not enclosed.

4. I have considered the submissions of the complainant. I have also perused the reply given by the insurance company to the insured which is placed on record stating therein the details of the payment which are not reimburseable. After due consideration of the matter I hold that insurance company was not justified in not releasing the sum of Rs.12000/- being an expenditure incurred by the complainant on sleep study, the complainant had made this payment vide bill dated 30.08.2009. As regards other deduction made by the insurance company the same appear to be in order. The submission of the complainant that in his case clause 4.16 and clause 4.3 are not applicable is not correct because he is bound by the terms and conditions of the policy and also by the various clauses of the policy. Accordingly, award is passed with the direction to the Insurance Company to make the payment of Rs.12000/- related to sleep study and it is held further that complainant is not entitled to any other relief. The insurance company had given detailed reasons for not allowing other claims.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/157/OIC/10
In the matter of Shri Arvind Kumar
Vs
The Oriental Insurance Company Limited

AWARD dated 03.02.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Shri Arvind Kumar (herein after referred to as the complainant) against the decision of Oriental Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complainant stated that his mother was hospitalized from 21.12.2005 to 30.12.2005 in Lokpriya Hospital, Garh Road, Meerut. Initially his TPA was M/s. Geniss India Ltd. so he informed M/s. Geniss about hospitalization of his mother and after completing al formalities, he was ready to submit the documents to M/s. Geniss but his agent Shri Attam Prakash Mittal informed him that the TPA had been changed to Raksha TPA Ltd. so he informed Raksh TPA about his mother's hospitalization. The Oriental Insurance Company neither informed him about the change of TPA nor sent TPA insurance card. After getting claim form from Raksha TPA, he submitted all bills, documents and original report to the Raksha TPA in February 2006. Raksha TPA informed him that he is required to submit all original report and Raksha TPA would return all reports after settling Mediclaim for further treatment. Due to lack of knowledge he submitted these documents late. Raksha TPA did not send any letter regarding status of his mother claim. Infact it was very tough to talk Raksha TPA on phone. He submitted all requisite documents which are necessary for settling the claim. He also sent all doctors bills, medical bills and documents of Rs.4176/- for post hospitalization treatment. He again contacted TPA regarding status of his mother's Mediclaim. He was informed that it closed his mother's claim on 13.06.2006 without informing him. He had made request to number of officers in the insurance company for claim to be settled but so far his claim has not been settled. As a matter of fact he has been repeatedly requested to submit documents. He had gone to USA for higher studies from October 2007 to April 2009 and he could not per pursue the matter. Again documents were required which were submitted by his father-in-law.

3. Though the insurance company was represented on the date of hearing but no reply was submitted. It was submitted during the course of hearing by the representative of the company that claim is not payable as the claim was filed late.

4. I have considered the submissions of the complainant. I have also considered the verbal arguments of the representative of the company that claim is not payable as the claim was made late. After due consideration of the matter I hold that the insurance company was not justified in repudiating the claim because complainant had made available all requisite documents to the concerned TPA for settling the claim. He had made all efforts to get the claim settled but the insurance company had not settled the claim. As a matter of fact the claim was closed without intimating the complainant. In my considered view the claim was payable and the insurance company ought to have settled the claim and the same should not have been closed without intimating the complainant. Complainant deserved to know as to why the claim is closed by the TPA since claim is payable, the insurance company is under obligation to make the payment. Accordingly award is passed with the direction to the insurance company to make the payment of an amount of Rs.33852/- along with penal interest @8% w.e.f. 13.06.2006 to the date of actual payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/166/NIC/10
In the matter of Shri Vijay Kumar
Vs
National Insurance Company Limited

AWARD dated 11.02.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Shri Vijay Kumar (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complainant stated that he is a policy holder of National Insurance Co. Ltd. He had taken a Mediclaim policy which covers his family. On November 11 his wife got admitted in the hospital and she was discharged on 13.11.2009. He submitted all requisite documents for settling the claim to the TPA but the claim was repudiated stating therein that the hospital where treatment was taken is not listed one. It is submitted by him that he was not aware about this fact. He had requested this forum to intervene in the matter and got his claim settled. He had already approached the grievance cell of the insurance company but had not got any reply.

3. TPA Alankit Healthcare Ltd. informed the Branch Manager of the insurance company vide its letter dated 02.01.2010 that while scrutinizing the claim documents, it was found that the expenses incurred during the hospitalization period to Sawan Neelu Angel's Nursing Home- New Delhi which is outside the approved list of Delhi Hospitals provided to it by the insurance company are not reimbursable. Accordingly claim is not payable at its end. No reply had been submitted on behalf of the insurance company neither any officer of the insurance company was present on the date of hearing.

4. I have considered the submissions of the complainant. I have also perused the letter as mentioned above written by the TPA to the insurance company. After due consideration of the matter I hold that the claim is payable. The same has been repudiated only on the ground that the treatment was not taken at the listed hospital. No other reason has been given even by the TPA for repudiation of the claim.

Thus the claim is payable and the same could not be rejected only on technical ground. Accordingly, award is passed with the direction to the insurance company to make payment of Rs.12500/- along with penal interest @ 8% from 02.01.2010 till the date of actual payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/170/NIC/10
In the matter of Shri Manish Jain
Vs
National Insurance Company Limited

AWARD dated 11.02.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Shri Manish Jain (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for.

2. Complainant stated that he got his Mediclaim policy renewed from National Insurance Co. Ltd., West Punjabi Bagh, New Delhi. He submitted that his mother Smt. Asha Jain was operated for right eye cataract at Veena Nursing Home on 22.09.2009. Two years earlier left eye operation was also operated at the same hospital and expenses relating to such treatment were reimbursed but now the insurance company had changed its policy that treatment will have to be taken in the listed hospital but such information was not provided to him. He requested this forum to intervene and got his claim settled.

3. M/s. Vipul MedCorp TPA Pvt. Ltd. informed the Divisional Manager of the insurance company vide its letter dated 28.12.2009 that the treatment was not taken by the patient at the listed hospital and had submitted file to the insurance company without taking any decision with regard to admissibility of the claim. The gist of this letter is that the claim is not payable because treatment was not taken in the listed hospital.

4. I have considered the submissions of the complainant. I have also perused the letter as mentioned above written by the TPA to the insurance company. After due consideration of the matter I hold that the claim is payable. The same has been repudiated only on the ground that the treatment was not taken at the listed hospital. No other reason has been given even by the TPA for repudiation of the claim. Thus the claim is payable and the same could not be rejected only on technical ground. Accordingly, award is passed with the direction to the insurance company to make payment of Rs.18795/- along with penal interest @ 8% from 28.12.2009 till the date of actual payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/167/NIC/10
In the matter of Shri Gurvinder Singh
Vs
National Insurance Company Limited

AWARD dated 11.02.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Shri Gurvinder Singh (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complainant stated that he had been getting himself and his family insured from National Insurance Co. Ltd., Roshanara Road, Delhi against Mediclaim policy for the last 10 years. He filed a claim for his son Kanwar Singh who was operated in M/s. Eden Hospital, East of Kailash on 04.05.2009. He informed M/s. Alankit Healthcare /National Insurance Co. Ltd. on 06.05.2009 and later submitted all papers and receipts from the hospital and claim to M/s. Alankit on 26.06.2009, but it is very sad to say that Alankit Healthcare Ltd. though received documents but refused to reimburse the claim on the ground that the hospital in which treatment was taken was not listed. It is submitted by him that this is not ethical or right for the Insurance Company as he was not provided the list of the hospitals. Insurance Company had not given list of hospitals where treatment is to be taken while issuing the policy.

3. The insurance company informed the complainant vide its letter dated 23.07.2009 repudiating the claim only on the ground that the treatment was not taken in the listed hospital. Insurance company also filed written reply dated 17.06.2010 which is placed on record wherein it has been mentioned that the claim was rejected because of Non-Network Hospital. Treatment was taken in the hospital which was outside the list of hospitals provided to the insured at the time of insurance.

4. I have considered the submissions of the complainant. I have also perused the letter of repudiation and written submission placed on record on behalf of the insurance company. After due consideration of the matter, I hold that the insurer was not justified to repudiate the claim because the claim is payable. The same has been repudiated only on the ground that the treatment was not taken at the listed hospital. No other reason has been given even by the TPA for repudiation of the claim. Thus the claim is payable and the same could not be rejected only on technical ground. Accordingly, award is passed with the direction to the insurance company to make payment of Rs.27658/- along with penal interest @ 8% from 23.07.2009 till the date of actual payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/168/NIC/10
In the matter of Shri Jawahar Goyal
Vs
National Insurance Company Limited

AWARD dated 11.02.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Shri Jawahar Goyal (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complainant stated that he had taken Parivar Mediclaim policy bearing no. 8500002126. He filed the claim in the D.O-09, on 17.06.2009 for a sum of Rs.262242/- for angiography and insertion of stent (coronary angioplasty surgery) at Escort Heart institute, Delhi. Despite National Insurance Co. issue him a cashless card but the concerned hospital authority had not given permission because the insurance company had not accepted the cashless card and advised him to deposit the amount in cash amounting to Rs.2,62,242/-. He submitted further that he had submitted all requisite documents comprising original bill and discharge summary etc. issued by the Escort Hospital dated 26.06.2009 but till date reimbursement has not been done by the insurance company. However, he had received a letter from the competent authority that it had repudiated the claim but it had not given any logical reason which is totally unjust and arbitrary. The complainant also approached the grievance cell of the insurance company but the claim has not been settled so far.

3. Insurance company vide its letter dated 23.12.2009 informed the complainant, that the patient was suffering from Coronary disease and since claim pertains to coronary artery disease and its complications, the same is chronic disease which has been excluded from the scope of Pariwar Policy under exclusion no. 4.3. Accordingly, competent authority had repudiated the claim.

4. I have considered the submission of the complainant. I have also perused the letter dated 23.12.2009. After due consideration of the matter I hold that insurance company was not justified in repudiating the claim because the complainant had taken Pariwar Mediclaim policy and the patient did not suffer from chronic disease, the chronic disease is one which is not cured even after the treatment. The patient in this case did not suffer from such disease. The patient was completely cured after treatment, therefore it cannot be said that the patient suffered from Chronic disease. It cannot be inferred reimbursement related to treatment of chronic disease. Accordingly, in my considered view the patient did not suffer from chronic disease and the expenses relating to treatment of the disease with which the patient suffered are payable. Accordingly, I hold that the insurance company was not justified in repudiating the claim; the patient had not suffered with the disease which is chronic in nature. Accordingly, award is passed with the direction to the insurance company to make the payment of Rs.262242/-.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/176/RSA/10
In the matter of Shri Dinesh Acharya
Vs
Royal Sundaram Alliance Insurance Company Limited

AWARD dated 11.02.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Shri Dinesh Acharya (herein after referred to as the complainant) against the decision of Royal Sundaram Alliance Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complainant submitted claim under policy no. HA00000276000107 for the period 28.06.2009 to 27.06.2010. Complainant stated that his daughter Ms. Arushi Acharya aged 8 years was complaining persistently pain in back for the last 1 ½ month. She was taken to Sir Ganga Ram Hospital, New Delhi on 07.01.2010 with severe pain in the OPD department. Her condition aggravated. During the process of examination, the consultant doctor advised her to admit her in the Paediatrics Ward (Unit-1) of Sir Ganga Ram hospital, for evaluation and for carrying out the clinical test/investigation in order to find out the cause of low back pain and associated vomiting. Since Ganga Ram Hospital was not in the list of panel hospitals of Insurance Company, he spoke to the customer care Executive Ms. Rajshree of Royal Sundaram Alliance Insurance Co., Chennai before admitting his daughter in the hospital. He was advised that claim may be put up for reimbursement after taking discharge from the hospital. After confirmation from the insurance company's office he got his daughter admitted in the hospital on 07.01.2010 in room no. 2315 B under Paediatrics ward (Unit-1) for further treatment. Doctor treated her first to control the low back pain and associated vomiting. He submitted that her daughter was finally discharged on 09.01.2010. He submitted the claim on 22.01.2010 along with requisite documents. The claim was repudiated on the ground that the treatment could have been taken as an OPD patient and hospitalization was not warranted. He approached Dr. Dinesh Kaul consultant, Deaprtment of Pediatrics of Sir Ganga Ram Hospital, New Delhi who told him that the investigating doctor at the hospital is the best judge to ascertain the condition of the patient whether admission in the hospital is necessary or not and to ascertain cause of action it was thought proper to admit patient in the hospital.

3. The insurance company repudiated the claim only on the ground that the patient could have been treated as OPD patient and hospitalization was not necessary and the same was done only for investigation purpose. However, the company further informed the complainant vide letter dated 05.04.2010 that the claim has been reviewed by Medical panel and it has been reconfirmed that the investigation done and treatment given could have been treated as an Out Door Patient and does not warrant hospitalization. Accordingly it regretted its inability to reconsider the claim. Insurance company also filed detailed reply dated 27.05.2010.

4. I have considered the submissions of the complainant. I have also perused the replies of the insurance company including repudiation letter, review letter and detailed written reply. After due consideration of the matter I hold that the insurance company was not justified in repudiating the claim of the complainant because admission in the hospital depended upon the advice of the doctor. In this particular case doctor's advice the patient got treatment in the hospital. Doctor was the best judge to admit the patient in the hospital or not whether to treat the patient in the OPD or not. As regards the complainant he had suffered and had made the payment for the treatment of his daughter. Accordingly, in my considered view the claim is payable and insurance company is under

the obligation to reimburse the claim as per terms and condition of the policy. Accordingly, award is passed with the direction to the insurance company to make the payment of Rs.26358/- along with penal interest @ 8% from the date of repudiation i.e. 05.04.2010 to the date of actual payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/165/IFFCO/10
In the matter of Smt. Nirmal Ahuja
Vs
Iffco Tokio General Insurance Company Limited
AWARD dated 11.02.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Smt. Nirmal Ahuja (herein after referred to as the complainant) against the decision of IFFCO Tokio General Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complainant stated that he had filed a claim and also approached the grievance cell of the insurance company to settle the claim but the company had not resolved grievance so far. During the course of hearing it was submitted by the representative of the complainant that Mediclaim policy has been taken since 2006. The insurance company was not justified in making the claim as no claim. It had given vague reasons while repudiating the claim. Complainant stated that all requisites documents were provided for settling the claim. Clarification was also given from the doctor wherein doctor stated that the duration of complaint of pain and stiffness in both the knees is approximately for 1 to 1 ½ years instead of 5 years.

3. During the course of hearing, insurance company was represented by its official and he stated that the patient suffered from 5 years whereas it was stated later on that the patient was suffering with stiffness only for 1 ½ years.

4. I have considered the submissions of the complainant. I have also considered the verbal arguments of the representative of the insurance company. After due consideration of the matter I hold that the claim is payable. Accordingly, award is passed with the direction to the insurance company to make the payment of Rs.2,20,000/- subject to the limitation to the sum assured including bonus.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/82/Reliance/10
In the matter of Shri Rajeev Wason

Vs
Reliance General Insurance Company Limited

AWARD dated 11.02.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Shri Rajeev Wason (herein after referred to as the complainant) against the decision of Reliance General Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complainant stated that he had sent a letter to the grievance cell of M/s. Reliance General Insurance Company for redressal of the grievance but no response has been received from the grievance cell. The complainant requested this forum to get the claim settled at an early date.

3. Insurance company had informed the insured vide its letter dated 02.03.2009 that it had received the claim and on scrutiny it was found that patient was admitted in Ganga ram hospital. Insured has taken gold plan of the Reliance Healthwise policy as per certificate. On scrutiny of the document it was found that actual facts regarding the history of the disease has been suppressed by the hospital and the patient. Hence the claim is not payable as per clause no. 15 of policy terms and conditions. It is clearly mentioned that that claim is not payable. Insurance company also submitted written reply dated 22.11.2010 which is placed on record wherein it has been submitted that the insured had taken policy for the period 23.07.2007 to 22.07.2008 which covers him and his spouse and also 2 daughters. Complainant got admitted in Sir Ganga Ram Hospital as a case of Coronary Artery Disease (CAD) with Acute Anterior Myocardial disease with Acute Anterior Myocardial infraction with Single Vessel Disease with LV dysfunction. He remained in the hospital for 4 days for treatment and preferred the claim of Rs.210781/-. It further stated that on verification it was found that hospital has suppressed or by oversight missed the mentioning of facts regarding the past history/duration of diabetes mellitus (DM). On account of breach of clause no. 15 the insurance company stated that it had repudiated the claim.

4. I have considered the submissions of the complainant. I have also perused the repudiation letter and also the letter dated 22.11.2010. I also considered the verbal arguments made by both the sides on the date of hearing. After due consideration of the matter I hold that insurance company was not justified in repudiating the claim because the insurance company had not substantiated the reasons of repudiation by bringing on record evidence. The claim is payable, the insured had submitted requisite documents for settling the claim. In my view the insured had not violated the condition no. 15 as alleged by the insurance company. Accordingly, it is held that the claim is payable. Award is passed with the direction to the insurance company to make the payment of the claimed amount of Rs.210781/- along with penal interest @8% from the date of repudiation to the date of actual payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/183/NIA/10
In the matter of Shri Surinder Monga
Vs
New India Assurance Company Limited

AWARD dated 03.02.2011 - Rrepudiation of the mediclaim

1. This is a complaint filed by Shri Surinder Monga (herein after referred to as the complainant) against the New India Assurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of the mediclaim.

2. The complainant stated that this policy was provided by his employer M/S.Godfrey Philips India Limited as an old age security/loyalty bonus. Under this policy the medical expenses to be incurred over the balance life span after retirement will be reimbursed up to the amount of the sum insured as a joint limit for the insured person and spouse. He had put up a claim for Rs.26851/-on 07.01.2010 and another claim for Rs.29877 on 17.02.2010. He received a letter dated 11.02.2010 in response to his claim of Rs.26851/- for submission of certain documents. He submitted that he was surprised to see the observation of the company that it is closing the claim file as hospital admission was not required. He submitted that admission to the hospital is subjected to doctor's prescription. It is not and never a whim or choice of patient. Looking to the sensitivity of the treatment, patient/family members have to think and consult about the benefits and drawbacks and have to seek opinions of others, before jumping to the immediate conclusions. The complainant had given full history and stated that the hospitalization was required and the company was not justified in repudiating the claim.

3. The company in its reply stated that treatment could have been taken as an OPD basis and hospitalization was not required. In repudiation letter also, the company had given the reason for repudiation that the hospitalization was not needed.

4. I have considered the submissions of the complainant and have also perused the repudiation letter and company's another letter giving therein the reasons for repudiating the claim. After due consideration of the matter, I hold that the company was not justified in repudiating the claim because the claim is payable and the hospitalization was done as per the need of the patient at particular point of time. In my considered view, the company cannot repudiate the claim citing the reason that the treatment could have been taken as an OPD basis and the hospitalization was not required. It was felt necessary to get him admitted in the hospital and the treatment was taken therein. The complainant had met the terms and conditions of the policy for reimbursement of the claim. **Accordingly Award is passed with the direction to the insurance company to make the payment of Rs.25225/- to the complainant. (Rs.26851.00 - Rs.1626.00 which**

is not payable as the same is related to the treatment taken before hospitalization).

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/179/RGI/10
In the matter of Shri Sanjay Gupta
Vs
Reliance General Insurance Company Limited

AWARD dated 03.02.2011 - Non-settlement of mediclaim

1. This is a complaint filed by Shri Sanjay Gupta (herein after referred to as the complainant) against the decision of the Reliance General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of non-settlement of mediclaim.

2. The complainant stated that the company had not granted the mediclaim for an amount of Rs.15413/- in respect of policy No.282550084858. He had approached the Grievance Redressal Officer of the company for redressal of the grievance but he had got no response. He submitted that the company had paid no attention to his request for settling the claim and he had come to this forum only as a last hope for getting his claim settled.

3. The company had submitted detailed written reply which is placed on record wherein it has been submitted that the insured had taken Reliance Healthwise Policy No.282550084858 from 20.05.2008 to 19.05.2009. The complainant was admitted in Sir Ganga Ram Hospital on 11.05.2009 with a complaint of discharge from the Lt. Ear and Reduced hearing Lt. Ear since 6 months. He was discharged on 12.05.2009 after necessary surgery. It is submitted that the claim for an amount of Rs.51865/- has already paid to Sir Ganga Ram Hospital. The complainant submitted bill for pre and post hospitalization claim amounting to Rs.15413/- which was repudiated by the TPA vide letter dated 30.10.2009. The claim was repudiated under Clause 3 of the claim procedure which stipulates that the company requires the insured person to deliver to the TPA at their own expense within 30 days of the insured from the date of discharge from the hospital.

4. I have considered the submissions of the complainant and have also perused the repudiation letter and also the written submissions of the company. After due consideration of the matter, I hold that the company was not justified in repudiating the claim merely because the claim was filed late by few days. The claim is payable and the company is under obligation to honour its liability. The company also had not acted as per verbal assurance given by its representative during the course of hearing. Accordingly Award is passed with the direction to

the insurance company to make the payment of Rs.15413/- along with the penal interest @ 8% from the date of repudiation to the date of actual payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/180/RGI/10
In the matter of Ms. Priya Chopra
Vs
Reliance General Insurance Company Limited

AWARD dated 03.02.2011 - Non-settlement of mediclaim

1. This is a complaint filed by Ms. Priya Chopra (herein after referred to as the complainant) against the decision of the Reliance General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of non-settlement of mediclaim.

2. The complainant submitted that she is the holder of health policy from Reliance General Insurance Company Limited for the last couple of years. She got suddenly ill and had to be hospitalized in Ashlok Hospital which is in the panel of Reliance General Insurance Company. She was denied cashless facility and she filed the claim which has already been repudiated on frivolous grounds casting aspersions on her dignity. She had made appeal to the company and submitted two letters to the Grievance Redressal Officer of the company but she had not received any reply. She requested this forum to look into the grievance and got the same settled at the earliest possible time.

3. The company vide its letter dated 14.09.2009 informed the complainant that the claim is not payable. It was mentioned therein that Ms. Priya Chopra was admitted at Ashlok Hospital on 28.04.2009 with diagnosis of Acute Pyelonephritis, case investigated and while going through the documents and evidences collected during investigation, it is observed that there is no advice from a qualified doctor for admission; thus not fulfilling the preamble of the policy.

   It was also mentioned that hospital has deliberately inflated the bills by charging the costly medicines, which were either nor administered to the patient or administered earlier and prescribed later. It is also observed that hospital has charged for all those visits of doctors which are nowhere present in the hospital records. On the basis of these evidences and document it is concluded that hospitalization is not genuine and fraudulent means are used to make the claim payable. Thus the company had regretted its inability to admit the liability under

the policy. The company also filed detailed submissions wherein also it had concluded that the claim was not payable. It has been stated that the insured had taken Reliance Health wise policy No.282510307947 for the period 22.08.2008 to 21.08.2009. It also accepted to have received the claim for an amount of Rs.98883/-. The claim was repudiated on 14.09.2009 under Condition No.15 of the policy condition that is, fraudulent claim. It has also quoted condition No.15 in the written submissions.

4. I have considered the submissions of the complainant and have also perused the written submissions on behalf of the company which are placed on record and also its repudiation letter. After due consideration of the matter, I hold that the company was not justified in repudiating the claim because there is no denying of the fact that the patient was admitted in the hospital and the treatment was done in the hospital which is on the panel of the company. The company had not placed on record supportive evidence to the effect that the claim was fraudulently made; it was supported by verbal arguments only. The company had not denied the fact that the patient was admitted in the hospital, treatment was taken during the currency of the policy period and accordingly the claim is payable. **Accordingly Award is passed with the direction to the insurance company to make the payment of Rs.98883/- along with penal interest @ 8% from the date of repudiation to the date of actual payment.**

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/161/NIA/10
In the matter of Shri Ratan Kanti Bose
Vs
New India Assurance Company Limited

AWARD dated 03.02.2011 - Non-settlement of the mediclaim

1. This is a complaint filed by Shri Ratan Kanti Bose (herein after referred to as the complainant) against the New India Assurance Company Limited (herein after referred to as respondent insurance company) in respect of non-settlement of the mediclaim.

2. The complainant stated that he has been holding Good Health Plicy (Mediclaim and Personal Accident) along with his wife for a sum of Rs.5,00,000/- each mediclaim policy and Rs.10 lakh and Rs.5 lakh Personal Accident policy for him and for his wife with the New India Assurance Company Limited through City Bank, Chennai. The policy was taken more than 12 years back with no break. He stated further that he had made regular and timely payments towards premium till today without any default. During the policy period neither he nor his wife has ever made the claim against any medical expenses or hospitalization till 30.01.2008. He submitted further that TPA of the New India Assurance

Company Limited has been kind enough in settling all the claims which he submitted for his wife towards hospitalization and medical expenses. During the period 31.01.2008 to 26.10.2009, his wife has been keeping indifferent health for quite some time and under advise from treating physician, he had to admit her in the hospital on four occasions during the period 03.12.2009 to 07.03.2010 but the TPA started dishonouring the claims towards hospitalization and medical expenses by referring clause 4.1 of the policy. He submits that the company is not justified in invoking Clause 4.1 of the policy for repudiating the claim. He had taken up the matter with the TPA for reconsideration of the decision but the TPA had not responded and the total claim declined amounting to Rs.1,03,919/-. He had also approached the Grievance Redressal Officer of the company. He had submitted all requisite documents to the TPA for settling the claim. He requested this forum to get the issue resolved at an early date.The complainant vide his letter dated 12.01.2011 stated that he had not received the cheque No.49513 dated 08.06.2010 amounting to Rs.41065/- which is stated to have been given by the company.

3. The company had submitted vide its letter dated 10.06.2010 that the company has been informed by the TPA, M/S.TTK Healthcare Private Limited that the claim has been settled for an amount of Rs.41065/- vide cheque No.49513 dated 08.06.2010. During the course of hearing, the representative of the company stated that the claim is payable and he promised to look into the matter. He was also required to submit report within the reasonable time but the company had not responded so far. This leaves me with no option but to decide the grievance on the basis of the evidence on records.

4. I have considered the submissions of the complainant very carefully and have also perused various letters of the company which are placed on record and also verbal arguments of the representative of the company made during the course of hearing. After due consideration of the matter, I hold that the company was not justified in repudiating the claims on the grounds of Clause 4.1 of the policy because the same is not applicable as the complainant is having the policy for the last 10 to 12 years in continuation without any break. The company had paid the claim and the insured as stated by him in the complaint that all claims have been paid by the company except for the treatment of his wife after 03.12.2009. The company had not given any specific reason for not allowing the claim for the treatment of the wife with effect from 03.12.2009 to 07.03.2010 except citing Clause 4.1 of the policy which is not applicable in the case of the complainant. In my considered view, all the four claims for a total amount of Rs.1,03,919/- are payable. **Accordingly, Award is passed with the direction to the company to make the payment of Rs.103919/- subject to verification of the receipt of the cheque No.49513 dated 08.06.2010 of Rs.41065/- by the insured.**

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/191/NIA/10
In the matter of Shri Anil Kumar
Vs
The New India Assurance Company Limited

AWARD dated 11.02.2011 - Non-settlement of All Risk Claim

1. This is a complaint filed by Shri Anil Kumar (herein after referred to as the complainant) against the decision of The New India Assurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non-settlement of All Risk Claim.

2. Complainant stated that his son had severe pain in the great right toe with swelling. He was taken to the doctor in Ganga Ram Hospital, Rajinder Nagar, New Delhi and was diagnosed by the doctor a boil. He was immediately given an incision and all the infection/push was drained out. The patient was advised to take rest for 3 days and put on strong antibiotics. However on 30.10.2009 when his son woke up in the morning he was surprised to see that whole feet had swollen and was having severe pain. He immediately rushed him to the doctor where he has been told that probably there been some foreign body present in the toe due to which the abscess and swelling has reoccurred. Doctor advised him for the hospitalization and he was hospitalized. He was operated upon and was discharged from the hospital a day after. Senior doctor was treating his son in the hospital which is one of the reputed hospital and the insurance company was not justified in repudiating the genuine claim. As a matter of fact complainant was surprised to receive the repudiation letter. He further submitted that his whole family is insured under Mediclaim policy for the last 11 years and has not claimed even a single claim till date.

3. Insurance company vide it letter dated 04.12.2009 informed the insured that the claim is not payable as patient was admitted as a case of abscess Right great toe and he was treated surgically and was discharged with follow up advice. Admission is not justified in this case as the patient was operated on the same day and could have been discharged also therefore the claim stands repudiated.

4. I have considered the submissions of the complainant. I have also perused the repudiation letter and also verbal arguments made by both the sides during the course of hearing. After due consideration of the matter I hold that the insurance company was not justified in repudiating the claim because the claim is payable and the insured had complied with all the requisite conditions for admissibility of the claim. Admission was taken in the hospital as per advice of the expert doctor and the insured was supposed to go by the advice of the medical doctor with regard to admission of his son. Therefore the claim otherwise admissible cannot be repudiated on flimsy ground. Accordingly, award is passed with the direction to the insurance company to make the payment of claimed amount of Rs.12200/-.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/228/NIC/10
In the matter of Shri Kanwaljeet Singh
Vs
National Insurance Company Limited

AWARD dated 23.03.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Shri Kanwaljeet Singh (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complainant stated that the insurance company was not justified in making only payment of Rs.228900/- out of total claim of Rs.274214/-. He submitted further that deduction as made by the insurance company out of the claimed amount is not justified. He provided a copy of the policy of the relevant period for which the claim has been furnished that there were no caps of the reimbursement of the expenses under various heads which have been referred to by the insurance company while making certain deductions. He requested that insurance company be directed to make the payment of balance amount of Rs.45314/-.

3. Representative of the insurance company stated that whatever claim was payable, the same was paid to the complainant. He submitted that deduction out of the claim has been made as per terms and conditions of the policy. Insurance company also submitted written reply wherein it has been stated that complainant was entitled only to Rs.228900/- out of the total claim of Rs.274214/- and therefore nothing further is payable.

4. I have considered the submissions of the complainant. I have also considered the replies of the insurance company placed on record and also the verbal arguments of the representative of the insurance Company. I have also perused the calculation sheet preferred by the insurance company indicating the deduction made out of the claim. After due consideration of the matter I hold that insurance company was not justified in deducting a sum of Rs.45314/- while making payment of Rs.228900/- out of total claim of Rs.274214/- because the caps on admissibility of expenses are not applicable during the currency of the policy. The complainant had taken the policy w.e.f. 21.04.2007 whereas

caps on the admissibility on the expenses under various heads became applicable only after issuance of the policy under reference therefore it is held that entire claim is payable. Accordingly, award is passed with the direction to the insurance company to make the payment of balance amount of Rs.45314/-.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/315/NIA/10
In the matter of Shri P.K. Garkhail
Vs
The New India Assurance Company Limited

AWARD dated 23.03.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Shri K.B. Srivastava (herein after referred to as the complainant) against the decision of Te New India Assurance Co. ltd (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complainant stated that he had made representation to the grievance cell of the insurance company. He noted with deep regret that several representations to the Regional Office and then his written representation to the grievance cell of the insurance company did not yield any result. During the course of hearing he stated that claim is payable. He submitted that he had taken Mediclaim policy bearing no. 312000/34/07/11/00000741 which covers himself and his parents. The policy was taken from Bikaji Cama Place Branch and is in continuation for the last 10 years. His mother who is covered under the policy developed some health problem in October 2007 and was diagnosed a case of M. Myeloma by AIIMs. Ever since she is under treatment at AIIMS for M.M. under advice of Dr. Lalit Kumar, Deptt. of Cancer AIIMS. When he approached the agent of the Insurance Company, he was surprised to find that he was told that the claim is not permissible as no hospitalization was involved. On 25.07.2008, the Divisional Manager required filing of certain details which were sent by e-mail on 26.07.2008. On 08.08.2008 he was informed by the Divisional Manager that the case has been referred to panel doctor. During the course of hearing it has been repeatedly argued by him that the claim is payable and in the facts and circumstances of the case hospitalization is not needed because the patient undergoes Chemotherapy treatment.

3. The case was heard on a number of occasions. Reply dated 12.01.2010 was filed on behalf of the insurance company wherein it has been stated that the complainant had not furnished the requisite documents. However, during the course of hearing the complainant stated that he had submitted all the requisite documents for settling the claim to the TPA.

4. I have considered the submissions of the complainant. I have also perused the written reply on behalf of the insurance company which is placed on record. After due consideration of the matter I hold that claim is payable as the patient suffered with M. Myeloma for which treatment is only Chemotherapy in Day Care. There is no requirement of hospitalization of 24 hours in the treatment of M. Myeloma as a matter of fact it is a continuous treatment and the policy is continued for the last so many years. Accordingly, Award is passed with the direction to the insurance company to make the payment of Rs.64085/-.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/224/NIC/10
In the matter of Shri Kuldeep Thakkar
Vs
National Insurance Company Limited

AWARD dated 23.03.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Shri Kuldeep Thakkar (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.
2. Complainant stated that Insurance Company was not justified in repudiating the claim on the ground that hospitalization at which treatment was taken was not included in the approved list of hospitals.

3. During the course of hearing the representative of the insurance company stated that claim was not paid only because of the fact that treatment was taken in the hospital which was outside the list of approved hospitals. However, he fairly admitted that claim is payable and the same surely be paid within a week.

4. I have considered the submissions of the complainant. I have also considered the verbal arguments of the representative of the insurance company. After due consideration of the matter I hold that insurance company was not justified in not settling the claim so far. The argument put forth by the representative of the insurance company during the course of hearing that claim was not paid on account of the fact that treatment was taken in the hospital which was outside the approved list of the hospitals could not stand, the claim is payable. Accordingly Award is passed with the direction to the insurance company to make the payment of the Rs.12424/-.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/234/Bajaj/10
In the matter of Shri Triloki Nath Gupta
Vs
Bajaj Allianz General Insurance Company Limited

AWARD dated 23.03.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Shri Triloki Nath Gupta (herein after referred to as the complainant) against the decision of Bajaj Allianz General Insurance Co. Ltd (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complainant stated that the insurance company was not justified in repudiating the claim. During the course of hearing it has been stated by him that the claim is payable. He stated that he has taken Mediclaim policy and had taken the claim in 2001, which goes to show that he is ensured earlier then 2001. The insurance company was not justified in repudiating the claim on belief that he had taken Mediclaim policy for the first time from them.

3. The representative of the insurance company fairly admitted that claim is payable because the same was repudiated on the ground of pre-existing disease. This ground would not stand now because he is ensured before 2001 and is enjoying Cumulative Bonus of 45%. During the course of hearing, Company was provided with the evidence that complainant was insured much before 2001.

4. I have considered the submissions of the complainant. I have also considered the verbal arguments of the representative of the insurance company and also the repudiation letter. After due consideration of the matter I hold that insurance company was not justified in repudiating the claim on the ground of pre-existing disease because the complainant had taken Mediclaim prior to 2001. Repudiation was done on wrong ground, the same has also been fairly admitted by the representative of the insurance company who stated that the claim is payable because insured for a number of years.
Accordingly, Award is passed with the direction to the insurance company to make the payment of Rs.32105/- along with the penal interest @ 8% from date of repudiation i.e. 23.12.2009 till the actual date of payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/173/NIC/10
In the matter of Shri Ved Prakash Gandhi
Vs
National Insurance Company Limited

AWARD dated 08.03.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Shri Ved Prakash Gandhi (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complainant stated that he filed claim for treatment of hospitalization of his wife but the insurance company denied to pay claim on the ground that hospitalization where treatment was taken is not approved by the insurance company. He submitted further that treatment was taken in the hospital which appears in the list of hospital provided to him by the TPA of the insurance company. Insurance company also does not suggest any clause or regulation regarding the invalidity of his claim. He also approached the insurance company to reconsider its decision but the insurance company had not given any reply. He requested this forum to get the claim settled at an early date.

3. The insurance company had denied the claim on the ground that the treatment was not taken in the hospital which is in the approved list of the hospitals. During the course of hearing it has been stated by the representative of the insurance company that the claim amount of the bill is exaggerated but no evidence to this affect has been produced. However, it has not been denied that the insured had not made the payment to the hospital for the claimed amount.

4. I have considered the submissions of the complainant. I have also perused the repudiation letter of the insurance company. After due consideration of the matter I hold that insurance company was not justified in repudiating the claim only on the ground that treatment was not taken in the hospital which was in the approved list of the hospitals. The claim which is admissible and payable as per terms and conditions of the policy could not be rejected only on technical grounds. The claim is payable. Accordingly, Award is passed with the direction to the insurance company to make the payment of Rs.40690/-. The insurance company is also required to pay penal interest @8% from the date of repudiation i.e. 19.11.2009 to the actual date of payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/175/NIC/10
In the matter of Shri Prabhat Verma
Vs
National Insurance Company Limited

REVISED AWARD dated 08.03.2011 - Non-settlement of Mediclaim

1. Shri Prabhat Verma has made a complaint to this Forum on 29.04.2010, against National Insurance Co. Ltd. regarding non-settlement of Mediclaim under policy no. 360300/48/05/88500004055.

2. Complainant stated that insurance company was not justified firstly in repudiating the claim on the ground that the hospital at which treatment was taken is outside the approved list of the hospitals. He further informed that the insurance company had paid him a sum of Rs.31175/- vide cheque no. 060166 dated 11.01.2011 towards full and final settlement of the claim. But the insurance company had not given any reasons for not paying the balance amount. He preferred the claim for an amount of Rs.67301/-. He submitted that he is entitled to the full claim. Insurance company was not justified in making part payment.

3. On the date of fixed for hearing none on behalf of the insurance company was present neither it had submitted any written reply nor had it sought any adjournment.

4. I have very carefully considered the submissions of the complainant. I have also perused the repudiation letter stating reasons for not paying the claim. After due

consideration of the matter I hold that the insurance company was not justified in repudiating the claim on the ground that treatment was taken at the hospital which was outside the list of approved hospital because the claim otherwise admissible, cannot be rejected on technical grounds, such condition was not stipulated in the policy. Subsequently insurance company had paid a sum of Rs.31175/- as against the claim of Rs.67301/- but without assigning any reasons for not paying the balance amount.

5. Accordingly, Award is passed with the direction to the Insurance Company to make further payment of Rs.36126/- and the insurance company is directed to pay penal interest @8% on Rs.31175/- from the date of repudiation on 19.08.2009 to 14.01.2011 and on Rs.36126/- from the same date to the actual date of payment.

6. This Award supersedes my order dated 24.01.2011.
7. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

8. Copies of the Award to both the parties.

Case No.GI/204/UII/10
In the matter of Shri S.S. Singhal
Vs
United India Insurance Company Limited

AWARD dated 08.03.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Shri S.S. Singhal (herein after referred to as the complainant) against the decision of United India Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complainant stated that he had filed a claim but the same was repudiated on the frivolous grounds. The claim was rejected on the ground that claim was not preferred within 7 days from the date of elapse of 60 days bit it is not out of place to mention that claim was made only for medication restricted to 60 days of post hospitalization and the claim was made after the treatment was completed. The patient was fully recovered on 14.11.2009 and claim was filed on 19.11.2009 and thus the claim was preferred within the prescribed time. It has been requested by him to get the claim settled.

3. It has been argued on behalf of the insurance company that the claim is not payable because the claim was filed late. It has been stated that claim is to be filed within 7 days from the date of completion of treatment which is limited to 60 days from the date of discharge from hospital under condition no. 5.4 of the policy. The patient was discharged from the hospital on 21.08.2009 and thus documents should have been submitted by 27.10.2009 but the same were submitted on 19.11.2009. Thus the complainant had violated the condition no. 5.4 of the policy. The claim relates to reimbursement of post hospitalization expenses.

4. I have considered the submissions of the complainant. I have also perused the reply of the insurance company and also the repudiation letter. After due consideration of the

matter I hold that the insurance company was not justified in repudiating the claim because the claim was preferred after 7 days of the completion of the post hospitalization treatment. The claim is payable and admissible. Accordingly, award is passed with the direction to the insurance company to make the payment of Rs.11,113/-.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/198/OIC/10
In the matter of Shri Om Prakash
Vs
The Oriental Insurance Company Limited

AWARD dated 08.03.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Shri Om Prakash (herein after referred to as the complainant) against the decision of The Oriental Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complainant stated that his wife had gone for check-up on 11.02.2009 on account of abdomen pain. Her treatment continued but she did not get relief. Thereafter she was admitted in the hospital on 07.04.2009. He requested the cashless facility to the TPA but that was not given and ultimately he had made payment to the hospital and made claim but the claim was rejected vide letter dated 03.11.2009 on the ground the claim is not payable due to pre-existing disease. The complainant had approached the grievance cell of the insurance company also but he had not received any reply. During the course of hearing the complainant stated that claim is payable and the claim was made in 3rd year of the policy.

3. Representative of the insurance company stated that claim is not payable due to pre-existing disease. Written submission were placed on record on behalf of the insurance company dated 12.07.2010 wherein it has been stated that the insurance company had granted individual Mediclaim policy to the complainant and his family vide policy no. 271602/48/2009/1919 valid for the period 20.02.2009 to 19.02.2010. it is further submitted that policy is in continuation w.e.f. 20.02.2007. it was submitted further that on 20.03.2009, the attending doctor came to know that Smt. Veena Kumari was suffering from the reported disease for the last two years. The insurance company had repudiated the claim on the ground of pre-existing disease and also sited 4.1 clause of the policy.

4. I have considered the submissions of the complainant. I have also perused the reply of the insurance company. After due consideration of the matter I hold that insurance company was not justified in repudiating the claim because policy is continued w.e.f. 20.02.2007. There is no evidence on record that the patient was suffering prior to taking the policy with the same disease. The claim was made in the 3rd year of the policy. Accordingly, in my view the claim is payable and thus Award is passed with the direction to the insurance company to make the payment of claim amount of Rs.107142/-.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/236/NIC/10
In the matter of Smt. Amita Goel
Vs
National Insurance Company Limited

AWARD dated 28.03.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Smt. Amita Goel (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complainant stated that insurance company was not justified in making deduction of Rs.6089/- while settling the claim. She further stated that she may allowed interest @24% on Rs.70353/- from 23.09.2009 to 11.11.2009 as the insurance company had not allowed cashless service for which he was entitled to. He further stated that insurance company had not given the details of the items which are non medical items and which are not reimbursable. She requested this forum to get this amount paid.

3. The representative of the insurance company stated that the claim was settled after deducting certain items which are not admissible as per clause 4.16 of the policy.

4. I have also considered the submissions of the complainant very carefully. I have also considered the verbal arguments of the representative of the insurance company. I also perused clause 4.16 and after due consideration of the matter I hold that the complainant is entitled to a sum of Rs.5753/- as against the claim of Rs.6089/- because many of the items are allowable only few items such as Thermometer etc. are not admissible. Accordingly, award is passed with the direction to the insurance company to make the payment of Rs.5753/-. I do not find any justification in allowing any interest as demanded by the complainant for not allowing cashless facility.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/237/NIA/10
In the matter of Shri Vijay Kumar Bradoo
Vs
The New India Assurance Company Limited

AWARD dated 28.03.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Shri Vijay Kr. Bradoo (herein after referred to as the complainant) against the decision of The New India Assurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complaint stated that due to callous and indifferent attitude of the insurance company, his claim was not settled. He submitted that he had filed a claim for post hospitalization treatment of his wife. His wife was suffering from high fever (Paraxic) during the period of her illness and the cause of fever could not be ascertained despite thorough clinical investigation. Though she seemed to be a healthy person clinically. He submitted that cause of the fever could not be ascertained which in medical Parlance was known as P.U.O (Paraxia of Unknown origin). She was discharged from the hospital when fever subsided but after few days it resurfaced again and she was treated subsequently. She was treated by the same doctor who treated her while she was in the hospital. But subsequently she consulted other doctor also. During the course of hearing the complainant fairly admitted that sum of Rs.2943/- was spent on the treatment given by other doctors after post hospitalization and remaining treatment was done by the doctor who treated her in the hospital. He had given the claim for an amount of Rs.14293/- out of which he admitted that the sum of Rs.2943/- is not admissible and thus his claim for a sum of Rs.11351/- be got settled.

3. No one attended the hearing on behalf of the insurance company though the insurance company was duly informed about the date of hearing. Neither any written reply was given on behalf of the insurance company. There is no point in giving further opportunity to the insurance company. Therefore the claim is being decided on the basis of evidence on record.

4. After careful consideration of the contents of the complaint and also verbal submissions of the complainant during the course of hearing, I consider fair and reasonable if the claim of the complainant of Rs.11351/- is allowed. Accordingly, Award is passed with the direction to the insurance company to make the payment of Rs.11351/-.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/246/OIC/10
In the matter of Shri Dipankar Chakrabarti
Vs
The Oriental Insurance Company Limited

AWARD dated 28.03.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Shri Dipankar Chakrabarti (herein after referred to as the complainant) against the decision of Oriental Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complainant stated that he obtained a Mediclaim policy from Oriental Insurance Co. Ltd. in November 2008, which was duly renewed and still in force. It provides for cashless settlement of claims directly to the hospital. The policy was issued after thorough medical check-up by the doctors of Safeway, TPA designated by the insurance company and findings of his medical reports to be normal/ acceptable. On 24.02.2010 he felt uneasy in his chest and at the medical advice of the local physician he consulted Dr. Sanjiv Dhawan, Consultant Cardiologist & Vice Chairman Department of Cardiology Dharma Vira Heart Center, Sir Ganga Ram Hospital. This Hospital is one of the hospitals approved by the insurance company for cashless settlement of the Mediclaim. As advised by Dr, Dhawan he underwent this test. Reports indicated the diagnosis as CAD, unstable angina and Double Vessel disease as advised by Dr. Dhawan, he had undergone angioplasty stenting to LAD & RCA in the same sitting. As the policy is for cashless settlement of hospital bills, the necessary documents were sent by the hospital to the TPA. It was clarified by the doctor that treatment given for CAD was by way of life saving measure and not a case of Hypertension/ Diabetes or pre-existing CAD, as contended by the doctor of TPA. Complainant submitted that cashless facility was not provided. It was submitted further that insurance company was not justified in not settling the claim at an early date.

3. Company was not represented during the course of hearing though insurance company was duly informed about the dates nor any written reply was submitted to this forum. Insurance company vide its letter dated 15.04.20140 informed the complainant that the claim is not payable. It has also cited reasons for not allowing the claim. It has been stated as under:

"after going through the submitted documents for the hospitalization as mentioned above, our medical team is of the opinion that the claim does not fall under the purview of the policy for the following reasons:
HTN and its complications fall under waiting period of 2 years and the policy is in second year hence the claim is repudiated (Clause 4.3)

4. I have very carefully considered the submissions of the complainant as made in the complaint and also made during the course of hearing. I have also perused the documents as placed on record by the complainant. I have also perused the repudiation letter and the reasons mentioned by the TPA for not admitting the claim. After due consideration of the matter I hold that insurance company was not justified in repudiating the claim because complainant was not suffering with HTN and its complication which is quite evident from the certificate given by the doctor which is placed on record where the patient was treated. As per discharge summary of the hospital the complainant underwent angioplasty + stenting to LAD and RCA in the same sitting as an emergency life saving measure. Treating doctor has verified that complainant was not a case of HTN, diabetes or prior coronary artery disease. Accordingly, in my considered view the claim is payable and the claim has been wrongly repudiated. Accordingly award is passed with the direction to the insurance company to make the payment of Rs.329000/- along with penal interest @8% from the date of repudiation to the actual date of payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/245/OIC/10
In the matter of Shri Basudeb Majumdar
Vs
The Oriental Insurance Company Limited

AWARD dated 28.03.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Shri Basudeb Majumdar (herein after referred to as the complainant) against the decision of The Oriental Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complainant stated that he was hospitalized at Escorts Heart Research Centre on 18.01.2010 and was discharged from the hospital on 21.01.2010. He submitted that his final payment has not been made. He had met the official of the insurance company on number of occasions and also TPA, however, no payment was released. He had requested the forum to intervene in the matter and get the claim settled. Besides getting the claim settled he also requested for payment of interest on the balance amount @18% and also other reliefs as mentioned in the complaint. During the course of hearing the complainant stated that he is entitled to a sum of Rs.75,000/- as per policy but the insurance company had restricted the claim only to the extent of Rs.40,000/-. The sum of Rs.31800/- was paid by the insurance company to the hospital directly. It is his submissions that if he was entitled to only a sum of Rs.40,000/- as per terms and conditions of the policy, the entire amount could have been paid to the hospital i.e. the insurance company could have made the payment of Rs.40,000/- instead of 31800/-.to the Hospital. Though he reiterated that he is entitled to a sum of Rs.75000/- as in his case the sum assured is Rs.75000/-.

3. Insurance company representative stated that the complainant is entitled to only a sum of Rs.40,000/- and since a sum of Rs.31800/- was directly paid to the hospital, the balance amount of Rs.8200/- can be released in his favour by the insurance company. He also referred to the observations of the TPA with regard to limitation of entitlement to Rs.40,000/-. It was submitted that patient was admitted from 18.01.2010 to 21.01.2010 and he underwent PPI again in 18.01.2010 the present sum insured is Rs.75000/- but in policy no. 272102/2006/699 for the period 16.11.2005 to 15.11.2006, the sum insured was Rs.40000/-. Since he already had the disease from 1999 and has not completed 4 years on the sum insured of Rs.75000/-, the insurance company had settled the claim on sum assured of Rs.40000/-. Insurance company also filed written submissions wherein it has stated that the complainant is entitled to only a sum of Rs.40,000/- and since cashless payment to the tone of Rs.31800 was made to the hospital in respect of the claim of the insured the remaining amount of Rs.8200/- is admissible and for payment of such amount

complainant is required to sign the discharge voucher so that TPA could release the balance amount.

4. I have considered the submissions of the complainant as made in the complaint and also made verbally during the course of hearing. I also considered the written reply of the insurance company and also arguments of the representative of the insurance company made during the course of hearing. After due consideration of the matter I hold that complainant is not entitled to a sum of Rs.75000/- as argued by him because as per terms and conditions of the policy, he is entitled to only a sum of Rs.40000/-. The same has been very clearly mentioned in the policy document. The insurance company had already paid a sum of Rs.31800/- directly to the hospital, therefore complainant is only entitled to balance amount of Rs.8200/- for which the complainant is required to submit discharge voucher duly signed to the TPA. Accordingly, Award is passed with the direction to the insurance company to make the payment of Rs.8200/- subject to submission of discharge voucher by the complainant. It is hereby made clear that complainant is not entitled to any other relief as claimed by him in the complaint.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No.GI/247/NIC/10
In the matter of Shri Parvinder S. Kandari
Vs
National Insurance Company Limited

AWARD dated 28.03.2011 - Non-settlement of Mediclaim

1. This is a complaint filed by Shri Parvinder S. Kandari (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for non-settlement of Mediclaim.

2. Complainant stated that he was holding Mediclaim policy bearing no. 361303/48/08/8500002328 issued by National Insurance Co. Ltd. He has been holding this policy since 2004 which covered himself and his family. He has been paying premium regularly since then. The policy was due for renewal on 07.02.2010 for which he had handed over the cheque bearing no. 120337 dated 27.01.2010 for a sum of Rs.13045/- drawn on Nainital Bank to his serving agent Shri Ashwini Kumar, as he had done on previous years as well. After handing over the cheque he constantly followed-up with the agent for confirmation and receipt of payment for which he assured that he had done the payment and receipt will be handed over to him soon. His wife had to undergo the surgery in February and submitted the hospital bill to the insurance company for reimbursement. He was informed that the policy had been lapsed as the renewal premium was not paid. On checking with the agent he was informed that he could not deposit the cheque with the insurance company in time. He assured him that he will get new policy in which the hospital bill of his wife will be reimbursed. However, he had not taken his signature in the proposal form and the agent got the new policy issued. When

he approached the insurance company for his claim against the new policy he was shocked to learn that the age mentioned of his wife and his wrong. Though actual age has crossed 50 but the age was mentioned as 44 years. Supporting documents were also forged. He met with the accident subsequently and got fractured on his leg. He also got the treatment and presented the claim of Rs.5838/-. He was informed that he would not get any benefits of the new policy since the same was prepared by manipulating the age. He approached again National Insurance Co. Ltd. and he was informed by the staff that he would have to pay further sum of Rs.4300/-. The insurance company has encashed the cheque for an amount of Rs. 13045/- against the premium of Rs.9262/-. During the course of hearing it has been submitted by the complainant that it was not his fault that the insurance company had issued him new policy. He only gave the premium for renewal so that old policy remained continued but due to mistake of the agent new policy was issued. He submitted that since he had been continuously paying his premium in time, he should be given the benefit of continuity and the claims should be settled accordingly. During the course of hearing he also stated that if the insurance company is ready to give continuity benefits in the new policy, he would not mind continuing that policy.

3. The representative of the insurance company agreed to help the complainant to the extent possible and he agreed with the fact that the complainant genuinely felt that the cheque he handed over to the agent could be used against the renewal of the policy but instead a new policy was wrongly issued and in case continuity benefit is not allowed to the complainant he would be at hardship and he agreed for settling the claim accordingly and the policy would be treated as continued for the purpose of allowing benefit and such benefit would be available in respect of new policy. The claims were denied because of the fact that fresh policy was issued because there was break in the previous policy.

4. I have very carefully considered the submissions of the complainant as made in the complaint and as made during the course of hearing. I have also perused the letters of the insurance company and also verbal submissions made by the representative of the insurance company during the course of hearing. After due consideration of the matter I consider fair and reasonable if the complainant is allowed the benefit of continuity because the complainant genuinely felt that cheque would issued by him will be deposited by the agent towards renewal of the policy. He had given the cheque in time for renewal of the policy. He had not signed the fresh proposal. The new policy issued to him by the insurance company was not desired by him. As agreed by the representative of the insurance company during the course of hearing the new policy will continue but the complainant would be allowed the benefit of continuity in the new policy. Accordingly, it is held that claim submitted by the complainant is admissible and payable. Therefore, Award is passed with the direction to the insurance company to make the payment of Rs.43202/-.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

In the matter of Shri Chelaram Rampal
Vs
National Insurance Company Limited

AWARD dated 18.03.2011 - Repudiation of mediclaim

1. This is a complaint filed by Shri Chelaram Rampal (herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant stated that he has mediclaim policy from National Insurance Company Limited. He felt some trouble in eye and he went to Maharaja Agrasen Hospital for eye check up. The attending doctor referred for hospitalization treatment on 05.09.2009. The TPA Alankit Health Care Limited issued approval letter for surgery on 12.09.2009 but the surgery was not done on that day and the same was done on 16.09.2009. After the surgery, the hospital authority sent him a copy of the bill to the TPA but the TPA rejected the approval order and advised the hospital to recover all expenses from the patient. Accordingly he paid for the hospital bill and claimed the reimbursement from the company. After discharge from the hospital, he submitted requisite documents along with the bill for Rs.39372/- on 07.10.2009 in the office of Alankit Health Care Limited but after two months TPA refused the claim. He approached the company but the claim has not been settled so far.

3. The company informed to the insured on 29.12.2009 that TPA has scrutinized the claim documents and found that the policy is under second year and the policy is not continued with the National Insurance Company Limited, hence the claim is considered under second year. Accordingly the claim is not payable as the disease has two years waiting period. The company also cited Clause 4.3 of the policy while repudiating the claim. During the course of hearing, the representative of the company stated that since the claim was made in the second year of the policy, the same is not payable. She further stated that though the complainant had taken medicalim policy from other insurer earlier but the company cannot allow the continuity benefit for such policy and it has to allow benefit according to the policy issued by it wherein it there is a waiting period of two years for this illness and thus the claim is not payable. During the course of hearing, she was specifically required to inform this office as to whether the company had specifically stated in the policy that benefits of the policy issued by other insurer will not be allowed. She was not able to precisely answer this question. Perhaps there is not such clause in the company's policy.

4. I have considered the submissions of the complainant and have also perused the repudiation letter and also considered the verbal arguments of the representative of the company. After due consideration of the matter, I hold that the company

was not justified in repudiating the claim because according to the complainant, the claim was made in the third year of the policy. The complainant had taken mediclaim policy from ICICI Lombard General Insurance Company Limited from 16.06.2007 to 15.06.2008 and thereafter from National Insurance Company Limited with effect 16.06.2008 to 15.06.2009 and from 16.06.2009 to 15.06.2010. Since continuity benefit of the earlier policy was not denied expressively in the policy schedule by the National Insurance Company Limited, it is bound to give the benefit of continuity to the insured. Then obviously the claim falls in the third year of the policy and in that case Clause 4.3 of the policy is not applicable. In my considered view, the claim is payable. **Accordingly, Award is passed with the direction to the insurance company to make the payment of Rs.39372/- along with penal interest @ 8% from the date of repudiation to the date of payment.**

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/215/NIC/10
In the matter of Smt. Kanchan Bhutani
Vs
National Insurance Company Limited

AWARD dated 18.03.2011 - Repudiation of mediclaim

1. This is a complaint filed by Smt. Kanchan Bhutani (herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant stated that despite approaching the complainant redressal cell of the company, the grievance has not been solved. She submitted that the insurance company has become insensitive and has no value for human life. She stated that her husband Shri O.P.Bhutani unfortunately expired on 10.11.2009. He was the lone earning member of the family. She is in dire need of money. She requested this forum to get the claim settled. The brother of the insured attended the hearing who stated that the claim was repudiated on technical ground that hospital where at treatment was taken is not in the approved list of the company.

3. The company had submitted reply dated 07.07.2010 wherein it has been stated that after scrutiny of the claim, the TPA has observed that expenses incurred during hospitalization in a hospital which is outside the approved list of the hospital as provided by the company, therefore, the claim is inadmissible under policy imposed clause as directed by Delhi Regional Office. During the course of hearing also, the representative of the company stated that the claim is not payable

because treatment was taken in a hospital which was outside the list of approved hospitals of the company.

4. I have considered the submissions of the complainant and have also considered the repudiation letter of the company and also the verbal arguments as made during the course of hearing by the representative of the company. After due consideration of the matter, I hold that the company was not justified in repudiating the claim on the ground that the hospital where at treatment was taken was outside the list of approved hospitals by the company. If the claim is admissible and payable, the same cannot be declined on technical ground. **Accordingly, Award is passed with the direction to the company to pay Rs.29348/- to the insured along with penal interest @ 8% from the date of repudiation, that is 04.08.2009 to the date of payment**.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/217/NIC/10
In the matter of Smt. Poonam Dawar
Vs
National Insurance Company Limited

AWARD dated 18.03.2011 - Late settlement of mediclaim

1. This is a complaint filed by Smt. Poonam Dawar (herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of late settlement of mediclaim.

2. It has been stated that the papers relating to claim were submitted on 25.04.2009. She was discharged from the hospital on 26.03.2009 but the claim was not settled at an early date. During the course of hearing, husband of the complainant stated that the claim was settled belatedly by the company and the company is under obligation to make the payment of penal interest also.

3. The representative of the company stated that the claim has been settled and she has been paid a sum of Rs.19809/- vide cheque No.876277 dated 10.09.2010.

4. I have considered the submissions of the complainant and also the verbal arguments made during the course of hearing on behalf of the insured. After due consideration of the matter, I find that the claim has been settled much after the submission of the claim papers. Though the claim was submitted on 25.04.2009 but the payment was made on 10.09.2010. I consider fair and reasonable if the insured is paid penal interest by the company for settling the claim late.

Accordingly Award is passed with the direction to the insurance company to pay penal interest @ 8% on the claimed amount with effect from 01.08.2009 to the date of payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/02/RGI/10
In the matter of Shri Vinod Dhatterwal
Vs
Reliance General Insurance Company Limited
AWARD dated 18.03.2011 - repudiation of mediclaim

1. This is a complaint filed by Shri Vinod Dhatterwal (herein after referred to as the complainant) against the decision of the Reliance General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that he had taken Health wise Policy from Reliance General Insurance Company Limited on 30.08.2007 which was renewed on 30.08.2008. He submitted further that his wife Smt. Mukesh Devi was admitted at Gaurav Hospital, Panipat on 23.04.2009 to 04.05.2009 for the treatment of septicemia with URTI illness. Since cashless facility was not available in the hospital, he had submitted his bills to Mediassist TPA, Delhi for reimbursement. He submitted such bills along with all requisite documents on 11.05.2009 but the claim was not paid to him. However, he was informed on 23.10.2009 that his claim has been repudiated. It was stated that the claim was a fraud. It has been submitted by him that the company had repudiated the claim on the grounds which are not substantiated. During the course of hearing, he submitted that he had provided details and information which were desired and required by the company from him. He also submitted that the hospital where the treatment was taken by his wife is a registered hospital. He further submitted that his claim is genuine and the company be directed to make the payment of his claim at an early date.

3. The representative of the insurance company attended on the date of hearing and it was found that the company was not satisfied with the genuineness of the claim. Company's written reply was also submitted wherein it has been stated that the complainant had made fraudulent claim and the same is not payable. It has been further stated that Smt. Mukesh Devi is covered under Reliance Health Wise Gold policy No.1305/282510299649 for the period 30.08.2008 to 29.08.2009.

Smt. Mukesh Devi got admitted at Gaurav Hospital and Heart care centre, Panipat on 23.04. 2009. She was diagnosed as a case of Septicemia with URTI with low GC. She was treated conservatively and discharged in stable condition on 04.05.2009. The claim was investigated and papers were also verified in the hospital. It was found that despite having diagnosed of Septicemia (Septicemia is a serious medical condition that is characterized by a whole-body inflammatory state (called a systemic inflammatory

response syndrome or SIRS) and the presence of a known or suspected infection. The condition usually begins with fever and chills. On verifying the ICU at the hospital, the same was found not equipped with a ventilator which is a necessity. The stay in ICU was not medically warranted. It was further found that it is a 11 bedded hospital which is also not registered with the local authorities.

4. I have very carefully considered the submissions of the complainant as made in the complaint and also during the course of hearing verbally. I have also perused the repudiation letter and written replies submitted on behalf of the company besides verbal arguments made by the representative of the company during the course of hearing. After due consideration of the matter, I hold that the company was not justified in repudiating the claim because the reasons cited for repudiating the claim are not substantiated and supported by any evidence whatsoever. The claim cannot be termed fraud just by saying; the same has to be proved conclusively by placing evidence on record. The hospital where the treatment was taken by the complainant's wife is also a registered hospital with the local authorities. The claim filed by the complainant is accompanied with the requisite documents. The complainant had made the payment of the amounts which he had claimed from the company. In my considered view, the claim is payable as per terms of the policy. **Accordingly Award is passed with the direction to the insurance company to make the payment of Rs.84474/- along with penal interest @ 8% on the amount of the claim from the date of repudiation to the date of actual payment.**

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/22/NIC/10
In the matter of Smt. Deepti Goel
Vs
National Insurance Company Limited

AWARD dated 18.03.2011 - Partial settlement of mediclaim

1. This is a complaint filed by Smt. Deepti Goel (herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of partial settlement of mediclaim.

2. The complainant stated that her husband is a pancreatic Cancer patient at the age of 43 with young family and many responsibilities. The insurance can only take care of his treatment. But she was harassed because the company had not settled the claim as per terms and conditions of the policy. She has approached this forum to get the claim settled as per terms and conditions of the policy. She submitted that she had submitted claim papers on 16.07.2008 for an amount of Rs.2,99,054/- out of which she had been given a cheque of Rs.1,50,000/-only on 16.09.2008. She submitted that she had not been paid the claim towards Bills No.134 (Rs.27368/-), bill No.892 (Rs.26368/-) and bill No.123 (Rs.25700/-) totaling Rs.79436/- which are the charges towards Chemotherapy, radiotherapy and drugs. She has also enclosed the bills for such treatment. She had not received the reply from the company in this regard. Meanwhile she had submitted

another claim on 11.05.2009 for an amount of Rs.1,08,441/-for additional medical bills for the period 16.07.2008 to 16.07.2009. During the course of hearing, she stated that claim was not settled as per policy. She stated that as per terms of the policy, she is entitled to the payment of room charges amounting to Rs.33150/-. She is also entitled to the payment of fees made to the doctors amounting to Rs.58100/-.

She had spent other amount on the treatment of her husband for purchasing medicines etc amounting to Rs.2,35,465/-. Since there is a cap of 50% of admissibility of such expenses of the sum insured along with cumulative bonus, she is entitled to reimbursement of Rs.177500/- because her husband is insured for Rs.3,00,000/- and earned cumulative bonus of Rs.55000/-also. Thus she is entitled to a sum of Rs.2,68,750/- on account of treatment of the disease whereas she has been paid only a sum of Rs.1,50,000/-. Thus she is further entitled to Rs.118750/-.

3. The company stated that a sum of Rs.1,50,000/- was paid to the complainant after making prescribed deductions in terms of medical policy effective from 01.04.2007 which provides limitation of maximum amount to the extent of 50% of sum insured in respect of treatment of Chemotherapy, Dialysis, radiotherapy etc.

4. I have considered the submissions of the complainant and also her verbal submissions made during the course of hearing. I have also perused the correspondence of the company which is placed on record and also the verbal submissions made by the representative of the company during the course of hearing. After due consideration of the matter, I hold that the company was not justified in restricting the payment only to the extent of 50% of the sum insured in respect of the diseases mentioned in the letter. I have very carefully perused the policy documents which prove the cap on various admissible amounts. It appears that the caps as mentioned in the policy on items were not applied for properly in this case. The policy provides that the room rent @ 1% of the sum insured or Rs.5000/- whichever is lower per day and in case of ICU the room rent admissible is Rs.10000/- or 2% of the sum insured and in respect of other treatments it is 50% of the sum insured which is reimbursable. If the policy conditions are applied in case of the complainant, she becomes fully entitled to the room rent charges, doctor's fees as mentioned in the policy. She is entitled to the reimbursement of an amount of Rs.2,68,750/- (Room rent charges Rs.33150/- fully reimbursable, doctor's fees Rs.58100/- fully reimbursable and Rs.1,77,500/- being 50% of sum insured and cumulative bonus of Rs.55000/- whereas the complainant was paid Rs.1,50,000/- as against Rs.2,68,750/-. **Accordingly Award is passed with the direction to the company to make the payment of Rs.1,18,750/- along with penal interest @ 8% on Rs.1,18,750/- from the date of part payment released to the date of actual payment.**

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

Case No. GI/216/Star Health/10
In the matter of Shri C.K.Sharma
Vs
Star Health and Allied Insurance Company Limited

AWARD dated 18.03.2011 - Non-settlement of mediclaim.

1. This is a complaint filed by Shri C.K.Sharma (herein after referred to as the complainant) against the Star Health and Allied Insurance Company Limited (herein after referred to as respondent insurance company) in respect of non-settlement of mediclaim.

2. The complainant stated that he is insured with Star Health and Allied Insurance Company Limited on 20.03.2008 under senior citizen red carpet policy for a sum insured of Rs.2,00,000/-. At the time of taking policy on 20.03.2008, he had declared all diseases including bye-pass surgery undergone by him in April, 2003 and did not hide anything from the company. The same policy No**.** P/161111/01/2008/000938 was further renewed on 20.03.2009 without any delay for the period 20.03.2009 to 19.03.2010. Again the policy renewed for the period 20.03.2010 to19.03.2011 and the policy No. is P/161111/01/2010/004821. Thus his policy is continued without any break since 20.03.2008. He submitted that he never suffered from diabetes earlier and was detected for the first time in the month of February, 2010 as per lab report of Indian Spinal Injury Centre. He further submitted that the company did not want to settle his hospitalization claim for Rs.1,03,051/- on flimsy grounds. He submitted hospitalization claim on 21.03.2010 to the Senior Sales Manager for settlement. He received repudiation letter on 14/15-04.2010 which also mentioned the reasons of repudiation. He approached the Grievance cell of the company for redressal of the grievance. He submitted that the reasons which have been given in the repudiation letter are not applicable in his case and the claim has been rejected on wrong grounds.

   The company had stated that the disease with which he suffered is caused due to pre-existing disease of diabetes suffering from past several years and this fact was not disclosed while taking the policy by the complainant. The company further stated the senior citizen policy does not cover pre-existing diseases. The complainant stated that the diabetes was detected much after taking the policy and the same was not detected prior to taking the policy. Therefore the ground of repudiation as cited by the company is not applicable in his case. As regards the CKD, he did not hide this fact at the time of taking the policy. He requested this forum to intervene and to get the claim settled at an early date.

3. The representative of the company informed this forum during the course of hearing that the claim is not payable on account of pre-existing disease. The company had informed the complainant vide letter dated 12.04.2010 that the claim is not payable because the policy issued to the insured does not cover the treatment of the illnesses as per stated exclusion: Misrepresentation of the facts and pre-existing diseases.

4. I have considered the submissions of the complainant and have also perused the representation letter and also considered the verbal arguments made during the course of hearing by the representative of the company. After due consideration of the matter, I hold that the company was not justified in repudiating the claim of the insured because the insured was not suffering from pre-existing disease. The complainant had not suppressed any fact relating to his health. The disease for

which treatment was taken by the insured and claim was filed is not caused by Diabetes but is caused by some bacteria. The insured does not suffer from diabetes prior to taking the policy; the same was detected much after taking the policy. He was also not suffering from Chronic Kidney disease. Accordingly in my view the company was not justified in repudiating the claim. The claim submitted by the insured is payable. Accordingly Award is passed with the direction to the insurance company to make the payment of Rs.1,03,051/- along with penal interest @ 8% from the date of repudiation of the claim to the date of actual payment.

5. The Award shall be implemented within 30 days of receipt of the same. The compliance of the Award shall be intimated to my office for information and record.

6. Copies of the Award to both the parties.

GUWAHATI

GUWAHATI OMBUDSMAN CENTRE
Complaint No. 11 -003-0051/10-11

Md. Habibur Rahman

- Vs -

The National Insurance Co. Ltd.

Award dated : 12.10.2010

Md. Habibur Rahman was an insured under Pol. No. 200800/48/09/8500000051 (Individual Mediclaim – Hospitalization Benefit Policy) procured from the above Insurer covering the period from 22.04.2009 to 21.04.2010. During the period covered under the policy, the Insured was admitted in the Gauhati Medical College Hospital, Bhangagarh, Guwahati and treated there for 2 days for his ailments. On completion of his treatments, a claim was lodged before the Insurer being supported by necessary documents. It is alleged that the Insurer has repudiated the claim without any justified ground. Feeling aggrieved, the Complainant has approached this Authority for redressal of his grievances.

The copy of the letter dated 08.07.2009 issued by the TPA M/s E-Meditek (TPA) Services Ltd. however proves that the claim lodged by the Complainant under the above policy was repudiated on the ground that "there was a break in the policy and the policy in question is considered as fresh under which disease is not payable since this is the complication arisen from the pre-existing disease". Applying policy exclusion clause 4.1, the claim was repudiated.

During the course of hearing, the Complainant had the mediclaim coverage with the above Insurer since last seven years. Admittedly there was however a break of 18 days in renewal of the above policy. It is admitted by the Complainant that after expiry of the previous policy on 02.04.2009, the present policy was renewed with effect from 22.04.2009 and hence there was delay of 18 days in renewing the policy in question under which claim was lodged. According to the

representative of the Insurer, the above policy was taken with effect from 22.04.2009 after break of the previous policy and hence it is considered to be a fresh one. The representative has also submitted that since the disease for which the Complainant suffered and treated, existed prior to inception of the above policy taken on 22.04.2009, hence expenses incurred in such treatment is not payable in view of the policy exclusion clause 4.1. Continuity of the mediclaim policy was not there and hence treating the above policy as fresh one (taken after a break of 18 days) cannot be said to be improper and irregular. The Complainant has also not been able to produce any document to prove that he was treated for a disease which developed only during the in force period of the above policy.

In view of the above facts and circumstances, decision of repudiation of the claim cannot be said to be improper and irregular and the complaint is treated as closed.

GUWAHATI OMBUDSMAN CENTRE
Complaint No. 11-004-0062/10-11

Mr. Swapan Kr. Paul

- Vs -

United India Insurance Co. Ltd.

Award dated : 13.10.2010

Mr. Swapan Kr. Paul was the insured under the above policy covering the period from 01.12.2007 to 30.11.2008 for a Sum Insured of Rs. 3.00 Lacs. During the period covered under the policy, the Insured was hospitalized on 24.10.2008 at G.N.R.C., Guwahati wherefrom he was shifted to Apollo Gleneguls Hospital, Kolkata wherein he was admitted and treated till 02.11.2008 as an indoor patient. There Angioplasty was done. On completion of usual treatments, a claim for Rs. 4,43,849.00 was lodged but the Insurer has settled the claim only at Rs.2.00 lacs although the Sum Insured was Rs.3.00 lacs. The Complainant felt aggrieved for such partial repudiation of the claim and hence this complaint was lodged.

The Insurer has contended in their "Self Contained Note" that out of total claimed amount of Rs.4,43,849/-, an amount of Rs.2.00 lacs has been paid as full and final settlement of the claim. The policy coverage was for Rs.3.00 lacs and Rs.1.00 lac was deducted due to the reasons that major surgeries i.e. "Angioplasty" where only 70% of the Sum Insured or maximum of Rs.2.00 Lacs is payable or whichever is less. The Insurer has further submitted that the settled amount was released through cheque and the Complainant has accepted the settlement towards his claim and also enchashed the cheque.

From the note of the Insurer as well as the statements made by the parties, it appears that the claim was settled by the Insurer and the settled amount was also released which were accepted by the Complainant who has encashed the cheque. During the course of hearing, the representative has submitted that the Complainant has voluntarily accepted the settled amount offered by them. The statement made by the Complainant goes to show that he had accepted the settled

amount offered by the Insurer and has also encashed the cheque. Admittedly he had received the settled amount after executing the Discharge Voucher voluntarily, of course, he has said about lodging protest. It is seen in the protest letter that he had expressed his dis-satisfaction because of deducting substantial amount from the claim. He had requested the Insurer to release the balance amount. Besides above, the endorsement made on the body of letter dated 28.01.2009, it appears that while accepting the cheque No. 335995 dated 28.01.2009 amounting to Rs. 2.00 Lacs, the Complainant has raised objection for making short payment of Rs.1.00 Lac and requested the Insurer to release the said deducted amount. The so called protest letters and the endorsement made on the body of letter dated 28.01.2009 failed to disclose levelling any allegation about playing any fraud or exercise of undue influence or his acceptance of the cheque for the settled amount due to misrepresentation, threat or under any circumstances which can be termed to be fraud. Thus, excepting expressing dissatisfaction for deduction of certain amounts, no other allegation was made while accepting the settled amount by the Complainant.

In view of the decision of the Hon'ble Supreme Court as reported in 2008 CTJ 329 (SC) (CP) and in 1999 CTJ 560 (SC) (CP), this Authority appears to have got no jurisdiction to entertain the complaint and to interfere with the decision of the TPA / Insurer since the Complainant has accepted the settled amount voluntarily without levelling any allegation of fraud, misrepresentation or exercise of undue influence while agreeing to settlement and accepting the cheques for the settled amount. This being the position, and finding no scope to interfere with the decision of the Insurer the complaint is treated as closed.

HYDERABAD

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.04.201.2010-11

Dr B. Dibbala Rao Vs. United India Ins co. Ltd.

Award No:G-111/1.10.2010

Dr. B. Dibbala Rao took the insurer's Individual Health Insurance policy for a SI limit of Rs.4.25 lakhs. He preferred hospitalization claim for the cardiac operation he underwent at Care Hospital, Visakhapatnam. The insurer settled the claim for Rs.2.00 lakhs applying the cap / restriction for cardiac surgery as per the revised terms and conditions of the policy. Dr. B. Dibbala Rao stated that the revised terms and conditions were not brought to his knowledge while renewing the policy by the insurer nor was his consent taken for the same. The policy was renewed by the complainant for the same SI

and he preferred another claim for the same disease and submitted bills for Rs.8,60,130/- and the insurer settled the claim for Rs.2,97,500/-. Dr. B. Dibbala Rao made a representation for payment of the claims for total sum insured limit under the policy without restriction / applying cap as he was renewing the policy, without any break, from 2001. The insurer rejected the claim the representation. Aggrieved, Dr. B. Dibbala Rao filed this complaint.

The complainant stated that he was covered under the insurer's mediclaim policy from 23.11.2001 and the policy was renewed by him every year till date. He stated that while renewing his policy from 4.12.2007, he was not informed of the changes made by the insurer in the policy, reducing the eligibility for specified sicknesses. The complainant stated that such changes in the policy conditions were unilateral. He further stated that he was first hospitalized for cardiac ailment at Care Hospital, Vizag from 9.7.2008 to 8.8.2008 and the claim was settled by the TPA for Rs.2.00 Lakhs. He further stated that he had two more major heart attacks on 26.11.2008 & 30.12.2008 and he did not prefer the claim of 26.11.2008 hospitalization as he had already exhausted the benefit under the policy for the year. Against the claim of 30.12.2008 hospitalization in which he incurred total expenditure of Rs.8,60,130/-, the TPA paid an amount of Rs.2,97,500/- in two installments. He stated that he was entitled for the total sum insured limit under the policy for both the hospitalizations, as the insurer could not reduce the benefit under the policy unilaterally without his consent.

The insurer stated that the terms and conditions of Individual Mediclaim Policy were modified by them after seeking prior permission from the IRDA and in place of mediclaim policies New Individual & Group Health Insurance polices were issued from 9.7.2007. The revised policy terms and conditions with caps / sub-limits were applicable to all the policy holders. The complainant was informed of the revised terms and conditions of the policy before its renewal. If the complainant had a grievance about application of the new terms and conditions, he should

have raised the same within 15 days from the date of commencement of policy as per the revised guidelines of the IRDA on Protection of Policy holders' Interest Regulations, 2002. The renewal of policy by the complainant for a further period of one year from 4.12.2009 showed his acceptance for the revised terms & conditions. The insurer further stated that the TPA erroneously paid the second claim for Rs.2,97,500/- instead of Rs.2.00 lakhs. There was excess payment of the claim by Rs.97,500/- to the complainant for which recovery was due. The insurer requested for absolving them from liability, if any, as they had already settled the claims as per the policy terms and conditions issued to the complainant.

ORDER

The insurer admitted the claim by applying the restriction as per the proviso 1.2 of the policy. The amount payable under the policy had already been settled by the insurer. The contention of complainant is that, without his consent, the conditions of policy were altered to his disadvantage. Insurance is a contract between the parties and they are bound by the terms and conditions of contract. The policy conditions were altered with the approval of the IRDA and such changed conditions applied to all. The complainant was not the only one in whose case the conditions were altered. The complainant admitted that he had not read the revised conditions of the policy. That does not, however, entitle him to differential treatment. It is also pertinent to note that complainant might not have opted to change the insurer even if he had known about the revised terms and conditions, in view of accrued policy benefits of coverage for PED.

On a careful consideration of the complaint, it was held that the insurer settled the claim as per the policy terms and conditions..

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.17.254.2010-11

Smt. Kanakalata Vs. Star Health and Allied Ins. Co. Ltd.

Award No:G-116/12.10.2010

Smt. Kanakalatha took insurer's Sr. Citizens Red Carpet Insurance Policy for the period from 26.8.09 to 27.8.10 for SI of Rs.2 Lakhs. She stated that on enquiring with policy bazaar team, she was assured that the policy covered all PEDs for Sr. Citizens. She underwent angioplasty during 2004-05 for one of the arteries. She stated that due to continuous bleeding from her nose, she went to the hospital on 18.10.2009 and on evaluating her case, the doctors advised another angioplasty immediately. Pre-authorization request sent by hospital was denied stating ailment as PED. The reimbursement claim was also rejected by the Insurer. Aggrieved, Smt. Kanakalatha, filed complaint for redressal.

The complainant stated that she took insurance cover with policy bazaar team on due verification of coverage for PEDs and after she disclosed about her earlier operation for heart problem. The complainant stated that on 18.10.09, she suffered from nose bleeding and consulted the doctor. On check up, she was advised some medication. She underwent angiogram on 20.10.09. It was found in the angiogram that the previous operated artery was good but there was another artery with 90% blockage and she was advised to undergo angioplasty. On furnishing the insurance policy details, the hospital sent pre-authorization request on her admission on 20.10.09. The representative of the insurer visited the hospital, obtained further details and stated that he would submit his report immediately and she might get authorization from the company for cashless benefit. Contrary to the assurance, the insurer rejected the request on the ground of PED. She stated that she underwent treatment and submitted all the bills again to the insurer for reconsideration. This request also was rejected. The complainant strongly contended that as per the policy brochure, the exclusion was as under:

> *"All pre existing diseases are covered from FIRST year except those for which treatment or advice was recommended by or received during the immediately preceding 12 months from the date of proposal."*

Exclusion stated in the policy, however, read as under:

"All pre existing diseases/conditions existing and/or suffered by the insured person for which treatment or advice was recommended by or received during the immediate preceding 12 months from the date of proposal."

The complainant stated that the insurer first rejected the claim as PED and on review the insurer noticed the mistake and changed the ground of rejection as "non-disclosure of material facts". She stated that the denial of claim by insurer was unjustified.

The insurer contended that the complainant was covered under their policy and they received a claim from her for the treatment of HT/BA/CAD/Post PTCA Status/CAG/LAP disease. The complainant underwent angioplasty and she was under medication for HTN/BA and IHD. She was on continuous treatment for the ailments and the present hospitalization was for the complications of the same ailment and so it fell under policy exclusion clause 1 as PED. The claim was also denied by them for non-disclosure of material facts in the proposal form about her previous health conditions. The rejection of the claim was in tune with policy terms and conditions and requested from absolving any liability under the policy.

O R D E R

The complainant who took the policy failed to verify the policy issued by the insurer. Insurance Policy is a contract the terms and conditions of which bind both parties equally. Also, the complainant did not disclose material facts relating to her health and obtained the policy. Insurance is based on the principle of utmost good faith, which the complainant did not adhere to.

In the circumstances, it was held that the insurer rejected the claim for valid reasons and as per the policy terms and conditions.

In the result, the complaint is dismissed without any relief.

Sri Mishrimal Jain Ranawat,Vs. Oriental Insurance Co.Ltd.

Award No:G-117/12.10.2010

Sri M.J.Ranawat took insurer's Mediclaim policy and preferred a claim for his hospitalization from 8.6.09 to 10.6.09 for swelling in both feet which was increasing as the day progressed and while walking and decreased by the morning with pain in both the limbs. The cashless request was denied by TPA advising him to prefer reimbursement claim. He preferred reimbursement. This was also rejected by stating that there was no 'Active Line of Treatment' during the stay in the hospital. Appeal made to insurer also yielded no positive result. Aggrieved, Sri M.J.Ranawat filed this complaint for redressal.

The complainant stated that he, along with his wife, was covered under the insurer's medicalim policy for the past few years. His claim was denied by the TPA / Insurer on baseless ground. On rejection of the claim, he submitted a clarification letter from his doctor specifying the need for hospitalization with the details on active line of treatment given to him during his stay in the hospital. In spite of that, the claim was rejected.

The insurer stated that the complainant was k/c/o DM/HTN/IHD and admitted with the complaints of swelling in both feet. During the stay in the hospital, investigations and evaluation were only done. He was treated conservatively with oral medications only. The complainant was admitted without any emergency care and treated with only oral medication for 2 days. His condition did not warrant hospitalization and it could be taken on OPD basis. The insurer stated that the claim was rejected under policy exclusion clause 4.10 and stated that the rejection was in order.

O R D E R

The insured person was admitted in a reputed hospital. There is no suggestion that the admission was engineered. The doctor who suggested admission and who treated the patient also is a reputed doctor in this line. The complainant suffered from swollen feet and he was evaluated for the cause thereof while he was under oral medication. Active

line of treatment does not necessarily mean IV route treatment. Depending upon the nature of illness and the condition of the patient, the treating doctor might adopt the line of treatment which he deems fit and which might not be IV route. Yet, such a treatment cannot be labeled as not active line of treatment. Nevertheless, the requirement under the policy is that the hospitalization should not be essentially for the purpose of evaluation and diagnosis.

It is noticed that the complainant had swelling in both feet associated with pain. The problem called for evaluation and diagnosis. The attending doctor advised the complainant admission in the hospital. Such admission was required for diagnosis while the patient was administered oral medicine for pain management. Thus, hospitalization in the case was primarily for evaluation. The insurer declined the claim on the premise that there was no active line of treatment that the complainant underwent in the hospital. This cannot be found fault with. Yet, the complainant was in pain. This necessitated treatment. Since he was admitted in the hospital as per the doctor's advice for management of pain, the complainant deserves some latitude. The insurer is directed that this is a fit case for grant an ex gratia. Accordingly, the insurer is directed to pay ex gratia of Rs.5000/- (Rs. Five thousand only) to the complainant.

In the result, the complaint is allowed in part as ex gratia for Rs.5000/-.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD)) G -11.08.273.2010-11

Shri K S Vijay KumarVs. Royal Sundaram Alliance Ins. Co.Ltd.

Award No:G-118/12.10.2010

Sri K.S. Vijaya Kumar was covered under insurer's Health Shield Policy from 2.3.10. He preferred a claim for cardiac surgery he underwent on 28.4.10, i.e. within two months from the date of coverage. The claim was rejected by the insurer as PED. Sri K.S. Vijaya Kumar made a representation asking the insurer to review the decision. The insurer reiterated the decision. Aggrieved, Sri K.S. Vijay Kumar filed complaint seeking redressal of his grievance.

The complainant stated that he felt un-easiness only on 27.4.10 for which he consulted Dr. Nagaraj, his regular doctor. Dr. Nagaraj advised him to consult Jayadeva Hospital. There he underwent the tests as recommended. The doctors in the hospital advised him to admit immediately in the ICU. Jayadeva Hospital, being a non-network hospital of TPA, he went to the Apollo Hospital and admitted there. In Apollo Hospital, he underwent Coronary Angioplasty and other treatments. He preferred the claim on the insurer. He stated that he had no heart problem before. The claim was rejected by the TPA / the insurer as PED even after submission of a certificate from the treating doctor that it was not pre-existing. The complainant stated that rejection of the claim by the insurer was unjustified.

The insurer stated that the complainant preferred claim on first year insurance policy with them for IHD within 2 months. The insurer stated that the complainant had similar complaints before 1 ½ months of the consultation he had with Dr. Nagaraj. It proved that the present ailment was contracted by the complainant within the first 30 days of the commencement of the policy. The policy coverage was subject to a waiting period of 30 days and the policy excluded any ailment/disease contracted by the insured person during the first 30 days from the commencement date of the policy. Further, the disease was PED which was excluded under policy exclusion clause D [1] also. The insurer contended that the rejection was justified as per the terms and conditions of the policy.

O R D E R

The definition of 'pre-existing disease' under the policy reads as under:

"Pre Existing Disease shall mean any disease, illness, medical condition, injury for which treatment of which claim is made under this policy, which existed prior to the commencement date of the policy, ***or is found by the insurer,*** *to be of such nature that* ***ought to have existed*** *or* ***begun to set in****, prior to commencement date of the policy,* ***whether or not the insured person was aware of such disease, illness****, medical condition or injury."* (emphasis supplied)

The complainant had 100% blockage of an artery. He had to undergo angioplasty for removal of the block. It is not possible to subscribe to the contention of the

complainant that the said artery was in a perfect condition when the complainant took the policy and that, within a short period of less than two months, the artery developed 100% block. The block must have existed when the policy was taken. Whether the complainant was aware of the problem or not is not relevant. The definition of PED under the policy has scant respect for the medical knowledge of the policy holder. The insurer's belief is of paramount importance in judging PED. The insurer's belief of PED in the case under consideration is based on evidence. Further, the claim that 100% blockage of an artery has developed over a period of two months is unacceptable.

In view of the foregoing, it was held that the ailment for which the complainant was hospitalized related to a pre-existing disease. Consequently, it was held that the insurer rightly rejected the claim.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD)) G -11.08.401.2009-10

Sri Vinod N Kudva Vs. Royal Sundaram Alliance Ins. Co.Ltd.

Award No:G-119/11.10.2010

Sri Vinod N Kudva took Hospital Cash insurance policy of the insurer which pays daily cash benefit in case of hospitalization of the insured persons for more than 24 hours subject to a maximum of 180 days as per the policy terms and conditions. The insured's wife was hospitalized for breathlessness, cough and ulcer over left ankle from 9.9.2009 to 12.9.2009. Sri Vinod N Kudva preferred a claim for payment of cash benefit under the policy. The insurer rejected the claim on the ground of PED. Aggrieved, Sri Vinod N Kudva filed this complaint.

The complaint fell within the scope of the Redressal of Public Grievances Rules, 1998 and so it was registered.

The complainant stated that the claim was rejected by the insurer on the basis of an erroneous noting of the hospital in the discharge summary. It was noted by the hospital that his wife was suffering from

DM for the past 10 years which was incorrect. She was a diabetic only from 2005. He stated that on taking up the matter with the hospital, they rectified the mistake and issued a corrected discharge summary stating that his wife was diabetic since 4 years only. He resubmitted the duly corrected discharge summary for payment of the claim. The insurer rejected the claim intimating that corrections were not acceptable.

The insurer contended that the cause of hospitalization fell under PED. The hospital records stated that the patient was k/c/o DM for 10 years. It was also stated under past history – Diabetes present since 10 years. The patient got admitted for ailment of diabetic foot. The rectification in the discharge summary was an after thought to get the claim under the policy. The insurer contended that the denial of the claim was in accordance with the policy terms and conditions issued to the complainant.

O R D E R

The dispute raised by the insurer for payment of cash benefit under the policy is that the hospitalization of the insured person was due to PED and so the benefit was not payable. The insurer, however, had settled the first claim without raising the issue of PED. The discharge summary furnished by the complainant gives an impression that it has been tampered with. The hospital record mentions existence of diabetes for longer than the period admitted by the complainant. With a view to dispel doubts about the veracity of the documents produced, the hearing in the case was adjourned for the purpose of production of the original discharge summary document. The complainant, however, did not produce the original document during the next hearing. Instead, he produced new documents after having them notarized.

The notarized discharge summaries submitted by the complainant state that the insured person had been suffering from diabetes only for the past 4 years in contrast to the discharge summaries furnished before which had noted that the complainant's wife was a k/c/o diabetes for 10 years. It is unlikely that the hospital would have mentioned the period incorrectly deliberately. It is, however, possible that the hospital issued a corrected document to suit the requirement of the complainant. The photocopy furnished by the complainant gave an impression that the period was altered or interpolated.

From the foregoing, the evidence in favour of either the complainant or the insurer is inconclusive. Nevertheless, it was held that the complainant deserves some latitude. Accordingly, the insurer is directed to pay a sum of Rs.1500 (Rs. One thousand and five hundred only) as ex gratia to the complainant.

In the result, the complaint is allowed in part for Rs.1500/- as ex gratia.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD)) G -11.03.216.2010-11

Sri Chandresh V Davey Vs National Insurance Co.Ltd.

Award No:G-122/25.10.2010

Sri Chandresh V Davey covered his family under the insurer's Family Floater mediclaim policy through Bank of India, Vijayawada with sum insured limit of Rs.5 Lakhs. He felt uneasiness in breathing and chest pain one day before his hospitalization at Purna Heart Institute and admitted with complaints of exertional breathlessness on 4.5.2009. He underwent Coronary Artery Bypass Grafting surgery on 7.5.2009 and he was discharged on 14.5.2009. He submitted all the relevant bills and reports to the TPA for settlement of claim for Rs.1,79,174/-. The TPA asked him to submit the original discharge summary which he submitted. Subsequently, the TPA asked the insured person to submit an affidavit confirming that he had not preferred any claim with any other insurer. He submitted this as well. Yet, the TPA did not settle the claim. The Insured sent a legal notice to the insurer and the TPA. This also did not elicit any reply. Aggrieved, Sri Chandresh V Davey filed this complaint.

The complainant stated that he had mediclaim policy earlier with United India Insurance Co. Ltd. for several years. He shifted to the present insurer consequent upon his financing bank, i.e. Bank of India, becoming the corporate agent of the present insurer. He stated that he had no health problem earlier and his hospitalization was due to sudden onset of disease. He stated that he was admitted at Purna Heart Institute, Vijayawada in emergency condition. The hospital issued certificate clearly

stating 'emergency condition on admission' which was also sent to the TPA / Insurer for settlement of the claim. He claimed to have sent reports of his medical check on 14.3.2009 which did not reveal any heart problem.

The insurer contended that the claim was processed by their TPA and called for certain claim documents. The complainant did not comply. The insurer sent instructions to the TPA to pursue the matter with the complainant and to process the claim at the earliest.

O R D E R

The hospital discharge summary recorded that the complainant is a known case of Coronary Artery Disease with chronic stable angina and on medication for diabetes which is under control. The complainant shifted the policy with break in renewal. Thereby he lost the coverage / benefit for all pre-existing diseases. Due to shifting and the break, the present ailment of the complainant fell under policy definition of Pre-existing disease. As per clause 3.5, pre-existing disease is a disease which existed when the policy incepts, whether or not the policy holder is aware of the disease. Coronary artery complication would not arise in a matter of a few days. The problem must have existed for a long time even though the complainant had not noticed it. The insurer is directed that the complainant's claim related to a PED. Following this, rejection of the claim by the insurer under policy exclusion 4.1 needs no intervention.

In the result, the complaint is dismissed with-out any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD)) G -11.04.301.2010-11

Smt. T N Lalitha Vs United India Insurance .Co. Ltd

Award No:G-123/12.10.2010

Smt.T.N. Lalitha was covered under the insurer's Health Insurance Policy [Gold] from 2005. She preferred a claim on her policy No. 071600/48/08/97/00001476 for the period from 5.1.2009 to 4.1.2010 for lung cancer. She was hospitalized / under treatment from 26.10.2009 to 14.12.2009. The insuer settled the claims for total sum insured limit of Rs.1.75 lakhs under the policy. The policy was renewed by her for further period from

5.1.201 to 4.1.2011 and she preferred claim on it for post hospitalization expenses incurred by her within 60 days from the date of discharge/ date of last admissible treatment. She also preferred claims for the subsequent scan and laboratory tests along with oral chemotherapy tablets prescribed by her doctor. The insurer /TPA rejected the claims as inadmissible. Aggrieved, Smt. T.N. Lalitha filed complaint for redressal.

The complainant stated that post-hospitalization expenses incurred by her within 60 days fell under the renewal policy period. So, her claim on 9.2.2010 for Rs.29,752/- for scans and medicines was admissible as per clause 3.2 of the policy. She preferred claims, along with essentiality certificate issued by the doctor, on 17.3.2010 & 8.5.2010 for Rs.20,951/- & Rs.31,304/- towards oral chemotherapy tablets. She stated that these expenses were admissible under the policy vide clause 2.1 which provided for chemotherapy. She further preferred a claim for Rs.43,569/- during August 2010 towards PET Scan & Lab Tests and oral chemotherapy tables for 3 months which also was not settled by the insurer.

In the self contained note, the insurer stated that the complainant was covered under their policy and admitted the claims for total sum insured limit under their policy No.: 071600/48/08/97/00001476. The insurer stated that the maximum liability of the insurer was for any hospitalizations including pre, post & domiciliary hospitalizations as clearly stated under clause 1.2 of the policy. The claim preferred on 9.2.2010 for Rs.29,752/- was denied due to total exhaustion of the sum insured limit under the policy. Post hospitalization expenses could not be admitted under roll over period of the policy. The subsequent claims preferred by the complainant were also denied for the following reasons:

- Without hospitalization, no claim was admissible under the policy.
- The chemotherapy treatment taken at Hospital / Nursing Home only was payable and oral chemotherapy tablets taken at home did not fall under this 24 hrs. exemption clause for admission of claim.

- The diagnosis and laboratory examination expenses though consistent with earlier diagnosis and treatment were not admissible unless followed by hospitalization within 30 days.

O R D E R

The claims of the complainant related to post hospitalization expenses, oral medication as follow up treatment and the expenses incurred for confirmatory scans and lab tests. The insurer settled the claims of the complainant for total SI limit and thereby the insurer was absolved of any further liability. The policy conditions are such that the complainant is not entitled for any post hospitalization expenses on roll over period and expenses on diagnostic and lab expenses without hospitalization. The 'Note' under clause 2.5 of the policy is clear that chemotherapy expenses incurred at the hospital / nursing home without 24 hours hospitalization are only admissible. Oral chemotherapy tablets taken at home and which do not call for hospitalization are not payable.

In view of above, it was held the claims of the complainant are not admissible under the policy. Following this, I do not find any infirmity in the decision of the insurer. Rejection of the claims by the insurer is justified under the policy.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.09.244.2010-11

Mrs. Chandra Prabha V/s Reliance General Ins.Co.Ltd.

Award No:G-126/12.10.2010

Smt. B.A. Chandra Prabha's husband took the insurer's Health Insurance Policy covering the family for SI Limit of Rs.4.00 lakhs for the period from 20.1.2010 to 19.1.2011. The insurer sent only the policy schedule without policy terms and conditions. She stated that she suffered from high fever with chills. The doctors were unable to control her fever. They could not diagnose her problem. They eventually cut open her abdomen to find out the underlying cause and operated her. When claimed for expenses, the insurer rejected the claim citing exclusion under clause 3 of the policy. She made a representation for reconsideration of the decision. The insurer did not rescind the decision. Aggrieved, Smt. B.A. Chandra Prabha filed this complaint for redressal.

The complainant stated that she had fever on 18.2.10 and she was treated for the same. USG Scan of Abdomen & Pelvis of the complainant on 19.2.2010 revealed normal ovaries and the impression was fluid collection in infraumbilical subcutaneous plane? The complainant was treated with antibiotics. After a gap of 12 days, the complainant still suffered with the same symptoms and further evaluation revealed "enlarged and cystic right ovary; cystic mass situated close to the funds of the bladder". On taking CT scan it was diagnosed as "Turbo-Ovarian" mass sudden in onset. She stated that she had not gone to the hospital for hysterectomy at all. But acute opendicular abscess with mass was suspected. It was a medical emergency and a decision was made for laparotamy on 7-3-10. All these were explained by the doctors in the revised discharge summary given by them. The complainant stated that the insurer was unjustified in rejection of the claim citing clause 3 of the policy.

The insurer contended that the complainant was admitted in the hospital for complaint of fever. Eventually, the complainant was operated for turbo-ovarian mass removal + sub-total hysterectomy + left salphingoophorectomy + appendicectomy. She was covered under the policy for the first time and the policy excluded all the expenses incurred for removal of cysts and hysterectomy under exclusion no. 3 of the policy. The insurer stated that this exclusion was not applicable if the insured person was covered under any health insurance policy in India at least for one year prior to taking the policy with them. Since the insured did not furnish the details of an earlier policy, the claim was denied as per the terms and conditions of the policy.

O R D E R

The complainant covered under insurer's policy for the first time. She was not covered under any other policy before. There is no doubt at all that the complainant went to the hospital with the complaint of fever associated with chill. The doctors treated her with antibiotics. This treatment, however, did not control her fever. Then she was subjected to several tests and yet there was nothing abnormal noticed. Finally, the complainant was operated for ovarian mass removal + sub-total hysterectomy + left salphingoophorectomy + appendicectomy.

The policy excludes expenses incurred for hysterectomy and all internal tumors/cysts of any kind (Exclusion 3). Even though the complainant did not go to the hospital for hysterectomy, the procedure that she was put through in the hospital was hysterectomy, salphingoophorectomy (removal of ovary) and appendicectomy. The first two procedures fell within exclusion 3 of the policy. The third procedure, i.e. appendicectomy, however, is not excluded under the policy.

The complainant's claim is that the expenses related to treatment of fever which did not subside with medication. There cannot be any dispute that the complainant reached the hospital with the complaint of fever and that the treatment that ensued was to control fever. The treatment included certain procedures, namely, hysterectomy, and salphingoophorectomy. Expenses relating to these procedures are specifically excluded for one year under the policy. Thus, the claim of the complainant for expenses relating to hysterectomy and salphingoophorectomy cannot be entertained under the policy. The complainant, however, is entitled to claim expenses relating to appendicectomy since this procedure is not excluded for cover under the policy.

In view of the above, it was held that the insurer rightly repudiated the claim insofar as the expenses relating to hysterectomy and salphingoophorectomy are concerned. Simultaneously, it was held that the complainant is entitled to succeed insofar as the claim relates to appendicectomy is concerned. In addition, the complainant is entitled to hospitalisation expenses in relation to treatment of fever other than expenses associated with the aforesaid excluded procedures. It is, however, noticed that the hospitalisation expenses are for composite treatment and it is difficult to segregate the same.

In view of the complexity involved in apportionment of the expenses, I deem it necessary to grant ex gratia in the case. The insurer is directed to pay an amount of Rs.35,000 (Rs.thirty-five thousand only) as ex gratia to the complainant.

In the result, the complaint is allowed in part as ex gratia for Rs. 35,000.

Sri S.Venkateswara Rao took the insurer's Mediclaim Policy covering his family for a sum insured limit of Rs.1.00 lakh each from 10.1.2007 to 9.1.2008. The policy is being renewed continuously without any break till date. Smt. Sashikala, wife of Sri S.Venkateswara Rao, was hospitalized from 24.10.2008 to 8.11.2008 for 'Bilateral Ovarian Cysts'. He preferred a claim on the insurer and submitted reimbursement claim for Rs.1,68,169/-. The claim was repudiated by the insurer invoking PED clause of the policy. Aggrieved by the rejection, Sri S.Venkateswara Rao filed this complaint.

The complainant stated that his wife suffered from pain in the abdomen frequently. She consulted the doctors of Sai Bhavani Super Specialty Hospital, Hyderabad and got admitted there. On conducting various diagnostic tests, the doctors suggested surgery. The hospital is a non-net work hospital of the TPA. Therefore, the TPA advised the complainant to prefer reimbursement. She was in the hospital for 24 days and underwent surgery. The claim documents were submitted to the insurer's Rajamundry office and in spite of repeated visits made to the office, the claim was not settled. The complainant stated that after a lot of persuasion only, he received a rejection letter dated 23.2.2009 on 1.3.2010, i.e. one year after the claim.

The insurer stated that the insured person preferred claim on 2nd year policy with them. The noting on discharge summary stated that the insured person was a k/c/o of HTN+ / DM+ with history of tubectomy 25 years back and Hysterectomy 23 years back and Left Ovarian Laparoscopic Cystectomy 5 years back. The policy excluded coverage for any pre-existing health condition or disease or ailment / injury. The disease of the insured person was pre-existing and so the claim was rejected by them invoking policy clause 4.

O R D E R

The hospital records submitted by the complainant reveal pre-existing nature of the ailment for which the insured person underwent surgery and preferred the claim. The claim fell under policy exclusion clauses 4.1 & 4.3 of the policy. Therefore, the claim was rightly repudiated by the insurer.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.02.261.2010-11

Sri Tummala Arun Kumar V/s New India Assurance Co Ltd.

Award No:G-130/26.10.2010

Sri T. Arun Kumar covered his family along with his dependent parents under the insurer's Mediclaim Policy from 1.4.2009 to 31.3.2010. His mother, Smt. Krishna Kumari, was covered for SI limit of Rs.1.00 Lakh under the policy. She was hospitalized for recurrent incisional hernia on 18.10.2009 and was discharged on 31.10.2009. The total expenditure incurred in the hospital was Rs.2,23,307.45 against which the hospital gave discount of Rs.60,887/- and the balance amount of Rs.1,62,410/- was claimed from the insurer. The TPA approved Rs.50,000/- on pre-authorization request sent by the hospital and paid the amount to the hospital. The claim for the balance sum insured of Rs.50,000/- was denied by the insurer / TPA. The sum insured under the policy was enhanced from Rs.50,000/- to Rs.1,00,000/- during 2007. The claim was not considered by the insurer for the enhanced SI limit. Aggrieved, Sri T. Arun Kumar filed this complaint for redressal.

The complainant stated that the TPA sent a letter dt. 19.2.2010 asking him to submit the original receipt for considering enhanced sum insured and the original receipt was sent to them for payment of the remaining sum of Rs.50,000/-. After hernia operation, complications had arisen and the TPA agreed, after taking expert opinion, for settlement of the claim, which was also concurred by Insurer vide their letter dated 22.2.2010. The claim was later rejected by the insurer vide letter dated 16.08.2010 invoking renewal policy condition and clause 4.3 dealing with waiting period for certain specified diseases / ailments / conditions.

The insurer stated that the complainant renewed the policy for 10 years with sum insured limit of Rs.50,000/-. The sum insured was enhanced from Rs.50,000/- to Rs.1,00,000/- from 1.4.2008. During the second year of enhanced sum insured policy, the complainant's mother preferred a claim for repeated incisional hernia and total cost incurred was above Rs.1.00 lakh. The

TPA approved pre-authorization request for original sum insured of Rs.50,000/- and also paid the amount to the hospital. The TPA called for certain documents and the original receipt to review the case for admission of the liability for enhanced sum insured limit. They sent the claim for investigation and investigator stated that the insured person claimed benefit from the State Govt. under GO MS No. 74 for the same hospitalization and the State Govt. released Rs.90,000/- as the entitled amount for the pensioner under their scheme. The insurer relied upon clause 6.0 of their revised Mediclaim policy in support of the insurer's stand. The relevant clause reads as under:

> *If the policy is to be renewed for enhanced sum insured then the restriction as applicable to a fresh policy will apply to additional sum insured as if a separate policy has been issued for the difference. In other words, the enhanced sum insured will not be available for an illness, disease, injury already contracted under the preceding policy periods.*

The insurer further stated that the claim of the complainant also fell under policy exclusion 4.3 which stipulated waiting period for specified diseases / ailments / conditions. The condition excluding payment of any claim for ***"Hernia of all types"*** for *TWO* years and so it was denied by them for enhanced sum insured limit.

O R D E R

I have heard the contentions of both the parties and perused the reports/documents submitted. The complainant's representative sent a detailed letter dated 25-10-2010 alleging that he was not allowed enough time to explain his complaint in the course of the hearing held on 22-10-2010. The complainant's representative was allowed enough time to dwell on the complaint. The insurer's representative was asked to state his defence only after the complainant's representative completed his version. The allegation leveled by the complainant's representative, therefore, has no merit. In fact, he appears to have resorted to making the aforesaid allegation since after conclusion of the hearing, my decision was pronounced that the complaint lacked substance.

The complainant's representative's letter dated 25-10-2010 contains nothing new. It is a rehash of the complaint and the contentions raised by him during the hearing. Nevertheless, I have carefully examined the documents furnished by the complainant again before passing this order.

The insured person underwent hernia surgery on 19.10.2010. It is the complainant's view that post surgery there were complications and treatment costs of the

said complications from 20.10.2010 required to be treated independently of hernia surgery. Once such distinction is maintained, exclusions would not apply.

It is significant that hernia surgery was performed on 19.10.2010 and complications ensued on 20.10.2010. It is impossible to look at the surgery and its complications as two distinctly different medical events. The policy covering the hospitalization period fell under the revised terms and conditions owing to which enhanced sum assured could not be allowed. It is relevant to notice that the policy condition specified in clause 4.3 restricts diseases / ailments / conditions of Hernia of all types for two years for enhanced sum insured limit. The complainant's claim for enhanced SI was hit by this clause of the policy.

The complainant's representative's main contention is that the TPA had agreed to settle the enhanced claim and that he should not be allowed to prevaricate. This plea is specious. If the TPA had committed a mistake, and if the TPA realised the mistake before long, it would be churlish to expect the TPA to hold on to the wrong decision tenaciously and implement the same knowing it to be wrong. I have no authority to hold that the TPA should honour its wrong communication even though on merits the TPA rightly rescinded its decision before effecting any payment.

In the course of the hearing, the insurer's representative mentioned that the expenses were defrayed by the State Government following which the claim of the complainant, if allowed, would result in abuse of insurance. To refrain from commenting on this plea for this is extraneous to the complaint under consideration.

In view of the above, it was held that the insurer rightly rejected the claim of the insured person for enhanced sum insured limit.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.08.282.2010-11

Sri Venkat P Nanduru V/s Royal Sundaram Gen. Co Ltd.

Award No:G-133/26.10.2010

Sri Venkata Purushothama Rao Nanduru took the insurer's Health Shield Insurance Policy covering himself and his wife for sum insured limit of Rs.2.00 lakhs for the period from 3.11.2009 to 2.11.2010. His wife suffered from low back ache and had

difficulty in walking with pain in lower limb and so she consulted Ashram Hospital, Eluru on 26.4.2010. On conducting some diagnostic tests, she was advised some medication and referred to KIMS, Hyderabad. She got admitted in KIMS and she underwent further diagnostic tests. Her ailment was diagnosed as "T6-9 Metameric AVM with paraparesis". As the AVM was complicated, she was advised by KIMS to go for "Embolisation" either at Mumbai, Chennai or Trivandrum. The insured took her to Trivandrum and there she was admitted in Sri Chitra Tirunal Institute & Medical Sciences on 12.5.2010. She underwent "Spinal Cord AVM – [Dorso Lumbar] Embolisation" on 19.5.2010. She was discharged from the hospital on 26.5.2010. The insured person submitted reimbursement claims to the insurer for settlement. The first claim was rejected by quoting policy exclusion as "internal congenital disorder". Afterwards, the insurer sent a letter informing policy cancellation for "non-disclosure of material facts" and forfeiture of premium paid. The second claim was rejected by the insurer stating that the policy was cancelled. Aggrieved, Sri Venkat Purushothama Rao filed this complaint.

The complainant stated that his wife was hale and hearty at the time of taking policy and had been attending to all the domestic and normal activities of married life. In support of his contention, he produced his son's marriage celebration photo taken during 2009 wherein his wife had actively participated. Her ailment was a development within one month and there was no previous history. He stated that denial of the claim as congenital disorder was unjustified and subsequent cancellation of the policy was against the interests of the policyholder.

The insurer contended that the claim of the insured person for back pain was due to dorso-lumbar AV malformation which was a congenital internal disorder and inadmissible under the policy. Further, the insurer contended that the insured person was suffering from 'hypertension' since 4 years and it was not disclosed in the proposal form. The insurer also stated that the insured was suffering from 'Filariasis' and it was also not disclosed. The insured person concealed important, essential and relevant information in the context of

underwriting the risk to be covered by the insurer and so the policy became void as per clause 6 of the policy. The policy was cancelled for non-disclosure of material facts.

O R D E R

On going through the literature on Metameric AVM paraperesis, I understand that this affliction is congenital and that it could manifest at any age. The policy excludes treatment of all congenital disorders for one year. The policy also excludes degenerative disorders for two years. Further, the policy excludes all congenital or degenerative disorders if they are pre-existing for 48 months. The policy was obtained on 3.11.2009. The complainant's wife suffered from low back ache and had difficulty in walking with pain in lower limb and so she consulted Ashram Hospital, Eluru on 26.4.2010 and, within a few months, she had to undergo treatment for Metameric AVM paraperesis. Thus, the treatment of Metameric AVM paraperesis which the complainant's wife underwent fell under policy exclusion. The insurer, therefore, rightly repudiated the claim in this regard.

The complainant's claim was also hit by "Clause 6 -Misdescription" of the policy. The complainant's wife suffered from filariasis. She also was a known case of hypertension. Yet, the proposal did not reveal these material facts. Contracts of Insurance are based on the principle of utmost good faith and obviously the policyholder transgressed this principle by concealing material facts while buying the policy. Since the policy was obtained by the complainant without revealing material facts, the contract is void.

In view of above, it was held that the insurer was justified in resorting to the rejection of the claim and cancellation of the policy.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.05.344.2010-11

Sri. Bhoormal A Jain V/s Oriental Insurance Co Ltd.

Award No:G-137/16.11.2010

Sri Bhoormal A Jain took the insurer's mediclaim policy for SI limit of Rs.1.50 lakhs for himself and his wife for the period from 2.2.10 to 1.2.11. It was a continuous renewal from 2.2.2006 without any break. He underwent RFQMR treatment at SBF Health Care Pvt. Ltd., Bengaluru for 'Osteo Arthritis' of both knees and preferred claim on the insurer for Rs.1,02,820/-. The TPA / Insurer rejected the claim stating that magnetic therapy was an exclusion under the policy. Aggrieved, Sri Bhoormal A Jain filed this complaint The complainant stated that he had submitted all the claim documents to the TPA. The TPA rejected the claim. He sent a copy of Kolkata Ombudsman Award given in favor of the insured urging the insurer for similar treatment. An appeal was also made to the insurer for reviewing the decision of the TPA in the light of Ombudsman Award. Yet, the insurer did not consider the claim. The complainant stated that the rejection of the claim was unjustified.

The insurer contended that the insured person preferred a claim on their policy for SBF Health Care Pvt. Ltd. for treatment of 'Osteo Arthritis of both knees. The insurer repudiated the claim of the insured person by invoking the following policy clauses / exclusions:

- Treatment under QMR Therapy for OA for both knees as an out patient was not admissible.
- SBF Health Care Pvt. Ltd. was not having indoor admission.
- QMR therapy is OPD basis only.
- Treatment did not require hospitalization and the hospital did not meet the definition of 'Hospital'.
- Treatment did not fall under the day care procedure for which relaxation is given under the policy.

O R D E R

The mediclaim policy issued to the complainant covers hospitalisation expenses for medical treatment in a hospital/ nursing home. The pre-requisite for admissibility of a claim under the policy is hospitalization. 'Hospitalisation period' is defined to mean a minimum period of 24 hours. The time limit of 24 hours is waived in respect of specialized treatments listed under clause 2.2 of the policy.

A careful examination of the record shows that the complainant was not hospitalized at all. The centre has no in-patient facilities. The policy envisages that the requirement of hospitalisation for 24 hours can be reduced in case of specialized treatments listed therein. Also, hospitalisation for some length of time is *sine qua non* for admission of any claim under the policy. When the patient is treated on OPD basis, the key condition of hospitalisation is not fulfilled. Moreover, the requirement of hospitalisation for 24 hours can be reduced for listed treatments and QMR therapy is not one of them. Altogether, the policy that governs the contract between the insurer and the complainant is such that the claim is not admissible.

In the course of the hearing, the complainant requested that the decision of Kolkata Ombudsman has to be followed by other Ombudsmen. This plea is not acceptable. The decisions of Ombudsmen do not constitute precedents. They, therefore, have no binding effect. Further, the notice that the decision of Kolkata Ombudsman was rendered in the context of the policy that was issued to the complainant in that case. It has to be recognized that mediclaim policies are not identical. They are often tailor made to suit the requirement of the specific person.

A policy of insurance is a contract between the parties thereto and the terms of the contract bind either party in equal measure. The terms also have to be strictly construed. Insurance Ombudsman cannot modify or re-write the terms of the policy for the benefit of either party.

In view of the above, it was held that the terms and conditions of the policy issued by the insurer to the complainant do not admit claim of expenses for QMR treatment. Consequently, I do not find any reason to interfere with the decision of the insurer. It was held that the insurer rightly rejected the claim as per the terms of the policy.

In the result, the complaint is dismissed without any relief.

Mr. Mohammadi S Raja took the insurer's mediclaim policy and it was being renewed by him continuously without any break. The SI under the policy was Rs.75000/- till 2006-07 and it was enhanced by him subsequently to Rs.1.25 lakhs under policy No. 160500/34/07/11/0000503 for the period from 18.8.2007 to 17.8.2008 as the insurer made minimum SI limit under the policy as Rs.1.00 Lakh as per their revised Mediclaim [2007] Policy Terms and Conditions. The Policy was further renewed without any break for revised sum insured up to 17.8.2010. Mr. Mohammadi S Raja underwent Total Knee Replacement surgery on 7.5.2010 and preferred the claim on the insurer on policy No. 160500/34/09/11/00000472 for Rs.3,01,744/-. The insurer settled the claim for Rs.78,750/-only (old SI of Rs.75,000/- + Cumulative Bonus of Rs.3,750/-) and rejected the claim for enhanced SI. The insurer rejected the representation stating that for enhanced sum insured limit shall be treated as fresh cover and all limitations of the policy applied. Aggrieved, Sri Mohammadi S Raja lodged this complaint.

The complainant stated that he was covered under the insurer's Mediclaim policy from 2003 with SI of Rs.75000/-. On specification of the insurer that minimum sum insured limit under the policy was enhanced to Rs.1.00 lakh during 2007, he renewed the policy with enhanced SI limit of Rs.1.25 lakhs. The policy was renewed for a further periods without any break. He preferred a claim for TKR and stated that TPA/ the insurer representatives orally informed that he was entitled for total SI limit under the policy. He was further informed that he was entitled for 90% of SI, i.e. for Rs.1.17 lakhs, as he undertook treatment outside Maharastra. The TPA approved only Rs.78,750/- and denied the balance stating that eligibility could not be ascertained. The complainant stated that rejection of the claim for enhanced sum insured was unjustified.

The insurer stated that the complainant was covered under their Mediclaim Policy and preferred a claim on 3rd year policy of revised terms and conditions. Clause 6 of the revised policy excluded diseases/ illnesses contracted during the preceding policy periods. The entitled claim amount under the policy was paid to the complainant and for the enhanced SI limit the PED clause applied. It was further stated by them

that as per clause 4.3 of the policy waiting period of 4 years was applicable for joint replacement and, therefore, under this clause also the complainant was not entitled for enhanced sum insured limit. They stated that their rejection was as per terms and conditions of policy.

O R D E R

The Renewal Clause of the revised Mediclaim policy [2007] stipulates the following:

> *"if the policy is to be renewed for enhanced sum insured, then the restriction as applicable to a fresh policy will apply to additional sum insured as if a separate policy has been issued for the difference"*

The aforesaid restriction applied to enhanced SI, whether compulsory or otherwise. The claim also was hit by the waiting period clause of the policy.

In view of foregoing, it was held that the insurer rightly settled the claim for the eligible sum insured limit. The insurer rejected the claim for the enhanced sum insured as per a clear restriction specified in the policy.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.02.320.2010-11

Sri Jogendra Kumar Saboo V/s New India Assurance Co Ltd

Award No:G-141/15.11.2010

Sri Jogendra Kumar Saboo took the insurer's mediclaim policy covering all his family members for SI of Rs.1.00 lakh each. His son Chetan Saboo underwent treatment for RTA at Columbia Asia Hospital, Bengaluru from 10.1.2010 to 21.1.2010 as an out patient for lacerated injuries on face. The claim preferred by him for Rs.13,214/- was repudiated by the insurer invoking policy clause '1'. Aggrieved, Sri Jogendra Kumar Saboo filed this complaint.

The complainant stated that his son underwent treatment for RTA lacerated injuries under local anesthesia as an out patient in Columbia Asia Hospital, Bengaluru. He further stated that the hospital was a multi specialty hospital with highly technologically advanced equipment where the patient could be treated and discharged the same day without

admission. Out patient treatment normally involves less expenditure. He stated that the hospital charged Rs.13,214/- for treatment of his son for 3 to 4 visits in a span of 10 days and hence it should be treated as an equivalent treatment as in-patient. The complainant stated that his claim was admissible based on policy clauses 3.4 & 3.12.

The insurer contended that for the alleged RTA no MLC was done as it was a self fall/skid from bike on 10.1.2010 and the date was over written as per hospital records. In claim form, the claimant stated the date of injury as 10.12.2009. The insured person was treated in the hospital as an out patient only. The insurer expressed inability to admit the claim without hospitalization as per clause 1 of the policy. OPD treatment was not covered under the policy.

O R D E R

The insured person underwent treatment in a hospital as an out patient. The policy covered hospitalization expenses if hospitalization was for more than 24 hours. In this case, the insured person was not hospitalized at all. Clause 3.4 of the policy also called for hospitalization but with duration of less than 24 hours. Clause 3.12 of the policy applied to cases of treatment in a day care centre. The insured person was treated in a hospital and not a day care centre.

In view of the above, it is clear that the medical problem of the insured person was such that it did not require hospitalization. Consequently, the insurer is not liable for the expenses incurred by the insured person. The insurer is directed hold that the claim of the insured person was rightly rejected by the insurer.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.02.424.2010-11

Mrs. Ratan Sequeira V/s New India Assurance Co.Ltd.

Award No:G-143/15.11.2010

Mrs. Ratan Sequeira took the insurer's Mediclaim Policy and preferred a claim for reimbursement of RFQMR therapy expenses incurred by her for treatment of OA of both knees. The claim was rejected by TPA quoting policy exclusions. She made a

representation to the insurer seeking a review of the decision and the insurer rejected this as well. Aggrieved, Mrs. Ratan Sequeria filed this complaint.

The complainant stated that she was suffering from OA of both knees and because of severe pain she had to decide between replacement surgery for both knees which had its high risk factors and side effects beside its prohibitive costs or RFQMR which had absolutely no side effects with high success rate and which required no hospitalization. She further stated that the Ombudsman, Kolkata directed an insurer to admit the claim vide Award dated 19.6.2009. She also stated that another insurer, Bajaj Allianz, admitted a claim basing on the award of Kolkata Ombudsman for the insured person Mrs. Marjorie Lobo. She requested her claim should be bestowed similar treatment.

The insurer repudiated the claim of the insured person by invoking the following policy clauses / exclusions:

- Treatment under QMR Therapy for OA for both knees as an out patient was not admissible.
- SBF Health Care Pvt. Ltd. was not having indoor admission.
- QMR therapy is OPD basis only.
- Treatment did not require hospitalization and the hospital did not meet the definition of 'Hospital'.
- Treatment did not fall under the day care procedure for which relaxation is given under the policy.
- QMR is still an experimental and unproven system of treatment.

O R D E R

The mediclaim policy issued to the complainant covers hospitalisation expenses for medical treatment in a hospital/ nursing home as an in-patient. The pre-requisites for admissibility of a claim under the policy are (i) hospitalization (ii) treatment in a hospital and (iii) treatment as in-patient. Further, 'hospitalisation' is defined to mean admission in a hospital/ nursing home for a minimum period of 24 hours. The time limit of 24 hours is waived in respect of any procedure agreed by the TPA/ Company which requires less than 24 hours hospitalization due to advancement in medical technology. The policy also excludes experimental and unproven treatment (not recognized by the IMC).

A careful examination of the record shows that the complainant was not hospitalized at all. She was not an in-patient in the centre where she underwent QMR

therapy. The centre has no in-patient facilities. The policy envisages that the requirement of hospitalisation for 24 hours can be reduced in some circumstances. Also, hospitalisation for some length of time is *sine qua non* for admission of any claim under the policy. When the patient is treated on OPD basis, the key condition of hospitalisation is not fulfilled. Moreover, the requirement of hospitalisation for 24 hours can be reduced if the procedure involves advancement in medical technology. Here again, such advanced treatment presupposes approval of the Indian Medical Council. As stated earlier, even if the said treatment is approved by the IMC, yet the claim cannot be allowed since there was no hospitalization at all in the case. Altogether, the policy that governs the contract between the insurer and the complainant is such that the claim is not admissible.

In the course of the hearing, the complainant's husband vehemently argued that the decision of Kolkata Ombudsman has to be followed by other Ombudsmen. This plea is not acceptable. The decisions of Ombudsmen do not constitute precedents. They, therefore, have no binding effect. Further, I notice that the decision of Kolkata Ombudsman was rendered in the context of the policy that was issued to the complainant in that case. It has to be recognized that mediclaim policies are not identical. They are often tailor made to suit the requirement of the specific person.

A policy of insurance is a contract between the parties thereto and the terms of the contract bind either party in equal measure. The terms also have to be strictly construed. Insurance Ombudsman cannot modify or re-write the terms of the policy for the benefit of either party.

In view of the above, it was held that the terms and conditions of the policy issued by the insurer to the complainant do not admit claim of expenses for QMR treatment. Consequently, I do not find any reason to interfere with the decision of the insurer. It was held that the insurer rightly rejected the claim as per the terms of the policy.

In the result, the complaint is dismissed without any relief.

Sri Abhayakumar H Shah took the insurer's mediclaim policy covering his wife Smt. Vasanthi Bai for SI of Rs.40,000 in the year 2004. He enhanced the SI from Rs.40,000 to Rs.50,000 on 27-1-2007 and to 1.00 lakh on 27.1.2009. His wife underwent Total Knee Replacement surgery at KIMS for Osteo Arthritis in November 2009 and preferred a claim for Rs.2,04,834/-. The insurer settled the claim only for Rs.45,000/- though SI limit was Rs.1.00 Lakh. His request for claim settlement at enhanced SI was turned down. Aggrieved, Sri Shah filed this complaint.

The complainant stated that the TPA rejected cashless facility even though they were entitled for the same and he was forced to pay the hospital bill. He stated that the sum insured under the policy was enhanced from Rs.50,000 to Rs.1,00,000 on 27.1.09 and therefore the claim was payable at enhanced sum assured. He stated that the insurer arbitrarily restricted the claim while collecting premium for enhanced SI.

The insurer stated that the policy was issued by the insurer's Adoni Office. The insurer pointed out that the claim fell in the second year after enhancement. The insurer stated that the enhanced SI limit excluded cover of PED because of which the claim was restricted to the original SI limit.

O R D E R

The insurer's contention that enhanced SI is inapplicable to PED is not a part of the policy issued. Therefore, the insurer cannot restrict SI on the strength of an imaginary condition in the policy. The other contention of the insurer is that the SI was enhanced beyond the permissible amount. This may be so but insofar as the customer is concerned, he paid the premium for the enhanced SI. The customer cannot be penalized for the mistake committed by the insurer's employee. Insurance policy is a contract, the terms of which bind the parties equally. Further, the terms of the policy have to be strictly construed. Consequently, the insurer has no option but to honour the policy in toto. In other words, the insurer has to assume SI under the policy at the enhanced amount of Rs.1,00,000.

In view of the foregoing, I find merit in the complainant's contention that the claim was payable as per enhanced SI together with bonus, if any. The insurer is directed to settle the claim accordingly.

In the result, the complaint is allowed

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.11.220.2010-11

Mrs. Praful J Vas **V/s** Star Health & Allied Ins. Co.Ltd

Award No:G-158/19.11.2010

Mrs. Prafulla J Vas took the insurer's Family Health Optima Insurance Plan policy for the period from 24.11.2009 to 23.11.2010 covering her family for sum insured limit of Rs.1.00 Lakh. Mr. Norbert T Vas, her husband, was hospitalized for abdominal pain at City Hospital, Mangalore on 6.1.2010. He underwent clinical tests for diagnosis and treatment. His illness was diagnosed as 'fatty liver changes' and was discharged on 13.1.2010. The insurer repudiated the claim stating that admission in the hospital was only for investigation and evaluation and it was not followed by active line of treatment. Representation seeking review of the decision was filed with the insurer. Mr. Norbert T Vas was admitted again for the same complaint in the same hospital on 9.2.10 and discharged on 12.2.10. On submission of claim documents, the 2nd claim was also denied by the insurer citing the reason 'outside the purview of the mediclaim policy'. Aggrieved by rejection, Mrs. Prafulla J Vas filed this complaint.

The complainant stated that he was admitted in the hospital for treatment on the advice of the doctor who also issued a certificate specifying the reasons for in-patient treatment. She stated that she made a representation to the Grievance Cell of the insurer to review the decision but there was no response.

The insurer contended that the documents and reports submitted by the insured did not support institutionalized treatment and, therefore, cashless facility was denied. On submission of reimbursement claim, their medical team evaluated the claim and rejected it on the grounds "Could have been treated on OPD basis as per exclusion No. 13 & 14 of the policy". Hospitalization was only for evaluation and investigation of an ailment and only oral medication was given. As per the discharge summary, there was no cough, fever or breathlessness. The insured person suffered from jaundice one month ago and details thereof were

not revealed to them. The insurer further stated that during the admission, the insured person was not investigated for pain in the abdomen and irrelevant investigations were carried out. The insured person was not treated with parenteral antibiotics, antispasmodics on PPIs for relief of pain. The insured person was put on only liver supportive appetizers, protein and vitamin supplements and digestive enzymes in tablet form which could have been administered as an out patient. The admission was basically for investigation and evaluation only and hence the claim was rejected.

O R D E R

The insured person stated that he became very weak and had pain in the abdomen. For first claim, he was in the hospital for 7 days. This is too long a period of stay in the hospital for investigation and evaluation. The insured person was passing blood in the stools and he was delirious. It is possible that his physical condition was such that the doctor advised him admission. He also had suffered from jaundice before. The treating doctor might have admitted him for cross consultation and to investigate the cause of the ailment followed by oral treatment to alleviate the pain.

This is a borderline case of hospitalization although apparently the insured person could have been treated on OPD basis. The insured person was in a difficult condition and his problem had to be first diagnosed. After diagnosis, he was administered medicine which gave him relief.

In view of the above, the insurer is directed to admit the first claim of the insured person and settle the same subject to deductions and inadmissibles, if any, as per the terms and conditions of the policy.

Insofar as the second hospitalisation is concerned, it was entirely for the purpose of diagnosis. In fact, the only event that occurred during the second hospitalisation was that the insured person went through colonoscopy. The insurer is not liable to pay hospitalisation expenses in this behalf. Therefore, the claim of hospitalisation expenses for the second admission cannot be allowed.

In the result, the complaint is allowed in part.

COMPLAINT No. I.O.(HYD) G -11.13.314.2010-11

Sri S Srinivasan V/s HDFC ERGO-Gen. Ins. Co. Ltd

Award No:G-159/19.11.2010

Sri S.Srinivasan was covered under a mediclaim policy with HDFC ERGO from 24.12.09. He filed two claims vide TPA claim reference no.7606 &6676. In respect of claim no. 7606, the date of admission was 10.1.2010 and discharge was on 13.1.2010 but claimed on 30.4.2010. The insurer denied the claim on the ground of late submission. The second claim no. 6676 was for hospitalization from 10.3.2010 to 11.3.2010. The insurer declined it under Clause 1.3 of the policy since the hospitalization was for less than 24 hours. Aggrieved, the policy holder filed this complaint.

The complainant stated that the first claim was denied due to delayed submission by the Insurer. The delay occurred because the treating doctor asked him to retain the original laboratory reports for verification till further tests with Columbia Asia were done. Moreover, his health was very bad and that also contributed to the delay. The second claim got rejected for the reason that hospitalization was for less than 24 hours. He stated that he approached the Columbia Asia Hospital and got a written letter from Dr. Naresh Bhat that his treatment started at 9 a.m. on 10.3.2010 and got discharged on 11.3.2010 at 12 p.m. Therefore, he was hospitalized for more than 24 hours. He requested that the insurer be advised to settle both the claims.

The Insurer submitted that the insured filed two claims. The first claim received by FHPL, their TPA, on 30.4.2010. This was denied for late submission invoking the relevant clause in the policy document PART 11. The second claim was denied because of hospitalization for less than 24 hours in accordance with clause 1.3 of the policy which stipulated that the hospitalization should be for a minimum period of 24 hours.

O R D E R

The group mediclaim policy by which the complainant is covered stipulates the conditions and claims procedure in Part 11-1 to 20. As per the conditions, the insured person or his representative shall immediately contact and intimate the TPA to provide claim services. The insured person shall immediately give a written notice to the TPA and thereafter submit full particulars of the claim within 7 days from the date of hospitalization. All supporting documents relating to the claim must be submitted to the TPA within 30 days from the date of discharge from the hospital. As against these requirements, the complainant filed the claim for reimbursement of hospitalization expenses incurred at Teja Nursing Home dt. 10.1.10 to 13.1.10 on 30.4.10 for Rs. 16891. The insured stated that he could not file his claim before because of the doctor who . advised him to retain the original laboratory reports for verification until further tests were done at Columbia Asia Hospital. He did visit the said hospital on 10.3.10 for a few investigations. Technically, the Insurer was correct in rejecting the claim. However, I am of the opinion that the claim is bona fide. The reason for the delay stated by the complainant is plausible. The insurer is direct the insurer to admit the claim as ex gratia and pay Rs. 16,445/- to the complainant for which he is otherwise eligible.

As regards the second claim relating to admission in Columbia Asia Hospital from 10.3.10 to 11.03.10, the stipulation of minimum hospitalization period of 24 hours as per 1.3 of policy conditions was not fulfilled. The document produced by the complainant to the effect that he was hospitalized for more than 24 hours cannot be accepted. Moreover, the hospitalization was for investigations/evaluation only. The Insurer was therefore justified in rejecting the second claim.

In the result, the complaint is partly allowed as ex gratia for Rs.16,445/-.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.11.324.2010-11

Smt. S Krishnaveni V/s Bajaj Allianz Insurance Co. Ltd.

Award No:G-160/19.11.2010

Smt. S. Krishnaveni along with her husband was covered under Silver Health Insurance policy of the insurer. The policy was proposed by her son Sri Venkatesh. The

sum insured limit was Rs.1.50 lakhs. The period of insurance was from 21.4.2010 to 20.4.2011 and it was the second year policy with the insurer. She preferred a claim on the insurer for her hospitalization from 2.6.2010 to 3.6.2010 at JK Institute of Neurology, Maduri and submitted claim bills for Rs. 30,533/-. The insurer rejected the claim on the ground that there was no active line of treatment. Aggrieved, Smt. S. Krishnaveni filed this complaint.

The complainant stated that she underwent treatment for recurrent bitemporal headache and nuchal pain as an in-patient which was followed by out patient treatment. During the stay at the hospital, the doctors conducted various tests on her in order to diagnose the problem and the tests were followed by treatment. The hospital, being a non-network hospital of the insurer, she submitted reimbursement claim. She stated that the insurer asked her to submit indoor case sheets from the hospital. These were submitted to them on 20.8.2010. Without verifying the papers, the insurer rejected the claim vide letter dated 10.8.2010 stating that "the document submitted reveals that there is no active treatment given to the patient during the course of hospitalization and hospitalization is primarily for investigation purpose". She stated that it was not at all true and she was given treatment in the hospital. She stated that the insurer rejected the claim without perusing the claim documents submitted. She contended that the denial was unjustified.

The insurer stated that perusal of indoor case sheets revealed that there was no active treatment given during the stay in the hospital. Thus, the claim fell under policy exclusion vide caluse C 16 of the policy, which read as under:

> "C. We shall not pay –
>
> 16. Medical Expenses relating to any hospitalization primarily and specifically for diagnostic, X-ray or Laboratory examinations and investigations."

The insurer stated that as a part of the treatment, primarily only tests of Digital Video EEG and Brain Mapping, Nerve Conduction Studies,

Biochemistry Reports, T3,T4,TSH tests, ECG were conducted and only medicines were given and this could not be treated as active treatment during hospitalization. The indoor case sheets also contained only noting of Body Temperature, B.P., Pulse Rate and respiration at various times. The Insurer further stated that none of the claim documents submitted by her showed that she had taken any active treatment. The insurer also stated that on receipt of indoor case sheets, they sent another letter dated 24.8.2010 to the insured person upholding their earlier repudiation.

O R D E R

The insurer denied the claim on the ground that hospitalisation in the case was only for evaluation and investigation not followed by active treatment. In other words, the insured person could have achieved the same result had she gone for treatment on OPD basis. In other words, hospitalization was unnecessary.

The Discharge Summary does not corroborate the complainant's averments. There is nothing in that which supports the claim that the insured person required in-patient treatment. The contention of complainant that she was administered IV fluids while she was in the hospital but the same was not recorded in the case papers cannot be accepted.

Notwithstanding the above, it is not easy to conceive a situation where a person seeks admission in the hospital only for the purpose of claiming insurance money. The insured person was suffering from head ache and the doctors did not know the reason for the problem. The problem had to be investigated. And after the diagnosis, she was administered medicine which gave her relief. The question is whether the person would have been relieved of her problem without hospitalization. Yet, it is clear that hospitalisation in the case was more for the purpose of investigation and less for treatment.

In view of the above, the inured person has to be allowed the benefit of the doubt. The insurer's representative stated that even if the claim is admitted, the insured person would get only Rs.10,918 as per the policy. As stated by me earlier, the insured person was hospitalized largely for the purpose of investigation of the disease. The insurer is directed consider it appropriate to allow ex gratia to the insured person and I am of the

view that payment of Rs.4000 as ex gratia would be adequate. Accordingly, the insurer is directed the insurer to pay ex gratia of Rs.4000 to the insured person.

In the result, the complaint is partly allowed for Rs.4000 as ex gratia.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.003.288.2010-11

Sri D. Srinivasan **V/s** National Insurance Co. Ltd**.**

Award No:G-164/22.11.2010

Sri D. Srinivasan obtained Varista Mediclaim policy meant for senior citizens from National insurance Company Ltd. for himself and his wife and got it renewed for three consecutive years. The present policy period is 2-4-2010 to 1-4-2011. He was charged additional premium in the first year of the policy for covering pre-existing ailments. He got admitted in the hospital, after the approval of TPA, for fluctuating B.P. and Blood Sugar levels for a continuous period of 3 months. On submitting the claim for his hospitalization expenses, the TPA and the insurer repudiated the claim stating that the purpose of hospitalization was only for evaluation of his ailment and not for the purpose of treatment. Aggrieved by the rejection of the claim, Sri D. Srinivasan filed this complaint.

The complainant stated that he got admitted in Care Hospital at Banjara Hills, Hyderabad after the hospital authorities confirmed that they had obtained prior approval for his admission from the TPA on 21.7.2010. After his medical treatment from 22nd to 24th July 2010, the Care Hospital received letter from the TPA on 25.7.2010 rejecting his claim. As per the advice of the Hospital authorities, he had to pay the bill and, only thereafter, he got discharged from the hospital. He contended that the insurer wrongly repudiated his claim. He stated that the fraudulent intention of the TPA was evident from the fact that the back dated letter dt.21.7.2010 of the TPA withdrawing their approval for his hospitalization was received by the hospital only on 25.7.2010.

The Insurer submitted that the claim was rejected by them as the discharge summary of the complainant revealed the purpose of

admission in the hospital as further evaluation and management of his ailments. They opined that there was no need for the hospitalization as the evaluation could be done on outpatient basis. Hence, the claim was rejected by them as per policy exclusion clause 4.10.

O R D E R

The discharge summary of the hospital and the other documents furnished show that the complainant was admitted in the hospital for evaluation and management of fluctuations in his B.P. and Blood Sugar levels. The TPA apparently gave a letter of approval for admission which was later withdrawn. The complainant stated that the TPA issued consent letter for hospitalization on 21-7-2010 and it was only after receipt of that letter that he admitted himself in the hospital on 22-7-2010. He contended that the TPA's letter of withdrawal was delivered to the hospital only on 25-7-2010 at about 3 p.m. although it was dated 21-7-2010. The complainant was discharged from the hospital on 24-7-2010 after he paid the bill as the hospital had not received clearance from the TPA by then.

The policy does not allow payment of hospitalization expenses incurred for the purpose of evaluation of ailment. It is evident that the complainant was hospitalized for the purpose of evaluation of fluctuating B.P. and Blood Sugar levels. Hospitalization expenses incurred for this purpose are not admissible under the policy. Clause 4.10 of the policy excludes the following:

> *"...charges incurred at hospital or nursing home primarily for diagnostic X- ray or other diagnostic studies not consistent with, nor incidental to the diagnosis and treatment of positive existence, or presence of any ailment, sickness, or injury for which confinement is required at a Hospital/Nursing Home."*

The insurer, therefore, rightly repudiated the claim by invoking exclusion under clause 4.10 of the policy.

The question is whether the TPA was estopped from withdrawing the approval given, that too, after the event was over. The complainant claimed that the withdrawal letter of the TPA was received by the hospital after the patient was discharged from the hospital. If the TPA had committed a mistake in issuing the letter of approval on 21-7-10, it should have communicated its withdrawal immediately and, in any case, before the date of admission of the complainant in the hospital, i.e. 22-7-2010. It appears that the TPA withdrew its approval by letter dated 21-7-2010 itself but it took no efforts to

communicate the same to the hospital or the complainant. The insurer has not contradicted the complainant's averment that the TPA's letter of withdrawal dated 21-7-2010 was handed over to the hospital only on 25-7-2010. It is clear that the complainant was allowed to believe by the TPA that the insurer would bear the expenses of his hospitalization and he acted in pursuance of such a belief. That being the case, the principle of estoppel applied to the TPA.

In view of the above, while upholding the decision of the insurer to repudiate the claim, I deem it fit to hold that the TPA misled the complainant and, therefore, the complainant is entitled to ex gratia, which I determine at Rs.5000 (Rs. Five thousand only).

In the result, the complaint is allowed partly for Rs.5000 as *ex gratia*.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.17.277.2010-11

Sri B. Panduranga Baliga **V/s** Star Health and Allied Ins. Co. Ltd

Award No:G-165/19.11.2010

Sri B. Panduranga Baliga took the insurer's mediclassic individual mediclaim policy for SI limit of Rs.3.00 lakhs with risk commencing from 5.3.2009 to 4.3.2010. Before accepting the risk, the insurer asked him to undergo medical checkup with their authorized doctor and he underwent medical checkup. On 8.9.2009, he felt giddiness and fainted in the office. After angiogram was done, he was diagnosed to be suffering from CABG and he underwent bypass surgery. He claimed hospital expenses from the insurer. The insurer rejected the claim on the ground that the expenses elated to PED. Aggrieved by the decision of the insurer, Sri B. Panduranga Baliga filed this complaint.

The complainant stated that he had medical insurance cover with ICICI Prudential Ins. Co. and got it shifted to the present insurer consequent upon placement of his workers mediclaim policies and upon the assurance given by the agent about good services of the present insurer. He underwent medical check up with the approved doctor of the insurer. The doctor did not give his report to the complainant. Instead, it was sent to the insurer directly by him for acceptance of the proposal.

Due to giddiness and loss of consciousness, he was taken to Beneka Health Centre and after giving first aid he was shifted to KMC, Mangalore. After two days of treatment, Angiogram was done which revealed 3 blocks and the doctors advised him to undergo bypass surgery. He underwent CABG at Narayana Hridayala, Bengaluru on 29.9.09. On submission of pre-authorization request by the hospital, the insurer initially credited Rs.25000/- to the hospital as initial payment. Later, the insurer rejected the claim and claimed back the initial payment made to the hospital. Aggrieved by rejection, he sent legal notice to the insurer. There was no response to this. He stated that he had no previous symptoms of illness and the problem had arisen all of a sudden. He stated that the insurer unjustly suspected his integrity and rejected the claim.

The insurer stated that CAG done on 10.9.2009 was suggestive of Triple Vessel Disease. ECG taken on 26.9.2009 showed ST-T changes in inferior leads. Pre-medical ECG dated 24.3.2009 was suggestive of old IWMI [ST-T changes]. Since ECG revealed similar changes and CAG was suggestive of TVD, the claim was rejected as PED and it was communicated to the insurer.

O R D E R

The complainant stated that he had no symptoms or signs of heart disease earlier to its detection during the current year policy. The insurer also does not have any evidence of adverse medical history of the insured person prior to the current policy. The HD/CAD is not excluded as PED under the policy. The definition of PED under the policy envisages existence of the signs or symptoms of a disease or diagnosis of a disease or treatment for a disease. It is obvious that the insured person was not diagnosed of heart disease nor was he under treatment for a heart problem before he took the present policy.

The question is whether the insured person had signs or symptoms of heart disease when he took the present policy. In the course of the hearing on 10.11.10, the representatives of the insurer showed the ECG taken at the time of medical check up and stated that the ECG revealed signs of heart problem. They, however, informed that the panel doctor did not notice the changes. The complainant did not know what the ECG

report looked like because the doctor did not give his report to the complainant and sent it to the insurer directly for acceptance of the proposal. The complainant, therefore, cannot be accused of misleading the insurer or of suppression of material facts relating to his health. Nevertheless, angiogram done in September 2009 showed 3 blocks which called for bypass surgery. Blocks of this magnitude would not have occurred all of a sudden. They must have existed for a considerable time. The complainant took the policy in March 2009 and it is quite likely that some symptoms of the problem must have been there in March 2009 although the evidence in this behalf is inconclusive.

PED is defined in the policy in such a manner that it allows latitude to the customer. Moreover, the only evidence, other than the general impression, which suggests that the problem of the complainant must have been in existence before the policy was taken, is the ECG which the insurer's approved doctor took. If the ECG report was read correctly, the insurer might not have issued the policy or would have issued the policy after excluding expenses relating to heart disease. It is, however, evident that the complainant did not mislead the insurer.

In view of the above, it was held that the insurer perhaps technically had some justification for repudiation of the claim but the complainant equally has reasons for being aggrieved. On balance, I am of the view that this is a fit case for grant of ex gratia. Accordingly, the insurer is directed to pay an amount of Rs.1,50,000 (Rs. One lakh and fifty thousand) only as ex gratia to the complainant.

In the result, the complaint is allowed for Rs.1,50,000 as ex gratia.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.12.010.2010-11
Award No:G-166/22.11.2010

Shri B.K. Mangal V/s ICICI Lombard Gen.Ins.Co.Ltd

Shri B K Mangal the complainant herein, filed a complaint, which is paraphrased as under:

During the year 2005, Sri B.K. Mangal proposed for Health Insurance Policy of the insurer, ICICI Lombard General Insurance Company Ltd. He requested the executive over voice mail to cover himself and Mrs. Urmila Mangal, his wife. On specifying the premium by the executive, he authorized payment of premium amount of Rs.6584/- during

October 2005 through his ICICI Credit Card on line. He stated that the insurer sent acknowledgment letter for his proposal. He further stated that the insurer's representative contacted him over telephone and asked him to submit medical reports, as they were above 60 years of age, which also were submitted to the insurer. Sri B.K. Mangal, however, did not receive the policy document. When followed up, the insurer expressed inability to issue the policy due to some technical problem as they were above 60 years of age. Sri B.K. Mangal then agreed to the suggestion of the insurer to be proposed by his son, who was below 60 years of age, for issuance of the policy. Subsequently, the insurer asked him to pay Rs.11,741/- and the same was also paid by him through on line with the same credit card during October 2005. For this amount also, the insurer sent acknowledgment letter. He, thus, paid Rs.18,325/- for the first year annual premium. He, however, did not receive the policy. He had been continuously following up with the insurer for non-receipt of policy but in vain.

During the February 2007, Sri B.K. Mangal was asked to pay the second year premium of Rs.7245/- by the insurer without giving him the details of the policy. The premium was paid on line using the same credit card. The insurer sent a policy certificate bearing No.4034/FNP/01861661/00/000 covering only Mr. Manish Mangal, his son. The complainant stated that the insurer wrongly issued the policy. This was taken up with the insurer for incorporating necessary correction in the policy so that the policy covered himself and his wife as family members and his son as the proposer. His request for correction did not elicit a response from the insurer. The insurer also did not reply to his mails.

Thereafter, a sum of Rs.31098/- was paid through on line with the same credit card during June 2009 for renewal of the policy for a further period. The insurer issued a policy covering Mr. B.K. Mangal, his wife and his son vide their policy No. 4034i/HIR/04793552/00/000 quoting the previous policy number as 4034/FNP/01861661/00/00 for the period from 24.6.2009 to 23.6.2010.

Smt. Urmila Mangal had a fall in the bath room in the first week of May 2009 and injured both her knee joints. She underwent Total Knee Replacement surgery for the left leg on 12.6.2009. Sri B.K. Mangal preferred a claim on the insurer for medical expenses of TKR. The insurer rejected the claim stating that the policy issued by them did not cover the date of hospitalization which was earlier to their enrolment date.

Smt. Urmila Mangal underwent TKR surgery for the right leg also on 16/17.12.2009. Sri B.K. Mangal claim preferred a claim for hospitalisation expenses of TKR. The insurer rejected the claim stating that the knee problem which called for TKR was a pre-existing disease (PED) and that the policy excluded PED.

Aggrieved by the rejection of claims and non-issuance of policy for the amount of premium paid by him on line, Sri B.K. Mangal filed this complaint seeking redressal of his grievance. He requested the Ombudsman to issue directions to the insurer for payment of the claims.

O R D E R

The complainant raised two issues. The first is non-receipt of the policy against the premium paid by him during October 2005. The second is non-payment claims of hospitalisation expenses of his wife, who underwent TKR during 2009.

The voice recordings produced by the insurer establish that that the complainant proposed the life of his son during February 2007 and the policy was issued by the insurer covering his son as proposed. The policy issued by the insurer confirmed the premium amount paid by the complainant. After expiry of the policy, with a gap of 4 months, there is another proposal by the complainant to cover three persons, i.e. the complainant, his wife and his son. The voice recording of 24.6.2009 confirms this and the insurer issued the policy from that date.

The insurer stated that the voice record of 2005 did not exist. The complainant stated that he paid the premium twice in October 2005. His claim is that he paid the premium through the credit card in EMIs. He was requested to produce credit card statements showing debit of the premium. He has not produced this. Thus, there is nothing on record which showed that the complainant paid premium against which the insurer failed to issue a policy. In the circumstances, the complaint that the insurer did not issue the policy even after collecting premium threreagainst is dismissed for want of evidence.

The other part of the complaint relates to hospitalisation expenses. It is noticed that the first claim of TKR was for hospitalization on 12-6-09. The insurer received premium of Rs.31,098/- for covering the complainant, his wife and son for the period from 24.6.2009 to 23.6.2010. Therefore, the claim was earlier to the policy cover date. Consequently, the claim could not have been entertained by the insurer. The policy was

auto renewed for the second year from 24.6.2010 to 23.6.2011. The second claim was for hospitalisation on 17-12-09. The insurer rejected this claim as PED basing on noting of the doctors on discharge summary and case sheets and consultation papers. The insurer, therefore, cannot be found fault with for repudiation of this claim also.

In view of the above, it is clear that the insurer established issuance of policies for which the premium had been received. It is also evident that the insurer was justified in rejection of the claims.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 010. 421. 2010-11

Sri. Kamisetty Satyanarayana V/s Iffco Tokio General Ins. Co. Ltd.

Award No:G-169/16.12.2010

Sri. K. Satyanarayana took the insurer's Med Shield Family Health Policy covering all his dependent family members for the period 28.7.2009 to 27.7.2010. His wife and daughter were admitted in hospital on 24.4.2010 for food poisoning at Gandhi Emergency & Multi Specialty Hospital, Khammam. They were treated as in patients at the hospital and were discharged on 29.4.2010. He preferred claims on the insurer for reimbursement of hospitalization expenses. The insurer short settled the claims. In spite of repeated reminders, the insurer neither furnished the reasons for short settlement nor settled the claims for the balance amount. Aggrieved, Sri K.Satyanarayana field complaint with this office for redressal.

The complainant stated that he preferred a claim of Rs. 40,786/- for his wife's treatment but the insurer settled it only for Rs. 15,399/-. In respect of his daughter, the insurer settled the claim for Rs.16,334/- as against the claim of Rs.32,196/-. He further stated that the insurer did not furnish any reasons for deduction in the claim amounts. He pleaded for intervention of our office for settlement of the claims in full by the insurer.

In the self contained note, the insurer stated that the claims were duly processed by their TPA and accordingly deducations were made. They further stated that their medical team had further reviewed the claim documents and it was found that there were inadvertent deducations made buy the TPA. The claims were re-

processed and the actual deductions to be made were re-worked out by them and the details were furnished in their self contained note. The insurer agreed to settle the following amounts:

Wife's Hospitalisation Claim-Rs.19,262/-.

Daughter's Hospitalisation claim-Rs.4,000/-.

O R D E R

Pursuant to the notice given by this office, both the parties attended hearing on 8.12.2010. The representative of the complainant was asked to verify the further settlement details agreed to with the insurer's representative. After verification, he stated that further settlement offered by the insurer was acceptable to him. The insurer is advised to send the claim cheques for the agreed amount without any further loss of time to the complainant.

In the result, the complaint is partly allowed for 23,262/-.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 004. 131. 2010-11

Mrs. Eashwari Shahani V/s United India Insurance Co. Ltd.

Award No:G-170/22.12.2010

Smt. Eashwari Shahani took the insurer's Individual Health Insurance Policy covering herself and her daughters for the period 14.9.2008 to 13.9.2009. One of her daughters was hospitalized at Kamobji's Hospital, Chandigrah for Typhoid fever. She underwent treatment for reimbursement of hospital expenses. The TPA rejected claim and the insurer stating that the expenses were inadmissible. She made a representation for review of the decision but in vain. Aggrieved, Smt. Eashwari Shahani field complaint with this complaint.

The complainant stated that the insurer's TPA instead of settling the claim made several queries and called for several other documents and all of them were replied by her by collecting the necessary information / documents from the hospital which was at a far off place. Later, the TPA and the insurer rejected the claim stating that her daughter had

not given timely intimation which denied the opportunity to them as well as TPA to investigate into the genuiness of the claim. She pleaded for the intervention of this office for settlement of her genuine mediclaim by the insurer.

In the Self Contained Note, the insurer stated that the insured / complainant was asked to submit soe clarifications regarding hospitalization and the details of hospital, i.e. registration number, number of beds, etc. and followed by a number of reminders and finally the TPA sent repudiation letter stating "despite repeated reminders and we have not received required information; hence the claim is not admissible". The insured person claimed 42 days of treatment for Typhoid fever at M/s Kamboji's Hospital, Chandigrah and she underwent various diagnostic tests during the period. The insured did not clarify the quries raised by the TPA suitably. Finally, the insurer sent their investigator to Chandigrah and on his investigation it was noted that the insured person underwent treatment as an out-patient only and the hospital did not have any in-patient treatment facilities. The hospital was only a Day Care Centre which was functioning from 10 a.m to 8 p.m. only. The treating the doctor at Kamboji Hospital issued a letter stating that the insured person was adimitted in the morning and discharged in the evening and was treated as an out-patient only.

The insurer stated as per policy clause 2.3, minimum 24 hours hospitalization is required for adimission of the claim under the policy. In this case, there was no continuous 24 hours hospitalization on any day. Further, the hospital also did not fulfill the definition of 'hospital' under the policy. The insurer, therefore, stated that the claim of the complainant was rightly rejected and pleaded for dismissal o the complaint.

O R D E R

The insurer's policy provide benfit only in case of continuous 24 hours hospitalization at a hospital as defined in the policy. The insured person underwent treatment at M/s Kamboji's Hospital, a day care centre. Thus, hospitalization for a minimum period of 24 hours, a key condition of the policy, has not been fulfilled in this case. , the insurer rightly repudiated the claim of the insured / complainant.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 12. 198. 2010-11

Sri Subramanian Rajan **V/s** ICICI Lombard General Co. Ltd.

Award No:G-173/22.12.2010

Sri Subramanian Rajan stated that the sales executives of M/s ICICI Lombard Gen. Ins. Co. Ltd. Contacted him from 16.2.2008 to 18.2.2008 on his mobile number 9885550649 for sale of the insurer's Health Insurance Policy. Their repeated entreaty mesmerized him to acquiesce to purchase their Health Insurance policy. He also was informed that the tele conversation was being recorded. He stated that he gave particulars of his credit card for collecting the premium payment. The insurer issued two policies covering the risk from 18.3.2008 – one for himself, spouse and daughter with a total premium amount of Rs.14,504/- and the other for his son and other daughter for a premium of Rs.5046/- and collected the premium through his credit card. He was hospitalized at Yasoda Hospital, Secunderabad on 12.3.2008 and discharged on 21.3.2008 and his ailment was diagnosed as GB Syndrome – AMAN Ankylosing spondylitis with peripheral arthritis. He preferred a claim on the insurers for payment of hospitalization expenses incurred by him to the tune of Rs.1,71,650/-. On informing non-receipt of documents, he submitted them again. He was informed by the insurer on 21.8.2008 that his claim was not registered as his policy start date was from 18.3.2008 while the date of admission in the hospital was prior to the policy commencement date. Sri Subramanian Rajan stated that the insurer issued the policy effective from one month after he had agreed to purchase the policies. He referred to the provisions of the protection of policy Holder's Interests Regulations, 2002. Yet, the insurer failed to settle the claim. Aggrieved, Sri Subramanian Rajan filed this complaint.

The complainant referred to clause [6] of "Proposal for Insurance" of Protection of policy Holder's Interests Regulations, 2002 which stipulates processing of proposal within 1 days and stated that he had given consent to the insurer on18.2.2008 following which his proposal ought to have been finalized by the insurer on or before4.3.2008 whereas it was finalized on 18.3.2008. He questioned the insurer how it was possible for him to propose/buy their policy when he was admitted in the hospital on 12.3.2008 and discharged on 21.3.2008. The complainant referred

to the various provisions of aforesaid Regulations and stated that it was serious breach of trust by the insurer. He claimed that the insurer had to pay him the medical reimbursement claim of Rs.1,71,650/- and compensation amount of Rs.3,00,000/- for the mental agony and strain which he had go through. He further stated that the insurer had not provided adequate prior information, failed to be transparent and indulged in serious breach of trust, unfair trade and unfair dealings. He also stated that the standards of customer service of the insurer were slipshod. He further stated that the insurer's callousness caused much humiliation.

In the self contained note furnished in response to the complaint, the insurer stated that the insurer issued their health insurance policy through tele-marketing and that the policy was issued on realization of premium by them on 18.3.2008. The insurer stated that the hospitalization of the complainant was prior to the inception of the policy in that their service provider collected the premium only on 18.3.2008. They stated that the claim was note registered as there was no policy on the date of hospitalization.

O R D E R

I have carefully examined the complaint and the elaborate written contentions of the complainant. I have also perused the reply of the insurer against the complaint and the insurer and the contentions of the insurer's representatives. I have also examined the documents submitted by both the parties.

The insurer has established that the premium from the complainant was received by them only on 18.3.2008. The complainant also does not dispute this inasmuch as he field his credit card statement along with his complaint to show that the premium was collected on 18.3.2010. The insurer stated that since the insurer received the premium on 18.3.2010, cover was granted from that date in pursuance of the provisions of Section 64 of the Insurance Act, 1939. In view of this, the insurer cannot be found fault with for issue the policy from the date of realization of premium. The admission of the complainant in the hospital occurred before the commencement of the policy. Thus, the complainant's claim for hospitalization expenses, therefore, fell outside the purview of the policy. I, therefore, do not find any infirmity in the decision of the insurer of not entertaining the claim. The alternative contention of the insurer also has merit in as much as clause 3.2 of the policy provided for a waiting period of 30 days. Thus, the

complainant's claim would not have been admissible even if the policy had been issued with effect from 18.2.2010 or before the premium was collected.

In view of the above, it was held that the complaint is without basis and that the insurer cannot be fastened with any liability.

Before parting, I may refer to the various allegations made by the complainant against the insurer. Insurance Ombudsman has jurisdiction only to deal with the complaints enumerated under the Redressal of Public Grievance Rules, 1998. The allegations against the insurer made by the complainant are not covered within the amplitude of the 'complaints' under the said Rules. I, Therefore, decline to take cognizance of the allegations.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 12. 198. 2010-11

Sri Santosh Agarwal **V/s** Oriental Insurance Co. Ltd.

Award No:G-174/31.12.2010

Sri Santosh Agarwal took the insurer's individual Mediclaim policy covering all his family members from 20.2.2007 and it was continuously renewed with the insurer without any break. His wife, Smt. Kirti Agarwal, underwent 'Hernia' operation on 22.6.2010 and he preferred a claim for reimbursement of hospitalization expenses. The claim was rejected by the TPA quoting 4.12 exclusion of the policy. Appeal made to the insurer was also rejected.

Aggrieved, Sri Santosh Agarwal filed this complaint for redressal.

The complainant stated that his wife underwent 'Hernia' operation during 2003 after LSCS delivery during 2002. She suffered with the same problem after 7 years and the insurer / TPA rejected the claim stating it as PED and related to child birth. He strongly contended that after 7 years of child birth it cannot be treated as a complication of child birth and the claim needed to be admitted by the insurer as general surgery. He pleaded for intervention of this office for settlement of his legitimate claim.

In the self contained note, the insurer stated that their TPA rejected the claim under policy exclusion 4.12. The treating doctor stated that Smt. Kirti Agarwal had

undergone repair of 'incisional hernia' which was a result of Caesarian Operation, i.e. related to child birth. Therefore, the claim was excluded from the scope of the individual mediclaim policy. The insurer further stated that Smt. Kirti Agarwal had previous history of LSCS in 1999,2002 & 2003 and so the rejection was justified as per the policy terms and conditions.

O R D E R

The complainant's claim was rejected by the insurer citing policy exclusion 4.12. This clause excludes treatment arising from or traceable to pregnancy. Smt. Kirti Agarwal suffered from 'incisional hernia' and it was repaired during 2003. It is possible that the present complication could be traced to LSCS. But clause 4.3 of the policy excludes specified diseases / ailments / surgeries for specified period only. Hernia surgery is excluded for a period of 2 years only from inception of the first policy with insurer. The complainant preferred claim on 4th year policy with the insurer for repair of hernia. The claim preferred is for 'incisional hernia' which is a complication of LSCS is deemed to be covered under the policy by specific wording of the clause 4.3 automatically after a period of 2 years from the inception of the first policy with the insurer. General exclusion cannot be invoked when a specific inclusion is available under the same policy.

In view of above, it was held that the insurer erroneously rejected the claim. Consequently, the insurer is directed to admit the claim as per terms and conditions of the policy.

In the result the complaint is allowed.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G-11.17.441.2010-11

Award No:G-180/10.2.2011

Shri Unmil Ghosh **V/s** Star Health & Allied Insurance Co. Ltd

Shri Unmil Ghosh suffered from CAD and underwent CABG incurring an expenditure of Rs.300775/-. He had medical insurance from two insurers. The first insurer settled the claim for an amount of Rs.202500/-, which was the maximum permissible under that policy. For the balance expenditure incurred for CABG and post surgery expenses, Shri Ghosh preferred the claim on the second insurer, namely, M/s.

Star Health & Allied Insurance Co. Ltd. The latter first settled the claim for Rs.32791/- and when Shri Ghosh represented against short settlement, the insurer settled a further amount of Rs.22500/-. Even after this, the settlement fell short of the claim. The insurer did not provide reasons for various deductions effected by the insurer against the claim. Dissatisfied with settlement of the claim, which was short, Shri Ghosh filed this complaint.

The complainant stated that he was dissatisfied with short settlement made by the insurer and in spite of his several telephone calls and e-mails; the details were not furnished by the insurer for short settlement. He claimed that the deductions made by insurer in the claim amount were not in accordance with the policy issued to him. He stated that the deductions were made by the insurer arbitrarily.

In the self contained note, the insurer stated that they discharged the liability by paying in all an amount of Rs.55291/- to the insured. The deductions or items which were not entertainable were shown clearly in their working sheet sent to the insured person. The insurer stated that they had considered the claim to the maximum permissible limit as per the policy terms and conditions.

O R D E R

The insurer deducted an amount of Rs.585/- against post hospitalization investigations on the ground that ECG and Body Fat Analysis expenses are not payable under the policy in terms of Exclusion 19. The claim of the insurer is not tenable inasmuch as Exclusion 3.19 of the policy provides for exclusion of expenses incurred on weight control services including surgical procedures for treatment of obesity, medical treatment for weight control / loss programs. The complainant did not undergo any treatment for obesity / weight control. Therefore, the deduction of Rs.585/- made by the insurer out of the claim is not in accordance with the terms of the policy. The insurer, therefore, is directed to pay this amount.

The insurer deducted an amount of Rs.2400/- against the claim of Angiogram charges on the ground that Angiogram is always done on package basis for which the maximum amount payable under the policy was only Rs.9600/-. Thus, the insurer restricted the claim to Rs.9600/- as against the expenditure of Rs.12000/- incurred

towards Angiogram charges. The restriction is reasonable since the policy provides for payment of only reasonable hospitalization expenses. I, therefore, uphold the deduction in this regard.

The complainant claimed an amount of Rs.44600/- towards other expenses. Against this claim, the insurer disallowed an amount of Rs.27400/- and paid only the balance amount. The reason for deduction under this item, according to the insurer, is that the amount towards other expenses is allowed for a period of 15 days instead of the period of 20 days claimed by the insured. Restriction of the period for which other expenses has been allowed is unreasonable and in any case not in accordance with the policy issued. Consequently, the insurer is directed to make good the shortfall on account of other expenses. In other words, the insurer is directed to make payment towards other expenses for 20 days as claimed by the complainant.

The insurer also effected deduction of Rs.4760/- out of investigation charges on the ground that charges for ECHO Colour Doppler are not payable. The policy has no provision restricting the number of times the insured can go for ECHO Doppler tests. The restriction, therefore, is not borne out by the policy. Consequently, the insurer is directed to make good the shortfall in this behalf.

The insurer made a deduction of Rs.5100/- against room rent on the ground that the maximum room rent payable as per the policy was Rs.28900/-. In the course of hearing, the insurer's representative could not furnish a plausible reason in justification of this deduction. The policy does not permit any such restriction. Thus, the restriction is unwarranted. Accordingly, the insurer is directed to pay a further sum of Rs.2100/- to the complainant towards room rent.

The complainant did not press his claim in regard to other short deductions and disallowances made by the insurer. In the course of hearing, he unequivocally stated that he wished not to dilate on the other items of deduction or disallowance. The claim of the complainant in regard to the deductions or disallowances not discussed hereinabove is, therefore, dismissed.

The insurer is directed to make further payments as mentioned, quantified or otherwise, in this order.

In the result, the complaint is allowed in part.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.04.457.2010-11

Award No:G-181/10.2.2011

Shri SR Patil **V/s** United India Insurance Co. Ltd.

Shri S R Patil and his wife Smt. Gouramma S Patil were covered under Mediclaim policy issued by United India Insc. Co.Ltd. He preferred a claim on the insurer for reimbursement of surgery undergone by Smt. G S Patil for total Thyoroidectomy on 3.3.2010 at Jupiter Hospital, Thane. The claim was rejected by the insurer stating that there was suppression of material fact at the time of proposal for insurance. Appeal made to review the decision was also rejected. Aggrieved, Shri S R Patil filed this complaint.

The complaint fell within the scope of the Redressal of Public Grievances Rules, 1998 and so it was registered.

The complainant stated that his wife was suffering from fever for about 2 ½ years and consulted many doctors and tried many medicines but in vain. Finally, she went to Mumbai and consulted Jupiter Hospital, Thane and after various tests the doctor advised her to undergo Thyroid operation which she underwent on 3.3.2010 and all the documents, bills were submitted to the Insurer for reimbursement. But the same was rejected by the Insurer.

In the self contained note, the insurer stated that the insured person was covered under their mediguard for SI of Rs.50,000 on each person, and the policy was renewed regularly from 9.5.2005 for the past 5 years. Mrs.G S Patil underwent surgery on 3.3.2010 for total thyroidectomy. The insured submitted all the required medical certificates, diagnostic reports, prescriptions and bills to substantiate the claim. However, scrutiny of the diagnostic reports and discharge summary of Jupiter Hospital revealed that the insured's wife had been suffering from this disease for the past 22 years and she was on regular medicine. The discharge summary further revealed that the swelling in the neck had been there for the past 10-12 years and it had increased in size over the last couple of years. Even though the insured was aware of the ailment he had not disclosed it in the proposal form filled, signed and submitted by him at the time of taking insurance. Hence, there was suppression of material fact at the time of taking cover because of which the claim was not payable.

O R D E R

The claim of the insured person is basically hit by non-disclosure of material facts about the health of the life assured at the time of proposing for policy. It was clearly stated in the discharge summary of Jupiter Hospital, Thane dt. 5.3.2010 that she had swelling in neck for the past 10-12 years and also that the hypothyroidism was diagnosed 22 years ago and that she was on regular treatment since then and that presently she took Eltroxin 50 mcg. The summary also states that the swelling increased in size over the last couple of years. This was a material fact which pre-existed before commencement of the first policy with the insurer, i.e. from 5/2005, which the life assured was supposed to disclose at the time of proposing for insurance. Further, it is seen that exclusion clause 4.3 of the policy document (which is wrongly printed as 4.1 in the document), under which the Insurer repudiated the claim by his letter dt.27.7.2010, applies to the claim, as the clause excludes hypertrophy if pre-existing at the time of proposal and it would not be covered even during subsequent period of renewal. The claim, therefore, was rightly rejected by the insurer. .

The policy of insurance is a contract between the parties thereto and the terms of the contract bind either party in equal measure. The terms also have to be strictly construed. In view of the above, it was held that the terms and conditions of the policy issued by the insurer to the complainant bar the complainant from obtaining the reimbursement of expenses incurred since the exclusion clause 4.3 is applicable.

The insurer is directed that the insurer rightly repudiated the claim.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.04.550. 2010-11

Shri K Krishna Murthy **V/s** United India Ins. Co. Ltd.

Award No:G-241/28.2.2011

Shri K Krishna Murthy underwent treatment for illness of Rt.Solitary Kidney, End Stage Renal Disease etc. He preferred a claim for reimbursement of Rs.80,000 from the insurer. The claim was rejected by the insurer on the ground that he had been suffering from HTN since 10 years and renal failure since 2003. Since these diseases

were pre-existing prior to obtaining the policy, they were not covered under the policy. Aggrieved, Shri K Krishna Murthy filed this complaint.

Sri Krishna Murthy stated that the Insurer issued the policy covering the period 26.9.2010 to 25.9.2011 and when a claim was made for his treatment in NU Hospitals from 2.3.2010 to 5.3.2010 the same was rejected by their TPA E-Meditek stating that the claim was not payable as per exclusion clause 4.1 under the policy. Further, he added that he was admitted in the Bangalore Hospital in December 2003 as he suffered from obstruction in urinary tract and he could not pass urine at that time. He was inserted a stent in urine tract and put on dialysis for 6 to 7 days to clear the urine blockage. Thereafter the stent was removed after a month and the doctors did not find any obstruction. He further added that he was born with a single kidney which he came to know at the time of scanning of kidney in June 2003 by the Bangalore Hospital. He also furnished a certificate from the doctors of NU Hospitals clarifying the illness. But the Insurer rejected the claim on the plea that the treatment he underwent was for a pre-existing kidney related disease.

The insurer contended that they repudiated the claim since the disease for which he had taken treatment was pre-existing and fell under exclusion clause 4.1 of the policy. The discharge summary of the NU Hospitals, Bangalore showed that he was diagnosed as illness of Rt.Solitary Kidney, Hypertension, End Stage Renal Disease and Secondary Hyperpara Thyroidism. Further, the hospital record showed that the patient was hypertensive for the past ten years and had had renal failure at least since June 2003 and episode of acute on chronic renal failure, secondary to obstruction of solitary functioning of kidney in December 2003. The present treatment related to a problem with the kidney. The insurer, therefore, stated that the claim was rightly repudiated.

ORDER

It is noticed that the complainant was hospitalized in NU Hospital, Bangalore which diagnosed him for illness of Right Solitary Kidney, Hypertension, End Stage Renal Disease and Secondary Hyperpara Thyroidism. The discharge summary stated that the life assured was having hypertension since 10 years and he had renal failure at least since June 2003 and had an episode of acute and chronic renal failure secondary to obstruction of solitary functioning kidney in December 2003 for which he was treated at Bangalore Hospital. He underwent two sessions of HD through internal jugular vein

catheter and improved following ureteric stenting and the stent was removed a month later. He was dialysis independent thereafter. Evidently, the present medical problem of the complainant is a continuation of the earlier problem.

Ombudsman was observed that the certificate given by the NU Hospitals dt.2.6.2010 states that the life assured was hypertensive since 10 years and was first detected to have renal failure in 2003. It also stated that he had right ureteric obstruction with worsening of renal function in Dec.2003 and he underwent a few sessions of dialysis and right ureteric stenting. He was presented in February 2010 when he was having severe renal failure, uremia and severely contracted right kidney with no evidence of obstruction. He was put on dialysis on 2.3.2010 and has been on twice a week maintenance hemodialysis since then.

In view of the above, there is clear evidence to show that the current illness of the complainant is kidney-related and it existed since 2003. Therefore, the disease fell in the category of pre-existing illness, which is excluded under 4.1 of the policy. Hence, it was found any infirmity in the decision of the insurer. Consequently, I uphold the decision of the insurer in repudiating the claim.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.03.492.2010-11

Sri H.S. Krishna Murthy **V/s** National Insurance Co.Ltd.

Award No:G-243/3.3.2011

Sri H.S. Krishna Murthy took the insurer's 'Varistha Mediclaim for Senior Citizens' Policy with the insurer for basic sum insured limit of Rs.1.00 Lac for the period from 22.12.09 to 21.12.10. He was diagnosed for enlarged Prostate Gland and underwent laser treatment. Before admission, pre-authorization request was sent to the TPA for approval of Rs.1.00 lakh and it was approved for Rs.20,000/-. He stated that he was informed by the hospital authorities that for the remaining amount TPA would issue approval before discharge. Hoping that the total amount was admissible, he underwent treatment and submitted bill for Rs.1,31,678/-. He was then informed by TPA that the maximum amount admissible as per policy was only Rs.20,000/- for the BPH and

balance/excess was liable to be born by the insured only. The matter was taken up by him with the TPA and the insurer and they rejected the claim quoting policy limitation clause. Aggrieved, Sri H.S. Krishna Murthy filed this complaint.

O R D E R

The insurer restricted their liability under the policy for BPH treatment at Rs.20,000/- and it was paid by them. The complainant's plea that "Laser Vaporization of Prostate under EA" treatment has to be reckoned as advancement in medical technology cannot be accepted to admit the claim over and above the limitation under the policy.

The grievance of the complainant is that the TPA misled him to believe that he would be entitled to the hospitalisation expenses incurred. The TPA also is bound by the terms of the policy. The insurance policy between the insurer and the insured person represents a contract between the parties. The terms of the agreement have to be strictly construed to determine the extent of liability of the insurer.

The insured person has to follow the terms of contract expressly set out therein in order to claim a benefit under the policy. The liability was admitted by insurer for the limit specified.

In the course of the hearing, the complainant made a reference to Mumbai Ombudsman's award and requested for similar consideration. This plea is not acceptable. The decisions of Ombudsmen do not constitute precedents. They, therefore, have no binding effect. Further, it was noticed that the decision of Mumbai Ombudsman was rendered in the context of a policy that was issued to the complainant in that case. It has to be recognized that mediclaim policies are not identical. They are often tailor made to suit the requirement of the specific person.

In view of the above, it was held that the insurer was justified in rejecting the claim for balance amount. The complainant sought compensation for non settlement of claim and the question of allowing such a claim does not arise.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.05.490. 2010-11

Mrs. Anzu Menezes **V/s** The Oriental Ins. Co. Ltd.

Award No:G-244/3.3.2011

Mr. Denzil Menezes, husband of Mrs.Anju Menezes, was hospitalized with severe chest pain and discomfort on 28.12.2009 at Columbia Hospital, Bangalore. Mrs.Anju Menezes's claim for cashless was rejected initially by the TPA and later on when she submitted all the bills for reimbursement, the insurer also rejected the claim. Aggrieved, Mrs.Anju Menezes filed this complaint.

Mr Denzil Menezes suffered severe chest pain and discomfort on 28.12.2009 and so he was rushed to Columbia Hospital for treatment. He was subjected to Stress Thalliam Scan and his medications were modified by the hospital. He was a post CABG, hypertensive and diabetes patient. Due to severe chest discomfort, he was rushed to the hospital for treatment. The insurer rejected their claim on the plea that there was no active line of treatment in the hospital. The complainant stated that the medicines were changed and some more were added only after which the condition of her husband stabilized. So, the insurer was very irrational in stating that there was no active line of treatment.

The insurer contended that the patient was admitted only for cardiac evaluation and there was no active treatment given by the hospital. In terms of clause No.4.1 of the policy, the expenses incurred in hospital or nursing home, primarily for evaluation/diagnostic purpose, not followed by active treatment were beyond the scope of the policy. Hence, the claim was rejected by the TPA and the insurer.

ORDER

The discharge summary of Columbia Asia Hospital where the complainant's husband was admitted states that the patient was admitted with severe left side chest discomfort even at rest and sometimes on exertion, which necessitated immediate admission. Further it states that the patient was subjected to Stress Thallium Scan which showed abnormality and the medications were also modified. The discharge summary is clear in stating that the condition of the patient was such that he needed admission, that his condition was evaluated by administering a test which was quite painful and that thereafter the medication was changed. There can be no doubt whatever that change of medicines constituted active line of treatment.

In view of the above, it was held that the rejection of the claim by the insurer on the premise that the admission was only for evaluation and there was no active line of treatment is not tenable. the insurer is directed to admit the claim and settle the same, arriving at the amount of all allowable expenses as per the policy.

In the result, the complaint is allowed.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.03.510.2010-11

Sri S Venkata Krishnan **V/s** National Insurance Co. Ltd.

Award No:G-245/28.2.2011

Sri Venkata Krishnan obtained a health insurance policy called Varista Mediclaim Policy for Senior Citizens from National Insurance Co. covering his father. His father, Shri Somasundaram, aged 68 years was referred to Madras Mission, Chennai on 20.12.2009 for sudden chest pain and was diagnosed as suffering from coronary artery disease. He underwent emergency angiogram and later, on 21.12.2009, he was operated for bypass grafting surgery. On 1.1.2010, he developed bradycardia and hypertension and expired. Sri Venkata Krishnan preferred claim on the insurer for payment of critical illness benefit under the policy by submitting the required documents. The insurer repudiated the claim on the ground that the minimum survival period of 30 days had not been completed which was a condition for payment of critical illness benefit under the policy. Aggrieved, Sri Venkata Krishnan filed this complaint.

The complainant stated that though his father suffered the illness which was of the critical illness kind, his claim was rejected on the ground that he did not survive for 30 days from the date of diagnosis of the illness. The condition was not a fair condition to have in a "Critically ill" scenario. He questioned how a critically ill patient could, in all cases, survive for 30 days when the condition was critical.

The insurer stated that as per the terms and conditions of the policy in question, the insured person did not survive for the period of 30

days which was the minimum period specified in the policy for availing the benefit. Hence, the rejection was proper.

O R D E R

The policy clearly states that it covers two benefits, viz. Hospitalisation and domiciliary hospitalization expenses cover and Critical Illness cover. There is no dispute insofar as the payment under the first cover is concerned. There also is no doubt that the insured suffered a specified critical illness but he survived only 13 days from the date of diagnosis. The critical illness cover under the policy clearly states that no claim shall lie against the company if the insured person does not survive the diagnosis of a critical illness as specified for a period of thirty successive days thereafter. The insurer invoked this condition for repudiation of critical illness benefit claim.

The question is whether the insurer was justified in rejection of critical illness benefit claim. The policy contains a stipulation that the insured must survive a period of 30 days for being eligible for the benefit. The complainant also admits existence of such a condition while however questioning the propriety of such a condition. He had no authority to comment on the propriety of inclusion of a condition. Ombudsman was stated that the policy which is a contract between the two parties has a condition which the insurer relied upon. The terms and conditions of the policy are binding on both the parties to the contract of insurance. If Ombudsman were to hold that the survival period of 30 days deserved to be ignored, that act would tantamount to rewriting a contract, which I am not competent to do.

In view of the above, it was held that the insurer correctly repudiated the critical illness benefit claim.

In the result, the complaint is dismissed without any releif.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.08.533.2010-11

Smt. Jayamma Sastry **V/s** Royal Sundaram Alliance Insc.Co. Ltd

Award No:G-246/3.3.2011

Smt.Jayamma Sastry had taken a Health Shield Insurance Policy (standard) from Royal Sundaram Alliance Insc.Co.Ltd. and was admitted in St.John's

Medical College Hospital, Bangalore for complaints of joint pain in both the knees. She preferred a claim from the insurer for the treatment she had undergone but the Insurer rejected the claim on the ground that the treatment was for "Morbid Obesity and other complications related to obesity" which were excluded under the policy. Aggrieved, Smt. Jayamma Sastry filed this complaint.

The complainant stated that she was taken on a wheel chair to hospital due to severe pain in right leg and as per the doctor's advice, she got admitted due to uncontrolled high BP. She was subjected to various tests and was treated there. She sent all the claim papers to the Insurer but they rejected the claim.

In the self contained note furnished, the insurer stated that the complainant was admitted in St.John's Medical College from 8.7.2010 to 12.7.2010 for treatment of "Morbid Obesity and other complications related to obesity". The TPA denied cashless claim as she was suffering from Morbid Obesity and the policy issued to her excluded all the ailments of obesity from the coverage. After rejection of cashless facility by the TPA, she did not make any claim to the insurer, which she ought to do within 30 days after discharge from the hospital, as per their claims procedure. Hence, the claim deserved rejection.

O R D E R

The insurer chose not to attend hearing in spite of a notice from our office. Therefore, the complaint is decided on merits ex parte insofar as the insurer is concerned.

The complainant was admitted in St.John's Medical College Hospital, Bangalore for complaints of severe pain in her right leg. She had undergone MRI of the Lumbosacral Spine, Abdominal scan, other radiological tests such as X Ray of Knee, Chest X Ray, etc. The hospital stated that the patient was a known case of Osteo Arthritis with Rt.Knee Joint pain radiating to calf since 3 weeks. The hospital records and reports do not indicate that the complainant underwent any treatment for obesity. She had problems with her leg and knee which were attended to in the hospital.

It appears that the TPA rejected cashless facility on the basis of the first note given by the hospital in which the hospital mentioned that the complainant was obese. The hospital appears to have erred in stating the problem of the complainant and the

treatment that was to follow. It transpires that the complainant was not treated for obesity. Whether she is obese or not is totally extraneous to the claim under consideration.

The complainant reported that she made a claim in July 2010 to the insurer after rejection of cashless facility by the TPA. She stated that she produced all the original documents to the insurer. This is vindicated by the complainant by producing the letter of repudiation dt.20th August 2010 issued by the insurer in original in which the insurer categorically referred to the claim of the complainant with the insurer and as to why the claim was not being accepted. It is, therefore, clear that the insurer informed this office incorrectly that the complainant did not prefer the claim. Evidently, the insurer is careless in furnishing replies to our office against a complaint. The insurer's attitude is indeed appalling. The insurer must have realized the mistake and probably that might have prompted non attendance of the insurer in the hearing. This conduct is despicable and graceless.

Be that as it may, the insurer cannot repudiate a claim on the ground that a person is obese. The policy allowed exclusion of obesity treatment. If the policy holder underwent treatment for an ailment which was not in the nature of obesity treatment, the claim has to be admitted.

Since the treatment that the complainant underwent was not for obesity, it was held that the insurer rejected the claim erroneously. the insurer is directed to settle the claim. The insurer in its letter dated 20th August 2010 admitted to have received the documents from the complainant. The insurer cannot now ask the complainant to furnish the documents again. The insurer is directed to settle the claim forthwith together with interest @ 9 % from 1-9-2010 till the date of payment.

In the result, the complaint is allowed.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.09.569.2010-11

Award No:G-256/31.3.2011

Md. Azmatulla Sharief **V/s** Reliance General Ins. Co. Ltd.

Md. Azmatulla Sharief took the insurer's Health Insurance Policy covering his family. He preferred a claim for reimbursement of expenses of Rs.6146/- in respect of his wife's hospitalization. The claim was first partially settled by the insurer for Rs.1941/- and on representation the insurer settled further sum of Rs.1955/-. They disallowed Rs.1000/- being the advance amount paid to the hospital and insisted for pre-numbered receipt which was not issued to him by the hospital. He stated that it was the practice at Raichur to collect advance amount at the time of admission and hospitals were not issuing any pre-numbered receipt for it. The advance amount was deducted from the final bill amount. He stated to have expressed his inability to submit the same to the insurer and represented to consider the amount without insisting for the bill. It was not considered by the insurer. Aggrieved, Md. Azmatulla Sharief filed this complaint.

O R D E R

The insurer is liable to reimburse hospitalization expenses subject to deductions/limits if any. The complainant has produced the bill for expenses incurred. The bill clearly states that advance of Rs.1000 was paid to the hospital. Insisting upon a receipt for the advance, therefore, is not justified especially when the policy holder has informed that the hospital does not separately issue a receipt for advance collected.

In view of the above, it was held that insurer erred in not paying Rs.1000 to the complainant. Accordingly, the insurer is directed to pay the sum of Rs.1000 [Rupees One thousand only] to the complainant forthwith.

The complainant asked for damages of Rs.10000/-. This is not allowed.

In the result, the complaint is allowed in part for Rs. 1,000.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.17.545.2010-11

Sri Sreekantha Reddy **V/s** Star Health and Allied Ins.Co.Ltd.

Award No:G-260/31.3.2011

Sri B. Sreekantha Reddy renewed the insurer's Family Health Optima Insurance policy from 24.1.10 to 23.1.11 and covered his family for SI limit of Rs.2.00 lakhs. His wife was admitted at VIMS Hospital, Bengaluru due to severe abdominal pain, loose motions and vomiting on 21.8.10. The problem was diagnosed by the doctors as Intestinal Obstruction Secondary to Volvulus and advised operative intervention. On

22.8.10 she underwent emergency Laparotomy. He claimed hospital expenses of Rs.81,250/- from the insurer. The insurer rejected the claim on the ground that the expenses related to PED as the treatment was a complication of previous surgery [LSCS during 2003] underwent by the insured person before commencement of first policy with them. Aggrieved by the decision of the insurer, Sri B. Sreekanth Reddy filed this complaint.

O R D E R

The complainant stated that his wife had no symptoms or signs of the present ailment earlier to its detection. The insurer also does not have any evidence of adverse medical history of the insured person prior to the first policy with them. The definition of PED under the policy envisages existence of signs or symptoms of a disease or diagnosis of a disease or treatment for a disease within 48 months prior to the first policy with the insurer. It is obvious that the insured person was not diagnosed of a disease nor was she under treatment for the ailment within 48 months of her taking the first policy with the insurer. The present ailment does not come under the purview of PED exclusion.

In view of the above, it was held that the insurer technically had no justification for repudiation of the claim. Accordingly, the insurer is directed to admit and settle the claim subject to limits, if any.

In the result, the complaint is allowed.

KOCHI

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-003-166/2010-11

Soosy Roy
Vs
National Insurance Co.Ltd.

AWARD DATED 07.10.2010

The complaint is against non-settlement of mediclaim raised for treatment of severe low back pain and related hospitalization. The claim was, however, repudiated by the insurer quoting no active line of treatment.

During the personal hearing, the complainant argued that she was having severe back pain and it was as per the doctor's advice that she got admitted in the hospital. The insurer submitted that during the period of hospitalization, she was given only some tablets. She could not give proper explanation as to the non-inclusion of physiotherapy charges mentioned in the main hospital bill.

There is also disparity in the date of discharge. In that, the discharge summary shows the date as 15.10.2009 whereas in some bills, it is 14.10.2009. This was brought to the notice of the insured at the time of hearing.

Taking into account the bills and treatment records, it is concluded that the hospitalisation was merely for evaluation and investigation purpose and hence the complaint is **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-082/2010-11

K.C.Babu
Vs
United India Insurance Co.Ltd.

AWARD DATED 06.12.2010

The complainant, a mediclaim policyholder of United India Insurance Co.Ltd., had raised two claims, which were repudiated by the insurer on the ground of pre-existing illness and alcohol related complications. Hence he approached this Forum for justice.

The complainant was hospitalized from 26.01.2009 to 25.02.2009 for treatment of ulcer burst. The claim for reimbursement of medical expenses was repudiated by the insurer under clauses 4.8 and 4.9. Earlier in 2007 also, he had raised a claim which was also repudiated by the insurer.

The insurer's contention is that the medical records available revealed that he was in the regular habit of consuming alcohol and a smoker. Hence he is not eligible to be reimbursed.

The discharge summary of 2007 mentions 'chronic alcoholic and smoker' under the head Personal History. However, there is no mention about alcohol consumption in the discharge summary of 2009. The complainant, during hearing, has admitted to consumption of alcohol, though not regularly.

The policy commenced initially in March 2006 and, thereafter, being renewed every year. As the discharge summary of 2007 clearly states consumption of alcohol by the complainant, for which he had undergone hospitalized treatment, it can only be assumed that the current ailment for which he had undergone hospitalization is related to the presence of pre-existing disease.

Hence the complaint is **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-017-097/2010-11

E.Jacob Mathew
Vs
Star Health & Allied Insurance Co.Ltd.

AWARD DATED 20.12.2010

The complaint was against repudiation of claim under mediclaim policy. The claim was rejected on the ground that the pre-existing diseases were not disclosed at the time of taking the policy. On an examination of various records made available, the following facts were observed. During the currency of the policy, the complainant was admitted in the hospital with complaint of CAD and CABG was done. The medical history revealed that he was diabetic for 14 years and hypertensive for 12 years, whereas, in the proposal form obtained at the time of taking the policy, all the relevant questions related to the diseases were answered negatively. Hence the existence of diabetes and hypertension has been clearly established which are essentially heart related risk factors and this has been suppressed by the insurer in the proposal form at the time of taking the policy. Taking all the facts into account, the insurer is justified in repudiating the claim due to suppression of material facts and pre-existing illness exclusion clauses. The complaint is **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002-143/2010-11

Jayasree S.Nair
Vs
The New India Assurance Co.Ltd.

AWARD DATED 21.12.2010

The complaint related to repudiation of claim for reimbursement of medical expenses under a mediclaim policy. The insurer denied the claim contending that the ailment was a pre-existing one. The insurer submitted that there was a correction in the discharge summary so as to bring the claim within the allowable period. Hence there was suppression of material fact in the proposal form regarding pre-existing illness.

On verification of discharge summary, it is found that there was a correction in 'history of illness'. Originally, it was written as '2 years', but it was corrected as '2 months'. A close scrutiny of the correction would reveal that the correction is made by the same hand which has written the other contents of the discharge summary. So it can be inferred that the correction was made at the instance of the doctor who had written the discharge summary, though the correction was not initialed by the doctor. In the absence of any other evidence to the contrary, it can only be concluded that the correction is a bonafide one made by the doctor at his instance. So it cannot be said that the ailment for which the complainant underwent surgery was a pre-existing one. Hence the repudiation of claim on the basis of suppression of material fact relating to pre-existing illness cannot be sustained. In the result, an award is passed directing the insurer to pay an amount of Rs.10,025/- with 9% interest.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002-192/2010-11

P.Radhakrishnan
Vs
The New India Assurance Co.Ltd.

AWARD DATED 21.12.2010

The complaint relates to repudiation of claim under a group mediclaim policy. The claim was repudiated on the ground that the treatment was taken in a private ayurveda hospital. The insurer contended that reimbursement could be made only if treatment is taken in a Govt.Ayurvedic Hospital. The complainant submitted that there have been several instances wherein the insurer had made reimbursement of

medical bills relating to treatment in private ayurveda hospitals and hence the repudiation is ill-motivated.

A detailed study of the case revealed that clause 2.7 of the policy conditions was revised/amended by a circular. As per the circular, expenses incurred for ayurvedic/homeopathic/unani treatment are admissible up to 25% of sum insured provided the treatment for the illness/disease and accidental injuries is taken in registered hospitals which are qualifying the definition of hospital excluding centres for spas, massages and health rejuvenation procedures. It is found that the ayurveda hospital, where the complainant took treatment is a registered one and hence he is entitled to reimbursement of 25% of the sum insured or the actual amount spent for the treatment, whichever is less. In the result, an award is passed directing the insurer to reimburse Rs.6,786/- or 25% of the sum insured, whichever is less, with 9% interest from the date of filing of the claim till this day and to pay Rs.1,000/- as cost.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-163/2010-11

Abdul Rahman Shaik
Vs
United India Insurance Co.Ltd.

AWARD DATED 21.12.2010

The complaint is challenging partial repudiation of claim by the insured for reimbursement of medical expenses met.

The complainant had undergone complete body check-up inApril 2009 at KIMS Hospital after getting the sanction of the insurer. Though bill for Rs.4,500/- was submitted for reimbursement, he was given only Rs.1,000/- contending that the insured is entitled to only 1% of the sum insured [Rs.1,00,000/-]. He has claimed the entire amount and also compensation for agony and pain caused to him.

The insurer's contention is that the complainant is a mediclaim policyholder since 2005. The claim is partially repudiated quoting Clause 8 of the policy conditions. Accordingly, the repudiation made is proper.

Clause 8 of the policy conditions is as follows: **:** *The insured shall be entitled to a free medical check-up to be carried out by the company/authorized TPAs once at the end of block of every 3 underwriting years provided there are no claims reported during the block.* The insurer contended that due to system error, at the time of generating the policy, the policy condition is incomplete. But the copies of policies issued to the complaint for the years 2008-2009 and 2009-2010 produced before this Forum have the above condition printed. Nowhere, there is restriction to 1% of the sum insured. It at all any error had crept in at the time of issuing the 1st policy, the same should have been rectified while issuing the renewed policy. It is presumed that there was some change in the condition of the policy as can be seen from the change in the number of block. Earlier it was block of 3 years which has been changed to block of 4 years. But the restriction to 1% is not mentioned in the renewed policy.

Insurance policy is a concluded contract. Both the parties are bound by the policy conditions. When the policy condition is clear as to the reimbursement, the insurer cannot turn around and quote change in the policy conditions, which actually is not evident in the policy issued to the complainant, on renewal of the policy. The contention of the insurer that there is change in the policy condition cannot be accepted.

The insurer is, therefore, directed to settle the balance amount of Rs.3,500/- [Rs.1,000/- paid as against the claimed amount of Rs.4,500/-] with 9% interest from the date of claim till this day, with cost of Rs.1,500/-, to the insured.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11 **OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

Complaint No.IO/KCH/GI/11-003-166/2010-11

Soosy Roy
Vs
National Insurance Co.Ltd.

AWARD DATED 07.10.2010

The complaint is against non-settlement of mediclaim raised for treatment of severe low back pain and related hospitalization. The claim was, however, repudiated by the insurer quoting no active line of treatment.

During the personal hearing, the complainant argued that she was having severe back pain and it was as per the doctor's advice that she got admitted in the hospital. The insurer submitted that during the period of hospitalization, she was given only some tablets. She could not give proper explanation as to the non-inclusion of physiotherapy charges mentioned in the main hospital bill.

There is also disparity in the date of discharge. In that, the discharge summary shows the date as 15.10.2009 whereas in some bills, it is 14.10.2009. This was brought to the notice of the insured at the time of hearing.

Taking into account the bills and treatment records, it is concluded that the hospitalisation was merely for evaluation and investigation purpose and hence the complaint is **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-082/2010-11

K.C.Babu
Vs
United India Insurance Co.Ltd.

AWARD DATED 06.12.2010

The complainant, a mediclaim policyholder of United India Insurance Co.Ltd., had raised two claims, which were repudiated by the insurer on the ground of pre-existing illness and alcohol related complications. Hence he approached this Forum for justice.

The complainant was hospitalized from 26.01.2009 to 25.02.2009 for treatment of ulcer burst. The claim for reimbursement of medical expenses was repudiated by the insurer under clauses 4.8 and 4.9. Earlier in 2007 also, he had raised a claim which was also repudiated by the insurer.

The insurer's contention is that the medical records available revealed that he was in the regular habit of consuming alcohol and a smoker. Hence he is not eligible to be reimbursed.

The discharge summary of 2007 mentions 'chronic alcoholic and smoker' under the head Personal History. However, there is no mention about alcohol consumption in the discharge summary of 2009. The complainant, during hearing, has admitted to consumption of alcohol, though not regularly.

The policy commenced initially in March 2006 and, thereafter, being renewed every year. As the discharge summary of 2007 clearly states consumption of alcohol by the complainant, for which he had undergone hospitalized treatment, it can only be assumed that the current ailment for which he had undergone hospitalization is related to the presence of pre-existing disease.

Hence the complaint is **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-017-097/2010-11

E.Jacob Mathew
Vs
Star Health & Allied Insurance Co.Ltd.

AWARD DATED 20.12.2010

The complaint was against repudiation of claim under mediclaim policy. The claim was rejected on the ground that the pre-existing diseases were not disclosed at the time of taking the policy. On an examination of various records made available, the following facts were observed. During the currency of the policy, the complainant was admitted in the hospital with complaint of CAD and CABG was done. The medical history revealed that he was diabetic for 14 years and hypertensive for 12 years, whereas, in the proposal form obtained at the time of taking the policy, all the relevant questions related to the diseases were answered negatively. Hence the existence of diabetes and hypertension has been clearly established which are essentially heart related risk factors and this has been suppressed by the insurer in the proposal form at the time of taking the policy. Taking all the facts into account,

the insurer is justified in repudiating the claim due to suppression of material facts and pre-existing illness exclusion clauses. The complaint is **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002-143/2010-11

Jayasree S.Nair
Vs
The New India Assurance Co.Ltd.

AWARD DATED 21.12.2010

The complaint related to repudiation of claim for reimbursement of medical expenses under a mediclaim policy. The insurer denied the claim contending that the ailment was a pre-existing one. The insurer submitted that there was a correction in the discharge summary so as to bring the claim within the allowable period. Hence there was suppression of material fact in the proposal form regarding pre-existing illness.

On verification of discharge summary, it is found that there was a correction in 'history of illness'. Originally, it was written as '2 years', but it was corrected as '2 months'. A close scrutiny of the correction would reveal that the correction is made by the same hand which has written the other contents of the discharge summary. So it can be inferred that the correction was made at the instance of the doctor who had written the discharge summary, though the correction was not initialed by the doctor. In the absence of any other evidence to the contrary, it can only be concluded that the correction is a bonafide one made by the doctor at his instance. So it cannot be said that the ailment for which the complainant underwent surgery was a pre-existing one. Hence the repudiation of claim on the basis of suppression of material fact relating to pre-existing illness cannot be sustained. In the result, an award is passed directing the insurer to pay an amount of Rs.10,025/- with 9% interest.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002-192/2010-11

P.Radhakrishnan
Vs
The New India Assurance Co.Ltd.

AWARD DATED 21.12.2010

The complaint relates to repudiation of claim under a group mediclaim policy. The claim was repudiated on the ground that the treatment was taken in a private ayurveda hospital. The insurer contended that reimbursement could be made only if treatment is taken in a Govt.Ayurvedic Hospital. The complainant submitted that there have been several instances wherein the insurer had made reimbursement of

medical bills relating to treatment in private ayurveda hospitals and hence the repudiation is ill-motivated.

A detailed study of the case revealed that clause 2.7 of the policy conditions was revised/amended by a circular. As per the circular, expenses incurred for ayurvedic/homeopathic/unani treatment are admissible up to 25% of sum insured provided the treatment for the illness/disease and accidental injuries is taken in registered hospitals which are qualifying the definition of hospital excluding centres for spas, massages and health rejuvenation procedures. It is found that the ayurveda hospital, where the complainant took treatment is a registered one and hence he is entitled to reimbursement of 25% of the sum insured or the actual amount spent for the treatment, whichever is less. In the result, an award is passed directing the insurer to reimburse Rs.6,786/- or 25% of the sum insured, whichever is less, with 9% interest from the date of filing of the claim till this day and to pay Rs.1,000/- as cost.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-163/2010-11

Abdul Rahman Shaik
Vs
United India Insurance Co.Ltd.

AWARD DATED 21.12.2010

The complaint is challenging partial repudiation of claim by the insured for reimbursement of medical expenses met.

The complainant had undergone complete body check-up inApril 2009 at KIMS Hospital after getting the sanction of the insurer. Though bill for Rs.4,500/- was submitted for reimbursement, he was given only Rs.1,000/- contending that the insured is entitled to only 1% of the sum insured [Rs.1,00,000/-]. He has claimed the entire amount and also compensation for agony and pain caused to him.

The insurer's contention is that the complainant is a mediclaim policyholder since 2005. The claim is partially repudiated quoting Clause 8 of the policy conditions. Accordingly, the repudiation made is proper.

Clause 8 of the policy conditions is as follows: **:** *The insured shall be entitled to a free medical check-up to be carried out by the company/authorized TPAs once at the end of block of every 3 underwriting years provided there are no claims reported during the block.* The insurer contended that due to system error, at the time of generating the policy, the policy condition is incomplete. But the copies of policies issued to the complaint for the years 2008-2009 and 2009-2010 produced before this Forum have the above condition printed. Nowhere, there is restriction to 1% of the sum insured. It at all any error had crept in at the time of issuing the 1st policy, the same should have been rectified while issuing the renewed policy. It is presumed that there was some change in the condition of the policy as can be seen from the change in the number of block. Earlier it was block of 3 years which has been changed to block of 4 years. But the restriction to 1% is not mentioned in the renewed policy.

Insurance policy is a concluded contract. Both the parties are bound by the policy conditions. When the policy condition is clear as to the reimbursement, the insurer cannot turn around and quote change in the policy conditions, which actually is not evident in the policy issued to the complainant, on renewal of the policy. The contention of the insurer that there is change in the policy condition cannot be accepted.

The insurer is, therefore, directed to settle the balance amount of Rs.3,500/- [Rs.1,000/- paid as against the claimed amount of Rs.4,500/-] with 9% interest from the date of claim till this day, with cost of Rs.1,500/-, to the insured.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-013-191/2010-11

V.John Paulose
Vs
HDFC Ergo General Insurance Co.Ltd.

AWARD DATED 23.12.2010

The complainant, holder of Health Insurance policy, had an accidental fall on his back resulting in back pain for which he had undergone treatment and surgery. The claim was repudiated by the insurer contending that the claim was under the first 2 years exclusion clause of the policy. The insurer contended that the insured was suffering from back pain before taking the policy and hence there was suppression of material fact. Various medical evidences like hospital treatment records, discharge summary and MRI scan reports were produced for verification. Contrary to the contention raised by the insurer that the complainant was suffering from osteoporosis, all the medical evidences were silent about the presence of osteoporosis. Similarly, there was nothing to show that the complainant was having backbone pain earlier and had taken treatment for the same at any point of time before taking the policy. The contents of the MRI scan report fully support the case of the complainant regarding accidental fall and consequential compression and upward migration of the bones. Hence the case of the complainant that he suffered the injury on account of the accidental fall is to be believed. Accident is not an item included in the first 2 years exclusion clause under the policy. Hence the treatment for the injury on account of accident is covered under the policy. In the result, an award is passed directing the insurer to reimburse Rs.44,783/- with 9% interest from the date of claim petition till this day.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-009-271/2010-11

P.Muraleedharan
Vs
Reliance General Insurance Co.Ltd.

AWARD DATED 28.12.2010

The complainant's wife underwent surgery for removal of fibroid uterus. The claim was rejected by the insurer under exclusion clause as the surgery was done within a period of one year from the inception of the policy. The complainant contended that surgery for removal of uterus was not included in the exclusion clause.

The question for consideration is whether surgery for removal of uterus has been excluded in the policy conditions. On an examination of Clause 3 of the policy exclusions, it is found that hysterectomy is included in the said clause. Hysterectomy is the medical term for removal of womb or uterus. So the contention of the complaint that surgery for removal of uterus is not included in the exclusion clause cannot be sustained. The complaint is **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002-340/2010-11

Dr.Raju Kurian Nian
Vs
The New India Assurance Co.Ltd.

AWARD DATED 04.01.2011

The complainant's wife had undergone an operation for removing a cyst in ovary. The claim for reimbursement of medical expenses was repudiated by the insurer. The insurer submitted that the surgery for the removal of benign cyst was within 2 years of the inception of the policy and, therefore, by virtue of Clause 4.3 of the policy conditions, the insurer is not liable to reimburse the medical expenses. On examination of the policy conditions, it is confirmed that the policy issued will not cover surgery for removal of tumors, cysts, etc., if it occurs within a period of 2 years from the inception of the policy. Hence the insurer is justified in repudiating the claim. The complaint is **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002-292/2010-11

Liny Ignishious
Vs
The New India Assurance Co.Ltd.

AWARD DATED 04.01.2011

The complaint was about partial repudiation of mediclaim. In the complaint, the complaint stated that though bills for Rs.3,040/- was submitted, only Rs.2,290/- was reimbursed. During the hearing, the complainant remained absent. The insurer submitted that out of Rs.3,040/-, bills for Rs.2,290/- was sanctioned. Payment of the balance amount of Rs.750/- was not considered since supporting medical report and prescription from the doctor were not produced. They also submitted that as and when the same are produced, they are ready to consider her application for further settlement. Since the supporting documents are not produced for consideration, the stand taken by the insurer is justified. The complaint is **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-003-198/2010-11

K.V.Devassy
Vs
National Insurance Co.Ltd.

AWARD DATED 07.10.2010

The complaint is regarding non-settlement of mediclaim raised for hospitalization to undergo treatment of discomfort of angina. The insurer repudiated the claim on the ground of pre-existing illness.

The complainant had pain in the jaw which was initially treated. But as the pain did not subside, he consulted another doctor who advised him to get admitted in the hospital.

On going through the medical certificate available in the file, it is clear that the duration of illness is for 6 months and diabetes for one year. The policy incepted on 16.07.2009 and he was hospitalized on 05.11.2009, within 4 months of policy inception, which means that the diseases are pre-existing, falling under exclusion clause 4.1. The insurer's decision is correct and the complaint is, therefore, **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-814/2009-10

Kurian Joseph
Vs
United India Insurance Co.Ltd.

AWARD DATED 07.10.2010

The complainant had taken a mediclaim policy through a social service centre. The complainant was admitted in the hospital and the claim submitted was rejected by the insurer under pre-existing clause of the policy conditions.

Though the insurer had declined the claim under pre-existing clause, during the hearing, they expressed their willingness to settle the claim up to his eligibility as per policy conditions, provided the bills are submitted. Hence the insured was advised to submit the bills to the insurer to enable them to process the claim. The insurer has been advised to settle the claim up to the eligibility as per the policy after receipt of bills. In the result, the complaint is **ALLOWED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-005-064/2010-11

Thomas Abraham
Vs
The Oriental Insurance Co.Ltd.

AWARD DATED 07.10.2010

The complainant, including his wife, was covered by the mediclaim policy issued by The Oriental Insurance Co.Ltd. His wife was hospitalised for treatment of severe headache/vomiting and swelling in the leg. The claim lodged by the insured was not settled. The insurer's contention was that they were not able to trace out the related papers and on two occasions, sought time for postponement. Based on the email correspondence exchanged between the insured and the insurer and furnished by the insured, the case was heard.

The claim has not been considered by the insurer on the ground that only oral medication was given to the patient which is outside the scope of the policy. But the insured contended that since his wife had severe headache and vomiting, she had to be admitted in the hospital. Subsequently MRI [Brain] was taken as per the treating doctor's advice.

Since the headache and vomiting continued for 3 months, it is quite normal for any person to consult a specialist. The hospitalization was required to keep her under observation. Hence the insurer is not justified in denying the claim. The insurer has not been able to produce any other papers to justify their repudiation. The complaint is, therefore, allowed for the claimed amount of Rs.7,870/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002-041/2010-11

S.Narayana Pillai
Vs
The New India Assurance Co.Ltd.

AWARD DATED 28.10.2010

The complainant was covered under the group mediclaim policy issued to employees of CEAT Limited, where his son was employed. He raised a claim for the hospitalized treatment undergone from 08.03.2009 to 24.03.2009. However, the claim was

repudiated by the insurer on the ground that the son of the complainant ceased to be an employee of CEAT Limited w.e.f. 15.02.2009. This was contested by the complainant as the coverage continued till 01.04.2009, the day on which cancellation was effected by the insurer.

The insurer submitted that the repudiation of mediclaim is on proper as the son of the complainant was no more an employee of CEAT Limited during the hospitalization period. The premium deducted from the salary of the complainant's son towards the group mediclaim policy was refunded vide refund voucher dated 01.04.2009.

Going through the records made available to this Forum and based on the hearing, it is observed that the premium was held by the insurer till 01.04.2009 though the son of the complainant ceased to be an employee of CEAT w.e.f. 15.02.2009. No communication was sent by the employer to the insurer with regard to his relinquishment of service. The insurer was made aware of this fact only on 01.04.2009 when the deletion list was provided to them. So it is only to be presumed that the complainant was covered under the policy till 31.03.2009 as the premium was retained by the insurer till such time. As the hospitalization was before 31.03.2009, the insurer cannot turn down the claim raised by the complainant.

The complaint is, therefore, **ALLOWED**, for the claim amount raised by the complainant.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/14-003-252/2010-11

James Abraham
Vs
National Insurance Co.Ltd.

AWARD DATED 09.11.2010

The complaint is with regard to non-settlement of medical expenses incurred in connection with the hospitalization of the wife of the insured, for treatment of irreducible incisional hernia. The claim has been denied by the insurer on the ground that the treatment for which reimbursement has been sought related to an alleged previous ailment. The insured contended that his wife had not undergone any surgery 1 ½ years earlier, though, she had undergone cesarean section 30 years back.

On hearing both the sides and on going through the medical records, there is no record to prove that the wife of the insured underwent some surgery 1 ½ years back. The policy exclusion clause stipulates that all diseases/injuries which are pre-existing when the cover incepts for the first time will be excluded. However, those diseases will be covered after 4 continuous claim free policy years and particularly so, if the policy is in continuance with the same insurance company.

The certificate from the treating doctor mentions that a surgery was performed 1 ½ years back but the insurer has not taken any steps to know the correctness of the contents of the said certificate. Instead they have only been insisting on

production of the medical records with regard to the said surgery, though the claimant has been denying such a surgery performed 1 ½ years back.

Taking all factors into account, the insurer is not justified in denying the claim to the insured and hence the complaint is ALLOWED. **The insurer is directed to process and settle the claim as per policy terms and conditions.**

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002-073/2010-11

P.P.Mathew
Vs
The New India Assurance Co.Ltd.

AWARD DATED 28.10.2010

The complaint is against partial repudiation of claim raised with the insurer. The complainant was initially having a mediclaim policy for Rs.15,000/- since 2003, which was enhanced to Rs.1,00,000/- in 2006. In October 2010, he underwent angiogram and submitted a bill for Rs.1,51,000/-. However, the claim was settled for only Rs.15,000/- on the ground of pre-existing illness vide clause 6[d] of the policy conditions which does not allow the enhanced sum assured for any illness contracted during the preceding policy years. This was contested by the insured and hence, he approached this Forum for justice.

At the time of personal hearing, the complainant submitted that he has been having mediclaim policy since 1996 for Rs.15,000/-. In 2006, the sum insured was raised to Rs.1,00,000/-. The present claim is for Rs.1,51,764/-. The insurer has settled the claim for Rs.15,000/- as they find that the complainant was treated for the same disease in 2004, though there are no records to prove that claim was raised for the said hospitalization.

As the insured has not disputed the fact that he had taken treatment for heart ailment in 2004 and the present claim is for the same illness, it is concluded that he has contracted the disease way back in 2004, the enhanced sum insured to cover up the current claim raised. The insurer is justified in settling the claim on the basis of original sum insured of Rs.15,000/-.

The complaint is, therefore, **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-081/2010-11

P.Sundar Rajan
Vs
United India Insurance Co.Ltd.

AWARD DATED 29.10.2010

The complainant, policyholder of United India Insurance Co.Ltd., had raised a claim for the period 15.04.2009 to 14.04.2010, which was repudiated by the insurer on the ground that the treatment could have been taken on OP basis. Challenging the rejection, he approached this Forum for justice.

The complainant was admitted in the hospital on 03.02.2010 due to sudden loss of vision in the left eye. As he was diagnosed as Large Sub Macular Haemorrhage in the left eye, he was administered intra vitreal injection under local anesthesia and discharged the very next day. The complainant is a heart patient and has been under anti-coagulants. He was hospitalized for subsequent monitoring. The claim for the said hospitalized treatment was rejected by the insurer. The insurer contended that the injection could have been given to him on OP basis.

During the personal hearing, the insured submitted that he is a heart patient spending around Rs.5,000/- every month towards medicines but till date, hasn't raised any claim. The administration of the injection stated above was to be done in an OT under local anesthesia and the same was done as per the doctor's advice. He had bleeding the next day which was duly rectified by injunction of gas. The insurer strongly objected to this saying that this injection could have been administered in the OPD.

The repudiation is done by the TPA and the insurer has not taken any step to find out if hospitalization was necessary. The TPA is not the final authority to decide on hospitalization or otherwise. The insurer's decision of repudiating the claim just by saying that the treatment could have been taken in OPD carries no weight.

The complaint is, therefore, **ALLOWED**. The insurer is directed to settle the claim relating to the hospitalization bills submitted by the insured.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-089/2010-11

Rosily Johny
Vs
United India Insurance Co.Ltd.

AWARD DATED 29.10.2010

The complaint was filed against repudiation of claim under a mediclaim policy. The claim for hospital expenses was rejected by the insurer on the ground that only oral medicines were given and no active line of treatment was given.

On a perusal of various documents as well as the points raised during the hearing, it is established that the insured was admitted in the hospital for 5 days due to severe pain in the ear and shoulder. She was admitted in the hospital after suffering from pain for nearly 4 months. Though it appears from the discharge summary that only oral medication has been given, taking into account the findings of MRI scan report, the treating doctor must have decided to observe the patient in the hospital for a few days. Taking all the factors into account, the insurer is not justified in repudiating the claim under Clause 4[c] of the policy conditions and hence the insurer is directed to process and settle the claim as per other policy terms and conditions.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-003-166/2010-11

Soosy Roy
Vs
National Insurance Co.Ltd.

AWARD DATED 07.10.2010

The complaint is against non-settlement of mediclaim raised for treatment of severe low back pain and related hospitalization. The claim was, however, repudiated by the insurer quoting no active line of treatment.

During the personal hearing, the complainant argued that she was having severe back pain and it was as per the doctor's advice that she got admitted in the hospital. The insurer submitted that during the period of hospitalization, she was given only some tablets. She could not give proper explanation as to the non-inclusion of physiotherapy charges mentioned in the main hospital bill.

There is also disparity in the date of discharge. In that, the discharge summary shows the date as 15.10.2009 whereas in some bills, it is 14.10.2009. This was brought to the notice of the insured at the time of hearing.

Taking into account the bills and treatment records, it is concluded that the hospitalisation was merely for evaluation and investigation purpose and hence the complaint is **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-082/2010-11

K.C.Babu
Vs
United India Insurance Co.Ltd.

AWARD DATED 06.12.2010

The complainant, a mediclaim policyholder of United India Insurance Co.Ltd., had raised two claims, which were repudiated by the insurer on the ground of pre-existing illness and alcohol related complications. Hence he approached this Forum for justice.

The complainant was hospitalized from 26.01.2009 to 25.02.2009 for treatment of ulcer burst. The claim for reimbursement of medical expenses was repudiated by the

insurer under clauses 4.8 and 4.9. Earlier in 2007 also, he had raised a claim which was also repudiated by the insurer.

The insurer's contention is that the medical records available revealed that he was in the regular habit of consuming alcohol and a smoker. Hence he is not eligible to be reimbursed.

The discharge summary of 2007 mentions 'chronic alcoholic and smoker' under the head Personal History. However, there is no mention about alcohol consumption in the discharge summary of 2009. The complainant, during hearing, has admitted to consumption of alcohol, though not regularly.

The policy commenced initially in March 2006 and, thereafter, being renewed every year. As the discharge summary of 2007 clearly states consumption of alcohol by the complainant, for which he had undergone hospitalized treatment, it can only be assumed that the current ailment for which he had undergone hospitalization is related to the presence of pre-existing disease.

Hence the complaint is **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-017-097/2010-11

E.Jacob Mathew
Vs
Star Health & Allied Insurance Co.Ltd.

AWARD DATED 20.12.2010

The complaint was against repudiation of claim under mediclaim policy. The claim was rejected on the ground that the pre-existing diseases were not disclosed at the time of taking the policy. On an examination of various records made available, the following facts were observed. During the currency of the policy, the complainant was admitted in the hospital with complaint of CAD and CABG was done. The medical history revealed that he was diabetic for 14 years and hypertensive for 12 years, whereas, in the proposal form obtained at the time of taking the policy, all the relevant questions related to the diseases were answered negatively. Hence the existence of diabetes and hypertension has been clearly established which are essentially heart related risk factors and this has been suppressed by the insurer in the proposal form at the time of taking the policy. Taking all the facts into account, the insurer is justified in repudiating the claim due to suppression of material facts and pre-existing illness exclusion clauses. The complaint is **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002-143/2010-11

Jayasree S.Nair
Vs
The New India Assurance Co.Ltd.

AWARD DATED 21.12.2010

The complaint related to repudiation of claim for reimbursement of medical expenses under a mediclaim policy. The insurer denied the claim contending that the ailment was a pre-existing one. The insurer submitted that there was a correction in the discharge summary so as to bring the claim within the allowable period. Hence there was suppression of material fact in the proposal form regarding pre-existing illness.

On verification of discharge summary, it is found that there was a correction in 'history of illness'. Originally, it was written as '2 years', but it was corrected as '2 months'. A close scrutiny of the correction would reveal that the correction is made by the same hand which has written the other contents of the discharge summary. So it can be inferred that the correction was made at the instance of the doctor who had written the discharge summary, though the correction was not initialed by the doctor. In the absence of any other evidence to the contrary, it can only be concluded that the correction is a bonafide one made by the doctor at his instance. So it cannot be said that the ailment for which the complainant underwent surgery was a pre-existing one. Hence the repudiation of claim on the basis of suppression of material fact relating to pre-existing illness cannot be sustained. In the result, an award is passed directing the insurer to pay an amount of Rs.10,025/- with 9% interest.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002-192/2010-11

P.Radhakrishnan
Vs
The New India Assurance Co.Ltd.

AWARD DATED 21.12.2010

The complaint relates to repudiation of claim under a group mediclaim policy. The claim was repudiated on the ground that the treatment was taken in a private ayurveda hospital. The insurer contended that reimbursement could be made only if treatment is taken in a Govt.Ayurvedic Hospital. The complainant submitted that there have been several instances wherein the insurer had made reimbursement of

medical bills relating to treatment in private ayurveda hospitals and hence the repudiation is ill-motivated.

A detailed study of the case revealed that clause 2.7 of the policy conditions was revised/amended by a circular. As per the circular, expenses incurred for ayurvedic/homeopathic/unani treatment are admissible up to 25% of sum insured provided the treatment for the illness/disease and accidental injuries is taken in registered hospitals which are qualifying the definition of hospital excluding centres for spas, massages and health rejuvenation procedures. It is found that the ayurveda hospital, where the complainant took treatment is a registered one and hence he is entitled to reimbursement of 25% of the sum insured or the actual amount spent for the treatment, whichever is less. In the result, an award is passed directing the insurer to reimburse Rs.6,786/- or 25% of the sum insured, whichever is less, with 9% interest from the date of filing of the claim till this day and to pay Rs.1,000/- as cost.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-163/2010-11

Abdul Rahman Shaik
Vs
United India Insurance Co.Ltd.

AWARD DATED 21.12.2010

The complaint is challenging partial repudiation of claim by the insured for reimbursement of medical expenses met.

The complainant had undergone complete body check-up inApril 2009 at KIMS Hospital after getting the sanction of the insurer. Though bill for Rs.4,500/- was submitted for reimbursement, he was given only Rs.1,000/- contending that the insured is entitled to only 1% of the sum insured [Rs.1,00,000/-]. He has claimed the entire amount and also compensation for agony and pain caused to him.

The insurer's contention is that the complainant is a mediclaim policyholder since 2005. The claim is partially repudiated quoting Clause 8 of the policy conditions. Accordingly, the repudiation made is proper.

Clause 8 of the policy conditions is as follows: **:** *The insured shall be entitled to a free medical check-up to be carried out by the company/authorized TPAs once at the end of block of every 3 underwriting years provided there are no claims reported during the block.* The insurer contended that due to system error, at the time of generating the policy, the policy condition is incomplete. But the copies of policies issued to the complaint for the years 2008-2009 and 2009-2010 produced before this Forum have the above condition printed. Nowhere, there is restriction to 1% of the sum insured. It at all any error had crept in at the time of issuing the 1st policy, the same should have been rectified while issuing the renewed policy. It is presumed that there was some change in the condition of the policy as can be seen from the change in the number of block. Earlier it was block of 3 years which has been changed to block of 4 years. But the restriction to 1% is not mentioned in the renewed policy.

Insurance policy is a concluded contract. Both the parties are bound by the policy conditions. When the policy condition is clear as to the reimbursement, the insurer cannot turn around and quote change in the policy conditions, which actually is not evident in the policy issued to the complainant, on renewal of the policy. The contention of the insurer that there is change in the policy condition cannot be accepted.

The insurer is, therefore, directed to settle the balance amount of Rs.3,500/- [Rs.1,000/- paid as against the claimed amount of Rs.4,500/-] with 9% interest from the date of claim till this day, with cost of Rs.1,500/-, to the insured.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-013-191/2010-11

V.John Paulose
Vs
HDFC Ergo General Insurance Co.Ltd.

AWARD DATED 23.12.2010

The complainant, holder of Health Insurance policy, had an accidental fall on his back resulting in back pain for which he had undergone treatment and surgery. The claim was repudiated by the insurer contending that the claim was under the first 2 years exclusion clause of the policy. The insurer contended that the insured was suffering from back pain before taking the policy and hence there was suppression of material fact. Various medical evidences like hospital treatment records, discharge summary and MRI scan reports were produced for verification. Contrary to the contention raised by the insurer that the complainant was suffering from osteoporosis, all the medical evidences were silent about the presence of osteoporosis. Similarly, there was nothing to show that the complainant was having backbone pain earlier and had taken treatment for the same at any point of time before taking the policy. The contents of the MRI scan report fully support the case of the complainant regarding accidental fall and consequential compression and upward migration of the bones. Hence the case of the complainant that he suffered the injury on account of the accidental fall is to be believed. Accident is not an item included in the first 2 years exclusion clause under the policy. Hence the treatment for the injury on account of accident is covered under the policy. In the result, an award is passed directing the insurer to reimburse Rs.44,783/- with 9% interest from the date of claim petition till this day.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-009-271/2010-11

P.Muraleedharan
Vs
Reliance General Insurance Co.Ltd.

AWARD DATED 28.12.2010

The complainant's wife underwent surgery for removal of fibroid uterus. The claim was rejected by the insurer under exclusion clause as the surgery was done within a period of one year from the inception of the policy. The complainant contended that surgery for removal of uterus was not included in the exclusion clause.

The question for consideration is whether surgery for removal of uterus has been excluded in the policy conditions. On an examination of Clause 3 of the policy exclusions, it is found that hysterectomy is included in the said clause. Hysterectomy is the medical term for removal of womb or uterus. So the contention of the complaint that surgery for removal of uterus is not included in the exclusion clause cannot be sustained. The complaint is **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002-340/2010-11

Dr.Raju Kurian Nian
Vs
The New India Assurance Co.Ltd.

AWARD DATED 04.01.2011

The complainant's wife had undergone an operation for removing a cyst in ovary. The claim for reimbursement of medical expenses was repudiated by the insurer. The insurer submitted that the surgery for the removal of benign cyst was within 2 years of the inception of the policy and, therefore, by virtue of Clause 4.3 of the policy conditions, the insurer is not liable to reimburse the medical expenses. On examination of the policy conditions, it is confirmed that the policy issued will not cover surgery for removal of tumors, cysts, etc., if it occurs within a period of 2 years from the inception of the policy. Hence the insurer is justified in repudiating the claim. The complaint is **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002-292/2010-11

Liny Ignishious
Vs
The New India Assurance Co.Ltd.

AWARD DATED 04.01.2011

The complaint was about partial repudiation of mediclaim. In the complaint, the complaint stated that though bills for Rs.3,040/- was submitted, only Rs.2,290/- was reimbursed. During the hearing, the complainant remained absent. The insurer submitted that out of Rs.3,040/-, bills for Rs.2,290/- was sanctioned. Payment of the balance amount of Rs.750/- was not considered since supporting medical report and prescription from the doctor were not produced. They also submitted that as and when the same are produced, they are ready to consider her application for further settlement. Since the supporting documents are not produced for consideration, the stand taken by the insurer is justified. The complaint is **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-003-198/2010-11

K.V.Devassy
Vs
National Insurance Co.Ltd.

AWARD DATED 07.10.2010

The complaint is regarding non-settlement of mediclaim raised for hospitalization to undergo treatment of discomfort of angina. The insurer repudiated the claim on the ground of pre-existing illness.

The complainant had pain in the jaw which was initially treated. But as the pain did not subside, he consulted another doctor who advised him to get admitted in the hospital.

On going through the medical certificate available in the file, it is clear that the duration of illness is for 6 months and diabetes for one year. The policy incepted on 16.07.2009 and he was hospitalized on 05.11.2009, within 4 months of policy inception, which means that the diseases are pre-existing, falling under exclusion clause 4.1. The insurer's decision is correct and the complaint is, therefore, **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-814/2009-10

Kurian Joseph
Vs
United India Insurance Co.Ltd.

AWARD DATED 07.10.2010

The complainant had taken a mediclaim policy through a social service centre. The complainant was admitted in the hospital and the claim submitted was rejected by the insurer under pre-existing clause of the policy conditions.

Though the insurer had declined the claim under pre-existing clause, during the hearing, they expressed their willingness to settle the claim up to his eligibility as per policy conditions, provided the bills are submitted. Hence the insured was advised to submit the bills to the insurer to enable them to process the claim. The insurer has been advised to settle the claim up to the eligibility as per the policy after receipt of bills. In the result, the complaint is **ALLOWED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-005-064/2010-11

Thomas Abraham
Vs
The Oriental Insurance Co.Ltd.

AWARD DATED 07.10.2010

The complainant, including his wife, was covered by the mediclaim policy issued by The Oriental Insurance Co.Ltd. His wife was hospitalised for treatment of severe headache/vomiting and swelling in the leg. The claim lodged by the insured was not settled. The insurer's contention was that they were not able to trace out the related papers and on two occasions, sought time for postponement. Based on the email correspondence exchanged between the insured and the insurer and furnished by the insured, the case was heard.

The claim has not been considered by the insurer on the ground that only oral medication was given to the patient which is outside the scope of the policy. But the insured contended that since his wife had severe headache and vomiting, she had to be admitted in the hospital. Subsequently MRI [Brain] was taken as per the treating doctor's advice.

Since the headache and vomiting continued for 3 months, it is quite normal for any person to consult a specialist. The hospitalization was required to keep her under observation. Hence the insurer is not justified in denying the claim. The insurer has not been able to produce any other papers to justify their repudiation. The complaint is, therefore, allowed for the claimed amount of Rs.7,870/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002-041/2010-11

S.Narayana Pillai
Vs
The New India Assurance Co.Ltd.

AWARD DATED 28.10.2010

The complainant was covered under the group mediclaim policy issued to employees of CEAT Limited, where his son was employed. He raised a claim for the hospitalized treatment undergone from 08.03.2009 to 24.03.2009. However, the claim was

repudiated by the insurer on the ground that the son of the complainant ceased to be an employee of CEAT Limited w.e.f. 15.02.2009. This was contested by the complainant as the coverage continued till 01.04.2009, the day on which cancellation was effected by the insurer.

The insurer submitted that the repudiation of mediclaim is on proper as the son of the complainant was no more an employee of CEAT Limited during the hospitalization period. The premium deducted from the salary of the complainant's son towards the group mediclaim policy was refunded vide refund voucher dated 01.04.2009.

Going through the records made available to this Forum and based on the hearing, it is observed that the premium was held by the insurer till 01.04.2009 though the son of the complainant ceased to be an employee of CEAT w.e.f. 15.02.2009. No communication was sent by the employer to the insurer with regard to his relinquishment of service. The insurer was made aware of this fact only on 01.04.2009 when the deletion list was provided to them. So it is only to be presumed that the complainant was covered under the policy till 31.03.2009 as the premium was retained by the insurer till such time. As the hospitalization was before 31.03.2009, the insurer cannot turn down the claim raised by the complainant.

The complaint is, therefore, **ALLOWED**, for the claim amount raised by the complainant.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/14-003-252/2010-11

James Abraham
Vs
National Insurance Co.Ltd.

AWARD DATED 09.11.2010

The complaint is with regard to non-settlement of medical expenses incurred in connection with the hospitalization of the wife of the insured, for treatment of irreducible incisional hernia. The claim has been denied by the insurer on the ground that the treatment for which reimbursement has been sought related to an alleged previous ailment. The insured contended that his wife had not undergone any surgery 1 ½ years earlier, though, she had undergone cesarean section 30 years back.

On hearing both the sides and on going through the medical records, there is no record to prove that the wife of the insured underwent some surgery 1 ½ years back. The policy exclusion clause stipulates that all diseases/injuries which are pre-existing when the cover incepts for the first time will be excluded. However, those diseases will be covered after 4 continuous claim free policy years and particularly so, if the policy is in continuance with the same insurance company.

The certificate from the treating doctor mentions that a surgery was performed 1 ½ years back but the insurer has not taken any steps to know the correctness of the contents of the said certificate. Instead they have only been insisting on

production of the medical records with regard to the said surgery, though the claimant has been denying such a surgery performed 1 ½ years back.

Taking all factors into account, the insurer is not justified in denying the claim to the insured and hence the complaint is ALLOWED. **The insurer is directed to process and settle the claim as per policy terms and conditions.**

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002-073/2010-11

P.P.Mathew
Vs
The New India Assurance Co.Ltd.

AWARD DATED 28.10.2010

The complaint is against partial repudiation of claim raised with the insurer. The complainant was initially having a mediclaim policy for Rs.15,000/- since 2003, which was enhanced to Rs.1,00,000/- in 2006. In October 2010, he underwent angiogram and submitted a bill for Rs.1,51,000/-. However, the claim was settled for only Rs.15,000/- on the ground of pre-existing illness vide clause 6[d] of the policy conditions which does not allow the enhanced sum assured for any illness contracted during the preceding policy years. This was contested by the insured and hence, he approached this Forum for justice.

At the time of personal hearing, the complainant submitted that he has been having mediclaim policy since 1996 for Rs.15,000/-. In 2006, the sum insured was raised to Rs.1,00,000/-. The present claim is for Rs.1,51,764/-. The insurer has settled the claim for Rs.15,000/- as they find that the complainant was treated for the same disease in 2004, though there are no records to prove that claim was raised for the said hospitalization.

As the insured has not disputed the fact that he had taken treatment for heart ailment in 2004 and the present claim is for the same illness, it is concluded that he has contracted the disease way back in 2004, the enhanced sum insured to cover up the current claim raised. The insurer is justified in settling the claim on the basis of original sum insured of Rs.15,000/-.

The complaint is, therefore, **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-081/2010-11

P.Sundar Rajan
Vs
United India Insurance Co.Ltd.

AWARD DATED 29.10.2010

The complainant, policyholder of United India Insurance Co.Ltd., had raised a claim for the period 15.04.2009 to 14.04.2010, which was repudiated by the insurer on the ground that the treatment could have been taken on OP basis. Challenging the rejection, he approached this Forum for justice.

The complainant was admitted in the hospital on 03.02.2010 due to sudden loss of vision in the left eye. As he was diagnosed as Large Sub Macular Haemorrhage in the left eye, he was administered intra vitreal injection under local anesthesia and discharged the very next day. The complainant is a heart patient and has been under anti-coagulants. He was hospitalized for subsequent monitoring. The claim for the said hospitalized treatment was rejected by the insurer. The insurer contended that the injection could have been given to him on OP basis.

During the personal hearing, the insured submitted that he is a heart patient spending around Rs.5,000/- every month towards medicines but till date, hasn't raised any claim. The administration of the injection stated above was to be done in an OT under local anesthesia and the same was done as per the doctor's advice. He had bleeding the next day which was duly rectified by injunction of gas. The insurer strongly objected to this saying that this injection could have been administered in the OPD.

The repudiation is done by the TPA and the insurer has not taken any step to find out if hospitalization was necessary. The TPA is not the final authority to decide on hospitalization or otherwise. The insurer's decision of repudiating the claim just by saying that the treatment could have been taken in OPD carries no weight.

The complaint is, therefore, **ALLOWED**. The insurer is directed to settle the claim relating to the hospitalization bills submitted by the insured.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-089/2010-11

Rosily Johny
Vs
United India Insurance Co.Ltd.

AWARD DATED 29.10.2010

The complaint was filed against repudiation of claim under a mediclaim policy. The claim for hospital expenses was rejected by the insurer on the ground that only oral medicines were given and no active line of treatment was given.

On a perusal of various documents as well as the points raised during the hearing, it is established that the insured was admitted in the hospital for 5 days due to severe pain in the ear and shoulder. She was admitted in the hospital after suffering from pain for nearly 4 months. Though it appears from the discharge summary that only oral medication has been given, taking into account the findings of MRI scan report, the treating doctor must have decided to observe the patient in the hospital for a few days. Taking all the factors into account, the insurer is not justified in repudiating the claim under Clause 4[c] of the policy conditions and hence the insurer is directed to process and settle the claim as per other policy terms and conditions.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002-073/2010-11

P.P.Mathew
Vs
The New India Assurance Co.Ltd.

AWARD DATED 28.10.2010

The complaint is against partial repudiation of claim raised with the insurer. The complainant was initially having a mediclaim policy for Rs.15,000/- since 2003, which was enhanced to Rs.1,00,000/- in 2006. In October 2010, he underwent angiogram and submitted a bill for Rs.1,51,000/-. However, the claim was settled for only Rs.15,000/- on the ground of pre-existing illness vide clause 6[d] of the policy conditions which does not allow the enhanced sum assured for any illness contracted during the preceding policy years. This was contested by the insured and hence, he approached this Forum for justice.

At the time of personal hearing, the complainant submitted that he has been having mediclaim policy since 1996 for Rs.15,000/-. In 2006, the sum insured was raised to Rs.1,00,000/-. The present claim is for Rs.1,51,764/-. The insurer has settled the claim for Rs.15,000/- as they find that the complainant was treated for the same disease in 2004, though there are no records to prove that claim was raised for the said hospitalization.

As the insured has not disputed the fact that he had taken treatment for heart ailment in 2004 and the present claim is for the same illness, it is concluded that he has contracted the disease way back in 2004, the enhanced sum insured to cover up the current claim raised. The insurer is justified in settling the claim on the basis of original sum insured of Rs.15,000/-.

The complaint is, therefore, **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-081/2010-11

P.Sundar Rajan
Vs
United India Insurance Co.Ltd.

AWARD DATED 29.10.2010

The complainant, policyholder of United India Insurance Co.Ltd., had raised a claim for the period 15.04.2009 to 14.04.2010, which was repudiated by the insurer on the ground that the treatment could have been taken on OP basis. Challenging the rejection, he approached this Forum for justice.

The complainant was admitted in the hospital on 03.02.2010 due to sudden loss of vision in the left eye. As he was diagnosed as Large Sub Macular Haemorrhage in the left eye, he was administered intra vitreal injection under local anesthesia and discharged the very next day. The complainant is a heart patient and has been under anti-coagulants. He was hospitalized for subsequent monitoring. The claim for the said hospitalized treatment was rejected by the insurer. The insurer contended that the injection could have been given to him on OP basis.

During the personal hearing, the insured submitted that he is a heart patient spending around Rs.5,000/- every month towards medicines but till date, hasn't raised any claim. The administration of the injection stated above was to be done in an OT under local anesthesia and the same was done as per the doctor's advice. He had bleeding the next day which was duly rectified by injunction of gas. The insurer strongly objected to this saying that this injection could have been administered in the OPD.

The repudiation is done by the TPA and the insurer has not taken any step to find out if hospitalization was necessary. The TPA is not the final authority to decide on hospitalization or otherwise. The insurer's decision of repudiating the claim just by saying that the treatment could have been taken in OPD carries no weight.

The complaint is, therefore, **ALLOWED**. The insurer is directed to settle the claim relating to the hospitalization bills submitted by the insured.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-089/2010-11

Rosily Johny
Vs
United India Insurance Co.Ltd.

AWARD DATED 29.10.2010

The complaint was filed against repudiation of claim under a mediclaim policy. The claim for hospital expenses was rejected by the insurer on the ground that only oral medicines were given and no active line of treatment was given.

On a perusal of various documents as well as the points raised during the hearing, it is established that the insured was admitted in the hospital for 5 days due to severe pain in the ear and shoulder. She was admitted in the hospital after suffering from pain for nearly 4 months. Though it appears from the discharge summary that only oral medication has been given, taking into account the findings of MRI scan report, the treating doctor must have decided to observe the patient in the hospital for a few days. Taking all the factors into account, the insurer is not justified in repudiating the claim under Clause 4[c] of the policy conditions and hence the insurer is directed to process and settle the claim as per other policy terms and conditions.

MEDICLAIM (life)

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-010-326/2010-11

P.C.Gopinathan
Vs
Reliance Life Insurance Co.Ltd.

AWARD DATED 13.01.2011

The complaint is against partial repudiation of medical claim. The complainant had taken policy under Wealth Plus Health Plan. He submitted a claim in connection with surgery done on his wife. He was given a cheque for Rs.650/- only whereas the claim was for 50% of the expenses met by him. The respondent repudiated the claim on the ground that treatment for fibroid uterus does not fall within the list of major surgeries. The complainant was paid Rs.650/- towards daily hospital cash benefit. Both sides were heard.

The fact that the wife of the complainant underwent surgery for removal of fibroid uterus is not disputed. A list of 33 major surgeries is incorporated in Clause 7 of Annexure 3 of the policy conditions. Item No.32 relates to uterus and surgery description is 'Total Pelvic Exenteration for malignant conditions'. The percentage of surgical benefit is 50. In the instant case, fibroid uterus was removed by surgical procedure. The term 'malignant' means 'virulent or tending to death'. The term 'malignant' need not invariably mean cancerous. The respondent has no case that fibroid uterus cannot be termed as malignant. The premium paid by the complainant is inclusive of major surgical benefit rider. When the surgery done on the wife of the complainant comes under the major surgeries included in Clause 7 of Annexure 3, he is entitled to reimbursement of 50% of the major surgical sum assured under the policy. He is also entitled to daily hospital cash benefit for one day.

Therefore, an award is passed directing the insurer to pay 50% of the major surgical sum assured under the policy in addition to daily hospital cash benefit. No cost.

MEDICLAIM(Life)

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/24-004-357/2010-11

Letha Sasidharan
Vs
ICICI Prudential Life Insurance Co.Ltd.

AWARD DATED 20.01.2011

The complaint is about delay in settlement of mediclaim.

The complainant, who was the holder of Hospital Care Plan Policy, submitted that she was admitted in the hospital and on discharge, submitted bills for Rs.29,000/- for reimbursement. But the claim was not settled till this date. She also submitted that the policy was issued only after medical examination and hence there was no need to refuse payment of the claim. The insurer submitted that the insured was suffering from liver cirrhosis with portal hypertension 7 months prior to taking of policy and this fact was not disclosed in the proposal form. Had she disclosed the same, the policy would not have been issued to her. As there is suppression of material fact, the policy is vitiated and hence she is not entitled to any amount under the policy.

The documents and records made available were examined. It is found that the specific questions relating to the history of various diseases, in the proposal form, were answered negatively. As far as the proposal form submitted by the complainant is concerned, there was no pre-existing illness. But the discharge summary issued by the hospital authorities revealed that she was having liver cirrhosis with portal hypertension in 2007 i.e., 7 months prior to taking the policy. It is also mentioned that she was a known diabetic and having 'esophageal varices'. Hence there is consistent medical evidence to prove that the complainant was having pre-existing illness, which was not revealed in the proposal form. As the suppression of previous ailment is very material, the policy is vitiated. So the complainant is not entitled to claim any benefit under the policy. The complaint is **DISMISSED**.

KOLKATA

MEDICLAIM POLICY

Kolkata Ombudsman Centre
Case No. 376/11/009/NL/10/2009-10

Shri Bikash Chowdhury
Vs.
Reliance General Insurance Co. Ltd.

Order Dated : 10.11.2010
Facts & Submissions :

This complaint was in respect of total repudiation of claim under Individual Mediclaim Policy issued by Reliance General Insurance Company Ltd. on the ground of pre-existing disease as per exclusion clause no. 4.9 of the policy.

The complainant Shri Bikash Chowdhury stated that his wife Smt. Arati Chowdhury was suffering from pain in the right hand followed by the development of a brownish patch in the right palm on 26.02.2009 and admitted at AMRI Hospitals, Kolkata on 02.03.2009 where she was treated conservatively and released from the said hospital on 06.03.2009. As per Treatment Summary the diagnosis of the disease was *'Hypertension, Dyslipidaemia, Purpura Simples and Cervical Spondylosis".*

He lodged a claim along with all relevant documents to the TPA of the insurance company M/s Paramount Health Services Pvt. Ltd. towards the expenditure incurred in connection with the above treatment for reimbursement. TPA vide their letter dated 31.07.2009 repudiated the claim stating that '*Treatment sheet provided by the hospital it was noted that the patient's Blood Pressure was normal at the time of admission. No drug was used during hospitalization period even oral anti-hypertensive (as mentioned in Consultant record dated 03.03.2009 written as 'no drug required') which signifies the patient was admitted basically for investigation & evaluation purpose. This clearly shows that the admission was particularly for investigations and no active line of treatment was given requiring hospitalization. Furthermore, there is no mention of any acute emergent condition or treatment administered which required the patient to be confined to the hospital. Hence hospitalization was not justified. In view of the abovementioned facts the claim was rightly rejected under clause no. 4.9 of the policy conditions".* He represented to the insurance company on 26.08.2009 to review and settle his claim. But his appeal did not yield any positive result from the insurance company. Being aggrieved, the complainant approached this forum for redressal of his grievance, seeking monetary relief of Rs.31,925/- plus interest.

DECISION:

The Hon'ble Ombudsman had gone through the written submissions of the complainant and examined the documentary evidence filed by him before this forum. On the other hand the insurance company did not file any reply. From the documents filed before this forum, it was clear that the insured got admitted in the hospital on the express advice of the treating doctor who was the best judge to advice on the condition of the patient and the treating doctor to decide whether the condition of the patient warranted immediate admission into the hospital or not. The treatment summary revealed that on examination the doctor found the patient severely hypertensive and she was placed on into antihypertensive medicine. Since the representative of the insurance company did not attend the hearing and there was no irrefutable proof on the part of the insurance company that she was suffering from the said disease, the decision of the insurance company was kept aside and award had been passed by the Hon'ble Ombudsman to this effect in favour of the complainant to pay claim.

Kolkata Ombudsman Centre
Case No. 388/11/003/NL/10/2009-10
Shri Dilip Kumar Banerjee
Vs.
National Insurance Co. Ltd.

Order Dated : 10.11.2010
Facts & Submissions :

This complaint was in respect of repudiation of a claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd. as per exclusion clause no. 4.3 of the policy.

The complainant, Shri Dilip Kumar Banerjee stated that his wife Smt. Pranami Banerjee was suffering from gynaecological problem and was admitted at West Bank Hospital, Howrah on 18.09.2008 where TAH + BSO was done on 19.09.2008 under general anesthesia and she was released from the said hospital on 24.09.2008. As per discharge summary the diagnosis of the disease was *"Fibroid Uterus'.*

He lodged a claim to the TPA of the insurance company M/s Medsave Healthcare (TPA) Ltd., Kolkata along with all relevant documents for reimbursement of medical expenses. But the TPA vide their letter dated 04.12.2008 repudiated the claim stating that '*the claim has arisen in the 2nd year of policy with National and there is an exclusion of two years, so reject the claim under clause 4.3 of the mediclaim policy'.* He represented to the insurance company on 26.06.2009 stating that previous two years his policy was with Iffco Tokio General Insurance Company Ltd.. But his representation did not yield any positive response. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.49,079/-.

The insurance company in their self-contained note dated 16.02.2010 stated that the claim has arisen in the 2nd year of the policy with National Insurance Company Ltd. and as per exclusion clause no. 4.3, the claim was rejected.

DECISION:

It was seen from Insurer's Head Office Circular dated 07.11.2007 that policies held with other insurers if transferred/ switched over to N.I.C, are treated as new/ fresh insurance for application of exclusion clause no. 4.1, 4.2 and 4.3. However, this stipulation has been relaxed by adding that in case the earlier policy is transferred with 5% CB with satisfactory proof and without break in insurance the exclusion period of one year may be waived and if the CB on previous policy is 10%, then two years may be waived. In case of a policy with no CB on renewal if transferred and even without break in insurance it shall be treated as a new policy.

From the policy schedule filed by the complainant it was not clear whether there was any CB on his policy with Iffco Tokio. The Hon'ble Ombudsman thought it proper to refer the case back to the insurer for review in the light of the above circular with the direction to verify whether there was a CB available to the insured under old policy and if so whether his case could be considered for continuity benefits and CB. Further they should also seek clarification from their competent authority whether benefits attached with such continuity can be extended in cases of switch over of group mediclaim policy with other insurance company to individual mediclaim policy with their own company. In case the benefits of continuity became allowable by the insurer in accordance with their competent authority's clarification on abovementioned circular, then the claim became payable as the exclusion clause would not be applicable being lodged in the 4th year of the policy.

Vs.
National Insurance Co. Ltd.

Order Dated : 10.11.2010
Facts & Submissions :

This complaint was in respect repudiation of a claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd. on the ground of pre-existing disease as per exclusion clause no. 4.1 of the policy.

The complainant Shri Asit Kumar Saha in his complaint has stated that his son Master Shreerup Saha was suffering from limping gait since childhood associated with bilateral flat foot and was admitted in Bhattacharyya Orthopaedics & Related Research Centre (P) Ltd. Kolkata on 23.11.2008 where he underwent an operation viz. Adductor tenatomy & distal femoral traction (Lt.) on 24.11.2008 and released from the said Centre on 27.11.2008. As per discharge summary the diagnosis of the disease was *'DDH (Lt) Group III'*

On 12.02.2009 he lodged a claim to the insurance company along with all relevant documents towards the expenditure incurred in connection with the above treatment for reimbursement. The insurance company vide their letter dated 05.05.2009 repudiated the claim stating that "*on scrutiny of the claim file they observed that the patient was admitted in the captioned hospital with a history of limping gain since childhood associated with bilateral flat foot and finally diagnosed as DDH (Lt) Group IIO. As it is a congenital disorder, therefore the TPA has repudiated the claim under the mediclaim policy exclusion clause no. 4.1 (i.e. pre-existing disease) & 4.8 clause'.* He represented to the insurance company on 31.07.2009 for review and settlement of his claim. But his representation did not yield any response from the insurance company. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.55,000/-.

The insurance company in their self-contained note dated 19.02.2010 stated that Master Shreerup Saha was admitted in the Bhattacharyya Orthopaedics & Related Research Centre (P) Ltd. on 23.11.2008 for a disease of Limping gait since childhood associated with bilateral flat foot. From the Record/Summary dated 11.11.2008 of the said hospital that the patient was admitted in the hospital with a history of limping gait since childhood associated with bilateral flat foot and finally it was diagnosed as DDH (Lt.) Group III. The discharge certificate dated 27.11.2008 of the said hospital wherein it is clearly mentioned that the patient has a history of limping gait since childhood associated with bilateral flat foot. Therefore, this is a congenital disease. As per the proposal form the date of birth of Master Shreerup Saha is 16.08.2006. The policy was first taken by the insured w.e.f. 09.08.2007 i.e., at the age of "above eleven months" of the patient. Accordingly, he had already sustained the disease prior to inception of the policy. Since it is a congenital disorder, therefore, the claim has been repudiated under the mediclaim exclusion clauses no. 4.1 & 4.8 of the policy.

DECISION:

We have gone through the written submission of the complainant and examined the documentary evidence filed by him before this forum. On the other hand the insurance company has filed their reply and has explained by submission of their self-contained note the grounds of repudiation of the claim. It is evident from the Discharge Certificate that the son of the complainant had Limping Gait since childhood associated with Bilateral – Flat Foot. Based on the discharge certificate the insurer repudiated the claim on the ground of pre-existence clause no. 4.1 and congenital as per clause no. 4.8 of the policy condition. The complainant has argued in his written submission that the disease is not pre-existing as at the time of inception of the policy when the baby was less than one year old, it is not possible to detect the existence of said disease at that stage unless the child starts walking. Hence the question of pre-existence as per clause no. 4.1 cannot be maintained. This forum is of the opinion, that a baby of 2 ½ years old (when the event took place) having limping gait associated with bilateral flat foot cannot develop the defects within

such short period of time. Bilateral flat foot and limping gait are known to be congenital in nature. The complainant has not stated that the said disease was an outcome of any external injury nor the treatment particulars disclose such possibility.

Under the circumstances, we are of the opinion that the decision of the insurer in repudiating the claim under clause no. 4.8 of the policy condition is valid and the same is upheld.

Kolkata Ombudsman Centre
Case No. 415/11/004/NL/10/2009-10
Shri Brijlal Beriwala
Vs.
ICICI Lombard General Insurance Co. Ltd.

Order Dated : 18.11.2010
Facts & Submissions :

This complaint was in respect repudiation of a claim under Individual Mediclaim Insurance Policy issued by United India Insurance Company Ltd. on the ground of pre-existing disease as per exclusion clause no. 4.1 of the policy.

The complainant Shri Brijlal Beriwala in his complaint dated 19.03.2009 has stated that his wife Smt. Shanti Devi Beriwala was suffering from Urinary Tract Infection and Diabetes mellitus and was admitted at The Calcutta medical Research Institute on 07.11.2003 where she was treated conservatively and released on 14.11.2003. As per discharge summary of the said hospital the diagnosis of the disease was *"Mal absorption Syndrome with UTI (Urinary Tract Infection) & Diabetes Mellitus".*

Complainant lodged a claim on 12.01.2004 to the insurance company along with all relevant documents towards the expenditure incurred in connection with the above treatment for his wife for reimbursement. The insurance company vide their letter dated 18.08.2004 repudiated the claim stating that *"your claim file was referred to our panelled doctor who has opined after going through the papers that the instant case of loss i.e., type II DM, Diabetic Neuropath, etc. are pre-existing in nature. In view of the above, we regret to state that the claim lodged by you cannot be entertained by us as per exclusion no. 4.1 of our mediclaim policy".* Both complainant and his wife represented to the insurance company several times and the last was on 19.03.2009 for review of her claim. Their representation did not yield any fruitful result. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.42,715/-.

The insurance company in their self-contained note dated 25.02.2010 stated that the claim was repudiated due to exclusion clause no. 4.1 under the policy condition which was intimated to the claimant vide their letter dated 08.06.2005.

DECISION:

We have carefully heard both the parties and examined the documents which have been filed before this forum by them. It is seen that the insured had preferred a similar claim in 2002 for hospital treatment of Diabetes which was allowed by the insurer. At that time insurer did not question the pre-existence of diabetes. It is further seen from the policy schedule for the period 13.04.2002 to 12.04.2003 that the insured had Rs.30,000/- of C.B on a sum insured of Rs.2 lakh which indicates that the policy is 3 to 4 years old. This being the situation the question of pre-existing disease for any claim preferred in 2003 cannot arise. Moreover, we find substance in the complainant's son's plea that urinary tract infection cannot be said to be pre-existing disease as it is caused of bacterial infection and can arise at any time. Therefore, going by the evidences placed before us we are of the opinion that the insurer has not established the pre-existing disease i.e., type-II DM, Diabetic Nephropathy in this case irrefutably with conclusive evidences and the

therefore exclusion clause 4.1 can not be attracted in this case. The decision of the insurer is not correct and the same is set aside. Therefore, we direct the insurance company to settle and pay the claim as per terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 423/11/003/NL/10/2009-10
Shri Ratindra Nath Maiti
Vs.
National Insurance Co. Ltd.

Order Dated : 18.11.2010
Facts & Submissions :

This complaint was in respect partial repudiation of a claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd.

The complainant Shri Ratindra Nath Maiti in his complaint has stated that he was suffering from exertional chest pain since 6 months. Coronary angiogram done on 07.01.2009 showed single vessel disease with normal left ventricular function and was admitted for PTCA to LAD at Apollo Hospitals Chennai on 11.03.2009 where PTCA to LAD was done successfully with xience V stent on 12.03.2009 and released from the hospital on 15.03.2009. As per discharge summary the diagnosis of the disease was '*Coronary artery disease, Chronic stable angina and Coronary angiogram on 07.01.200 – single vessel disease with normal left ventricular function'.*

He lodged a claim for Rs.1,91,987/- on 06.04.2009 to the TPA of the insurance company M/s Rothshield Healthcare (TPA) Services Limited along with all relevant documents for reimbursement. The TPA paid Rs.71,028/- towards full and final settlement of the claim. He represented to the insurance company on 15.09.2009 requesting for a review of the claim. In the review order dated 17.09.2009, the insurance company stated that "as per norms, continuing or recurrent nature of diseases/complaints will be excluded from the scope of cover of enhanced sum insured". Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.1.55 lakh. The complainant has given his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between himself and the insurance company.

The insurance company in their self-contained note dated 08.12.2009 stated that the insured was admitted into hospital on 11.03.2009 and discharged on 15.03.2009 and thereafter submitted the bill for an amount of Rs.1,91,987.38. Their TPA sent the discharge voucher dated 04.07.2009 for an amount of Rs.71,028/- to them which was handed over to the agent of Shri Maiti. Till date they have not received the same from him. On 15.09.2009 Shri Maiti wrote a complaint letter to their H.O. with a copy to them for review of the claim. On reviewing, it was seen that Rs.71,150/- will be payable to him on the basis of sum insured of Rs.1 lakh and CB of Rs.5,000/- as the enhanced sum insured is not considered for the current year as per norms. This was clarified to the insured vide their letter dated 17.09.2009.

Further they stated that they have received a copy of letter dated 07.12.2009 of their TPA originally addressed to Shri Maiti requesting to sent the Discharge Voucher so that a fresh cheque could be issued .

DECISION:
We have carefully heard both the parties and perused the documents filed before this forum. It is observed from the discharge summary of Apollo Hospitals, Chennai that the complainant had been suffering from coronary artery disease and had undergone coronary angiogram on 07.01.2009 before enhancement of the sum insured. Therefore, as per clause no. 5.12 the enhanced sum insured cannot be considered for settlement of the claim. We therefore find that there is no infirmity in the calculation of the insurer which

has been done correctly on the basis of previous sum insured of Rs.1 lakh and the sum of Rs.71,150/- has been correctly arrived at as per the allowable limits prescribed under the policy. The insurer is however directed to allow the benefit of CB, if the same is not allowed before. I am therefore, of the considered opinion that the decision of the insurer is correct and the same is upheld.

Kolkata Ombudsman Centre
Case No. 426/11/009/NL/11/2009-10
Shri Subrata Sengupta
Vs.
Reliance General Insurance Company Ltd.

Order Dated : 22.11.2010
Facts & Submissions :

This complaint was in respect of partial repudiation of claim under Reliance Health Care Insurance Policy issued by Reliance General Insurance Company Ltd.

The complainant Shri Subrata Sengupta in his complaint has stated that his wife Smt. Rumki Sengupta felt unwell and approached family physician Dr. Sanjay Dasgupta for check up on 21.06.2008. Dr. Dasgupta prescribed some medical tests and after analyzing the test reports realized the necessity of an operation, and suggested for further confirmation by a surgical doctor. Additional check up was carried out by Dr. D. Sarkar (surgical doctor). As per Dr. D.Sarkar's suggestion tests were carried. On the basis of test reports Dr. Sarkar concluded that the disease was Breast Cancer and the patient needed immediate surgery. Dr. D. Sarkar operated on the patient on 06.07.2008. Because of the nature of the disease, Dr. Sarkar further recommended to keep the patient under the observation and medical procedures by an Oncologist. She was referred to the Oncologist Dr. Chanchal Goswami, who advised the patient to be admitted for chemotherapy treatment. The patient was also referred to TMH for validating the success of the operation and Dr. R.A Badwe of TMH performed the follow on check up on the patient on 28.07.2008. Dr. R.A Badwe of TMH had confirmed that the operation was successful and also suggested for follow on chemotherapy treatment. The doctor concurred with Dr. Goswami and the patient was administered medicine as per Dr. Chanchal Goswami's prescription. She was admitted at B.P.Poddar Hosptial & Medical Research Ltd. on 30.07.2008 for chemotherapy and released on 31.07.2008. As per discharge summary the diagnosis of the disease was 'Carcinoma Left Breast (LABC) (P/O)'.

He lodged a claim along with all relevant documents to the TPA of the insurance company M/s E-Meditek Solutions Limited towards pre and post hospitalization expenses incurred in connection with the above treatment for reimbursement. The said TPA partially settled the claim. He represented to the insurance company against such partial repudiation on 12.08.2009 to review and settle his claim. But his appeal did not yield any result. Being aggrieved, the complainant approached this forum for redressal of his grievance, seeking monetary relief of Rs.29,937.39.

DECISION:

We have heard the complainant and gone through the documents submitted by him before this forum. We have also gone through the replies given by the insurer while settling the claim. We have noted that the complainant is mainly dissatisfied because he has not been explained the reasons of deductions made from the bill and wherever the reasons have been mentioned the same are not adequate to satisfy him. We therefore think it proper to refer the case back to the insurer with the direction to review the case in the light of the objections raised and submitted by him in his letter dated 19.11.2010 submitted before this forum as called for subsequent to the hearing. Insurer is further directed to furnish the reasons for bill-wise disallowances vis-à-vis his claims quoting therein related policy conditions. The complainant is also directed to send a copy of his letter dated 19.11.2010 submitted to us to the insurer.

After considering all the facts and circumstances of the case, we find that no further intervention is called for, at this stage.

Kolkata Ombudsman Centre
Case No. 434/11/019/NL/11/2009-10
Shri Satyendra Tripathi
Vs.
Apollo Munich Health Insurance Company Ltd.

Order Dated : 24.11.2010
Facts & Submissions :

This complaint is against partial repudiation of claim under Easy Health Insurance Policy issued by Apollo Munich Health Insurance Company Ltd.

The complainant Shri Satyendra Tripathi in his complaint has stated that his daughter Ms. Pragya Tripathi was suffering from Multifocal caries spine with large cervical abscess and was admitted at Park Clinic, Kolkata on 03.04.2009 where she was treated conservatively and released on 24.04.2009. As per discharge summary the diagnosis of the disease was "*F/u case of caries spine (cervical & dorsal)".*

He lodged a claim for Rs.165,361/- along with all relevant documents to the insurance company towards the expenditure incurred in connection with the above treatment for reimbursement. The insurance company vide their letter dated 20.05.2009 settled Rs.47,642/- disallowing Rs.1,17,719/-. He represented to the insurance company against such repudiation on 28.05.2009 to review and settle his claim. But his appeal was not considered by them. Being aggrieved, the complainant approached this forum for redressal of his grievance, seeking monetary relief of Rs.1,19,875/-.

The insurance company in their self-contained note dated 16.03.2010 stated that the complainant was insured with them under Easy Health Insurance Policy for the period 31.03.2008 to 30.03.2009 with a family floater coverage for self, his wife and two children for a sum insured of Rs.4 lakh. The complainant further renewed the policy for the period 31.03.2009 to 30.03.2010 with same terms. The complainant submitted a claim on 09.02.2009 of Rs.59,790/- for expenses incurred on hospitalization of his daughter, Ms. Pragya Tripathi, for extensive abscess at cervical region with epidural extension and cord compression (later diagnosed as a case of tuberculosis). She was hospitalized from 29.01.2009 to 04.02.2009 at Park Clinic, Kolkata. They have settled the said claim for Rs.53,665/- disallowing a sum of Rs.6,125/- for expenses not covered under the policy such as nursing charges beyond the hospital bill and external appliance (s).

The complainant submitted another claim on 30.04.2009 for reimbursement of Rs.1,65,361/- for expenses incurred on hospitalization of his daughter from 03.04.2009 to 24.04.2009 at Park Clinic, Kolkata, they have settled the said claim for Rs.47,642/- disallowing a sum of Rs.1,17,719/- for expenses not covered under the policy such as nursing charges beyond hospital bills, pharmacy bills without name and an external appliance, Halo brace.

Further the complainant again submitted a claim on 17.08.2009 for reimbursement of Rs.3,730/- incurred for day care admission for conducting MRI. The said claim was rejected as MRI does not require any admission/ hospitalization and is clearly excluded under the terms and conditions of the policy.

However, the complainant submitted four other claims for reimbursement of total amount of Rs.2,18,465/- incurred for continued treatment of his daughter for the period 29.01.2009 to 03.10.2009 at Park Clinic,

Kolkata, they have settled an amount of Rs.2,05,876/- disallowing a sum of Rs.12,589/- for expenses not covered under the policy Thus the insurance company has settled a major part of the claim of the complainant, except disallowances of Rs.1,17,719/- which includes expenses incurred on Halo brace, private nursing charges, doctor's fees for want of registration details, along with shared accommodation allowance of Rs.3,000/-. They concluded that they have paid all the benefits to the complainant for which he is entitled to under the terms and conditions of the policy and disallowed only those expenses which are not payable at all under the terms and conditions of the policy.

DECISION:

We have carefully heard the submissions of both the parties and examined the medical reports, literature, photographs and other documents filed by them before this forum. After examining these material evidences, we agree with the contention of the insurer that Halo Brace is an external device which is not reimbursable in view of the provision of exclusion clause 6 (e) (xxv). The extract taken from the journal "Physical Medicine & Rehabilitation: Principle & Practice – volume – I" shows the photograph of the Halo Brace and Halo Vest which clearly fall under the category of external equipments and can not be covered under section 1 a (viii)which apply to internally implanted devices. The complainant's argument is that the appliance was surgically fitted into scalp and therefore it falls under the category of internally implanted device. We do not find much substance in this argument. It is seen that the policy conditions make a clear distinction between "external appliances" and "internally implanted appliances" and the description and photograph of the Halo brace make it clear that the insurer has correctly treated it as an external appliance. The procedure of fitting the appliance cannot change the nature and purpose of the appliance. The purpose of the Halo brace is to give support from outside and not to support any internal function of any organs. The decision of the insurer is found to be valid and correct so far as 'Halo Brace' is concerned. Therefore disallowance of the same is upheld.

However, the insurance company is directed to settle and pay the claims regarding doctor's fees, nursing charges and other expenses as per terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 440/11/009/NL/11/2009-10
Shri Girija Sankar Ghosh
Vs.
Reliance General Insurance Company Ltd.

Order Dated : 22.11.2010
Facts & Submissions :

This complaint was against repudiation of claim under Individual Mediclaim Policy issued by Reliance General Insurance Company Ltd.

The complainant Shri Girija Sankar Ghosh in his complaint has stated that he was a diabetic & hypertensive patient with history of Ischaemic Heart Disease and shortness of breath. He was admitted at Ruby General Hospital Ltd., Kolkata on 13.11.2008 and was implanted with a permanent pacemaker and got released from the hospital on 26.11.2008. As per discharge summary the diagnosis of the disease was *'symptomatic sick sinus syndrome – treated by permanent pacing in a case of diabetes mellitus & hypertension'.*

He lodged a claim along with all relevant documents to the TPA of the insurance company M/s Paramount Health Services Pvt. Ltd. towards the expenditure incurred in connection with the above treatment for reimbursement. The TPA of the insurance company vide their letter dated 20.01.2009 repudiated the claim

stating that *"since long standing hypertension & diabetic mellitus are the pre-disposing factors to the presenting ailments (IHD, LVF, SSS) so this claim falls under pre-existing disease category under policy exclusion clause no. 4. Secondly due to non-disclosure of the facts this claim also falls under policy clause no. 5.7 which states that 'the company shall not be liable to make any payment under this policy in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the insured person or by any other person acting on his behalf'.* He represented to the insurance company against such repudiation on 10.08.2009 to review and settle his claim, but his appeal was not considered by them. Being aggrieved, the complainant approached this forum for redressal of his grievance, seeking monetary relief of Rs.6 lakh along with interest.

DECISION:

We have heard the submissions of the complainant and gone through the reports relating to his treatment and other relevant documents filed before this forum. It is seen that the policy was taken on 21st January 2008 at the age of 69 years and therefore as per norms, before underwriting a mediclaim policy all necessary medical tests as referred by insurer were conducted based on which the policy was issued. The only pre-existing disease mentioned in the policy schedule is Diabetes for which additional premium was also paid by the insured. There is no mention of HTN in the policy schedule. We have also observed that insured had undergone detailed heart examination at RTIICS before his surgery. The results of such medical examination did not reveal any dysfunction of the heart which could arise from HTN. The discharge summary has also not mentioned the period of HTN and doctor on discharge did not advice any ante-HTN medicines. From these documents it is clearly established that insured did not have a history of HTN and therefore the TPA's ground of rejection was not valid. Permanent pacemaker was implanted, which is only a devise to correct rhythm of the heart and it can not be said to be arising directly out of the condition of the Diabetes mellitus, so as to attract the exclusion clause no. 5.7 for his claim and same cannot be treated as fraudulent and therefore application of the exclusion clause here is not justified. The TPA has mentioned that hospital documents have mentioned that duration of HTN for 10 years but they could not produce any documentary evidence to corroborate their statement.

Under the circumstances, we find that the decision of the insurer is not valid and the same is set aside. We hold that the claim is exigible. Therefore, we direct the insurance company to settle and pay the claim as per terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 442/11/002/NL/11/2009-10
Md. Salim
Vs.
The New India Assurance Company Limited.

Order Dated : 24.11.2010
Facts & Submissions :

This complaint is against partial repudiation of a claim under Mediclaim Policy (2007) issued by The New India Assurance Company Limited.

The complainant Md. Salim stated that his wife Smt. Aisha Begum was suffering from dysfunctional uterine bleeding and was admitted at New Union Nursing Home Pvt. Ltd. on 06.08.2008 where TAH with BSO done under GA on 09.08.2008 and released on 14.08.2008.As per discharge summary the diagnosis of the disease was "DUB + Fibroid Uterus" .

He lodged a claim for Rs.68,201/- along with all relevant documents towards the expenditure incurred in connection with the above treatment to the TPA of the insurance company M/s E-Meditek Solutions

Limited for reimbursement. The TPA settled Rs.28,551/- deducting Rs.39,650/-. He represented to the insurance company against such partial repudiation and requested the insurance company to review and settle his claim. But his appeal was not considered. Being aggrieved, the complainant approached this forum for redressal of his grievance without mentioning any quantum of relief in the 'P' form details.

The insurance company in their self-contained note dated 02.03.2010 stated that the complainant Md. Salim had taken Mediclaim policy sometime in the year 2005 and the same is continuing without any break. The policy period under the current claim is from 22.05.2008 to 21.05.2009. It appears from the records that Smt. Aisha Begum, wife of Md. Salim was admitted in a nursing home on 06.08.2008 and was discharged on 14.08.2008. During the period of medical treatment he had lodged the instant claim with them. The claim was processed by M/s E-Meditek (TPA) Services Ltd., the concerned TPA Services who have settled the claim for Rs.28,551/- and issued cheque dated 12.12.2008 for that amount. It also appears from the settlement voucher, that Rs.30,000/- (Surgeon fees Rs.25,000/- + Consultant Specialist's fees Rs.5,000/-) was deducted since there was no numbered money receipt in support of those payments.

They further stated that they are also of the opinion that the claim was duly processed and the settlement of claim was made in accordance with the terms and condition of the captioned policy. Deduction of Surgeon/ Consultant Specialist fees was made since the claimant have submitted two money receipts which are not in the form of numbered money receipts, required for the purpose of reimbursement.

DECISION:

We have gone through the submissions of both the parties and examined the documents filed before this forum. We find that the insurer has disallowed the doctors fees of Rs.25,000/- and Rs.5,000/- in view of clause no. 2.3 (Note No. 2) of the Mediclaim policy (2007). However, Insurer have over looked the revised policy conditions with the modified clause no. 2.3 note no. 3 (b) which says that if the doctor's fee is made by cheque, 25% of the sum insured will be allowed and if paid by cash Rs.10,000/- will be allowed if not included in hospitalization bill.

The insurer is therefore directed to pay Rs.10,000/- (Ten thousand only) to the complainant being reimbursement for Doctor's Fees.

Kolkata Ombudsman Centre
Case No. 450/14/004/NL/11/2009-10
Shri Gokaran Kumar Shorewala
Vs.
United India Insurance Company Ltd.

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Order Dated : 08.12.2010
Facts & Submissions :

This complaint is against delay in settlement of claim under Individual Mediclaim Policy issued by United India Insurance Company Ltd.

The complainant Shri Gokaran Kumar Shorewala in his complaint has stated that he was suffering from Gastroenteritis, DM, HTN & IHD and was admitted at Bansal Nursing Home, Howrah on 15.04.2006 where he was treated conservatively and released on 17.04.2006. As per discharge summary the diagnosis of the disease was '*acute gastroenteritis, DM, HTN & IHD'.*

He lodged a claim to the TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd. for reimbursement. But after a lapse of considerable period his claim was not settled by the TPA or insurance

company. Then he represented to the insurance company on 09.02.2009 requesting them to settle his claim at the earliest. Being aggrieved, the complainant approached this forum for redressal of his grievance without mentioning any quantum of relief in the 'P' form details.

DECISION:

The request of the complainant is pending as the insurer did not get a confirmation from the TPA whether the cheque was revalidated or not. Now the insurer has confirmed that the cheque has been encashed by the complainant as per the bank details obtained by them. It is also noted that the complainant had filed a false complaint and suppressed the fact of encashment of his mediclaim cheque on 17.01.2008 which is about one and half year prior to filing the complaint dated 25.05.2009 received at this forum on 08.06.2009. He also did not care to withdraw the complaint in time thus he tried to mislead the forum with ulterior motive. The complaint is dismissed, being a false complaint.

Kolkata Ombudsman Centre
Case No. 462/11/003/NL/11/2009-10
Smt. Tapati Rakshit
Vs.
National Insurance Company Ltd.

Order Dated : 30.11.2010
Facts & Submissions :

This complaint was in respect repudiation of a claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd. as per exclusion clause no. 4.8 of the policy.

The complainant Smt. Tapati Rakshit in her complaint has stated that her grandson Sri Prtatik Sharma was suffering from acute respiratory distress and had consulted Dr. P.N. Sengupta on 30.04.2008. After examining the patient doctor advised for an immediate admission at ILS Multispeciality Clinic at Salt Lake, Kolkata for indoor care and treatment. He was admitted at ILS Multispeciality Clinic on the same day where he was treated conservatively and became stable he was discharged from the clinic on 04.05.2008. As per discharge summary the diagnosis of the disease was *'Recurrent unexplained respiratory distress/ hyperventilation'.*

She lodged a claim to the TPA of the insurance company M/s Genins India Ltd. along with all relevant documents towards the expenditure incurred in connection with the above treatment for reimbursement. The TPA authority had made only one additional requisition – i.e., to furnish 1st prescription of the doctor consulted for respiratory distress, which was complied by her on 25.07.2008. After that the insurance company vide their letter dated 19.09.2008 repudiated the claim stating that *'apropos to your above claim, we have received the entire claim file from our duly appointed TPA, M/s Genins India Ltd. who has recommended for repudiation of the claim. On examining the same we find that the present hospitalization is related to hyperventilation episode which is a type of psychosomatic illness which is not covered under Mediclaim Policy. Hence, we have no other alternative but to repudiate the claim as per clause 4.8.'* She represented to the insurance company on 23.09.2009 against such repudiation and requested the insurance company to review and settle his claim. But her representation did not yield any result. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.22,379.82 plus compensation.

The insurance company in their self-contained note dated 14.01.2010 stated that the insured had submitted the subject claim on 25.06.2009, in respect of Master Pratik Sharma for his hospitalization claim to their TPA. The patient was admitted to ILS Multispeciality Clinic, Salt Lake, Kolkata with recurrent unexplained respiratory distress and hyperventilation. On scrutiny of the claim papers while processing the claim the panel of doctors of the TPA had the opinion that the present hospitalization is related to Hyperventilation episode which is a type of psychosomatic illness which is excluded as per clause 4.8 of mediclaim policy. Since their TPA is not authorized to repudiate the claim, they only recommended the repudiation and forwarded the entire claim file to them. On examining the entire claim file, they had issued the formal repudiation letter to the insured on 19.09.2009.

DECISION:

We have heard both the parties and examined the documents filed before this forum. We have also consulted medical journals and internet material on hyperventilation. The final diagnosis as given by the doctor in the discharge summary is recurrent unexplained respiratory distress/ hyperventilation. Thus it appears that the treating doctor could not identify the real cause of the respiratory problem suffered by the insured. According to medical journal hyperventilation refers to rapid or deep breathing problem that can occur with anxiety or panic. However, such a condition may also arise due to low level of CO2 in the blood or any other infection. Thus going by the doctor's prescription and discharge summary we are of the opinion that hyperventilation is only due to panic or psychological reasons could not be conclusively established in this case. We therefore do not agree with the decision of the insurer which takes into consideration only hyperventilation and not the other observation "recurrent unexplained respiratory distress". Since the cause of the respiratory distress is not finally proved by the insurer, we find their decision is incorrect and set aside the same. Insurer is directed to settle the claim and pay the same as per terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 520/11/002/NL/12/2009-10
Shri Saptak Kumar Sengupta
Vs.
The New India Assurance Company Limited.

Order Dated : 30.11.2010
Facts & Submissions :

This complaint was in respect of partial repudiation of a claim under Mediclaim Policy (2007) issued by The New India Assurance Company Limited.

The complainant Shri Saptak Kumar Sengupta stated that he was suffering from low back pain and Lt. sciatica and bilateral neurogenic claudication for last three years and was admitted at Park Clinic, Kolkata on 15.09.2008 where all routine and necessary investigations done, L4/5 laminectomy and L4/5 transpedicular fixation was done using Titanium system under GA on 16.09.2008 and released from the clinic on 24.09.2008. As per discharge summary the diagnosis of the disease was '*L4-5 stenosis + instability'*.

He lodged a claim on 11.11.2008 for Rs.98,031/- to the TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd. along with all relevant documents towards the expenditure incurred in connection with the above treatment for reimbursement. The TPA settled Rs.68,681/- deducting Rs.33,700/- towards full and final settlement of the claim. He represented to the insurance company against such partial repudiation on 27.01.2009 requested the insurance company for review and settle his claim amount of Rs.33,700/-. The TPA of the insurance company vide their letter dated 19.02.2009 again furnished the inadmissible amount of Rs.33,700/- and stated that the payment was made as per terms and conditions of

the policy. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.33,700/-.

The insurance company in their self-contained note dated 04.03.2010 stated that the insured lodged a claim with TPA for Rs.1,03,031/-. On the basis of the documents, and panel doctor's opinion, the TPA had settled the claim for Rs.68,681/- and replied to Shri Sengupta stating the details of the deductions head wise. Shri Sengupta in his representation letter dated 27.01.2009 had requested further release the short settlement amount of Rs.33,700/-.

The insurance company further stated that bill amount of Rs.36,000/- was on account of doctor's fee paid in cash was restricted to Rs.10,000/- as per Mediclaim Policy (2007) under clause 2.3 (note 3). Other disallowances included. Rs.1,150/- towards investigations not allowed due to non-submission of support documents, cost of brace charge of Rs.3,500/- excluded under clause 4.4.4 and registration charge of Rs.150/- during pre hospitalization. In view of the above, their TPA has rightly settled the claim and they are in agreement with their views.

DECISION:

We have heard both the parties and examined the documents submitted by them before this forum. We find that the complainant has made several correspondences with the insurer and complied with all their requirements. He also submitted a revised bill on 20th August 2009 as per the direction of the insurer. The bill has been duly acknowledged by the insurer's office and therefore it cannot be accepted that the letter was not received by them. Anyway a copy of the revised bill was given to the representative of the insurance company during the course of hearing. We find that the claim is pending for more than a year without any valid reasons which is highly unfair to the insured. The ground taken by the TPA that certain items were disallowed (doctors and surgeons fee) as these were not included in the nursing home bill cannot stand now, since a revised bill showing all these items have been submitted by the insured. The insurer is therefore directed to settle the claim of the insured on the basis of the revised bill.

The insurance company is further directed to pay interest at a rate which is 2% above the prevailing bank rate from 01.10.2009 [i.e., one month after the date of receiving the revised bill from the insured by the insurer) as per their terms and conditions till the date of payment of the claim

Kolkata Ombudsman Centre
Case No. 524/11/003/NL/12/2009-10
Shri Pushpal Majumder
Vs.
National Insurance Company Ltd..

Order Dated : 29.11.2010
Facts & Submissions :

This complaint is in respect partial repudiation of a claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd.

The complainant Shri Pushpal Majumder in his complaint has stated that he was suffering from chest discomfort, radiating to back & both hands and was admitted at AMRI Hospitals, Kolkata on 16.11.2008 where facilitated angioplasty of prox LAD with DES done on the same day and was released from the said hospital on 21.11.2008. As per discharge summary the diagnosis of the disease was *'Hypertension, Acute ant Wall MI-thrombolysed & facilitated angioplasty (Proximal LAD with DES)'.*

He lodged a claim for Rs.1,37,182/- to the TPA of the insurance company M/s Heritage Health Services Pvt. Ltd. along with all relevant documents towards the expenditure incurred in connection with the above treatment for reimbursement. TPA vide their letter dated 01.04.2009 settled Rs.41,174/- vide Ch. No. 14561 dated 01.04.2009 towards full and final settlement of the claim. The complainant did not accept the cheque and returned the same. He represented to the insurance company on 17.06.2009 against such partial repudiation requested the insurance company to review and settle his claim for Rs.1,37,182/-. But his representation did not yield any result.

DECISION:

We have heard both the parties and gone through the submissions made by both the parties and examined the documents filed before this forum. We find that the patient was insured with sum insured of Rs. 2 lakh with cumulative bonus of Rs.74,850/-for the period from 12.06.2008 to 11.06.2009. It is seen that the complainant has made several correspondences with the TPA but nobody has bothered to reply/ clarify to his objection on partial settlement. TPA has simply informed the insured vide their letter dated 01.04.2009 that out of the total bills submitted for Rs.1,37,182/- they had allowed only Rs.41,174/- and the balance was disallowed under the different capping limits as per the terms and conditions of the policy. Insurer has now explained the reason for their inability to process the claim of hospitalization for Rs.60,000/-.

On the subsequent day i.e., 25.11.2010 the complainant and representative of the insurer appeared before this forum. The claimant furnished a break-up of expenses of Rs.60,000/- which was handed over to the insurer for necessary action at their end. The insurer is directed to settle the claim based on the break-up details provided by the claimant.

Kolkata Ombudsman Centre
Case No. 401/11/002/NL/10/2009-10
Smt. Bivabati Dubey
Vs.
The New India Assurance Company Ltd..

Order Dated : 23.12.2010
Facts & Submissions :

This complaint has been filed against repudiation of a claim on the ground that the patient was a known case of hypertension since last 10 years under Individual Mediclaim Insurance policy.

The complainant, Smt. Bivabati Dubey stated that the policy was issued after due medical examination and on completion of the formalities, wherein they did not mention any ailment connected with diabetes and hypertension. Since inception of policy, she was first time admitted and utilized mediclaim for treatment of excision of "LIPOMA" from her left upper arm on 05.03.2007 under care and supervision of Dr. Saurav Ghosh (Surgeon). Subsequently after a long gap, she was again hospitalized at the Kalra Hospital, New Delhi from 13.10.2008 to 20.10.2008 for the treatment of CVA – Rt. Hemiparesis Cerebro-vascular Accident and payment of Rs.37,000/- to this effect was made by the TPA of the insurance company. Incidentally, she was again hospitalized at Belle Vue Clinic, Kolkatta for the same ailment i.e. Cerebro Vascular Accident from 11.12.2008 to 15.12.2008 and relapsed again from 15.12.2008 to 17.12.2008 at the same clinic. After completion of her treatment, she submitted a claim for Rs.31,030/- to the TPA of the insurance company. The insurance company had turned down her claim on the ground that she was a known patient of hypertension for the last 10 years which was pre-existing. She represented against the decision of the insurance company in repudiating the claim on 29.09.2009 followed by a certificate issued by Dr. Anirban Neogi on 04.02.2009 substantiating that hypertension was detected only one month back.

She requested the insurance company for a review of the same and get her claim settled which yielded no result. Being aggrieved, she approached this forum for relief of Rs.31,030/-.

The Insurance Company in their self-contained note dated 31.12.2009 stated that they issued a Mediclaim policy No. 512800/34/07/11/00003947 for the period 17.12.2007 to 16.12.2008 in the name of Smt. Bivabati Dubey. She was hospitalized at Belle Vue Clinic, Kolkata from 11.12.2008 to 15.12.2008 and again from 15.12.2008 to 17.12.2008 in the same hospital. The claim was repudiated by the TPA of the Insurance Company on 17.03.2009 on the basis of the opinion of the Claim Adjudication Department and panel doctor's opinion that the patient was suffering from hypertension for the last 10 years which was pre-existing. The insurance company also stated that no loading on premium was paid by the complainant to this effect. They stated that they received one letter dt.16.02.2009 from the complainant along with a certificate dated 04.02.2009 issued by Dr. Anirban Neogi certifying that the HTN in question was detected only one month back and duration of 10 years mentioned in Form No. I was a mistake committed by the hospital authorities. The opinion of the insurance company was that it was purely after thought and clinical history including investigation reports did not corroborate with history of hypertension of one month. To justify their stand of repudiation as correct they took the defense of Dr. Mittal 's opinion which stated as under :-

" The claim documents reflect that the insured has admitted with complaints of chest pain, shortness of breath, fluctuation of blood pressure and disturbance of vision, under the policy period starting from 17.12.07 and was treated for the complaints and a final diagnosis of hypertension was made.

The claim documents reflect that at the time of hospitalization of cashless approval, a form was sent from the hospital which mentioned the complaints as shortness of breath with presence of hypertension for 10 years, signed by the same doctor Neogi who latter on certified it as only one month, when the said claim was repudiated on grounds of pre-existence.

However, the clinical picture is suggestive of long time hypertension as the ECHO report notes presence of left ventricular hypertrophy –which is possible only in chronic hypertension and not in hypertension of one month as subsequently certified – moreover the initial clinical history as per cashless form was also signed by the same doctor after being told about the same by the patient and then how come he certifies it so strongly that the same was not 10 years but one month for that's also the patient version. The entire picture put forward subsequently is an afterthought and clinical picture including investigation reports do not corroborate with history of hypertension of one month."

On the basis of the above report of Dr. Mittal, the insurance company repudiated the claim considering that the patient had a history of hypertension for the 10 years which was a pre-existing disease and they reiterated the decision of repudiation of the TPA as justified.

DECISION:

We have heard both the parties and examined the documents submitted by them before this forum. It is seen that the decision of the insurer is based entirely on the claim documents which reflect that at the time of hospitalization a cashless approval form was sent from the hospital which mentioned that the complainant had shortness of breath with presence of HTN for 10 years. The insurer has no other material evidence in support of their contention and they have failed to produce any other treatment related papers to establish conclusively and irrefutably that the insured had a history of HTN for exact 10 years. The policy is almost 9 years old and in the absence of any conclusive evidence to show that the insured suffered from HTN for last 10 years, we cannot accept the decision of the insurer. We also reject the certificate given by the treating doctor that the patient had suffered from HTN for one month. No reliance can be placed on a certificate given subsequently by the doctor which is nothing but an after thought. However, the insurer has also not established the exact date of inception of the HTN with conclusive evidence and therefore, we find their decision is based on conjecture and surmise and the same is set aside. Giving the benefit of doubt to the insured, we direct the insurance company to settle the claim and pay the same as per terms and conditions of the policy.

Shri Narendra Kumar Lihala
Vs.
The Oriental Insurance Company Ltd.

Order Dated : 23.12.2010
Facts & Submissions :

This complaint was in respect of total repudiation of claim under Individual Mediclaim Insurance Policy issued by The Oriental Insurance Company Ltd. due to pre-existing disease as per exclusion clause 4.1 of the policy.

The complainant Shri Narendra Kumar Lihala stated that his mother Smt. Lilawati Lihala was suffering from breast cancer and was admitted at AMRI Hospitals, Kolkata on 02.01.2009 where Pan hysterectomy with wide excision of right chest wall nodule was done under GA on 03.01.2009 and released on 10.01.2009. As per discharge summary the diagnosis of the disease was 'Carcinoma right breast'.

He lodged a claim along with all relevant documents towards the expenditure incurred in connection with the above treatment to the TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd. for reimbursement. The TPA vide their letter dated 18.03.2009 repudiated the claim stating that *'the date of inception of policy is from 2006. Considering the break in the policy the ailment carcinoma of breast was detected in 2003 long prior to inception of fresh policy. As per policy terms and condition the claim is repudiated as per exclusion 4.1 of the OIC policy. We regret the claim as not payable as we are bound by the policy terms'.* He represented to the insurance company on 26.05.2009 against such repudiation requested the insurance company to review and settle his claim. But his appeal did not yield any result. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.1 lakh.

The insurance company in their self-contained note dated 05.01.2009 stated that Shri Narendra Lihala had taken a mediclaim policy from the Oriental Insurance Company vide no. 383/2008 and the period of insurance of that policy was 10.05.2007 to 09.05.2008. The policy was renewed for the next year on due date vide policy no. 456/2009.

They further stated that Shri Lihala produced a policy copy of United India Insurance Company, Kanpur Branch no. 080802/48/06/20/00000096 with period of insurance 10.05.2006 to 09.05.2007 and on that basis the OIC had issued the policy. As per their record it was observed under policy no. 080802/48/05/20/00000085 the policy period was from 05.05.2005 to 04.05.2006 and not from 10.05.2005 to 09.05.2006, so there is a 5 days gap in the policy period. The complainant lodged a claim on 02.03.2009 under policy no. 456/2009 for Rs.1,38,672/-, but it was observed that the policy was not in force continuously for last 4 years. Though the ailment was first operated in the year 2003, the pre-existing disease will not be covered if the policy is not run for a period 4 years under clause no. 4.1 of the policy exclusions.

DECISION:

We have heard both the parties and examined the documents filed before this forum. The repudiation was on account of the fact that new policy with the present insurer was not in force for continuously 4 (four) years. There is a gap of 5 days between the policies for the year 2004-05 (ending 29.04.2005) and 2005-06 (starting 05.05.2005) and again gap of 5 days between the year 2005-06 (ending 04.05.2006) and 2006-07 (starting 10.05.2006). So even if the first gap is ignored then remains a gap of 5 days when it was renewed with the present insurer and as per the terms of the policy, a waiting period of 4 years is mandatory for any claim. Since the claim was preferred in 4th year, the exclusion clause no. 4.1 is applicable.

After considering all the facts and circumstances of the case we find that there had been a break in continuity and also the policy did not run for a continuous period of 4 (four) years with the present insurer on whom claim was raised.

The decision of the insurer is found to be correct and the same is upheld.

Kolkata Ombudsman Centre
Case No. 466/11/003/NL/11/2009-10
Shri Nripendranath Karmakar
Vs.
National Insurance Company Ltd.

Order Dated : 23.12.2010
Facts & Submissions :

This complaint was in respect repudiation of a claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd. on the ground of pre-existing disease as per exclusion clause no. 4.1 of the policy.

The complainant Shri Nripendranath Karmakar stated that his wife Smt. Dipali Karmakar was suffering from tumor simultaneously with hernia and was admitted at Anandalok Hospital Kolkata on 01.10.2008 where Mesh repair with TAH with BSO done under G.A on 02.10.2008 and released from the hospital on 07.10.2008. As per discharge summary the diagnosis of the disease was *'Huge incisional hernia with fibroid uterus'.*

He lodged a claim to the TPA of the insurance company M/s Genins India Ltd. along with all relevant documents towards the expenditure incurred in connection with the above treatment for reimbursement. The insurance company vide their letter dated 04.02.2009 repudiated the claim stating that *"as the present claim is for the surgical treatment of incisional hernia related to previous LUCS incision prior to policy inception , the claim is denied as per clause no. 4.1 of standard policy condition. Therefore, we are unable to settle the claim and present claim is hereby closed as No Claim".* He represented to the insurance company on 23.02.2009 against such repudiation and requested the insurance company to review and settle his claimed amount. But his appeal was not considered by the insurance company. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.36,805/-.

The insurance company in their self-contained note dated 27.01.2010 stated that TPA has repudiated the claim on the following grounds:-

"*The claim documents were scrutinized and it was noted that the said claim was related to management of uterine fibroid and hernia in the 2nd year of policy coverage. The clinical documents in the claim file reflect that the insured presented with fibroid uterus and incisional hernia through the previous LUCS incision scar. The insured has preferred the claim related to its treatment in her 2nd year of policy coverage, wherein Hysterectomy and Hernia are excluded peril for 4 year if it is pre-existing. Thus as the present claim is related to Hysterectomy (TAH) and repair of Hernia in the 2nd year of policy coverage, the said claim stands non-admissible as per exclusion clause 4.3 of policy terms and condition."*

The insurance company further stated that after having scrutinizing the claim file they are also agree with the opinion of Genins India (TPA) Ltd. that this claim is not payable.

DECISION:

We have heard both the parties and examined the documents filed before this forum. We also find that the claim was related to the operation performed in the second year from the inception of the policy. The discharge summary clearly states that the insured had undergone operation for fibroid tumor and incisional hernia. The operation notes mention that mesh repair with TAH (hysterectomy) with BSO was done under general anesthesia. The exclusion clause 4.3 of the policy terms prescribes 2 years waiting period (and not 4 years as mentioned by TPA) both for incisional hernia and hysterectomy. Thus we find no merit in the argument of the complainant that his claim pertains to the operation of tumor which is allowable under clause 1 of the policy. After careful evaluation of all the facts and circumstances of the case we are of the opinion that the insurer's decision in repudiating the claim in view of clause 4.3 is correct and within the framework of the policy terms and conditions. The repudiation of the claim by the insurance company is upheld.

Kolkata Ombudsman Centre
Case No. 467/11/003/NL/11/2009-10
Shri Pabitra Kumar Roy
Vs.
National Insurance Company Ltd.

Order Dated : 08.12.2010
Facts & Submissions :

This complaint was in respect of repudiation of a claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd. as per exclusion clause no. 4.8 of the policy.

The complainant Shri Pabitra Kumar Roy in his complaint has stated that due to shortage of sodium and potassium in his blood and as per advice of doctor he was admitted at Northland Nursing Home, Kolkata on 03.12.2008 where he was treated conservatively and released on 07.12.2008. As per discharge summary the diagnosis of the disease was *''HHD with AN".*

On 16.02.2009 he lodged a claim for Rs.16,354.23 along with all relevant documents to the TPA of the insurance company M/s E-Meditek Solutions Limited, Kolkata towards the expenditure incurred in connection with the above treatment for reimbursement. The insurance company vide their letter dated 12.06.2009 repudiate the claim stating that *'patient was suffering from depression disorder with paranoid symptoms + anxiety tremor – anxiety neurosis but nothing about HTN has been mentioned here, treatment taken was also related to psychiatric field. So according to clause 4.8 no psychiatric & psychosomatic disorder are payable."* He represented to the insurance company against such repudiation on 16.10.2009 requested for review and to settle his claim. But his representation did not yield any result. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.16,354.23.

The insurance company in their self-contained note dated 12.01.2010 stated that Shri Pabitra Kumar Roy was first examined by Dr. Ganesh Bedajna who has opined that he was suffering from nausea, irrelevant talk, and then he was examined by Dr. Sudip Kumar Roy who advised him for admission as well as to consult with a psychiatrist. Shri Roy was next examined by Dr. Amitabha Mukerji (Consultant Psychiatrist) on 06.12.2008 who stated in his findings that the patient was suffering from Depression Disorder with paranoid symptoms plus anxiety Tremour and suggested medicine for the said treatment.

They further stated that discharge certificate issued by Northland Nursing Home states that the diagnosis is HHD and A.N – Anxiety Neurosis under the supervision of Dr. Roy. The medicine prescribed as per bed head ticket was administered to the patient by the treating doctor Dr. Sudip Kumar Roy. The medicines

prescribed in the discharge certificate under the guidance of Dr. Roy are identical with the medicines prescribed by Dr. Mukerji.

However, it is observed that Shri Roy was treated at Northland Nursing Home by Dr. Roy and thereafter referred to the Psychiatrist Dr. Mukerji for treatment. The entire course of treatment given to the patient and medicine suggested is for depression disorder with paranoid symptom plus anxiety which attracts the exclusion clause no. 4.8 of the policy condition under the head exclusion.

In view of the above they were left with no other option but to agree with the opinion of their TPA M/s E-Meditek Solutions Ltd., to repudiate the claim since the entire course of treatment imparted to the patient is for psychiatric and psychosomatic disorders/ disease (which is an excluded disease under the policy) as suggested by a Psychiatrist Dr. Amitabha Mukerji and endorsed by the treating doctor, Dr. Sudip Kumar Roy.

DECISION:

We have heard both the parties and examined the documents and copies of medical records filed before this forum. It is seen from the report of the biochemistry that the sodium level had marginally fallen below the normal range and the potassium level was close to the lower limit but it cannot be said that the Na, K, deficiency had reached a critical level. This is corroborated by the fact that the treating doctor did not prescribe any medication for the deficiency except oral salt which could be administered at home. The advice of the doctor for consultation with a psychiatrist and prescribes medicines as suggested by the psychiatrist point to the fact that the patient had suffered mental and psychological disorder necessitating hospitalization. It is further seen from the discharge summary of the hospital that the patient was not given any medicine or any advice for correction and control of his sodium and potassium level. The entire treatment and the medicines prescribed in the discharge summary are identical with the medicines prescribed by the consultant psychiatrist. Thus after careful evaluation of all the facts and circumstances of the case, we are inclined to accept the decision of the insurer which is within the framework of the policy. The disease suffered by the insured as per discharge certificate fall within the exclusion clause no. 4.3 of the policy and therefore his claim is dismissed.

Kolkata Ombudsman Centre
Case No. 470/11/009/NL/11/2009-10
Shri Bhupendra Mishra
Vs.
Reliance General Insurance Company Ltd.

Order Dated : 08.12.2010
Facts & Submissions :

This complaint is against repudiation of claim under Reliance Healthwise Policy issued by Reliance General Insurance Company Ltd.

The complainant Shri Bhupendra Mishra in his complaint has stated that his wife Smt. Ratna Mishra was admitted at Bhagirathi Neotia Woman & Child Care Centre Kolkata on 08.03.2009 for operation of Exploratory Laparotomy under Dr. Gouri Kumra and released on 12.03.2009. As per discharge summary the diagnosis of the disease was *"Left Adenexal Cyst with Hydrosalpinx PID".*

He lodged a claim along with all relevant documents to the TPA of the insurance company M/s Medi Assist towards the expenditure incurred in connection with the above treatment for reimbursement. The

TPA vide their letter dated 07.09.2009 repudiated the claim stating that *'as per documents received patient admitted in Bhagirathi Neotia Women and Child Care Centre on 08.03.2009 and discharged on 12.03.2008 and diagnosed as left adenexal cyst with Hydrosalpinx PID. Policy since 14 Mar 2008 – history of long standing abdominal pain since one year as provided on date 08.03.2009 – ailment found to be pre-existing in Reliance Healthwise policy – claim is denied as per policy exclusion no. 1. Hence, we regret our inability to admit this liability under the present policy conditions.* He represented to the insurance company on 10.09.2009 to review and settle his claim. Even on review dated 26.11.2009 the insurance company informed him their stand of previous decision of repudiation. Being aggrieved, the complainant approached this forum for redressal of his grievance, seeking monetary relief of Rs.15,000/-.

DECISION:

We have heard both the parties and examined all the documents filed before this forum. We have observed that the insurer has not considered the fact that the policy is a rollover from an existing continuous policy from the New India Assurance Company Ltd. and the insured had waited for 3 consecutive without any claim history. This fact is very important for deciding whether the exclusion clause can be applied in this case or not. Without considering the facts of continuity it is not correct for the insurer to apply the exclusion clause and deny the claim on the ground of pre-existing disease. We direct the insurance company to reconsider the claim, taking into account her earlier policy with the New India Assurance Company Ltd. and settle the claim as per terms and conditions of the policy. If the waiting period is already over and there is no break in the earlier policy then her claim becomes exigible. This fact may be verified by the insurer.

Kolkata Ombudsman Centre
Case No. 474/11/005/NL/11/2009-10
Shri Bimal Kumar Goenka
Vs.
The Oriental Insurance Company Ltd.

Order Dated : 08.12.2010
Facts & Submissions :

This complaint is in respect of repudiation of claim under Individual Mediclaim Insurance Policy issued by The Oriental Insurance Company Ltd. as per exclusion clause no. 4.3 of the policy.

The complainant Shri Bimal Kumar Goenka stated that he was suffering from Diabetes and Hypertension and was admitted at Marwari Relief Society Hospital, Kolkata on 28.02.2009 where he was treated conservatively and was discharged on 06.03.2009. As per discharge summary the diagnosis of the disease was *'Acute Myocardial Infarction'.*

He lodged a claim on 23.04.2009 along with all relevant documents towards the expenditure incurred in connection with the above treatment to the TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd. for reimbursement. The TPA vide their letter dated 06.05.2009 repudiated the claim stating that *'the ailment myocardial infarction is due to rupture of an atheromatous plaque causing thrombosis and has 2 major risk factor diabetes and HTN, for this member. The OIC revised policy has exclusion for treatment of diabetes and hypertension for 2 years. Hence the claim is repudiated as per exclusion 4.3 of the policy'.* He represented to the insurance company on 14.05.2009 against such repudiation stating that as per exclusion 4.3 of the policy Myocardial Infraction caused by any other ailment is not included in the exclusion and it is payable and requested the insurance company to review and settle his claim. Again on review the TPA of the insurance company repudiated the claim. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.30,381/-.

The insurance company in their self-contained note dated 26.02.2010 stated that Shri Bimal Kumar Goenka was admitted in Marwari Relief Society Hospital on 28.02.2009 with sudden heart pain and discharged on 06.03.2009 giving advice for complete bed rest. The diagnosis of the disease was Acute Myocardial Infarction Further, their TPA opined that Myocardial Infarction is the direct application of both diabetes and hypertension and the patient was suffering from diabetes & hypertension at the time of taking the policy. On the basis of clause no. 4.3, the claim was repudiated by TPA.

DECISION:

We have heard both the parties and examined the documents filed before this forum. It is seen from the policy conditions clause no. 4.3 that any treatment of ailment/ diseases/surgeries resulting from HTN or Diabetes is not admissible for 2 years. As per medical dictionary "Myocardial Infarction" refers to " death of a part of the heart muscles after coronary thrombosis". Thus it is a case of heart problem which has 2 (two) major risk factors being HTN and Diabetes, as resultant cause. Ailment was incepted in the second year of the policy hence the condition of 2 years waiting period is clearly applicable. We therefore find that the decision of the insurer is correct and same is upheld.

MEDICLAIM

Kolkata Ombudsman Centre
Case No. 481/11/011/NL/12/2009-10
Shri Tapas Banik
Vs.
Bajaj Allianz General Insurance Company Ltd.

Order Dated : 14.01.2011
Facts & Submissions :

This complaint was in respect of repudiation of claim under Individual Health Guard Policy issued by Bajaj Allianz General Insurance Company Ltd. on the ground of pre-existing disease as per exclusion clause no. 13A of the policy.

The complainant Shri Tapas Banik stated that complaint of swelling in left groin for 1 year and was admitted at ILS Multispeciality Clinic Kolkata on 05.11.2008 where he underwent Laparoscopic Left hernioplasty (TEP) on 06.11. 2008 and was released on 08.11.2008. As per discharge summary the diagnosis of the disease was 'Left Inguinal Hernia'.

He lodged a claim to the insurance company along with all relevant documents towards the expenditure incurred in connection with the above treatment for reimbursement. The insurance company vide their letter dated 04.12.2008 repudiated the claim stating that *' verification of the claim documents reveal that Mr. Tapas Banik was hospitalized for the treatment of left inguinal hernia. The claim stands repudiated under policy exclusion clause 13A as the illness existed prior to the inception of policy with Bajaj Allianz General Insurance Company Ltd. and the same is not disclosed on the proposal form'.* He represented to the insurance company on 08.07.2009 requested the insurance company to reconsider their decision as the disease was not existing at the time of commencement of the policy because he was insured with other insurance company since 2000. But his representation did not yield any result. Being aggrieved, the complainant approached this forum for redressal of his grievance without mentioning any quantum of relief in the 'P' form details.

The insurance company in their self-contained note dated 28.12.2010 stated that the complainant was covered under Individual Health Guard policy for the period 15.06.2008 to 14.06.2009. The complainant has not disclosed the facts which are material to the policy issued to the insured. In the present case; the fact was that the complainant was suffering from the said disease and had also undergone some treatment which was never intimated to the insurers and thus the repudiation of the claim of the complainant was well within the right and the complaint needs to be dismissed in the light of the abovementioned facts. On 05.11.2008 the complainant was admitted in ILS Multispeciality clinic and was treated for Left Inguinal Hernia. The pre-authorization letter issued by the hospital at the time of admission clearly states that the

duration of the ailment is for the past 1 year, i.e., prior to the risk inception period. The insurance company submits that the discharge summary further states a surgical history of Rt. Sided hernioplasty 6 years back however this medical condition was not declared in the proposal form. Insurer has further submitted that in the proposal form, the complainant gave deliberate wrong answers and did not disclose that he has been suffering from Left Inguinal Hernia prior to the risk inception period and the same was not disclosed in the proposal form and in view of the same the insurance company repudiated the claim, under clause D 13 A of the policy terms and conditions.

DECISION:

It is seen that the complainant was earlier covered by Group Mediclaim Policy with Iffco Tokio General Insurance Company Ltd. and changed over to Bajaj Allianz General Insurance Company Ltd. from the year 2008 onwards. The sum insured under the Bajaj Policy for the relevant period was Rs.50,000/-. It is seen that the complainant had a surgical history of right sided hernioplasty 6 years back as mentioned in the discharge summary. However this fact was not disclosed in the proposal form at the time of switching over to the new insurer. The complainant answered in the negative to the specific question, whether he has suffered from any diseases or undergone any surgery in the past. It is well settled that the contract of insurance is based on the principle of utmost good faith wherein the parties to the insurance contract must deal in good faith making full and true disclosure of all material fact in the proposal form. The facts that the insured had undergone surgery in the past and he did not disclose the same in the proposal form are not disputed. We therefore agree with the insurer's decision of repudiation on the ground of suppression of material facts. The decision of the insurer is upheld.

Kolkata Ombudsman Centre
Case No. 522/11/004/NL/12/2009-10
Shri Shanti Kumar Jain
Vs.
United India Insurance Company Ltd.

Order Dated : 18.01.2011
Facts & Submissions:

This complaint is filed against repudiation of a claim under Individual Health Insurance Policy issued by United India Insurance Company Ltd.

The complainant Shri Shanti Kumar Jain stated that his wife Smt. Lalita Jain was covered under policy no. 030500/48/08/97/00002200 for the period 12.09.2008 to 11.09.2009. She was admitted for treatment of Metabolic Syndrome at Advanced Medicare Research Institute (AMRI) Kolkata on 05.01.2009, where Laparoscopic Sleeve Gastrectomy was done under GA on 06.01.2009. She was released from the hospital on 09.01.2009. As per discharge summary the diagnosis of the disease was '*Metabolic Syndrome'.*

On 18.02.2009 he lodged a claim for Rs.2, 98,190.18 to the TPA of the insurance company M/s Heritage Health Services Pvt. Ltd. along with all relevant documents towards the expenditure incurred in connection with the above treatment for reimbursement. The TPA vide their letter dated 31.03.2009 repudiated the claim stating that "*as the patient had done metabolic surgery for obesity which as per our medical officers opinion is related to cosmetic surgery. Therefore as per terms & conditions of the policy the claim is not admissible".* He represented to the insurance company on 24.07.2009 for review and settlement of his claim. But his representation was not considered by them. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.2,98,190.18 along with interest.

The insurance company in their self-contained note dated 15.03.2010 stated that their TPA M/s Heritage Health Services Pvt. Ltd. repudiated the claim on 31.03.2009 on the ground that as per opinion of their medical officer Metabolic Surgery for Obesity is related to Cosmetic Surgery and it is excluded as per policy condition 4.5 (b). The insured was informed vide their letter dated 26.05.2009. Thereafter the insured lodged a complaint to their Grievance Department, Kolkata Regional Office on 22.09.2009. Kolkata Regional Office referred the file to Dr. Vineet Kumar Mittal for opinion, who opined that the claim can be considered according to its merit. Accordingly they advised their TPA on 08.12.2009 that the claim

is admissible and advised to reopen the claim file and settle the claim on its merit. In the meantime insured lodged a complaint to this office and they called back the file from TPA on 09.02.2010. Their TPA sent back the file dated 29.12.2009 with their opinion *"that Mrs. Lalita Jain was admitted to AMRI Hospital on 05.01.2009 for treatment of 'Metabolic Syndrome with past history of hypertension (on treatment)".* She got discharged on 09.01.2009 with final diagnosis "Metabolic Syndrome". Earlier she had consulted with Dr. V.K. Bhartia (Specialist in Obesity Surgery) on 19.12.2008 and Dr. Pranab Das Gupta on 02.11.2008. Dr. Bhartia observed that the weight of the insured was 107 Kg., BML-37 & Height 5'-9" and advised Sleeve Gastrectomy/ by pass. Both the doctors have not mentioned the chief complaints, symptoms & signs of any disease.

They further stated that this clearly reflects that the surgery was for the reduction of weight. The existing HTN is not principally due to Obesity. She was not having any complaints or disease. She opted to be slim at the age of 48 years, purely a cosmetic reason.

Dr. Mittal has explained the complication of obesity which may occur in future. It is the view of the TPA that the disease mentioned by Dr. Mittal can happen even in non-obese cases. The explanations given by Dr. Mittal are purely in patient's favour which can make a milestone in the history of insurance company. Any one who is obese will take an insurance of 5 lakh and will enjoy the life and cheating the insurance company.

The case was again referred to Dr. K.K. Das and Dr. Sharma C.P for their opinion in the matter. As per opinion of both the doctor, "*it was a mere cosmetic surgery to reduce the excessive body weight without any complaints, symptoms and signs of any organic disease".* Since the operation was only for cosmetic purpose, the claim is not admissible under exclusion clause no. 4.5 (b) of the policy, which states as "*vaccination or inoculation or change of life or cosmetic or aesthetic treatment of any description".*

DECISION:

It is seen that the insurer had repudiated the claim based on their TPA's recommendation by attracting exclusion clause no. 4.5 (b) of the policy condition which states that the surgery undergone is cosmetic in nature and hence not payable. The insurer thereafter sought the opinion of their panel doctor, Dr. V.K. Mittal who stated that the case cannot purely be treated as cosmetic one and therefore, the claim can be admitted on merit. However, TPA was not inclined to make the payment on the basis of Dr. Mittal's opinion and therefore they got the case reviewed by Dr. K.K.Das and Dr. Sharma C.P (none of them are surgeon) who gave the opinion in favour of the TPA. It is also seen that the insured had consulted a number of doctors before deciding for the surgery. Complainant has filed the prescriptions of Dr. L. N. Tripathy and Dr. V.K. Nevatia (both surgeons) whom his wife had consulted prior to the surgery. From these prescriptions it is seen that the insured was diagnosed as obese and advised weight reduction, back care and use of L.S. Belt. None of the doctors, whom she had consulted prior to the operation pointed out any serious disease or complication as alleged by the complainant. Due to the conflicting opinions of several doctors consulted by both the parties, a confusion has arisen regarding the real nature of the surgery done. There is absolutely no dispute with regard to the fact of hospitalization and dates of hospitalization which were also within the period of the subject policy which was in force. Hence the point for determination is whether metabolic syndrome falls under the category of cosmetic treatment or it is essential for life function of the patient. After careful evaluation of all the facts and circumstances of the case, we conclude that it is difficult to take a decision without any expert and independent surgeon's opinion on this point. It would therefore be felt that it would be necessary to obtain another opinion from a renowned specialist doctor in the related filed outside the panel of the insurer/TPA and also those already consulted by the insured. Therefore, we direct the insurer to refer the case to a renowned specialist for proper review. The complainant must be allowed to represent his case to such specialist doctor at the time of review. The complainant is also directed to submit all the necessary documents/ medical reports as may be required by the specialist doctor. A copy of the opinion of the said specialist doctor has to be handed over to the complainant. The opinion of the specialist doctor will be final and this forum will not adjudicate on his opinion if it goes against the interest of the insured.

Based on specialist doctor's opinion Insurer will process the claim as per terms and conditions of the policy within 15 days of the receipt of the doctor's opinion.

Kolkata Ombudsman Centre
Case No. 523/14/002/NL/12/2009-10
Shri Kumar Dip Bahal
Vs.
The New India Assurance Company Limited**..**

Order Dated : 20.01.2011
Facts & Submissions:

This complaint was filed against delay in settlement of a claim under Individual Mediclaim Policy issued by The New India Assurance Company Limited.

The complainant Shri Kumar Dip Bahal stated that as per advice of the doctor his mother Smt. Saila Bahal was admitted at Woodlands Medical Centre on 01.11.2007 where Hemicolectomy (Right) operation was done successfully but she expired on 04.11.2007. As per Medical Certificate of Woodlands Medical Centre, the cause of death was *'acute myocardial infarction in a post operative case of Hemicolectomy (Right)".*

Being the legal heir of the insured, he lodged a claim on 03.12.2007 for Rs.74,903.90 to the TPA of the insurance company M/s E-Meditek Solutions Limited along with all relevant documents for reimbursement of hospital expenses. After a lapse of considerable period his claim was not settled by the TPA or insurance company. Then he represented to the insurance company on 04.02.2009 requesting them to settle his claim at the earliest. He sent an e-mail on 04.02.2009 requesting the insurance company to settle this claim. But his appeal was not considered by them. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.87,375.31 (including interest).

The insurance company in their self-contained note dated 10.05.2010 stated that the insured Smt. Saila Bahal (since deceased) was admitted in Woodland Medical Centre on 01.11.2007 where she was operated for Hemicolectomy (right) and she died on 04.11.2007. According to the medical certificate, the cause of death was acute myocardial infarction in a post operative case of Hemicolectomy (right). Their TPA M/s E-Meditek Solutions Ltd., on verification of claim papers, requested vide their letter dated 18.02.2008 to provide the following documents/ information which were essential to process the claim.

a) History of hypertension certified by the treating doctor, and
b) All IPD papers.

They further stated that since the complainant could not submit the above documents/ information, TPA had no option but to mark the claim as 'No Claim' which was communicated vide their letter dated 31.03.2008. Unless the requisite documents/ information are submitted by the insured/ complainant, it is not possible for TPA to process the claim.

DECISION:

The complainant being the only legal heir of the deceased insured had approached this forum for non-settlement of his claim for treatment of his mother who expired after undergoing surgery for Hemicolectomy (Right). It is seen that the insurer has based their decision merely on the report of the TPA and closed the case as 'No Claim' on the ground that the complainant has not submitted the history of HTN certified by the treating doctor and all IPD papers. They have not taken a practical and independent view in deciding this case.

We find that there is no dispute that the cause of death was acute myocardial infarction in a post operative case of Hemicolectomy (Right). The deceased insured was 70 years old and she died of heart failure during the post operative period. Therefore, it is not understood how the history of HTN is going to help the TPA in settling the claim because the patient died of heart attack after a surgery and it is in no way related to the history of HTN. The cause of death is post surgery complications, which could not be sustained by the patient, who is of advanced age. How the past history of HTN comes into the picture is beyond our comprehension. If the insurer had any doubt about the genuineness of the claim they could have made independent enquiries at their end instead of writing to the complainant and waiting for his reply and

closing the case as ‘no claim’. Thus after evaluation of all the facts and circumstances of the case, we conclude that the insurer’s decision in treating the case as no claim is not justified and we set aside their decision. This is the first claim of the insured in a period of 10 years and on the basis of the documents filed before this forum we find that the claim is clearly exigible. The insurance company is therefore directed to settle the claim and pay the amount as per the terms and conditions of the policy..

Kolkata Ombudsman Centre
Case No. 541/11/005/NL/01/2009-10
Smt. Tunna Majumdar
Vs.
The Oriental Insurance Company Ltd.

Order Dated : 21.01.2011
Facts & Submissions:

This complaint is filed against repudiation of claim under Individual Mediclaim Insurance Policy issued by the Oriental Insurance Company Ltd. due to pre-existing disease as per exclusion clause 4.1 and 4.3 of the policy.

The complainant Smt. Tunna Majumdar stated that she was admitted at Rabindranath Tagore International Institute of Cardiac Sciences (RTIICS) on 11.04.2009, where she had undergone an operation on 16.04.2009 and was released from the hospital on 19.04.2009. As per discharge summary the diagnosis of the disease was *"Ruptured wide necked right ophthalmic segment ICA Aneurysm".*

She lodged a claim along with all relevant documents towards the expenditure incurred in connection with the above treatment to the TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd. But the said TPA vide their letter dated 09.06.2009 repudiated the claim stating that *"this is a first year running policy. The claim is lodged for Carotid Artery Aneurysm which is a congenital internal anomaly and therefore cannot be covered under the scope of the policy as it has a waiting period of 2 years vide clause 4.3 of amended OIC policy condition. Moreover, it is obviously pre-existent to the policy inception, hence inadmissible also under condition 4.1 of policy.* She represented to the insurance company on 26.06.2009 to reconsider her case in view of her treating doctor's certificate, where the doctor has clarified that ruptured artery aneurysm is not congenital in nature. But her appeal did not yield any positive result. Being aggrieved, the complainant approached this forum for redressal of her grievance seeking monetary relief of Rs.1 lakh.

The insurance company in their self-contained note dated 21.07.2010 stated that their TPA has processed the claim and before taking final decision they sent the file to the panel doctor for his opinion. As per the opinion and remarks of their panel doctor – the claim has been lodged during the first year of the policy, for treatment of Carotid Artery Aneurysm which was a congenital internal anomaly for which there is a waiting period upto 2 years under exclusion no. 4.3. Therefore, liability does not come under purview of the policy and recommended for repudiation of the claim.

They further stated that on request of the claimant they have reviewed the claim on merit on the basis of the opinion of their TPA adjudication panel doctor, who did not find any valid reasons and/ or additional points to alter earlier decision of repudiation as per policy exclusion no. 4.3. On receipt of complaint letter from this office they have again obtained opinion from professional expert in respect of the claim aspect. The professional expert has examined and reviewed the claim and is consonance with the decision of the panel doctor of TPA that the claim is not admission under exclusion clause no. 4.3 of the policy. In view of all the expert opinion, the claim is not admissible under policy exclusion no. 4.3 as referred above and accordingly the file is closed with remarks as "No Claim".

DECISION:

There is no dispute about the fact that the claim has arisen in the first year of the policy for 2008-09. It is seen from the Butterworth's medical dictionary that aneurysm means "*a localized dilatation of the walls of a blood vessel, usually an artery, due to weakening through infection, injury, degenerative conditions or* ***congenital defects****".* Therefore, the possibility of congenital defect cannot be ruled out. The point of dispute between the insured and the insurer is whether ruptured aneurysm had resulted from a congenital defect/ disorder or any other reason as per the dictionary meaning. In case it is congenital internal diseases then there is normally a waiting period of 2 years as per the clause 4.3 of the amended O.I.C policy conditions and if it is arising out of sudden accident/ injury then the claim becomes admissible under the

policy conditions. Both the parties have obtained their respective doctors opinion in support of their contentions. This forum is unable to come to a definite conclusion regarding the nature and the date of inception of the ruptured aneurysm in this case. We, therefore, feel that it would be necessary to obtain an opinion from a specialist doctor outside the panel of the insurer/ TPA and therefore, we direct the insurer to refer the case to a renowned Neuro Surgeon outside their and TPA panel and also those already consulted for proper review. The complainant must be allowed to represent her case before such specialist doctor at the time of review. The complainant is also directed to submit all the necessary documents/ medical reports as may be required by the specialist doctor. A copy of the opinion of the said specialist doctor has to be handed over to the complainant. The opinion of the specialist doctor will be final and this forum will not adjudicate on his opinion if it goes against the interest of the insured.

Based on specialist doctor's opinion they are to treat and process the claim as per terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 577/11/002/NL/02/2009-10
Shri Pijush Kumar Mitra
Vs.
The New India Assurance Company Limited.

Order Dated : 04.02.2011
Facts & Submissions:

This complaint is filed against repudiation of claim under Mediclaim Policy (2007) issued by The New India Assurance Company Limited due to non receipt of required documents for processing the claim.

The complainant Shri Pijush Kumar Mitra stated that his son Sri Mangalick Mitra was suffering from Facial Cellulites and was admitted at Dafodil Nursing Home (P) Ltd., Kolkata on 25.11.2008 where he was treated conservatively and he was discharged on 29.11.2008. As per discharge summary the diagnosis of the disease was *'Facial Cellulites (left side)'.* He lodged a claim on 19.12.2008 for Rs.19, 130/- to the TPA of the insurance company M/Medicare TPA Services (I) Pvt. Ltd. for reimbursement. TPA vide their letter dated 11.07.2009 repudiated the claim stating that "*investigation reports proving 'staphylococcus infection' required for processing the claim. Until receipt of the abovementioned document the file will remain closed as No Claim".* He represented to the insurance company on 19.11.2009 requesting for settlement of his genuine claim. His appeal did not yield any result. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.19, 130/-.

The insurance company in their self-contained note dated 23.04.2010 stated that Shri Mangalick Mitra son of the complainant Shri Pijush Kumar Mitra was admitted at Daffodil Nursing Home, Kolkata on 25.11.2008 for facial cellulites (left side) and was discharged on 29.11.2008. The complainant submitted all treatment related documents and bills to their TPA for reimbursement of treatment expenses for an amount of Rs.19, 130/-. On the basis of Panel Doctor's opinion their TPA had asked the insured to furnish the complete set of indoor case papers including investigation report proving staphylococcus infection of the said nursing home. Daffodil Nursing Home vide their letter dated 10.02.2009 stated that the same were faxed to M/s Medicare on 29.11.2008 which was denied by them. TPA in their letter dated 26.03.2009, 06.05.2009, 11.07.2009 issued reminders to the insured to submit the indoor case papers.

Further on examination of all the claim papers with underwriting documents, they observed that:-

i) There was no OT procedure involved.
ii) During the stay only some investigations and two oral medicines were prescribed.
iii) Papers required to prove that the ailment required hospitalization were not produced.

In view of the above, their TPA has rightly closed the claim as 'No Claim' and they are in agreement with their views.

DECISION:

We find that complainant had submitted Xerox copies of almost all the relevant papers and doctor's advice to the TPA in time, but the insurer has repudiated the claim as no claim because the complainant failed to furnish the investigation papers called for by their TPA. These are indoor case papers to be obtained from the concerned nursing home. It is clear from the letter of the nursing home dated 10.02.2009 that the required papers were faxed by them to the TPA. We have no reason to disbelieve them. If the TPA had any doubt about the genuineness of the claim they could have obtained these papers directly from the nursing home engaged an investigator instead of closing the case as 'no claim'. Moreover, we do not find any justification in the contention of the TPA that since no OT procedure was involved and only some investigations and oral medicine were prescribed, hospitalization was not necessary. We are of the opinion that the treating doctor is the best judge of the condition of the patient and if he had suggested hospitalization then no one else could decide otherwise without physically examining the patient. We also do not find anywhere in the policy terms and conditions that claim can be allowed only in case of a disease which need compulsory OT procedure. The insurer could not produce any medical literature to justify their

action and they did not take any action on their own to obtain the papers from the nursing home when a doubt has arisen. After evaluation of all the facts and circumstances of the case we do not find the insurer's action as fair and valid and the same is set aside. The insurer is directed to admit the claim and settle the same as per terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 586/11/012/NL/02/2009-10
Shri Vikash Shah
Vs.
ICICI Lombard General Insurance Company Ltd.

Order Dated : 10.02.2011
Facts & Submissions:

This complaint is filed against repudiation of a maternity benefit claim due to 9 months waiting period under Group Health (Floater) Insurance Policy issued to Sanjeevani Health Club by ICICI Lombard General Insurance Company Ltd.

The complainant Shri Vikash Shah stated that his wife Smt. Sangeeta Shah was admitted at Matri Mangal Pratishthan, Kolkata on 11.02.2006 for Caesarean delivery of a female child on 12.02.2006 and was discharged on 17.02.2006.

He lodged a maternity claim to the TPA of the insurance company M/s Family Health Plan Limited for reimbursement. The TPA of the insurance company vide their letter dated 29.04.2006 repudiated the claim stating that "*as per the submitted documents, the claim falls under the '9months waiting period' clause of the given mediclaim policy. Hence we regret to inform that your claim is repudiated".* He represented to the insurance company on 01.11.2008, 03.09.2009 and 23.09.2009 stating that the above mentioned clause is applicable only for the fresh entrant to group mediclaim policy but his policy is a renewal of group mediclaim policy with same benefit from an Indian Insurance company, viz. the Oriental Insurance Company Ltd. So, the question of 9 months waiting period clause will not be applicable for his case and requested them for early settlement of his claim. He did not get any favourable reply from the insurance company. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.23, 466/- with interest.

DECISION:

It is seen that the policy in question had incepted from 01.04.2005 and a period of 10 months had already over before the claim was made on 12.02.2006. Since the policy holder was insured earlier with the Oriental Insurance Company's policy, she has to be given the benefit of continuity and should be treated as an existing member and relevant clause in her case would be 8, sub-clause (viii). Under this clause her claim is clearly admissible. Insurer's decision to repudiate the claim is therefore set aside. Insurer is therefore directed to admit the claim and settle & pay the same as per terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 598/11/005/NL/02/2009-10
Mr. Shahid Hussain Khan
Vs.
The Oriental Insurance Company Ltd.

Order Dated : 10.02.2011
Facts & Submissions:

This complaint is filed against repudiation of claim under Individual Mediclaim Insurance Policy issued by The Oriental Insurance Company Ltd. as per exclusion clause no. 4.8 of the policy.

The complainant Mr. Shahid Hussain Khan, stated that his wife Mrs. Farzana Tabassum was suffering from pain and weakness in the limbs and as per advice of the doctor she was admitted at West Bank Hospital,

Howrah on 28.04.2007 where she was treated conservatively and discharged on 09.05.2007. As per discharge summary, the diagnosis of the disease was *"Neurolept Syndrome".*

At the time of admission of his wife he approached the TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd. for cashless facility but the same was denied by them. He lodged a claim to the TPA of the insurance company for reimbursement of hospital expenses. The TPA vide their letter dated 22.11.2007 repudiated the claim stating that *"Psychiatric disorder is not payable by revised policy norms. (It is clear from indoor case paper that patient has psychiatric problem and is on SSRI or antipsychiatric treatment vide entry dated 05.03.2007). Obesity leading to joint pain does not require hospitalization and can be treated on domiciliary basis. The claim is therefore repudiated".* He represented to the insurance company on 18.01.2008 against such repudiation and requested the insurance company to review and settle his claim. But his appeal was not considered by them. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.35,240/-.

The insurance company in their self-contained note dated 08.04.2010 stated that insured Mrs. Farzana Tabassum was hospitalized from 28.04.2007 to 09.05.2007 for treatment of psychiatric and severe obesity problems as observed by medical expert of TPA from the available record sheets of treatment during hospitalization. The clinical examination of the patient categorically revealed that she has all the feature of depression and was on anti-psychotic drugs. As informed by TPA and also as per nursing home available records the patient was treated for psychiatric problem which made her ineligible to get the claim as it attracts the exclusion no. 4.8 of mediclaim policy which specifically excludes *"all psychiatric and psychosomatic disorder interalia other diseases/ ailments".*They further stated that it was observed by medical experts of TPA that during hospitalization the patient did not consult any orthopaedic specialist for her limbs problem and was only given paracetamols (mild pain killers) without any rigorous treatment like traction etc. She had continuously taken physiotherapy which could have been very well taken whilst domiciled.

In view of the above, insurer stated that the patient took admission to nursing home primarily for psychiatric treatment (which is specific exclusion under policy) but in order to get the benefit of the policy she took recourse to some treatment for pains in the limbs which could have been taken at home without getting admission to a hospital/nursing home.

DECISION:

It is seen from the discharge summary of West Bank Hospital that the patient was admitted through emergency for pain and weakness in her limbs and she had severe obese structure, her blood reports showed normal RA factor and increased CRP, Aluminum Phosphate level and CPK level suggestive inflammatory muscle disease. The patient was seen by the Neurologist and Psychiatrist on the advice of the treating doctor. The indoor patient case history has also been filed by the insurer which shows the history of severe obesity, inability to stand up due to excessive weight and bit of psychiatric complications. The doctor has mentioned in the medication column "obesity with generalized body ache". The fact of severe obesity has been mentioned by the doctor repeatedly in the treatment papers and he has also mentioned that the patient had all features of depression. Thus it is clear that her joint pain has resulted from the morbid obesity and for pain management she was given physiotherapy. She was also referred to a Dietician for weight reduction. During hospitalization her treatment consistent of some simple analgesics and physiotherapy.

In view of the above, we find substantial merit in the contention of the insurer that she was admitted in the hospital for treatment of obesity related problems and mental disorders at that point of time. This fact is also obvious from the course of treatment during hospitalization. The patient did not consult any orthopaedic specialist and was prescribed mild pain killers and advised physiotherapy which could have been very well taken whilst domiciled. After evaluation of all the facts and circumstances of the case, we find that her case is squarely covered by clause no. 4.8 and 4.19 of the mediclaim insurance policy (individual). Clause 4.8 excludes all psychiatric and psychosomatic disorders and 4.19 excludes treatment of obesity or condition arising therefrom or any other weight control programme. However we find that at the time of admission the patient had severe pain in her limbs and doctor has noted some muscle diseases for which she was given analgesics and continued physiotherapy. The admission into the hospital was on the specific advice of the doctor and we cannot overlook the doctor's advice in this respect as he is the best

judge of the situation. Management of pain through medicines and physiotherapy definitely fall under permissible treatment and it cannot be said that this constitute treatment of obesity. We, therefore direct the insurer to pay an amount of Rs.5,000/- (Five thousand only) purely on ex-gratia basis for the treatment taken for pain reduction of the patient.

Kolkata Ombudsman Centre
Case No. 592/11/003/NL/02/2009-10
Shri Jayanta Chatterjee
Vs.
National Insurance Company Ltd .

Order Dated : 10.02.2011
Facts & Submissions:

This complaint is filed against repudiation of claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd. as per exclusion clause no. 4.3 of the policy.

The complainant Shri Jayanta Chatterjee stated that his wife Smt. Moutusi Chatterjee was suffering from abdomen/ chest pain with vomiting tendency, indigestion and she consulted Dr. Sanjay Kumar Nag, M.D. on 04.07.2009 and as per his advice ultrasound of upper abdomen, E.C.G and other relevant tests were done and as per doctor's advice she was admitted at Apollo Gleneagles Clinic, Kolkata on 22.08.2009 where she underwent laparoscopic cholecystectomy under GA and discharged on 24.08.2009. The discharge summary of the hospital diagnosed the disease was *"Calculus Cholecystitis"*.

He lodged a claim on 09.09.2009 for Rs.25, 295/- to the TPA of the insurance company M/s Genins India TPA Ltd., for reimbursement of the hospital expenses. The TPA vide their letter dated 23.10.2009 repudiated the claim stating that *"this claim pertains to Moutusi Chatterjee for the case of Calculus Cholecystitis. The present claim is for the surgical treatment of calculus cholecystitis in 1st year of policy. Hence the claim is denied as per clause no. 4.3 of standard policy condition"*. He represented to the insurance company on 30.12.2009 against such repudiation requesting them to reconsider and settle his claim at the earliest. He did not get any favourable reply from them. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.25, 295/-

The insurance company in their self-contained note dated 18.03.2010 stated that the complainant preferred a claim in respect of his wife Smt. Moutusi Chatterjee for Rs.25,295/- towards an ailment diagnosed as 'Calculus Cholecystitis' by Apollo Gleneagles Clinic, Kolkata where Smt. Chatterjee was treated as an indoor patient during the period from 22.09.2009 to 24.09.2009. The original claim papers was submitted to their TPA M/s Genins India TPA Ltd. and they processed the file as well as recommended for 'No Claim' under policy exclusion clause no. 4.3 vide their letter dated 23.10.2009 and on the strength of which they issued respective repudiation letter on 13.11.2009 to the insured.

DECISION:

It is seen that as per clause 3.5 of the policy, the pre-existing disease means any ailment / disease/ injury that the person is suffering from (known/ not known, treated/untreated, declared or not declared in the proposal) whilst taking the policy. Further it is seen from exclusion clause no. 4.3 that there is a waiting period of two years for the surgery on gall bladder. Therefore, in view of these two policy conditions, we find that the insurer has rightly rejected the claim as the event took place and the claim was made in the very first year of the policy. Complainant's plea that he was not aware of such clause by the insurer at the time of taking the policy and it was discovered accidentally later on at the time of hospitalization has no merit in view of the definition of pre-existing diseases given in clause 3.5. Ignorance of policy rules and conditions cannot be taken as an excuse for admitting an invalid claim. After evaluation of all the facts and circumstances of the claim, the decision of the insurer in repudiating the claim is found to be correct and the same is upheld.

Kolkata Ombudsman Centre
Case No. 636/11/002/NL/03/2009-10
Shri Samar Banerjee
Vs.
The New India Assurance Company Limited.

Order Dated : 24.03.2011
Facts & Submissions:

This complaint was filed against partial repudiation of claim under Mediclaim Policy (2007) issued by The New India Assurance Company Limited.

The complainant Shri Samar Banerjee stated that his wife Smt. Leela Banerjee sustained an injury due to a fall from the stairs and was admitted at Calcutta Medical Research Institute on 30.03.2009 where she had undergone an operation on 01.04.2009 for loose THR prosthesis and replacement of loose acetabular component and was released on 10.04.2009. He lodged a claim for Rs.1,27,173/- to the TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd. for reimbursement of hospital expenses. TPA had settled Rs.67,500/- towards full and final settlement of the claim. He represented to the insurance company on 18.02.2010 and requested for settlement of the balance amount of Rs.43,957/-. The insurance company vide their letter dated 19.2.2010 advised the TPA to settle the claim stating that *"From the enclosures of the letter we find that Calcutta Medical Research Institute issued a certificate on 20.10.2009 that the disease occurred due to fall, but you had not considered the enhanced amount of Rs.55,000/- as per clause 6.0. In our opinion though Mrs. Banerjee is a known patient of RA on medication since 1998, but in this case the loose acetabular component of right THR is due to fall i.e., a case of accident. Hence you may settle the balance amount due to Mrs. Banerjee ignoring the condition 6.0".* The insurance company also sent a copy of the above letter to him. But till date the TPA did not settle his balance claim. Being aggrieved, he approached this forum for redressal of his grievance seeking monetary relief of Rs.55,000/-.

The insurance company in their self-contained note dated 11.02.2011 stated that Shri Samar Banerjee took a mediclaim policy for him and his wife Smt. Leela Banerjee for the period from 30.09.2008 to 29.09.2009 with sum insured of Rs.1 lakh each with a CB of 45% on Rs.45,000/- and 5% on Rs.55000/- for his wife. Smt. Banerjee was admitted at Calcutta Medical Research Institute for loose acetabular component of right THR and was discharged on 10.04.2009. Shri Banerjee submitted all treatment related documents/ bills to their TPA M/s Medicare TPA Services (I) Pvt. Ltd., on 07.07.2009 for an amount of Rs.82,173/- being the balance reimbursable amount. On the basis of the documents as available in the file and panel doctor's opinion, Medicare TPA Services (I) Pvt. Ltd., in their letter dated 05.09.2009 stated that as per discharge certificate since the patient is a known case of rheumatic arthritis (RA) since 1998, the present disease is direct consequence of ailments as revealed in the x-ray report dated 02.11.2001. Hence the enhanced sum insured of Rs.55,000/- in the year 2007-08 was not considered for treatment of this disease as per clause 6.0. of Mediclaim Policy 2007 whichinter-alia states that 'if the policy is renewed for enhanced sum insured then the restriction as applicable to a fresh policy wil apply to the additional sum insured as if a

separate policy has been issued for the difference. In other words, the enhanced sum insured will not be available for an illness, disease, injury already contracted under the preceding policy periods.'.

They further stated that on examination of all the claim papers with underwriting documents they found as under :-

a) X-ray report dated 02.11.2001 reveal 'gross destruction of femoral head in right side with diminution of joint spaces, evidence of sclerosis & suggestive or arthritis with destruction of femoral head sequla, presence of phlebolith in left lower pelvis.'
b) The x-ray of hip & joint dated 06.03.2009 much prior to the accidental fall reveals slightly displaced prosthesis as compared with the previous x-ray dated 06.08.2008.
c) The above indicates that the patient was under constant follow up for her earlier hip replacement & hence the accidental fall may not be considered as a separate disease.
d) The TPA had just adjudged the admissible liability for the maximum amount, i.e., earlier sum insured and the CB thereon.
e) We have examined the terms, policy conditions, definitions, exclusions and explanations of Mediclaim Policy (2007).

In view of the above, their TPA has rightly settled the claim and they are in agreement with their views.

DECISION:

The main dispute in this case is the cause of the present illness, whether it was a consequence of an accidental fall or pre-existing disease of RA. We have noted that the treating doctor in his certificate dated 20.10.2009 has stated that the present ailment is a direct result of a fall from the stair case which loosened her THR Prosthesis and the loose component had to be replaced. The opinion of the doctor was also accepted by the insurer as mentioned in the Branch Manager's letter dated 19.02.2010. However they changed their decision on the basis of the TPA panel doctor's opinion, who is neither a specialist nor had examined the patient physically. It cannot be denied that the insured could have led a normal and active life for many more years, had she not been injured in an accident which resulted in loosening of her acetabular component of right THR. We are therefore inclined to accept the version of the treating doctor who is a specialist in this field. He is the best judge of the situation. The TPA's panel doctor has not given any convincing argument and or irrefutable documentary proof that loosening of acetabular component of right THR has resulted from earlier disease.

After evaluation of all the facts and circumstances of the case, we do not find the insurer's decision as valid and fair and the same is set aside. The claim of the complainant is genuine and we direct the insurer to admit the claim and pay the full amount admissible under the policy with enhanced sum insured as this is an accident case.

Kolkata Ombudsman Centre
Case No. 643/11/003/NL/03/2009-10
Shri Anil Kumar Roy
Vs.
National Insurance Company Ltd.

Order Dated : 18.032011
Facts & Submissions:

This complaint is filed against partial repudiation of a claim under Individual Mediclaim

Insurance Policy issued by National Insurance Company Ltd.

The complainant Shri Anil Kumar Roy stated that he was suffering from painless bleeding P/R for 15 days and was admitted at Apollo Gleneagles Hospitals, Kolkata on 08.03.2009 where colonoscopy and Left hemicolectomy done under general anesthesia on 10.03.2009 and he was discharged on 22.03.2009. As per discharge summary the diagnosis of the disease was "*Adeno Carcinoma Sigmoid Colon with multiple proximal polyps".* For this reason he was admitted in Apollo Gleneagles Hospitals on different dates for

Chemotherapy. As per discharge summary the diagnosis of the disease was *'Carcinoma Colon' & 'Carcinoma Colon stage C2'* He lodged a claim on 20.04.2009 for Rs.24,960/- to the TPA of the insurance company M/s Genins India TPA Ltd. along with all relevant documents towards the expenditure incurred in connection with the above treatment for reimbursement. TPA vide their letter dated 10.06.2009 settled Rs.11,200/- deducting the balance amount without any valid reason. Further he submitted a claim for Rs.75,166/- for 6 cycles chemotherapy after renewal of new policy no. 1573. The TPA vide their letter dated 20.10.2009 settled Rs.2,700/- but he refused to accept the same. He represented to the insurance company on 15.10.2009 against such partial repudiation and requested the insurance company to review and settle his claim. His representation did not yield any result. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of full claim amount.

The insurance company in their self-contained note dated 18/23.08.2010 stated that as per mediclaim policy, there are limitation of admissible amount under various heads, such as bed charges, Doctors fees, medicines and diagnostics etc. beyond which they do not have any authority to pay. They further stated that their TPA while settling each claim of the insured had enclosed a statement explaining therein admissible and non-admissible amount. While processing the claim amount of Rs.75,166/- dated 10.08.2009 the total amount is nothing but a clubbed amount of various bills for admission in hospital. But the actual reimbursable amount is Rs.9,679/- which falls under renewed policy no. 101000/48/09/ 8500001573. Their TPA has already sent the cheque for Rs.9,679/- to the claimant on 12.08.2010.

DECISION:

The complainant has given us a break up of his total claim for various days on which he had undergone chemotherapy. His total claim has arisen under 2 (two) insurance period as under :-

Sl. No.	Year	Policy No.	Policy Period	Date of Treatment	Submitted Amount
1	2008-09	101000/48/08/8500001597	13.07.08 to 12.07.09	07.04.2009 30.04.2009 21.05.2009 11.06.2009 02.07.2009	under scrutiny Rs.9,947/- Rs.16,252/- Rs.20,481/- Rs.18,807/-
2.	2009-10	101000/48/09/8500001573	13.07.09 to 12.07.10	23.07.2009	Rs.9,679/-

The insurer has only settled the claim for the year 2009-10. But they have not considered the claims pertaining to the insurance period 2008-09. We, therefore, refer the case back to them with the direction to consider all the claim related bills for Day Care Centre treatment at Apollo Hospital and make the payment as per terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No656/11/003/NL/03/2009-10
Shri Satindra Krishna De
Vs.
National Insurance Company Ltd.

Order Dated : 29.03.2011
Facts & Submissions:

This complaint is filed against repudiation of a claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd.

The complainant Shri Satindra Krishna De stated that his daughter Smt. Gargi De was suffering from uterus problem and Dr. (Mrs.) Champa Singh of Emily Nursing Home, Kolkata advised her to be admitted in the nursing home. Primarily she was considered for operation but later on Dr. (Mrs.) Singh adopted an alternative method of treatment. She was given three costly injections three times on 12.08.2009, 10.09.2009, 07.10.2009 and on every occasion she was advised for admission in the Emily Nursing Home with the purpose of observing the reactions of injection and also to restrict the movements of the patient. As per discharge summary dated 12.08.2009 and 10.09.2009 of the said nursing home the diagnosis of the disease was *'Fibroid Uterus'*.

He lodged a claim to the TPA of the insurance company M/s E-Meditek Solutions Ltd. for reimbursement. The insurance company vide their letter dated 29.01.2010 repudiated the claim stating that "the patient was admitted in nursing home for multiple fibroid of uterus. Injection decapeptyl given. Claim is not payable under clause no. 2.6 (procedure/treatment usually done at OPD are not payable under the policy even if converted to day care surgery procedure or as inpatient in hospital for more than 24 hours)". He represented to the insurance company on 24.02.2010 against such repudiation requesting them to reconsider his claim but did not get any favourable reply. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of 18,876/-.

The insurance company in their self-contained note dated 23.07.2010 stated that Smt. Gargi De was under treatment for Multiple Fibroid of Uterus. Dr. (Mrs.) Champa Singh advised her medical treatment instead of surgical treatment considering her age factor. The attending doctor prescribed three injection of Decapeptyl and two medicines named Stemetil & Recania. For the above treatment she was admitted thrice in Emily Nursing Home, Kolkata. The insured lodged the claim for Rs.12,337/- on 24.11.2009. The claim was rejected by them under exclusion clause no. 2.6 (Note) on the ground that the same treatment could be undertaken as an out patient. They intimated the insured their decision of repudiation vide their letter dated 29.01.2010.

DECISION:

It is seen that the Insurer has rejected the claim by invoking clause no 2.6 (note) very mechanically without appreciating the special circumstances of the case. The patient is a young and single woman suffering from the problem of multiple fibroid in the uterus. Initially the doctor considered uterus operation but as she was single and young doctor did not advise operation as seen from doctor's certificate dated 10/08/2009. To treat her, the doctor adopted an alternative method of treatment under which, the patient was given 3 special injections of decapeptyl consecutively for three months.. Since it was a non-conventional method of treatment, the doctor advised the patient to take admission in the nursing home for observation of any adverse side effects and rest.

There is nothing to suggest that the insured had taken the decision on her own in admitting herself in the nursing home. Whatever decision the complainant had taken in admitting the patient in the nursing home was as per doctor's categorical advise and was necessary for protection of her life from possible adverse effects of the injections. The hospitalization was just for one day on each occasion and claim is for a small amount of Rs.18.876/-.

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that the Insurer's decision is not fair and justified. While accepting the contentions of the complainant, we set aside the Insurer's decision and direct them to admit the claim and make the payment as per policy conditions.

Kolkata Ombudsman Centre
Case No.664/14/002/NL/03/2009-10
Shri Narayan Bhattacharjee
Vs.
The New India Assurance Company Limited.

Order Dated : 21.03.2011
Facts & Submissions:

This complaint is filed against delay in settlement of a claim under Individual Mediclaim Policy issued by The New India Assurance Company Limited.

The complainant Shri Narayan Bhattacharjee stated that he was suffering from heart problem and was admitted at N.R.S. Medical College and Hospital on 18.12.2007 where he implanted pacemaker and he was discharged on 08.01.2008. As per discharge summary of the said hospital the diagnosis of the disease was '*Exhausted PPM'* .

He lodged a claim to the TPA of the insurance company M/s Heritage Health TPA Pvt. Ltd. for reimbursement. But after a lapse of considerable period of time his claim was not settled. He represented to the insurance company on 31.07.2009 for settlement of his claim. He did not get any reply from them. Being aggrieved, the complainant approached this forum for redressal of his grievance without mentioning any quantum of relief in the 'P' form details.

The insurance company in their self-contained note dated 07.06.2010 stated that the insured Shri Narayan Bhattacharjee was covered under mediclaim policy having sum insured of Rs.15,000/- with C.B. 25%. The insured was admitted in NRS Medical College Hospital on 18.12.2007 and was discharged on 18.01.2008. After a long gap, the insured had submitted the documents on 22.09.2009 and papers were sent to their TPA M/s Heritage Health Services Pvt. Ltd.

On scrutiny of the documents, it is clearly declared by the insured that the pacemaker was implanted well before inception of hospitalization and domiciliary hospitalization benefit policy (Individual Mediclaim Policy) and as per exclusion/condition no. 4.1, the present claim as preferred by the insured for replacement of pacemaker is not tenable and merits repudiation. Hence, the claim file was recommended to close as "No Claim".

DECISION:

It is observed that the policy was first incepted with the New India Assurance Company Ltd. on 24.04.2002 and the said policy had been continuing with the same insurance company till 23.04.2008 without any break for which he had earned cumulative bonus to the extent of 25% of the sum insured of Rs.15,000/-. It is also seen that there was no claim by the insured during the last 7 years since inception of the policy. This time the claim was for replacement of existing pacemaker hence the question of pre-existence of disease prior to inception of policy does not hold good here. The insurance company before covering of such risk should have conducted medical tests of their own and excluded such disease from the scope of the policy. The representative of the insurance company could not produce the original claim form from which it could be verified whether any false declaration was made regarding his age. We also could not verify whether he had disclosed his pre-existing diseases. It is seen that the sum insured is meager amount of Rs.15,000/- with cumulative bonus of 25%. In the absence of the original proposal form, we can not say whether he has disclosed the pre-existing disease or given a false declaration of his age. It is not conclusively proved that he made the false declaration about his pre-existing disease or age.

Under the circumstances we give the benefit of doubt to the insured and direct the insurance company to admit the claim and pay the same as per terms and conditions of the policy on ex-gratia basis.

Kolkata Ombudsman Centre
Case No. 674/11/009/NL/03/2009-10
Shri Pawan Kumar Lilha
Vs.
Reliance General Insurance Company Ltd..

Order Dated : 30.03.2011
Facts & Submissions:

This complaint is filed against repudiation of claim under Reliance Healthwise Policy issued by Reliance General Insurance Company Ltd. as per policy condition no. 15 of the policy.

The complainant Shri Pawan Kumar Lilha stated that he was admitted at Apollo Gleneagles Hospitals, Kolkata on 02.11.2009 for coronary angioplasty done on the same day and he was released on 06.11.2009. As per discharge summary the diagnosis of the disease was *'Unstable Angina, Double Vessel Coronary Artery Disease'.*

He lodged a claim on 05.12.2009 for Rs.5,58,637/- to TPA of the insurance company M/s Medi Assist for reimbursement of the hospital expenses. The TPA vide their letter dated 29.01.2010 repudiated the claim stating that "*as per the indoor case papers from the hospital, patient was having a history of chest pain 2 years back. Insured had not disclosed these pre-existing ailments while taking the policy for the 1st time with the insurance company. The claim was repudiated under clause 15 (mis-representation/ non disclosure of the material facts).* He represented to the insurance company against their repudiation decision on 02.02.2010 stating that he was not at all aware of any such kind of disease and did not consult any cardiologist prior to the present suffering. He further stated that he is neither a smoker nor taking any alcohol and his lifestyle is very simple and requested the insurance company to consider his case favourably. His request was not considered by the insurance company. Being aggrieved, he approached this forum for redressal of his grievance, seeking monetary relief of Rs.5,58,637/-.

We have received the written submissions of the insurer explaining the grounds of repudiation being suppression of material facts. They have repudiated the claim under policy terms and conditions No. 15 (misrepresentation / non-disclosure of the material facts). It is stated that indoor case papers from the hospital shows that the patient had a history of chest pain two years back but insured did not disclose the pre-existing ailments while taking the policy for the first time with the insurance company.

DECISION:

There is no dispute about the fact that the indoor case papers of Apollo Hospital mentions the past history of chest pain but no other supporting documents such as doctor's prescription, medical reports etc. could be produced by the insurer in support of their contention that the insured was suffering from heart problem prior to taking the policy. From the copy of the ECG report done at the time of taking the policy, it is seen that the results were normal and the doctor has noted "normal ECG". The policy was taken on 06.02.12007 whereas he was admitted in the hospital on 02.11.2009 for angioplasty. The insurer could not establish with irrefutable evidence that he had cardiac problem prior to the date of inception of the policy. One single remark of the doctor in the medical history about chest pain does not prove it conclusively that he had preexisting cardiac problem. There is no corroborating evidence in this respect. Even the ECG at the time of taking the policy shows normal results. Insurer had accepted the proposal with the said normal ECG report otherwise they would have excluded this ailment in the policy schedule which they had not done. Now to mislead this forum they cannot take a plea that it was pre-existing and there had been a material suppression of fact on the part of insured. Therefore suppression of material fact is not established in this case.

After evaluation of all the facts and circumstances of the case, we are of the considered opinion that the decision of the insurer is not fair and justified and the same is set aside. The claim of the complainant is genuine and the insurer is directed to admit the same and make the payment as per terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 037/11/008/NL/04/2010-11
Shri Arijit Ghosh
Vs.
Royal Sundaram Alliance Insurance Company Lt

Order Dated : 31.03.2011
Facts & Submissions:

This complaint is filed against partial repudiation of claim under Health Shield Insurance Policy issued by Royal Sundaram Alliance Insurance Company Ltd.

The complainant Shri Arijit Ghosh stated that he was suffering from exertional chest pain with non-critical coronary artery disease with anaemia and he was admitted in AMRI Hospital, Salt Lake, Kolkata on 13.06.2009 where coronary angiography was done on the same day and he was discharged from the hospital on 14.06.2009. Again he was admitted in the same hospital on 19.06.2009 where blood transfusion was done for internal haemorrhoids and he was discharged on 21.06.2009.

He lodged a claim on 07.07.2009 for Rs.33, 964/- to the TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd. for reimbursement of above two hospital expenses. The insurance company vide their letter dated 20.10.2009 paid Rs.16, 982/- towards full and final settlement of the subject claim. He represented to the insurance company on 29.10.2009 against such partial payment stating that the insurance company had settled the amount arbitrarily at 50% of the expenses and returned the cheque for a fair assessment. The insurance company vide their letter dated 06.11.2009 reviewed the claim but confirmed that their settlement of Rs.16,982/- was in order and they are resending the cheque along with detailed deduction letter. Being aggrieved, he approached this forum for redressal of his grievance seeking monetary relief of Rs.16,982/-.

The insurance company in their written submission dated 15.06.2010 has stated that a claim was made by the complainant for expenses of Rs.33, 964/-incurred in connection with his hospitalization for chest pain and anemia from 13.06.2009 to 14.06.2009. However, they allowed only 50% of the admissible amount due to the following reasons.

"*The patient was admitted twice. First admission was for chest pain and 2nd for blood transfusion due to anemia. During first admission, ECG and coronary angiogram were done, which were normal. Blood investigation done shows patient hemoglobin is 6.6 mg% . Clinically chest pain is due to decreased HB%. Patient was unnecessary subjected to coronary angiogram, when ECG was normal. Second hospitalization for blood transfusion due to anemia was evaluated and found to have bleeding internal and external hemorrhoids. This may be the cause of anemia"*

In view of the above, the claim of the complainant for a sum of 50% was considered and a sum of Rs.16, 982/- was paid to the complainant.

DECISION:

It is seen that the insured was hospitalized twice first from 13.06.2009 to 14.06.2009 and again from 19.06.2009 to 21.06.2009. The claim for the first hospitalization was for Rs.19, 567/- and Rs.14, 397/- for the second hospitalization. While the second claim was fully paid, the first was repudiated on the ground that expenses incurred on angiography were not necessary as ECG was normal. This ground of repudiation is totally untenable. We have noted that on the first occasion the patient was admitted on specific advice of the doctor when he suddenly developed chest pain on exertion. After hospitalization certain tests including angiography was done to evaluate his case. Dr. K.B. Baksi's prescription dated 08.06.2009 advises *"urgent admission in a cardiac unit for necessary management"*. Thus it cannot be said that the patient was admitted on his own without doctor's advices. It is a common knowledge that once the patient is admitted in the hospital, he has no control over the procedure and treatments given by the doctors. The contention of the TPA that the patient was unnecessarily subjected to CAG when his ECG was normal is not acceptable

to us. There is sufficient merit in the insured's contention that once he was admitted into the hospital as a patient he had no control over the cost and course of the treatment. It is the decision of the doctor which prevails as he is the best judge of the then situation. We, therefore, find that the decision of the insurer to disallow 50% of the total expenses is arbitrary and without any justification. We set aside the decision of the insurance company and direct them to admit the full claim and settle the same as per terms and conditions of the policy.

LUCKNOW
MEDICLAIM

Case no.G-14/11/09/2010-11

Saurabh Agarwal Vs Reliance Gen. Insurance Co.Ltd.

The complainant's daughter Ms. Rochisha Agarwal slipped and suffered green stick fracture' in her left arm on 10.10.2009 she was taken to Pushpanjali Hospital Agra where 'Osteoclasis reduction plaster under general anesthesia' was done. However the TPA Medi Assist repudiated the claim on the ground that hospitalization was less than 24 hours and as per policy condition the insured person should stay in hospital at least for 24 hours. The complainant's is submission was that the treatment comes under the head 'Day care Treatment' where 24 hours stay is not necessary.

The respondent relied heavily on the policy condition of 'Day Care Treatment' vide policy condition '2' which allows hospitalization for less than 24 hours for disease / treatment such as Dialysis, Chemo therapy, Radiotherapy, Eye Surgery, Dental Surgery, Lithotripsy (Kidney Stone removal), Tonsillectomy, Dilatation and Curetiage, Cardiac Catherization, Hydrocele Surgery, Hernia repair, surgery and surgeries / procedures that require less than 24 hours hospitalization due to advancement in technology. Thus in all fairness it was concluded that the green stick plaster comes under the last category mentioned above. The respondent company was instructed to honour the claim.

MEDICLAIM

Case no.G-02/11/03/2010-11

Ashok Saxena vs National Insurance Co.Ltd.

The complainant's daughter insured under mediclaim policy with respondent company got admitted at Prayag Hospital NOIDA for treatment of respiratory disorder and nose bleeding. After her discharge from the hospital the complainant submitted a claim bill for `46,182/- which was repudiated by the insurer on the ground that treatment was not taken in a network hospital approved by the insurer.

The complainant in his letter written to Divisional Manager has clarified that the patient was admitted in emergency at Prayag Hospital due to acute respiratory disorder with breathlessness and nose bleeding. As per the policy conditions a hospital or nursing home has been specifically defined. The respondent has not disputed that this hospital where treatment was taken does not confirm to the definition of hospital / nursing home as defined in the policy document. As such the claim cannot be rejected if otherwise in order. Therefore the respondent company was directed to honour the claim and settle the same within 30 days.

The complaint was disposed off accordingly.

MUMBAI

THE OFFICE OF THE INSURANCE OMBUDSMAN

(MAHARASHTRA & GOA) MUMBAI

Complaint No. GI 12 of 2010-2011

Award No. IO/MUM/A/ 275 /2010-2011

Complainant : Ms. Sonu Belani
V/s
Respondent: The New India Assurance Co. Limited

Ms. Sonu Belani had taken a Mediclaim Insurance cover of Rs. 2 lakhs from New India for the first time on 10/5/2007. The said policy was renewed for a further period of one year effective from 10/5/2008 to 9/5/2009 and a Policy bearing No. 110800/34/08/11/00002484 was issued to her. However, the said policy was cancelled immediately by the Insurance Company due to dishonour of the cheque by the drawee's bank for want of funds. Thereafter, Ms. Belani proposed for a fresh cover on 12/6/2008 by paying the premium in cash. The said policy was renewed for a further period of one year vide Policy bearing No. 110800/34/09/11/00003967 valid from 12/6/2009 to 11/6/2010.

Ms. Belani lodged a claim for Rs. 26,186/- under the renewed policy in respect of her hospitalisation from 2/9/2009 to 11/9/2009 at Dr. Desai's Sushrut Clinic for complaints of severe back ache. As per the hospital's discharge summary, she was diagnosed as Acute PID L5-S1. The TPA on processing the claim, found that the claim was inadmissible as per exclusion clause 4.3 of the Policy and conveyed their decision accordingly to the Insured vide their letter dated 15/3/2010.

The facts under this claim are fairly straight forward. As per details/documents submitted by the Insurance Company, the Insured/Complainant issued premium cheque bearing no. 990927 dated 7/5/2008 drawn on United Bank of India for renewal of her Mediclaim policy which was received by the Insurance Company on 7/5/2008. The same was accounted by the Company on 10/5/2008 and premium cheque was presented to the Company's banker i.e. Corporation Bank on the same day. Cheque was returned by the drawee's bank i.e. from United Bank of India on 16/5/2008 for want of funds and the dishonoured cheque with Banker's remarks was received by the Company on 20/5/2008. The policy was immediately cancelled ab-initio on 20/5/2008 vide endorsement no. 110800/34/08/11/84000030. The Insured was intimated about the cheque dishonour and cancellation of the policy through registered AD letter dated 20/5/2008. The insured proposed for fresh insurance only on 12/6/2008 resulting into a break in continuity of the policy by about 1 month.

It is observed from the medical papers that Smt. Belani was treated for Acute PID at Sushrut Clinic on 2/9/2009. The Insured's policy was in operation for two years and the claim has been preferred in the second year of the policy. Since PID was specifically excluded during the first two years of the policy operation, the claim was repudiated invoking the relevant clause which appears to be in order.

Dated at Mumbai, this 5th day of October, 2010.

8.10.2010 Mediclaim

Complaint No.GI-415 of 2009-2010
Award No.IO/MUM/A/287/2010-2011-8.10.2010
Complainant : Shri Sharadchandra N. Risbud
Respondent : National Insurance Co. Ltd.

Shri Sharadchandra Risbud was covered under Mediclaim Policy issued by National Insurance Co. Ltd. with exclusion "ACCIDENT IN SEPT 2003 INJURY TO RIGHT LEG STEEEL ROD IS FIXED IN LALWANI HOSP." Shri Risbud was hospitalized for Subtrochanteric Fracture Right Femur and underwent Interlocking IM nailing with bone grafting. When complainant lodged a claim under the Policy, Insurance Co. rejected the same under exclusion clause appearing on the policy. Not satisfied with the decision of the TPA, complainant represented to them by stating that – he underwent surgery in September 2003 which was honestly declared in the proposal form. In September 2005, implants fixed in the year 2003 were removed. In June, 2006, he had a fall in Madras and admitted in Sundaram Medical Foundation and the same was immediately informed to the Office of TPA, Madras. Complainant stated that the episode of fall in Madras was an accident and no way related to the history of past surgery of the

year 2003. Insurance Company however maintained their stand. Being aggrieved complainant approached this Forum.

It was noted that the complainant had the history of accident in the years Septembers 2003 and underwent DHS fixation. It was noted that the discharge card had a mention of h/o fall. In the present case, since the complainant underwent entirely new episode of fall, it was held that the fracture resultant from the same cannot be solely termed as pre-existing or complication of earlier fracture.

It was also observed that the implants fixed in the earlier surgery were removed in the year 26.9.2005 i.e. four months prior to the current surgery. As per the information available on Internet, the removal of the dynamic hip screw is usually not adhered to due to the increased risk of re-fracture after implant removal. In the present case, the complainant underwent the fracture immediately four months after removal of DHS. On discharge, the complainant was advised medication of Tab. Osteophos 70 mg once a week for 6 weeks. Osteofos 70 (Generic Fosamax 70mg) once in a week is used to treat osteoporosis.

Thus considering the information downloaded from the internet site, removal of DHS and Osteoporosis are the risk factors to cause the fracture. However, in the hospital papers, the episode of accidental fall was clearly mentioned and there was no document on record to conclusively proof that complainant was suffering from Osteoporosis. Under the circumstances, benefit of doubt was awarded in favour of the complainant to the extent of 50% of the admissible expenses.

THE OFFICE OF THE INSURANCE OMBUDSMAN

(MAHARASHTRA & GOA)MUMBAI

Complaint No. GI 888 of 2009-2010

Award No. IO/MUM/A/300/2010-2011

Complainant : Shri K.Nagraj Shetty
V/s
Respondent: The Oriental Insurance Co. Limited

Shri K. Nagraj Shetty along with his wife were insured under an Individual Mediclaim Policy with the Oriental Insurance Company valid from 5/12/2007 to 4/12/2008 for a sum insured of Rs. 4 lakhs each.

In the following year, Shri Shetty was hosptialised at Wockhardt Hospital from 14/8/2009 to 21/8/2009 for Acute MI (Anterior Wall) in a k/c/o HTN. The Insured's claim for reimbursement was repudiated by the TPA of the Insurer, M/s. Raksha TPA, as per exclusion clause 4.3.on the ground that medical papers of Wockhardt Hospital clearly reveal that the Insured was a known case of HTN and for reimbursement of expenses for treatment of HTN a waiting period of 2 years is applicable. Further, HTN being a known

risk factor of heart related ailments, the present illness is a complication of pre-existing HTN and hence the claim was inadmissible. Not happy with the decision, Shri Shetty represented to the Company for review and not getting any favourable reply, he approached the Office of the Insurance Ombudsman for redressal of his grievance.

Analysis of the case reveals that Shri Nagraj Shetty was first covered under Mediclaim Policy from 10/12/2007 at the age of 59 yrs. As per the underwriting practice of the Company he was evaluated through medical/pathological tests for which M/s. Expert Medicolegal Consultancy was authorized by Oriental Insurance to send a suitable medical report. It is closely observed from Expert Medicolegal Consultancy's report that the conclusion drawn was Prostate Enlargement from USG Report and Old Fracture of Upper and of Right Tibia as per the X-ray of Both Knees which were suggested to be specifically excluded together with its consequences. However, it is observed that the Policy was issued without any exclusions to Shri Shetty reflecting the casual manner of policy underwriting.

The dispute is regarding pre-existence of HTN for which Shri Shetty was under medications as per the hospital records. It is necessary to examine how far the contention of the TPA and the Company would be valid to sustain their rejection.

Shri Shetty was admitted to Wockardt Hospital on 14th August, 2009 for chief complaints of sudden onset of chest pain, severe in intensity, radiating to left arm, scapula bilateral along with sweating and palpitations. The discharge summary of Wokhardt Hospital in respect of hospitalization for which the present claim was preferred mentioned the diagnosis as Acute MI (Ant. Wall) in a k/c/o HTN. Past History mentioned k/c/o HTN on medications. His BP was recorded as 140/104 mmHg. It was also mentioned that he had a history of Aspirin Intake + Losartan+Hydrochlormiazide and Atorvastatin. Coronary Angiography done revealed severe Left Anterior Descending Artery revealed Proximal LAD 80% Stenosis, Distal LAD 90% stenosis, Left circumflex artery OM2 showed 80% Ostial and 90% mid stenosis. The conclusion as per the CAG Report was Severe LAD and OM disease. In the column of Plan of action it was mentioned "relatives not willing for intervention". He was medically managed and discharged from the hospital on 21/8/2009.

The medical analysis of the case out of the hospital recordings would reveal that first of all the ECG indicates signs of Hyperacute, Anterior Wall Myocardial Infarction. The 2D Echo suggested he had a poor Left Ventricle Ejection Fraction which was mentioned as only 20% together with severe Hypokinesia. Discharge summary as well as Indoor case papers of the hospital clearly record that Insured was already on some medications for HTN. Further, CAG revealed Proximal LAD and Distal LAD Stenosis of 80% and 90% respectively which bore evidences

to having stenosis of severe nature which would be of evolving and developing nature over a period. Long standing hypertension would evidently be a favourable factor to cause the same. It therefore, follows that there was sufficient documentary evidence to establish the pre-existence of the disease.

The complainant countered the rejection of the claim stating that he did not suffer from hypertension as substantiated by the pre-insurance health check up report. Further, the history in the hospital papers were wrongly entered. His treating doctor, Dr. D.K. Kumbla, vide certificates dated 17/12/2009 and 22/12/2009 certified that "Shri Shetty did not have any previous history of HTN/DM and that he was treated for Acute Myocardial Infarction and in his case, HTN was not the cause. Further, his previous medical history was Nil.

It is a known fact that the patient or his relative inform the past medical history of the patient to the attending doctor at the time of admission to the hospital for proper diagnosis and treatment of the illness. Such history given to the doctor is recorded in the hospital case papers. In the instant case, the case papers recorded Shri Shetty had a h/o HTN for which he was on medications. Apart from that it was also mentioned that he had h/o of aspirin intake and three other medicines were noted which are proven drugs for HTN and High Cholesterol. In the face of the above recordings in the discharge summary/ Indoor case papers of the hospital, it is difficult to accept the certificate of the treating doctor which appears to have been issued based on the request made by the Insured consequent upon the rejection of the claim.

As regards, the complainant plea that his pre-insurance medical reports were all normal, it should be noted that if the Insured was under medications for some ailment, the test results would obviously show normal results for the same. Therefore, the defence taken by the complainant, that the reports were normal and therefore, he was eligible for the claim is not tenable.

Based on the documentary evidence, as examined above, the stand of the Insurer to reject the claim under exclusion clause 4.3 cannot be faulted.

Dated at Mumbai, this 14th day of October, 2010.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)

MUMBAI

Complaint No. GI 442 of 2010-2011
Award No. IO/MUM/A/ 370 /2010-2011

Complainant: Shri khushroo Rusi Ghaswalla
V/s
Respondent: United India Insurance Company Limited.

Shri Khushroo Rusi Ghaswalla along with his family members were covered under an Individual Mediclaim Policy bearing No. 020901/48/09/97/000001742 valid from 10/11/2009 to 9/11/2010.

On 18/12/2009, the Complainant's daughter, Ms. Parinaz Ghaswalla was hospitalized at Mehta International Eye Institute, Mumbai for complaints of blurred vision, distortion while driving and problem with working on the computer since 3 months. She was diagnosed with Very High Myopia in both eyes for which she was advised Lasik Laser Vision Correction. A claim preferred for Rs. 45,000/- was repudiated by the Insurer on the ground that cosmetic/aesthetic of any description such as correction of eye sight was not admissible under the policy as per exclusion clause 4.3. The attending doctor, Dr. Cyres K. Mehta under whose care Ms. Parinaz Ghaswala was admitted certified that Ms. Ghaswala was suffering from High Myopia and the lasik surgery was done to save further loss to her eye sight and it was not at all a cosmetic or aesthetic surgery. He mentioned that the eye surgery was also not performed for the correction of eye sight but to get rid of her blurring and distortion of vision which was affecting her job performance.

It is recorded in the discharge card of the Hospital that Ms. Ghaswalla had blurred vision, distortion of vision at night while driving and also while working on the computer and she was a case of very high Myopia, which is a severe visual disability. Her spectacle prescription for Distance Spherical was mentioned as minus 8 in the right eye and minus 10 in the left eye.

People who have minus number glasses more than 6 diopter in power are said to have high or pathologic myopia. The eyeball in such cases is enlarged leading to thinned out coats of the eyeball so the central area may be very weak (chorioretinal degeneration) leading to poor vision. The retina in these eyes is weak in the periphery also and usually has some degeneration, atrophic holes, or even retinal tears. These retinal holes or tears may sometimes lead to a serious condition of retinal detachment, leading to sudden loss of vision, and may require major surgery urgently to settle the retina.

It is clear from the medical records that in the instant case the surgery was necessitated to deal with optical ailment which was disabling the person. Hence for no reason it can be termed as treatment for cosmetic or aesthetic reason. The decision of the Insurance Company is intervened by the following order.

Dated at Mumbai, this _25th day of November, 2010.

27.12.10Individual Mediclaim

Complaint Nos.GI-657 of 2010-2011
Award No.IO/MUM/A/ 417/2010-2011
Complainant : Shri G.C. Garg
Respondent : The Oriental Insurance Co. Ltd.

Smt. Asha G. Garg, spouse of the complainant was covered under Individual Mediclaim Policy issued by The Oriental Insurance Co. Ltd. Smt. Garg was diagnosed a case of disc prolapse at C3.4.5.6.7 and underwent Nerve Root Injection + Facet Block Paravertebral on 29.12.2009 & 29.1.2010 at P.D. Hinduja National Hospital & Medical Research Centre. Insurer rejected the claim under clause 2.3 of the Policy. Being aggrieved, Shri Garg approached this Forum. The parties to the dispute were heard during the personal hearing. A serious note of the lackadaisical approach of the Insurance Company was taken as it was noted that in spite of sending well in advanced notice dated 23.8.2010 for Submission of the Written Statement, their Office failed to submit the same. Further, in spite of serving well in advanced notice for personal hearing, their Official could not defend the case on the pretext of lack of information/data. During hearing the Insurance Company was directed to send their Written Submission.

In the Written Submission, it was stated that insured had taken OPD treatment which was for less than 24 hours and as such the claim was rejected under clause 2.3 of the Policy which states that "Expenses for hospitalization are admissible only if hospitalization is for minimum 24 hours". Complainant however was of the view that his wife was treated by highly qualified specialist doctor in a reputed Hospital having latest equipments. He also argued that this is a special type of Pain Management treatment which is possible only in the Hospital and as per clause 2.3 © of the Policy due to advancement in medical technology, 24 hours' hospitalization is not required.

The analysis of the entire case revealed that although the treatment was taken in the reputed Hospital there was no admission in the hospital as an inpatient as was evident from the bill raised by the Hospital where the Patient Type was stated as – "Clinic". Although, the treating doctor had mentioned that the treatment needs to be taken only in the hospital, but in the MMR report he certified that the said treatment does not require hospitalization. Further, the treatment given was only injections.

Observations : Mediclaim Policy basically grants reimbursement of hospitalisation expenses under certain conditions and in all these cases, the hosptialisation as such is not compromised but only relaxation of minimum period of hospitalisation is granted to specific treatments in view of lesser time taken now for the treatments as compared to earlier times due to advancement of medical science. In the instant case, the basic criteria of Hospitalisation itself was not fulfilled. Also, the claim did not qualify under the waiver of 24 hours hospitalisation, as again the criteria of hospitalisation itself was not fulfilled.

Under the circumstances, the decision of the Insurance Company to reject the claim was upheld.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI 472 of 2010-2011
Award No. IO/MUM/A/ 447/2010-2011
Complainant: Shri Raman Narayan
V/s
Respondent: Oriental Insurance Co. Limited

Shri Raman Narayan took a Traweltag Policy bearing No. 121800/48/2009/10244/WR/WAI/BR/6/HRM/1220633 valid from 4/7/2009 to 20/11/2009 issued by Oriental Insurance Company Limited from his travel agent covering his study trip to France and USA . After around 40 days of his overseas trip, whilst in Michigan, he developed acute back pain and problems of evacuation. He sought medical assistance from the University of Michigan Hospitals for the above referred physical discomforts. He was referred to various Specialists and underwent all sorts of procedures and diagnostic test as per US practices commencing from 24/8/2009 to 1/10/2009.

During his treatment, he kept in touch with Coris Miami for prior approvals for the treatment which was apparently not given and later the TPA, Heritage-Mumbai gave their repudiation letter dated 9th October,2009 rejecting the claim on the grounds that complaints had started 1-2 months back. His representations made to the Insurance Company did not evoke any response for which he approached the Insurance Ombudsman praying for release of payment to University of Michigan Hospitals, aggregating to US $ 9385 towards diagnostic expenses and US$ 3813 for professional charges as also release of medical expenses incurred by him in India for treatment. On going through the various medical records produced to the Forum it is observed that the complainant was presented to the Michigan University Hospital on 24/8/2009 and he was diagnosed to be suffering from severe spinal stenosis with internal and external haemorrhoids and atypical lipoma versus low grade liposarcoma. In the case papers there is a mention of the insured's past history of the ailments of approx. 1-2 months duration.

The scrutiny of the medical records coupled with the investigation reports and treatments recommended throws light to the fact that all the 3 ailment were suggestive to be of a longer duration than between 1-3 months as recorded in the case papers. This view emerges from the impression of the MRI report of the Spine done giving the findings as 'Spine Stenosis'/'advanced degeneration' and revelations of multiple polyps and external and internal haemorrhoids from the Cystoscopy done and the size of the mass in the left thigh which are no doubt a progressive process over a period of time. It is also noted that the complainant was aware that the problems were existing, although not diagnosed, prior to taking the Insurance Policy, since he narrated his past complaints precisely to the consultants which were duly recorded in hospital case papers. Hence to that extent it was not only within the knowledge of the Insured but also a pre-existing condition.

The nature of coverage of the policy, makes it necessary to incur the medical expenses for a sudden and unexpected sickness or accident arising when the Insured Person is outside the Republic of India. The claim also attracts our attention on the pre-existing exclusion and condition.

Strictly as per the policy conditions, the Insurance Company's standpoint that the ailment was pre-existing is acceptable, however, the whole issue being a borderline case with symptoms occurring for 1-2 months as recorded in the hospital papers, would be just before the policy was taken coupled with the fact that the ailment was not identified or diagnosed before and there being no past surgical history or medications taken except a haemorrhoid steroid cream for painful bowel movement as per records, the case deserves some consideration and therefore, 50% of the admissible expenses should be reimbursed in respect of two ailments denied by the Insurance Company for which he availed treatment abroad.

As regards, the complainant's plea for reimbursement of medical expenses incurred in India for Spine surgery under the said policy, Specific condition No. 7 of the Policy is clear to mention that "no claim shall be paid under the policy in respect of medical treatment and related services obtained within the republic of India except as stated."

Dated at Mumbai, this 10th day of January, 2011.

18.01.2011 Mediclaim

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI
Complaint No. GI-1110/2009-2010
Award No. IO/MUM/A/457/2010-11 dt. 18.01.2011
Complainant: Shri Jitendra Chokshi
Respondent: The New India Assurance Company Ltd

Shri. Jitendra Chokshi along with his wife Smt. Sushila J. Chokshi was covered under Mediclaim Insurance Policy(2007) No. 111200/34/08/ 11/00013330 for the period 23.12.2008 to 22.12.2009 for SI of Rs.1,00,000/- plus 45% CB each, issued by The New India Assurance Co. Ltd. Smt. Sushila was admitted to Sunflower Nursing Home, Mumbai from 08.08.2009 to 13.08.2009 for 1st degree Uterine Prolapse with Cystocele & Rectocele and underwent Colpo Vaginal Hysterectomy with Ant. & Post. Colpoperineorrhaphy. The claim preferred for Rs.88,752/- under the policy was settled for Rs.25,069/-. Shri Chokshi's representation to the TPA/Insurance Company against the short-settlement elicited no positive response. Being aggrieved he approached this Forum for intervention of the Ombudsman for settlement of the balance claim amount.

A joint hearing was scheduled to be held with the parties to the dispute. However no official from the Insurance Company appeared for deposition. Shri Chokshi submitted that he was not aware of any such condition in the policy restricting reimbursement of payment if made by cash and had made the entire payment to the hospital in cash. However he was issued separate bills by the hospital, surgeon and anesthetist. He

pleaded that Dr. Tushar Shah who performed the surgery was a panel surgeon of the hospital and requested for payment of the amount deducted from Surgeon charges. The Insurance Company vide their written statement dt. 07.01.2011 submitted that as per Clause 2.1 Room rent + Nursing charges are payable up to 1% of SI. Hence Rs.14,100/- has been deducted. O.T. charges are payable as per entitled Room category; hence Rs.7,333/- has been deducted. Surgeon and Anesthetist fees paid in cash will be reimbursed up to a limit of Rs.10,000/- under policy condition no.2. Hence Rs.40,500/- has been deducted on this count.

The analysis of the entire case revealed that the surgeon and anesthetist's fees were not raised through Hospital as required as per Note 2 to clause 2.3 of the Policy. Ignorance of the terms and conditions of the policy as pleaded by the complainant, does not make the terms, conditions and exclusions inoperative. It should be noted that whenever any dispute arises it is settled based on the terms & conditions of the policy. However, it appears that the Insurance Company, on receipt of number of such complaints decided to give some relief to such complainants and it was decided that fees paid by cash may be entertained up to a limit of Rs.10,000/- only, provided the surgeon/anesthetist provides a numbered bill. In view of the same, Insurance Company settled these fees for Rs.10,000/-. It is however felt that since two different services were rendered by two separate doctors, Insurance Company should consider the fees of anesthetist and surgeon separately and since the payment was effected in cash, the individual limit of Rs.10,000/- should be applied to each. As such, complainant should be paid additional Rs.8,000/- towards reimbursement of anesthetist fees.

Further, no material viz. Rate list of the hospital was produced on record by the Company to show that O.T. charges varied with the category of room and the amount of actual O.T. charges applicable to the category of room opted by the patient. In view of the same there appeared to be no justification in deducting these charges in proportion to the room rent for the entitled category. "Operation Theater Service Charges" would however not be payable in view of the clear-cut exclusion mentioned under clause 4.4.22 of the policy as regards Service charges as these are essentially hospital costs which are deemed to be kept out of the purview of the medical costs necessarily incurred in connection with the diagnosis and treatment of the diseases. Also the deduction from Room rent appeared to be in order being as per express policy condition no.2.1 which restricts room and nursing expenses to 1% of the SI (without CB) per day. Under the circumstances the Company was directed to reimburse Rs.8,000/- towards anesthetist's fees and Rs.7,333/- deducted from Operation theatre charges, over and above the settlement already made.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI- 651 of 2010-2011
Award No. IO/MUM/A/470/2010-2011

Complainant: Smt. Rani Hashu Vazirani
V/s

Respondent: The New India Assurance Co. Ltd.

Complainant, Smt. Rani H. Vazirani, lodged a complaint with this Forum against New India Assurance Co. Ltd., in the matter of non-settlement of Personal Accident Death Claim of her husband, Late Shri H.H. Vazirani following an accidental fall in the temple. Late Shri. Vazirani was covered under New India's Personal Accident Insurance Policy bearing No. 111900/42/09/01/00000111 for a sum insured of Rs. 1 lakh under Table A and Rs. 2 lakhs under Table D with accrued CB of 50% issued for the period from 24/4/2009 to 23/4/2010. A claim preferred by the complainant under the PA Policy for accidental death was repudiated by the Insruance Company stating that the insured was not having gainful income and as post mortem was not done, the exact cause of death was not known.

On detailed analysis of the case together with the records submitted it is observed that the complainant's husband slipped in the temple on 11/10/2009 and was admitted to Railway Hospital for Head Injury on 14/10/2009. Conservative treatment was given to him there and he was advised to be shifted to a government hospital for Neurosurgical evaluation. However, complainant did not act as per the advice given and shifted her husband to Hinduja Hospital on 15/10/2009. Hinduja Hospital papers revealed Shri Vazirani was managed conservatively for head injury and a repeat CT Scan of the brain done on 22/10/2009 revealed that the extra axial hypodense collection had reduced since previous study done on 15/10/2009. From the notings in the indoor case papers it is seen that he developed complaints of chest pain on 20/10/2009 and then on, his condition went on deteriorating. His LVEF was monitored which was not favourable meant failing of the heart. He was shifted to the ICU and started on NTG and Lasix. He had labored breathing and was not responding to Lasix. A decision for haemodialysis was taken and he had sudden hypotension with bradycardia and became unresponsive. Cardio pulmonary resustitation started but he could not be revived. He was declared dead on 28/10/2009. The final diagnosis in the discharge summary was mentioned as Cardiac Failure with Renal Failure with recent sub-dural haemorrhage with HTN with IHD.

As per terms & conditions of PA Policy, the risk covered is bodily injury resulting solely and directly from accident caused by external, violent and visible means and such injury shall be the sole and direct cause of death of the insured. In the instant case, medical papers strongly suggest that death was caused due to renal and heart failure. The past history notings of k/c/o chronic renal disease, Myocardial Infarction, HTN for which he was on treatment/medications as also the death certificate which mentions the immediate cause of death to be cardiac failure due to renal failure corroborate the above fact.

In the instant case, there were no such presenting symptoms recorded as per the railway hospital papers except pain and it was recorded that he was presented with bifrontal headache not associated with visual blurring, loss of consciousness and vomitting at Hinduja Hospital which was managed only conservatively and had also shown considerable reduction after the treatment. Therefore, the claim does not strictly fall within the ambit of the Personal Accident Policy – death cover.

However, the fact remains that admission to the hospital was necessitated consequent to the accidental fall and he died in less than 15 days after the episode and

hence it can be said that the fall resulting into head injury had, to some extent, contributed to his subsequent complications and death. Taking a considerate view of the whole case as also reckoning the long association of the Insured with the Insurance Company I am inclined to give some relief to the complainant for which the following order is being passed.

Dated at Mumbai, this 28th day of January, 2011.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI- 88 of 2010-2011
Award No. IO/MUM/A/ 479 /2010-2011

Complainant: Shri Nilesh M. Gala
V/s
Respondent: The New India Assurance Co. Ltd.

Shri Nilesh M. Gala along with his wife and daughter were covered under an Individual Mediclaim Policy bearing No. 140400/34/08/11/00002502 valid from 28/7/2008to 27/7/2009. Shri Gala was hospitalized at Dr. Ashesh C. Bhumkar's ENT Hospital from 11/12/2009 to 12/12/2009 for Left Ear Ossiculoplasty with Titanium Chain Prosthesis under general anaesthesia. A claim preferred by him for Rs. 42,431/- incurred by him for the above procedure was partially settled by the Insurance Company disallowing the cost of Titanium Chain Prosthesis amounting to Rs. 18,000/- as per exclusion clause 4.4.4

Analysis of the case reveals that the main dispute is only the disallowance of cost of prosthesis implanted in his left ear which was very essential for his hearing. The expenses for basic treatment received by him during hospitalisation was admitted by the Company under the terms of the policy which was accepted by the Insured.

The Insurance Company took shelter under excl. 4.4.4. to disallow the cost of titanium prosthesis since spectacles, contact lenses, hearing aids, wheel chair and similar other external apparatus are not designed to be paid under the policy. However, they have not provided any medical substantiation in support of their rejection.

On the other hand, the complainant, Shri Gala obtained opinion from two other ENT surgeons in addition to the treating doctor's certificate as also submitted medical information on the subject to counter the company's contention.

From the clarifications provided by the ENT Surgeons as also from the information provided about cochlear implant, hearing aid and titanium prosthetic, it would be reasonable to conclude that the said device is an internal prosthetic of ossicular chain implanted in the middle ear of the patient to improve his hearing. The metal used in the prosthetic has favourable characteristics including immunity to corrosion, high bio-compatibility, strength and high capacity for joining with the bone of the ear and

other tissues and may be implanted for an extensive length of time. In fact it is akin to occular lens and pace maker implanted inside the human body, cost of which are admissible under the Mediclaim policy.

In the facts and circumstances, the rejection of the cost of titanium prosthetic chain by the Insurance Company is not tenable.

Dated at Mumbai, this 2nd day of February, 2011.

21.2.2011

Complaint No. GI- 747of 2010-2011
Award No. IO/MUM/A/509/2010-2011-21.2.2011
Complainant : Smt. Kamla Ghanshani
Respondent : New India Assurance Co. Ltd.

Smt. Kamla S. Ghanshani was covered under Mediclaim Policy (2007) issued by The New India Assurance Co. Ltd. for Sum Insured of Rs.3,00,000/- with CB Rs.1,50,000/-. She underwent Left Total Knee Replacement surgery in Lilavati Hospital. Her claim of Rs.3,65,186/- was settled for. Rs.2,97,801/-. As this amount was not agreeable to the complainant, when she represented to the Insurance Company, a further sum of Rs.2,199/- was paid her. Whilst adjusting the claim, Company reduced surgeon's fees of Rs.1,30,000/- to Rs.75,000/- and disallowed Rs.55,000/- on the ground that the said fees was not forming a part of main hospital bill and hence only 25% of the Sum Insured was considered, as the payment was made in cheque. Being aggrieved complainant approached this Forum. The parties to the dispute were heard during personal hearing.

The analysis of the case revealed that surgeon's fees were not raised through Lilavati Hospital where the complainant was operated and she made direct payment of Rs.1,30,000/- to Dr. Rajesh Maniar as surgeon and asst.'s fees. Company reduced the surgeon fees based on Clause 2.3 of the Policy states as :" "Following reasonable, customary & necessary expenses are reimbursable under the Policy : Surgeon, Anesthetist, Medical Practitioner, Consultants' Specialist fees." Further, it is mentioned that "No payment shall be made under 2.3 other than part of the hospitalisation bill".

It was noted that New India on receipt of number of such complaints decided to give some relief to such complainants, stating that if the payments are made by cheque and a proper numbered receipt is given by the surgeon/anesthetist, then the same can be considered for payment upto the limit of maximum of 25% of the Sum Insured even if the payment is made directly to the doctors and not raised in the main hospital bill. In the instant case, it was noted that since the fees of Dr. Maniar were paid by cheque, Insurance Co. settled the same at 25% of Rs.3,00,000/- which was the Sum Insured indicated on the Policy. However whilst adjusting this amount, an amount of Rs.1,50,000/- indicated on the Policy as Cumulative Bonus was not added to the Sum Insured of Rs.3,00,000/-.

Observations : In case of any claim under the Policy, Company's maximum liability under the Policy is arrived at by adding the Cumulative Bonus earned by the

insured to the Sum Insured indicated on the Policy. Whilst adjusting the claim, except for room rent, all other expenses are payable upto the limit of Sum Insured indicated on the Policy including CB earned by the Insured. In view of the same, the decision of the Company to restrict the surgeon fees to 25% of the Sum Insured, without considering CB amount was held as not tenable.

Complainant was given relief to the extent of 25% of Rs.4,50,000/- (Sum Insured Rs.3,00,000/- + CB Rs.1,50,000/-). The disallowance of Rs.585/- being non medical expenses & Rs.1,000/- on the ground that X-ray report not submitted was held as correct.

24.2.2011 Mediclaim

Complaint No.GI-802 of 2010-2011

Award No.IO/MUM/A/517/2010-2011-24.2.2011
Complainant : Shri Mehernosh Daroga
Respondent : The Oriental Insurance Co. Ltd.

Smt. Aloo Daroga, spouse of the complainant who was covered under Mediclaim Policy issued by The Oriental Insurance Co. Ltd. was hospitalised in The B.D.Petit Parsee General Hospital from 15.10.2009 to 4.11.2009, where she was diagnosed a case of Vertigo. Insurance Company repudiated the claim under clause 2.3 of the policy which states that procedures/treatments done in OPD basis are not payable even if converted to IPD. Being aggrieved Shri Daroga approached this Forum. His plea was that his wife was admitted to the hospital in an emergency for severe vertigo under the advice of highly qualified doctor. He also stated that Policy does not exclude the treatment taken for Vertigo. Parties to the dispute were heard during the personal hearing.

Observations : Vertigo can be caused by decreased blood flow to the base of the brain. Any signs and symptoms of vertigo warrant an evaluation by a doctor. Certain signs and symptoms of vertigo may require evaluation in a hospital's emergency department: viz. double vision, headache weakness, difficulty in speaking, abnormal eye movements, altered level of consciousness, not acting appropriately, difficulty in walking. Vertigo can be caused by problems in the brain or the inner ear. The word "ischemic" indicates a loss of blood supply to a particular region of the body. (taken from internet site) The analysis of the case revealed that at the time of admission in the Hospital, Smt. Daroga had presenting symptoms of giddiness, difficulty in walking/standing, weakness, lower back pain and also had history of falls several time since last 10 days. During hospitalization detailed investigations were also done. The Brain MRI report revealed – "mild fullness of ventricle and sulci atrophic in nature and bilateral para ventricular deep white matter T2 and FLAIR hyperintensities are ischaemic in nature".

It was observed that it would be illogical to ask the 67 years' old hypertensive patient who had history of several falls in past few days and suffering from giddiness, weakness to not to get admitted to the hospital. Nobody would take a chance of keeping such patient at house and go on treating her without proper evaluation of the health status.

Further, if the patient is taken to a hospital, the decision as to whether to treat him/her in an OPD or to admit her in the hospital would always be a prerogative of the doctor attending him/her and the same is also dependent on his/her presenting symptoms/complaints. In the instant case Smt. Daroga had presenting symptoms and in that context hospitalisation was justified. As regards the issue of treatment received, the most appropriate investigations would be essential for deciding the course of treatment and unless those are done, even the diagnosis is not full-proof. Although, it was accepted that during the course of entire hosptialisation, Smt. Daroga was treated with only medicines and hot water bag treatment, but considering her age, the presenting symptoms at the admission and the very fact that she was hypertensive, the decision of the Company to out rightly reject the claim stating that the treatment was possible on OPD basis was held as not tenable.

Insurance Company was directed to settle the claim.

3.3.2011 Mediclaim Family

Complaint No. GI-877/2010-2011
Award No. IO/MUM/A/ 532/2010-11-3.3.2011
Complainant: Shri Amit Sukhadare
Respondent: United India Insurance Co. Ltd.

Smt. Anvee Sukhdare, wife of the complainant was covered under Mediclaim Family Floater issued by United India Insurance Co. Ltd. to M/s Previlage Hospitality P. Ltd. A/c Amit D. Sukhdare for Sum Insured (Floater basis) of Rs.50,000/-. Shri. Sukhdare approached this Forum with a complaint against United India stating that TPA and Insurance Company rejected his claim of Rs.19,802/- lodged under the policy in respect of Maternity expenses incurred on his wife's delivery (FTND) in Mother Care Clinic and Nursing Home, where she was hospitalized from 30.5.2010 to 2.6.2010 on the ground of non-intimation of hospitalization.

The parties to the dispute were heard during the personal hearing. On scrutiny of the documents, it was noted that United India had issued a specific tailor made policy to M/s Previlage Hospitality P. Ltd. who were in the business of providing time share holidays to its members and also providing Health, Personal Accident and Fire Insurance to them. In the present case, it appeared that although an immediate notice of the claim was not given by the complainant to the TPA but the claims papers were submitted on on the third day from the date of discharge. Thus, it was observed that although the complainant had violated policy condition 5.3 but condition 5.4 was fulfilled by him by submitting the claim papers in time. Insurance Company's decision to deny the claim on the ground that no intimation of hospitalization was given, was held as not tenable.

Further, the perusal of the policy conditions for Silver Plus Plan revealed that for Maternity claim, the Company's liability was restricted to 10% of the Sum Insured subject to maximum Rs,20,000/- or actual claim amount whichever is less. However, during hearing complainant produced brochure issued by M/s Previlage Hospitality Pvt. Ltd. wherein the benefits towards Maternity claim were stated as : "maximum upto Rs.20,000/- or claim amount whichever is lower". Thus, an obvious discrepancies were observed in the documents produced by the Company and the complainant as regards the

limit of indemnity for Maternity claims. The Company clarified that the terms & conditions were given to M/s PHPL and the limits of indemnity indicated in the clauses of the Policy were the exact indemnity limits and not as shown in the brochure issued by M/s PHPL. The complainant however raised an issue that he was given only the brochure and he was not aware of the terms & condition of the Insurance Company.

Observations : It should be noted by the Insurance Co. that whenever a Group Mediclaim Policy is issued, it is their duty to ensure that all the members covered under the Policy are well informed about the exact terms & conditions. Insurance Co. should not simply shirk their responsibility by stating that the terms and conditions were given to the master policy holder. As regards the issue of brochure, it is expected that the Insurance Co. should make it a point whilst entering into an MOU with master policy holder that no brochures will be issued without permission & approval of the Insurance Co. and in case any such brochure is floated in the market an immediate appropriate action is taken. Considering these facts, the complainant should not be penalized for the commission and omission of the Master Policy holder in absence of any concrete proof that the policy terms & conditions were made known to him. The complainant was therefore awarded expenses upto an amount of Rs.19,802/-.with advices to the. Insurance Co. that they may recover the excess amount of liability from M/s PHPL, as deem fit.

9.3.2011

Complaint No. GI- 742 of 2010-2011
Award No. IO/MUM/A/534 /2010-2011-9.3.2011
Complainant : Shri. Tarun Rai
Respondent : The Oriental Insurance Co. Ltd.

Shri. Tarun Rai availed Overseas Mediclaim Insurance Policy through M/s Travel Tag. The said policy was issued by The Oriental Insurance Co. Ltd covering his mother Late Smt. Satya Mehta Rai during the period 4.4.2009 to 30.9.2009 with Certificate Exclusions of "Medical Expenses section restricted upto US$10000 including Hospitalization due to an accident. Hypertension." The claim arose under the Policy when Smt. Rai during her stay abroad was admitted to South Warwickshire General Hospital NHS Trust from 10.7.2009 to 21.7.2009 where she was diagnosed a case of Biventricular failure with global poor RV and LV and the secondary diagnosis and co-morbidities were mentioned as "Asthma, Ovarian Ca, Hypertension". Smt. Satya Rai succumbed to her illness and expired on 6th September, 2009 at Warwickshire. When complainant lodged a claim of UK pounds 6889 towards the expenses incurred on medical expenses, hospitalization expenses and funeral cost, the same was denied by M/s Heritage Health TPA Pvt. Ltd., TPA of the Insurance Company by stating that the ailment suffered by the insured is a direct complication of past medical history of hypertension, which is excluded from the scope of policy coverage. Being aggrieved complainant approached this Forum. The parties to the dispute were heard during the personal hearing. Complainant contested that in the opinion of the doctors the ailment suffered by his mother was not the result of pre-existing condition of hypertension.

Observations : The analysis of the case revealed that the coverage under Medical Expenses cover was intended for use by the person insured under the Policy in the event of sudden and unexpected sickness or accident arising when he/she is outside the

Republic of India, which included expenses for physician services, hospital and medical services. In the instant case it was observed that Smt. Rai was suffering from Hypertension and was on medication for the same, prior to taking an OMP Policy. No doubt, it is well established fact in Medical Science that Hypertension is one of the major risk factors for Cardiac diseases. In the instant case however, Smt. Rai was hospitalized & treated in the hospital for severe impairment of the left and right ventricular function. The coronary angiography report indicated – "Clinical scenarion suggests presented with myocarditis". The treating doctor ruled out the possibility of the role of hypertension or coronary disease to cause the present ailment and was of the view that the presentation fitted best with an acute inflammatory or infected insult of heart muscle giving rise to a myocarditis.

It was observed that for denial of claim, Insurance Company/TPA chose to take the cause of death mentioned in the death certificate as an ailment suffered by her and linked the same to the condition of hypertension. even though it was a fact that the death of Smt. Rai took place after nearly two months from the date of hospitalization. It was further noted that the doctor to whom the file was referred for his opinion asked the TPA to call for ECG, Angiography report, complete set of indoor medical records and any test reports showing evidence of myocarditis. However, Insurance Company/TPA had not even bother to examine the indoor case papers of the hospital before rejecting the claim neither had they taken cognizance of the Angiography Report. The Oriental had merely taken the contention of the TPA and supported their view based on the cause of death mentioned in the Death Certificate without taking into account the contents of Angiography Report and views expressed by the Treating doctor. Insurance Company did not challenge the views expressed by the Consultant Cardiologist by referring the case to an independent Cardiologist of the repute and an opinion was just sought from the M.S. doctor. Also, the advices given by this doctor to call for further papers & reports were simply ignored and the decision of the TPA was upheld. Considering these facts, it was observed that the decision of the Insurance Company to reject the claim on the ground that the ailment suffered by Smt. Rai was a complication of hypertension was not conclusively established and hence was not accepted.

complainant was also awarded reimbursement of Funeral expenses except the Air Ticket charges and the decision of the Insurance Company to restrict the coverage for Medical Expenses section up to US$10,000 was held as not acceptable in view of the fact that the complainant had submitted medical documents at the time of taking the Policy.. The expenses incurred on consultation for low back pain and the corresponding X-ray report were considered as not payable since the same were not falling under the scope of the Policy.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI- 860 of 2010-2011
Award No. IO/MUM/A/549 /2010-2011

Complainant: Shri Asil Asif Madoo
V/s

Respondent: National Insurance Company Limited

Shri Asil A. Madoo along with his family members were covered under an Individual 253200/48/09/8500004116 valid from 10/2/2010 to 9/2/2011. Complainant's son, Mast. Musa A. Madoo, aged 6 yrs, was hospitalized at Cumballa Hill Hospital & Heart Institute for Bilateral Profound SNHL (Sensorineural Hearing Loss). He underwent Cochlear Implant under GA on 7/5/2010 and discharged the following day after surgery.

A claim preferred by the complainant for reimbursement of the medical expenses incurred by him for the above procedure was repudiated by the Insurance Company 4.6

Analysis of the case reveals that Mast. Musa Madoo underwent Cochlear Implant surgery. The exclusion under which the Company had rejected the claim talks about non- payment of surgery cost only for correction of eye sight and not correction of hearing disability. Further, it specifically excludes cost of hearing aids. In the instant case, the hospitalisation was for cochlear implant which is a surgically implanted device that helps overcome problems in the inner ear or cochlea, whereas a hearing aid is an external device consisting of microphone, amplifier along with battery that are body worn (chest level and ear level) or worn behind the ear and does not involve any surgery. Hence both the procedures are different and hence not compatible. In any case, the present complaint is not for reimbursement of cost of cochlear implant or hearing aid, but for reimbursement of hospital expenses for the basic treatment received during the implant surgery, and therefore, the exclusion clause invoked by the Company is not applicable in this case.

Dated at Mumbai, this _16th day of March, 2011.

18.3.2011 Mediclaim Policy

Complaint No.GI-1378 of 2010-2011

Award No.IO/MUM/A/552 /2010-2011-18.3.2011
Complainant : Ms. Pavitra K. Bhat
Respondent : The New India Assurance Co. Ltd.

Ms. Pavitra Bhat was covered under Mediclaim Policy (2007) issued by The New India Assurance Co. Ltd. for the period 13.5.2010 to 12.5.2011.. Ms. Bhat was hospitalized at Kallianpurkar Nursing Home from 1.6.2010 to 5.6.2010 where she was diagnosed a case of Calculus Cholicystitis. Thereafter, she was admitted in Ghanshyam Govind Kamat Memorial Hospital from 21.6.2010 to 24.6.2010, where she underwent Laparoscopic Cholecystectomy. Insurance Company rejected the claim in respect of first hospitalization by stating that the claim is not payable under clause 4.2 & 4.3 of the policy as duration of current illness is within 30 days from the inception of the Policy and also the same is falling within a waiting period of 2 years and the claim in respect of second hospitalization was rejected under clause 4.3 of the Policy by stating that policy

has a waiting period of two years for Cholecystitis. Being aggrieved, Ms. Bhat approached this Forum. Both the parties were heard during the personal hearing.

On scrutiny of the documents it was noted that complainant was included in the Group Mediclaim Scheme of the LIC employees of Goa Office upto 31.3.2009. From 17.1.2009, Ms. Bhat was covered under ICICI Prudential Life Insurance Policy – Crisis cover – for Sum Assured of Rs.3,00,000/- each for Death Benefit cover & Critical Illness/TPD Benefit cover. The cover cessation date of the Policy was 17.1.2048. This Policy was however lapsed on 16.1.2010 as complainant stopped paying the premium. Thereafter, she took a Mediclaim Policy from New India for the period 13.5.2010 to 12.5.2011 i.e. after a gap of about more than three months. It was thus observed that there was no continuity in the Insurance Coverage.. Further, the contention of the Insurance Company that coverage of the Policy issued by ICICI Prudential does not match with their Mediclaim Policy (2007) also appeared to be logical. Considering these facts, the Policy issued by New India for the period 13.5.2010 to 12.5.2011 was treated as a fresh Policy.

For rejection of claim in respect of first hospitalization, the decision of the TPA to invoke clause 4.2 appeared illogical since clause 4.2 clearly states that any disease, **other than those listed in clause 4.3**, contracted during first 30 days from the commencement date of the policy is excluded. According to exclusion clause 4.3, the claim in respect of stone in Gall Bladder is not payable for the first two years from the inception of the cover. Although, accepting the contention of the complainant that the ailment suffered by the complainant was not pre-existing and the same was acute and she had no knowledge about the same until she was hospitalized, but as per express clause of the Policy, claim in respect of stone in gall bladder which is specifically listed under exclusion clause 4.3, was not payable for the duration of Two Years from the inception of the cover. Hence, Insurance Company's decision to reject the claims was upheld.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI- 624 of 2010-2011
Award No. IO/MUM/A/ 561/2010-2011

Complainant: Shri Balaram Ajamool
V/s
Respondent: The New India Assurance Co. Ltd.

Shri Balaram Ajamool and his spouse were covered under an Individual Mediclaim Policy bearing No. 111700/34/07/20/0571 valid from 17/4/2007 to 16/4/2008 for a sum insured of Rs. 3 lakhs each with 45% accrued CB.

Shri Ajoomal was admitted to Jaslok Hospital & Research Centre for complaints of ulceration over soft palate, initially small gradually and reach upto the present extent. It was mentioned he had pricking sensation one eating spicy food. Past h/o recorded was

h/o HTN & DM on treatment, Surgery of cataract, haemorrhoids and tonsillectomy. It was also mentioned he had history of smoking, alcohol and pan masala chewing. He was diagnosed to have Atypical Verrucous Hyperplasia (soft palate lesion) and underwent Wide excision for the same for which the admission was from 1/4/2008 to 5/4/2008.

A claim preferred by the complainant for reimbursement of medical expenses incurred to the tune of Rs. 1.76 lakhs was settled by the Company for Rs. 1.26 lakhs.

Scrutiny of the papers reveal that Shri Ajamool incurred a total expenses of Rs.1,76,888/- for the treatment taken by him at the hospital as against which the Insurance Company paid him Rs. 1,26,042/- leaving a short fall of Rs.50,846/- out of which major deduction pertained to surgeon's/ anaesthetist fees amounting to Rs.46,750/- . The Insurance Company have gone by the rate list of Jaslok Hospital, 2007 for grade II surgery and paid an amount of Rs. 25,000/- and Rs. 7500/- towards surgeon's/Anaesthetist's fee respectively as against the claimed amount of Rs. 70,000/- and Rs. 9,250/-.

The complainant contended that the surgery undergone by him was supra grade surgery as informed to him by Jaslok Hospital and not grade II as alleged by the Company. Further, he also mentioned that the Jaslok Hospital Rate Chart of 2002 forwarded to him by the Insurance Company mentions "Negotiability in surgeon fees for Class C and above." Hence, he felt the Company was liable to pay the charges as claimed.

On scrutiny of the hospital bill, it is observed that the surgery undergone by the complainant has been clearly classified as Grade II. Therefore, the complainant's contention that he underwent supra grade surgery is not acceptable in the absence of any documentary evidence. Regarding his point that the surgeon's fee was negotiable, it is observed that the complainant has nowhere admitted that fees charged by the doctor amounting to Rs. 70,000/- were actually the negotiated fee as he did not take this stance nor did he inform about this to the Insurance Company at any point of time prior to receipt of the tariff chart from the Insurance Company.

Similarly, the Company settled the surgeon/anaesthetist's fee as per the rate chart of the hospital which was as per the claim settlement procedure and also acceptable, but it is felt that the Company should have found out from the hospital as to why the patient was charged fees over and above the hospital tariff and accordingly taken suitable action if not at the time of settlement atleast after the complaint was lodged with the Forum, which they have not done.

The issue is such that honestly there cannot be any specific adjudication at this juncture. Both the complainant as well as the Company have not made the required efforts to defend their respective stand. On balance therefore, it is felt that issue be resolved with an additional payment of Rs. 25,000/- towards surgeon's/anaesthetist fees.

As regards Rs. 2746/- deducted towards unrelated investigations/medications (pertaining to pre-existing DM and HTN not related to the present ailment), it would be

pertinent to mention here that as per the guidelines of General Insurance Council, the benefit of coverage of pre-existing disease/condition is available after completion of 48 months of continuous policy coverage. Further, as per the Mediclaim Policy terms and conditions, pre-existing DM & HTN are covered on payment of additional premium. Since in the instant case, the Policy has completed 9 years of continuous coverage as evident from the accrued CB of 45% for Shri Ajoomal, the Company to settle the above expenses after collecting the requisite additional premium from the Insured for compulsory coverage of the same. As regards reimbursement of cost of engaging private nurse, the same is not payable as per policy clause 4.4.21.

Dated at Mumbai, this 25th day of March, 2011.

25.03.2011 Individual Mediclaim Policy

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI
Complaint No. GI-828/2010-2011
Award No. IO/MUM/A/559/2010-11 dt. 25.03.2011

Complainant: Shri Mukund H. Mokashi
Respondent: National Insurance Company Ltd.

Shri Mukund Mokashi was covered under Individual Mediclaim Policy No.260600/48/09/8500000023 for the period 07.04.2009 to 06.04.2010 for Sum Insured Rs. 2,50,000/-, issued by National Insurance Co. Ltd.. Shri Mokashi suffered from Left Eye Total Retinal Detachment with Horse Shoe Tear for which he was admitted to Dr. Shah's Unique Smile & Vision Care Clinic on 03.10.09 and underwent Bimanual Vitrectomy+PFCL+EC+EL+SIL OIL under L.A. The claim lodged under the policy for Rs.52,467/- was rejected under Clause 4.1 of the policy. Shri Mokashi represented to the TPA as well as to the Insurance Company forwarding certificates from the treating doctor stating that the current retinal detachment was not related to cataract surgery undergone by him earlier or its complication but was spontaneous in nature and could occur even if patient had undergone cataract surgery or not. The TPA however reiterated their stand of repudiation whereas the Insurance Company did not respond to any of his representations. Aggrieved, he approached this Forum seeking relief in the matter.

A joint hearing was scheduled to be held with the parties to the dispute. However no official from the Insurance Company appeared for deposition. Shri Mokashi in his deposition insisted that the occurrence was sudden and if it was not so he would have taken timely precaution and treatment earlier. He requested for settlement of the claim. The Insurance Company vide their written statement confirmed that the claim was repudiated due to the reason that retinal detachments & breaks is one of the complications of cataract surgery which the patient had undergone in the year 2005 and also because the policy specifically excluded cataract of both eyes and related problems.

Retinal detachment is a disorder of the eye in which the retina peels away from its underlying layer of support tissue. Initial detachment may be localized, but without rapid treatment the entire retina may detach, leading to vision loss and blindness. It is a medical emergency. There are some known risk factors for retinal detachment. The most common worldwide etiologic factors associated with retinal detachment are myopia (i.e. nearsightedness), aphakia, pseudophakia (i.e. cataract removal with lens implant), and trauma. Cataract surgery is a major cause, and can result in detachment even a long time after the operation. The risk is increased if there are complications during cataract surgery, but remains even in apparently uncomplicated surgery [taken from internet site]. From the above it is evident that Cataract surgery is one of the major contributory factors for retinal detachment. The fact that it can occur in a person even without undergoing a cataract surgery cannot be denied. It may also be agreed that in the instant case, it could be spontaneous and the ailment of retinal detachment suffered by the insured may not in itself have been pre-existing; but as studies show, it is certainly one of the complications of cataract surgery which was pre-existing for the said policy and expenses on treatment of Cataract with its related problems have been specifically excluded from the scope of the policy. In view of the express exclusion on the policy and on the basis of what is stated hereinabove, the decision of the Insurance Company to deny the claim could not be faulted with and was upheld.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI- 1024 of 2010-2011
Award No. IO/MUM/A/604 /2010-2011

Complainant: Shri Ajay V. Joshi
V/s
Respondent: The New India Assurance Co. Limited

Shri Ajay V Joshi insured his Laptop under Portable Electronic Equipment Policy bearing No. 160100/46/09/77/00000078 for a sum insured of Rs. 45,000/- valid from 4/6/2009 to 3/6/2010. It was reported that on 24/11/2009 Insured was working on the laptop and it suddenly got restarted which happened twice after which it got hanged with the display going off finally. The Insured took the laptop to the authorized service provider, M/s.M/s. Simtech Computronics, on the advice of the dealer and on checking, the engineer found that the System Board and LCD panel were not functioning properly and needed replacement. The complainant intimated the loss to the Insurance Company who deputed Surveyor Sandeep Mashru & Co. to survey and assess the loss. The surveyor visited the service centre and as per his discussion with the engineer, the surveyor advised the Insured to go ahead with the replacement of the above referred damaged parts (as the damaged parts could not be repaired) and submit the necessary invoice and payment receipt for processing & finalizing the claim. Since the required papers were not forthcoming from the Insured and the Insurance Company was insisting for survey report, the surveyor released his report based on the available documents.

Based on the surveyor's report, the Company quantified the loss to be around Rs. 15000-16000/- and informed the same to the Complainant which was not acceptable to him.

Let us examine whether the Insurance Company's decision eventually to settle the claim on constructive total loss basis was as per the terms and conditions of the policy.

The Basis of Indemnity as per the policy terms and condition is reproduced below:

a) In cases where damage to an Insured item can be repaired, the Company will pay expense necessarily and reasonably incurred to restore the damaged machine to its former state of serviceability and customs duty if any provided such expenses have been included in the sum insured. Cost of parts as per manufacturers list price or the market value whichever is lower with deduction for value of any salvage will be taken into account. No deduction shall be made for depreciation in respect of parts except those with limited life. **If the cost of repairs equals or exceeds the actual value of the machinery insured, settlement shall be made on the basis provided for in (b) below.**

b) In cases where an Insured Item is destroyed , the Company will pay the actual value of the item immediately before the occurrence of the loss plus custom duty if any, provided such expenses has been included in the sum insured. Such actual value to be calculated by deducting proper depreciation from the replacement value of the item. The salvage will be taken into account. The cost of any alterations, improvements or overhauls shall not be recoverable under this policy."

In the instant case, the cost of repairs as per the quotation dated 26/11/2009 submitted by the Insured from M/s. Simtech Computronics which was Rs. 25,828.75 was neither equal to or exceeding the actual value of the machinery as on the date of loss which was estimated at Rs. 30,000/- by the surveyor. Hence, there was no question of the Company offering settlement on constructive total loss basis at the first place. The Complainant was eligible for claim on repair basis as per the policy terms and conditions and the Company should have settled the same on that basis at the first instance. The Forum sees no reason as to why the complainant should not have been informed of the quantum assessed by the surveryor when asked for. Had the Insured's request been considered at the appropriate time, this dispute could have been avoided.

It is felt that the Company should have been more practical in their approach and considering the long delay, I feel they should improve their final offer by settling the claim as per the surveyor's assessment on repair basis amounting to Rs. 25,818.75 with a penalty of Rs. 5000/- for initial improper handling of the case by them, to resolve the dispute in the present case.

Dated at Mumbai, this _29th day of March, 2011.

Late Shri. Mathuradas Mulani, father of the complainant was covered under Mediclaim Insurance Policy issued by The Oriental Insurance Co. Ltd. for Sum Insured of Rs.2,00,000/- with Domiciliary Hospitalization Limit of Rs.35,000/-. Shri. Janak Mulani approached this Forum with a complaint against the Insurance Company for non-settlement of Domiciliary Hospitalisation Claims lodged by him in respect of his father who was suffering from Parkinsons disease which became acute since August, 2009 when he stopped swallowing food and Ryle's tube was required to be inserted. As doctor opined that his father was too frail to be moved to the hospital, since August 2009 to March 2010, he was provided with hospital like care at home i.e. nurse, hospital bed, oxygen, suction machine, nebulizer etc. When a claim of Rs.79,079/- was lodged on the Policy issued for the period 2008-09 towards domiciliary care and a day care visit to Hinduja Hospital on 25.8.2009 for PEG insertion, Insurance Co. sanctioned only the expenses incurred on Day Care Hospitalization at Hinduja Hospital and disallowed the expenses incurred on Private Nursing charges, doctor's home visit fees, cost of diapers, protein powder, folder charges etc. They took a stand that the expenses incurred on domiciliary care cannot be reimbursed under pre & post hospitalization benefit of the Policy. The second claim which was lodged on the subsequent renewed policy, for Domiciliary Hospitalisation, was rejected on the ground that the claim papers were not submitted within 7 days from the date of discharge from the Hospital. Being aggrieved complainant approached this Forum. Both the parties were heard during the personal hearing. It was noted that the expenses claimed by the complainant towards Private Nursing charges and home visit charges of the doctor had been denied under exclusion clause 4.26 which states as "Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of doctor's home visit charges, Attendant/Nursing charges during pre & post hospitalization period". Company also took a stand that Shri. Mulani was taken to the hospital for an endoscopy procedure and therefore the claim towards Domiciliary hospitalization is not payable. Complainant however was of the view that his father was not admitted to the hospital for treatment of Parkinson but it was a day care visit to insert PEG in place of Ryle's tube and the claims were lodged for Domiciliary care which was provided to his father on the advices of the doctor.

The analysis of the case revealed that Late Shri. Mulani was a known case of Parkinson and since July, 2009, he stopped taking oral feeds and as such was on Ryle's tube feeds. As per doctor's certificate he was extremely debilitated and weak, had severe cough and difficulty in breathing. The papers submitted to the Forum indicate that since July 2009, he was provided with medical care such as Fowlers bed, oxygen, suction for removal of secretions and also the services of special nursing were availed from 7.00 a.m. to 7 p.m. The contention of the Company that since Shri. Mulani was taken to Hinduja Hospital, he was not eligible for Domiciliary treatment claim was not accepted in view of the fact that PEG procedure requires to be done in a hospital and Shri. Mulani was to undergo the same under general anesthesia and such the complainant had no option but to take his father to the hospital for the said procedure.

Shri. Mulani was suffering from difficulty in walking, eating and breathing and was on Ryle's tube as he stopped taking oral feeds. Considering his condition, the

treating doctor advised him hospitalization. Thus, taking into account the recommendations of the doctor and looking to the condition of Shri. Mulani, the hospitalization was warranted and had it been done, the Insurance Company would have settled the claim upto the limit of Sum Insured available under the Policy. But considering his age and the suffering he was undergoing, denial of domiciliary hospitalization claim just because he refused to get admitted in the hospital, was observed as too technical. During domiciliary hospitalization, the complainant was administered oxygen and suction for removal of secretions was recommended by the doctor and hence the services of Nurses would have been definitely needed.

Considering the age of Shri. Mulani, the sufferings underwent by him and the recommendations of the treating doctor for domiciliary treatment, compensation to the complainant was granted under both the Policies for Domiciliary treatment given to his father.