AHMEDABAD

Total Repudiation

AHMEDABAD OMBUDSMAN CENTRE

Case No.14-005-0268-08

Mr.Paresh Shah vs. Oriental Insurance Co.

Award dated 08.04.08

Mediclaim case. The dispute was raised for repudiation of claim.

The documents on record and personal hearing of both sides, following facts were revealed.

Complainant was hospitalized for Lt.Vericocel +Sec.Phimosis + short tight ferum. Complainant was diagnosed for Primary Infertility and admitted for Obligospermia (normal sperms count). The relation of Vericocel and Infertility is controversial. All the treatment was performed simultaneously. The phimosis and frenuloplasty are not related to infertility. The clause 4.8 was invoked by Respondent.

As the treatment for sterility and infertility are excluded the Respondents repudiation is justified for surgery of Varicocelectomy. The phimosis and frenuloplasty are allowed and becomes payable.

The complaint succeeded partially and Respondent was directed to consider the claim for Phimosis and frenuloplasty.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0295-08

Shri Vimal R. Panchal vs. Oriental Insurance Co.Ltd.

Award dated 29.04.08

Mediclaim Policy. Dispute was raised as the claim was repudiated. The material on record and hearing of both sides reveals the following facts.

The Complainant's claim for insured's treatment for UTI was repudiated under Clause 4.1 (Pre-existing disease which was not disclosed). The attending physician's case history for UTI since many years. As the name UTI suggests infection and not disease because the infections are from many sources and area. It cannot be called as disease.

The infection even after cure can again recur due to some or other reason/bacteria/area. Thus the infection need not continuously exist. The insured was hospitalized after 3 years of policy does not mean that infection continued for 3 years thus cannot be defined as pre-existing.

The case was decided by directing the respondent to pay claim.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0401-08

Shri Ghanshyambhai M.Patel Vs. United India Insurance Co. Ltd.

Award dated 29.04.08

Mediclaim. Dispute under RPG Rules 1998 was raised as the claim was repudiated.

The material on record and hearing of both sides, following facts were revealed.

The insured complainant was injured in road accident and diagnosed for close fracture of proximal phalanx of middle finger. After operation, he was discharged but again hospitalized for removal of wire used to fix broken bone. He was further advised rest for 5 days. Thus treatment lasted for around 2 months, meanwhile insured informed TPA but claim was rejected as the grounds that lodgment is after 7 days. TPA did not examine papers for 1 month and returned to complainant thereafter without reason. Respondent's plea that they cannot comment as no claim papers submitted to them was ruled out as they could have called same from TPA for post hospitalization confirmation.

Award directed respondent to call back claim papers and process as claim is supported by valid and authentic documents and receipts and no delay is observed in intimation.

AHMEDABAD OMBUDSMAN CENTRE

Case No.14-004-0405-08

Mr. K.K.Dave Vs. United India Insurance Co.

Award dated 29.04.08

Mediclaim Case. Dispute under RPG Rules 1998 was raised for not allowing expenses for Myomectomy surgery of Insured.

The material on record and hearing of both sides facts found were as follows:

The Respondent confirmed that the claim papers were refused by TPA as they were not submitted within 7 days. The complainant was under treatment and settled bill for cash on 30-11-2007. As per claim form, Certificate from attending Medical Practitioner that patient is fully cured was required which was given by doctor on 11th Dec.2007

and papers were submitted on 17th Dec.2007 which were refused. The fact proves that there is no delay and further that respondent had themselves not interpreted the provision of condition No.5-G.

Award was given directing the respondent to call for papers and process the claim within 30 days.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0382-08

Shri V.K.Vora Vs. Oriental Insurance Co.Ltd.

Award dated 29.04.08

Mediclaim Case. The dispute was raised under RPG Rules 1998 for repudiation of Mediclaim.

The material on record and personal hearing of both the sides following facts was revealed.

The claim was repudiated under Clause 4.1 - Pre-existing disease. The Insured was admitted for recurrent right renal Pelvic Stone. The right PCNL renal stone was done in 1998. The policy commenced in 1998. This had Pre-existing disease.

The Complainant pleaded that no claim was preferred from 1998. Similarly Clause 4.1 is not applicable in view of modification of policy condition.

The prospectus of Respondent confirms that after inception of cover for first time, the ailment is excluded for 4 years of policy being in force continuously.

Since the policy was incepted in 1998 and renewed with Respondent without break the Respondent admitted that there was mistake as part of TPA and have settled claim by drawing cheque of Rs.37,422/- prior to hearing. The case was disposed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0366-08

Smt.Rekhaben A. Patel Vs. United India Insurance Co.

Award dated 30.04.08

Mediclaim Case. The dispute was raised under RPG Rules 1998 for repudiation on the ground of late submission.

Material on records and hearing of both sides, following facts were obtained.

The Insured had right knee operation in March/April 2007 (27-3-07 to 03-04-07). Complainant's plea was that TPA refused to accept the claim papers without examining details, only under a reason of late submission. The complainant has acknowledgement date 02-04-2007. As per discharge summary, patient was advised for subsequent visit for dressing and follow-up. Patient has subsequent 8 visits between 7-4-07 & 26-06-07. The consulting note has all details. Patient was declared fit as 26-06-07 which proves that lodgment was within time. Post hospitalization is also having 60 days time frame.

Award was given directing to decide claim after calling for claim papers within 30 days.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0378-08

Shri Vinay R.Chauhan Vs. United India Insurance Co.

Award dated 30.04.08

Mediclaim case. The dispute was raised under RPG Rules 1998 for repudiation on the ground of late submission.

Facts based on verification of documents on record and hearing of both sides are:

Claim was not repudiated but refused to accept the claim papers for late submission. The reason was completion of post hospitalization of treatment which lasted up to 01-10-2007. (Original hospitalization was 27-7-2007 to 17-08-2007). If we take date of fitness, the actual delay is 14 days. Clause 5.4 states time limit of 7 days from discharge and post hospitalization 60 days and document be submitted after completion of treatment. Complainant has stated that delay of 14 days is due to bereavement in family which deserves condonation. The TPA's outright refusal is unfair. Respondent also erred in not examining total facts of case for condonation.

Award directed the respondent to decide the claim condoning delay and calling papers from complainant.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0307-08

Mr.Sumatilal K.Shah Vs. Oriental Insurance Co.Ltd.

Award dated 30.04.08

Mediclaim case. Dispute was raised under RPG Rules 1998 for repudiation of claim.

The case after material on record and hearing of both sides are as under:

The claim was repudiated on the ailment was pre-existing.

The Insured was admitted in hospital for treatment from 06-06-2006 to 14-06-2006. He was earlier operated on 22-09-2005 and 09-06-2006. Complainant was suffering from Cancer since 1998. After surgery, he was alright. The complainant's plea to prove non pre-existing ailment his papers were submitted by respondent to medical referee gives that disease pre-existed.

The insurance incepted from 1999. Thus claim repudiated as this was not disclosed the fact of Tongue Cancer. The case was dismissed.

MAY 2008

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0143-08

Shri Kalimullah Khan Vs. United India Insurance Co.Ltd.

Award dated 13.05.08

The Claim was lodged for mediclaim reimbursement of wife of the insured who was hospitalized for treatment against 'Suicidal Depression'.

There was no dispute about policy being in force or the member was not covered in the scheme. The respondent repudiated the claim under clause 4.8 which disallow the claim for the reason that the patient was admitted for suicidal depression. During hearing, the respondent informed that the patient had taken overdose of medicine ALPRAZOLAM and the hospital records mentions that patient was under treatment for suicidal depression and final diagnosis was ALPRAZOLAM overdose. The medical journal showed by the respondent in support of the

case mentions that the medicine is for pelting reliant from anxiety but the overdose indicates that it tantamount to "intentional self injury".

The complainants plea that the wife, having two small children not being well educated, has taken the overdose as per the doctor's advise who said that dose can be increased if not feeling better. Out of anxiety to get faster relief the wife had taken the overdose. There was no suicide note nor any police information as it would have been treated as medicolegal case.

The Respondent was unable to prove the nexus between overdose and intent to commit suicide has not established. Besides this tact of pelting suicide not or police authority intervention also was not proved. Thus the exclusion under clause 4.8 of intentional self injury is not established from material on record and the respondent is not justified in rejection of claim under clause 4.8.

The award directed the respondent to settle the claim.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-044-08

Shri Rashmikant N.Shah Vs. New India Assurance Co.Ltd.

Award dated 15.05.08

The Claim was lodged under mediclaim policy for reimbursement of expenses of hospitalization.

The claim was settled by the respondent in a manner which was not acceptable to complainant.

The dispute was quantum of settlement, for disallowing post hospitalization expenses. The respondent reimbursed the amount of Rs.24, 958/- and disallowed Rs.6, 726/-.

The Respondent submitted that they have settled claim of Rs.1, 29,000/- against maximum eligibility of Rs.1, 00,000/- and excess payment was made through an oversight.

It was observed that taking into consideration the total cover available (effective sum insured) and treatment taken earlier, the respondent's contention for eligible amount is correct.

The case was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0357-08

Shri Siddharth N.Shah Vs. New India Assurance Co.

Award dated 16.05.08

The claim was lodged under the mediclaim policy for reimbursement of hospital expenses of Rs.7, 71,969/- .

The effective sum insured was Rs.6.90 Lacs but there was exclusion imposed for Rs.2.50 Lakh and the dispute was only on determining the so called exclusion imposed.

The policy was having cover since 1998 for Rs.1 Lakh. The cover was increased to Rs.5 Lakhs from 1999 to 2001 but restriction was imposed at the renewal for 2001-2002 which continued up to 2006-07 and renewed for 2007-08. There was no claim under the policy and for cumulative bonus of 50% maximum has continued.

The respondent was asked to give reason for exclusion of Rs.2.5 Lakh which could not be given. No reason for was given.

From the policy papers where it was mentioned exclusion by medical examination or insured's declaration in proposal form and not any generalized amount. The Insurance Company should have given justification and notice to complainant. The same was not mentioned in policy document.

The Award was given directing the respondent to set aside the restriction of Rs.2.5 Lakh and settle the claim.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0376-08

Shri Kamlesh Patel Vs. United India Insurance Co.Ltd.

Award dated 20.05.08

A claim was lodged under mediclaim for father was treated as 'No Claim'.

The dispute is raised by the complainant. The respondent did not submit any thing in this case nor attended the hearing. The case was decided on merit and submission of the complainant only.

The claim was repudiated as there was no hospitalization (Clause 1.1) for treatment of IHD and non-submission of discharge summary for treatment of C.A.D.

The complainant argued that instead of Discharge Summary, he had given certificate from the hospital which contains all required details.

Except for the letters to treat this as no claim, there were no papers on record to prove that the respondent has called for any requirement from complainant.

Award was given directing the respondent to reopen the case and the complainant is directed to submit the requirement called by the respondent as supportive evidence.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0377-08

Shri Agamsharan D.Patel Vs. United India Insurance Co.Ltd.

Award dated 20.05.08

The mediclaim was lodged in Sept.2006 by the complainant who was repudiated. The patient was admitted for inguinal hernia. Age of patpient 3 years congenital external disease and claim was rejected under Clause 4.8 and this was excluded. The respondent did not submit any S.C.N.

The Complainant submitted the certificate mentioning that patient was operated for Labial Synichiac on 18-10-2005 and at that time patient was not having inguinal Hernia Right of Left.

The forum obtained the opinion of independent surgeon Dr.Desai and on the basis of his opinion the inguinal hernia may develop at any age.

The award was given directing the respondent to settle claim as the restrictive clause is inoperative in this case.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0374-08

Shri Pradipsinh P.Chudasma Vs. New India Assurance Co.Ltd.

Award dated 20.05.08

Shri Pradipsinh P.Chudasma lodged mediclaim under his HHI policy for hospitalization of Folicular Carcinoma of Thyroid which was repudiated for the reason of non disclosure due to misrepresentation of conflicting facts.

On hearing the complainant and absented through the notice was acknowledged by him. It was confirmed that complainant does not have to say beyond the papers submitted by him.

Under HHI policy under winner's card cover S.I. of Rs.4, 000/- only as against claim lodged was for Rs.27, 869/-.

The Respondent's submission of discharge summary reveals that complainant was suffering from the ailment for 10 years as against the actual proposal incepted from 01-03-2002. Thus it was pre-existed and was excluded under clause 4.1.

The case was dismissed without interfering in the decision of respondent.

AHMEDABAD OMBUDSMAN CENTRE

Case No. 14-005-0413-08

Shri Pankaj J.Shah Vs. Oriental Insurance Co.Ltd.

Award dated 21.05.08

The Claim lodged for hospitalization for Fistula in Ano was repudiated for the reason Ayurvedic treatment not taken from Govt.Ayurvedic Medical College under Clause 2.1.

Though the complainant submitted that cover is continuously for last 10 years and the patient's hospital is well known and famous it was contradictory to clause 2.1 of respondent.

Case was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0369-08

Mr.Saurin P.Shah

Vs. New India Assurance Co.Ltd.

Award dated 22.05.08

The Complainant lodged mediclaim when he met with an accident on 28th March 2007 and was repudiated by respondent.

On hearing both sides and facts on record, it was revealed that-

The dispute was on the point of fact whether hospitalization was required on not. The Complainant had weakness in lower limbs due to poliomyelitis and was admitted mainly due to general poor condition of complainant for general observation for 2 days only.

The complainant's plea that he had covered policy since 1995. The accident happened at 8.30 p.m and looking to the condition and injuries, the doctor advised him to go to hospital. The doctor on admission also recorded the complaint of Nausea, vomiting, O/E C.L.W over forehead and both lips. BP 136/90 and pulse rate 96 p.m.

The Award directed the respondent to settle the claim on the basis of facts on record and documents submitted.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0365-08

Shri Ghanshyam R.Sharma Vs. United India Insurance Co.Ltd.

Award dated 22.05.08

The mediclaim was lodged for reimbursement of hospital expenses of insured wife of the complainant for Acute Ulcerative Colitis. Dispute was raised as the claim was repudiated.

On hearing and papers on record, it was revealed that (in absence of respondent) the claim was rejected as it was submitted late (not within 7 days). The policy prospectus however say that claim be submitted in 30 days from completion of treatment.

The respondent has not acted wisely by not looking at the claim file to see that paper have been submitted without fitness certificate. The claim is also supported by valid and authentic reports and receipt of various diagnostic centers. Thus it is fit cases for condoning delay on the papers on record justifies condition of delay in submission.

The award directed the respondent to process the claim after calling the papers from complainant.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0384-08

Shri P.A.Ramkrishnan Vs. New India Assurance Co.Ltd.

Award dated 27.05.08

The mediclaim was lodged for hospitalization expenses of complainant's daughter. Claim settled for Rs.50, 000/- against total claim of Rs.63, 015/-.

The dispute was raised for disallowing Rs.13, 015/-.

On perusal of documents submitted and hearing of both the parties, facts revealed were:

The policy was having Sum Insured for Rs.50, 000/- in previous year and was revised to Rs.1, 00,000/- only in relevant policy year when claim arises.

The ailment of Acute Lymphoblastic Luekemia was pre-existing at the time of revising the Sum Insured to Rs.1,00,000/- and as such claim settled against only for Rs.50,000/- disallowing Rs.13,015/- as per clause 5.9 for enhancing the cover.

The case was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-010-0371-08

Shri Ranjitsinh B.Parmar Vs.IFFCO-TOKIO Gen.Ins.Co.Ltd.

Award dated 29.05.08

The mediclaim was lodged by the complainant for Rs.8, 256/- for hospitalization reimbursement which was repudiated and dispute was raised by complainant under RPG Ruled 1998.

After perusal of documents submitted and hearing of both the parties, the facts revealed are as under:

The Complainant was admitted for treatment of Malaria and Upper Respiratory Tract Infection and gastritis. However he took treatment for knee injury which was pre-existing and was excluded in the cover.

The hospital papers have recorded the state of health as normal temperature and other vital status. No malarial parasites found. The claim proved to be false.

The complainant's plea that after admission for malaria, he had knee injury was ruled out as the facts were drastically different.

The case was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0383-08

Shri P.A.Ramkrishnan Vs. New India Assurance Co.Ltd.

Award dated 29.05.08

The claim was lodged for reimbursement of hospital expenses of complainant's daughter Janki was settled for Rs.50, 000/- disallowing Rs.53, 147/-. Dispute was raised under RPG Rules 1998.

After perusal of documents submitted by both the parties and hearing of both sides, following facts were revealed. The complainant had insurance cover for S.I. of Rs.50, 000/- Up to year 2004-05 and was raised to 1 lac from 2005-06. The claim arisen after increase of cover. The policy condition and clause No.5.9 restricts the pre-existing disease as such the cover up to Rs. 50,000/- was effective in 2005-06 and claim was settled accordingly.

(The other claim of same insured under case No.11-002-0384-08 has same thing).

The complainant's plea can not be read with the restrictive clause.

Case was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0408-08

Shri B.C.Vaghela Vs. United India Insurance Co.Ltd.

Award dated 29.05.08

Shri B.C.Vaghela lodged claim for mediclaim reimbursement of expenses for hospitalization was repudiated. Dispute case was registered under RPG Rules 1998.

After perusal of documents submitted by the complainant and personal hearing revealed facts are :

(The Respondent did not submit documents nor attended hearing).

The son B.B.Vaghela was admitted for treatment of Neutrogena Bladder. The patient has frequent urination since age of 4 years amounting to pre-existing disease and disallowed as per clause 4.1.

The complainant defended by narrating chain of event and condition of baby since birth with supporting documents. He said that as the history was wrongly recorded the case was viewed otherwise

The award was given directing the respondent's decision to repudiate claim is set aside and to pay claim within 15 days.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0404-08

Mr.Mihir C.Sandesara Vs. National Insurance Co.Ltd.

Award dated 12.06.08

Mediclaim Policy

Dispute was raised as the claim was repudiated. On perusal of documents submitted and hearing of both the sides the revealed facts are :

The complainant's son was diagnosed for recurrent urine infection since 3-4 months and right TV hydrocele, phimosis. Suggested for surgical operation which was done in June 2007. The Respondent's pleading was that the ailment is congenital external and claim was refused as clause 4.8 infers exclusion for the ailment.

As it was established that the insured was hospitalized and operated for the congenital external ailment, the case was dismissed and respondent's decision to repudiate the claim was upheld.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0399-08

Mr.Raghuvir R.Luste Vs. New India Assurance Co.Ltd.

Award dated 12.06.08

Mediclaim Policy

Dispute was raised for repudiation of claim. On perusal of documents submitted and hearing of both sides, following facts revealed.

The treatment was taken for insured having burn injury on 31-03-2007. After treatment the insured died after 40 days. Complainant's plea was that burn injuries was due to accident and claim is payable.

The Respondent submitted and pleaded that the case was registered under Criminal procedure code 174 which is unnatural death including suicide.

It was deduced that the case can not be conclusively uphold death by suicide or unnatural. The police statement regarding telephonic talk from the hospital stated that DLA set herself on fire to each rid from old illness. Inquest Panchnama also states similar lines. As per dying declaration that she was caught by fire was not given in presence of Executive Magistrate. Thus the complainant fails to succeed.

Award stated that case is dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-002-0412-08

Mr.Shailesh M.Pandya Vs. New India Assurance Co.Ltd.

Award dated 13.06.08

Mediclaim Policy

The dispute was raised under RPG Rules 1998 as the Respondent repudiated the claim of reimbursement of hospitalization expenses for treatment of his wife.

The facts came on record, after perusal of documents submitted and personal hearing of both sides is as under:

The complainant's wife was admitted in the hospital for the period from 24-06-2006 to 26-06-2006 and discharged on 26-06-2006 for Chronic Ostcomyelitis, but the treatment continued. The policy provides hospitalization expenses up to 60 days of discharge i.e. up to 26-08-2006 in this case. The record reveals that subsequent treatment was continued up to 01-09-2006 and papers should have been submitted on or before 15-02-2007.

The complainant pleaded that oral drugs was to be taken up to 2 years after bone grafting which was contradictory to clause 7.2 for time limit was ruled out as reasons were not justifiable.

The case was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-002-0407-08

Shri Darshanlal M.Anand Vs. New India Assurance Co.Ltd.

Award dated 17.06.08

Mediclaim Policy

The dispute was raised for Laser Capsulotomy of Insured's wife was repudiated.

On perusal of documents submitted and hearing of both sides, following facts are revealed.

The Yag Laser Capsulotomy is done on OPD and it is not payable after the cataract operation. The natural lens of the eye is situated in elastic like capsular bag. While operating for Cataract the front portion of capsular is opened to remove lens. Following the cataract surgery the capsule may produce cloudy cell causes blurred vision. The treatment for this is simple Yag laser and is out patient procedure.

Thus respondent is justified in repudiating claim under exclusion clause. The case was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0009-09

Shri Dharmesh H.Shah Vs. Oriental Insurance Co.

Award dated 18.06.08

Mediclaim Policy

Dispute was raised under RPG Rules for operation of Fistula in Ano was repudiated.

The facts revealed after perusal of documents submitted and hearing of both the sides.

Clause 2.1 restricts the claim if the operation is done in Ayurvedic/Homeopathic/Unani treatment is not done as in-patient in Govt. Hospital/Medical College.

In this case the operation was done by Ayurvedic Surgeon in Private Hospital. The complainant's plea that this private hospital is well known and was registered under Bombay Nursing Home was ruled out because just by registered hospital cannot be Govt. Hospital.

The complaint was dismissed on the repudiation under clause 2.1 was correct.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-007-0005-09

Mr.Dharmendra J.Sanghvi Vs. Tata AIG Gen.Ins.Co.Ltd.

Award dated 18.06.08

Maharaksha Policy

Dispute was raised on the claim for reimbursement of expenses for Dental Treatment was repudiated.

On perusal of documents submitted by both the parties and hearing of both sides, the facts revealed were:

The repudiation was that tooth injury/accident, no hospitalization was done. The policy issued restricts the claim payment if it is not after hospitalization.

It was observed that the claim was out of the purview of policy condition.

The case was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0402-08

Mr.Dhirajlal R.Mehta Vs. United India Insurance Co.Ltd.

Award dated 23.06.08

Mediclaim Policy

The dispute was raised as the claim was repudiated.

On perusal of submitted documents and hearing of both the sides, facts revealed :

Insured patient had diabetes and already laser treatment taken.

The illness pre-existed and excluded under clause 4.1.

Fairly large numbers of documents were submitted in proof of previous treatment and the diabetes pre-existed the insurer which was incepted in 2001.

On this basis, the case was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0010-09

Dr.Ashok P.Patel Vs. Oriental Insurance Co.

Award dated 23.06.08

Mediclaim Policy

Dispute was raised as the claim for hospitalization for Chest Pain of Insured wife was repudiated under exclusion clause 4.1.The facts revealed after verification of documents and hearing of both the parties:

The Respondent's plea was that the hospitalization was for diagnostic purpose and not treatment. As per complainant, the insured was advised for Angiography for angina pain (suspected). Meanwhile due to sudden pain the patient was admitted and coronary angiography was done as per recommendation of experts.

The prescription showing previous medication and advice for angiography is on record was the plea of complainant. Respondent submitted that no active treatment was given for angina pectoris. The primary tools like Electro Cardiogram of Heart etc. were not used for diagnosis of Chest pain. The angiography was done only to trace blockage in vessels. Case was dismissed and it was established that hospitalization was for diagnostic purpose.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0388-08

Mr.Nandkishore S.Shodhan Vs. United India Insurance Co.

Award dated 23.06.08

Mediclaim Policy

Dispute was raised under RPG Rules 1998 for repudiation of claim.

On verification of submitted documents and hearing of both the sides following facts revealed.

The Claim was excluded by invoking Exclusion clause 4.1 for pre-existing illness. The documents on record like discharge summary diagnosis was Left Respiratory tract infection, Bronchitis, Sinusitis and known case of allergic

bronchitis for 10 years. The bronchitis was disclosed in proposal incepted in 2001. Therefore Exclusion was put in policy.

It was turns established that ailment was pre-existing.

The case was dismissed.

Case No.11-002-0398-08

Mr.Atulbhai J.Parikh Vs. New India Assurance Co.Ltd.

Award dated 24.06.08

Mediclaim Policy

Dispute was for repudiation of claim.

After hearing of both sides and papers on record it was found that repudiation was for pre-existing ailment long standing hypertension. Due to this insured developed chronic renal failure.

On conclusive evidence on record it was seen that the hypertension was not categorically proved.

Award was given directing respondent to pay claim amount.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0400-08

Mr.Kishore H.Raghani Vs. United India Insurance Co.Ltd.

Award dated 25.06.08

Mediclaim Policy

Dispute was raised for repudiated facts revealed after verification of documents on record and hearing of both sides are:

Claim was by invoking clause No.4.1 which excludes pre-existing disease. The insured was hospitalized for treatment of CAD/TVD/Double Vessel disease bilateral insignificant renal artery disease, HTN.

The previous history of myocardial infarction before 6 years i.e. 2001. The policy incepted in 2001 and the history of M.I given as 6 years is only approximation evidence. It thus was evident from facts on record that M.I was after the policy was taken, hence cannot be pre-existing ailment.

The award was given directing the respondent to pay claim.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0019-09

Shri Dilip B. Acharya Vs. Oriental Insurance Co.Ltd.

Award dated 26.06.08

Mediclaim

Dispute rose for repudiating the claim for Obstructive Sleep Apnoea (OSA) Syndrome defining as Diagnostic treatment.

On hearing both the sides and documents on record it was sufficiently proved that the complainant was breathless and felt chocking for breath during sleep. The consulting physician's recommendation the complainant was admitted for this syndrome. Respondent pleaded that Polysonography was done to confirm the diagnosis and no other investigations were done and respondent's two medical referee had same opinion of diagnostic and not treatment for OSA (Obstructive Sleep Apnoea) is condition which stops breathing. In addition to impact as quality of life OSA may lead to hypertension or Heart disease and arrhythmia. This requires referral to qualified respiratory physician. The Polysonography require overnight stay.

Thus respondent's repudiation was unjustified. Award directed them to pay claim.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0406-08

Mr.Sameersingh A.Chauhan Vs. Oriental Insurance Co.

Award dated 26.06.08

Mediclaim

Dispute was on repudiation of claim on verification of documents on record and hearing of both sides facts revealed:

The claim was repudiated on the ground that hospitalization was not required as the injury could have treated by local anesthesia on OPD basis. Injury to right middle finger and little finger by debridement and suturing and fracture reduction of finger was done under local anesthesia.

Respondent submitted that despite repeated request the insured did not submit pre-operative X-ray plate and report for proof. Post operation x-ray plate & report were also not submitted. This shows that injury was not serious enough.

The complainant's plea that he was admitted for poor general condition of health but this is also excluded as per policy clause.

The case was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0381-08

Mrs.Archita B.Vyas Vs. National Insurance Co.Ltd.

Award dated 26.06.08

Mediclaim case repudiated.

The facts on the basis of documents submitted and hearing of both sides revealed were as under:

Claim was repudiated under exclusion clause 4.12 "Disease directly or indirectly traceable to pregnancy, childbirth including caesarian section are not covered.

The insured complainant underwent LSCS operation. The progress summary proved that severe headache, high B.P, pulmonary Oedema etc.

It was proved that the above ailment was directly/indirectly traceable to pregnancy and the opinion of Dr.Vadalia called by this forum infers the same. Case was dismissed and decision of respondent was upheld.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-391-08

Shri Rameshbhai J.Patel Vs. New India Assurance Co.Ltd.

Award dated 30.06.08

Mediclaim repudiation. Exclusion Clause 4.1 alleging that disease was pre-existing prior to policy inception. The Policy was taken from 17-08-2004 to 16-08-2005 and renewed up to 16-08-2006. First consultation dated 30-05-2006 showed difficulty in walking since 1½ years. The record proved that ailment was not pre-existing as history does not go back to inception. Award directed respondent to pay claim.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0018-09

Mr.Rohinton S.Elavia Vs. New India Assurance Co.Ltd.

Award dated 08.07.08

The Mediclaim Case was repudiated by invoking policy Clause 4.1 Exclusion of pre-existing ailment. The Insured was suffering from DM Type-II since last 10 years. The Policy first incepted from 1999. History goes prior to 10 years before inception of policy.

Complainant's plea was that policy first incepted from 1995 and was renewed in continuation with United India Insurance Company in the year 1999-2000. Policy was renewed with New India Assurance Co. The recorded discharge summary of the hospital, the history of DM reaches to 1997 and claim cannot be pre-existing.

The Respondent submitted that through the contention of complainant is correct, there was a gap in continuation/renewal of policy in 1997-98 and as such the contract subsequently has to be asserted as fresh insurance claim which process that the ailment is pre-existing.

Based on the material on record and hearing of both the sides, the complainant fails to succeed and was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0379-08

Mr.Rajendra Bhagat Vs. New India Assurance Co.Ltd.

Award dated 11.07.08

The Mediclaim of the complainant for Rs.4, 20,000/- for treatment of Heart disease was repudiated on the ground of pre-existing Hypertension and Angiography which was suppressed by the complainant when the policy was incepted in 2003-04.

During renewal, Respondent insisted for exclusion of Heart Disease and its complications which was not accepted by complainant and approached to CDRF. On medication it was agreed by Respondent to exclude the imposition subject to fresh trade bill that found satisfactory. The TMT however was positive. The Respondent wanted

exclusion of Heart Disease. The policy was issued for 2005-06 without exclusion on renewal of Policy in 2006-07 claim was lodged by the complainant.

The cashless facility was denied as Hypertension was risk factor. The discharge summary also stated that complainant had undergone Angiography in 2000, 2003 and 2006.

The complainant denied the history and got the history corrected by giving Notarized Affidavit, which was declared an oath, Hospital however in their revised certificate mentioned that hospital can not substantiate the statement of insured that he is not suffering from HT for last 10 years and past Angioplasty.

The decision under the case to admit or to repudiate the claim depends on verification of truth as to the history of HT and angioplasty initially the discharge summary affirms the history and subsequently same is rejected by same hospital by mentioning that changes are made on the basis of Affidavit of complainant.

Since the Forum operates in limited area and specific process led down by RPG Rules 1998, to ensure speedy disposal on the basis of documents only.

The Forum neither have infrastructure nor power to undertake the above exercise and thus falls outside the ambit of forum and leave the complainant to pursue other means.

The complaint is thus disposed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0409-08

Mr.Rajendrakumar H.Soni Vs. National Insurance Co.Ltd.

Award dated 14.07.08

A mediclaim policy claim case of the complainant was repudiated on the grounds of material concealment of pre-existing disease/operation of LSCS with legation in 1995, prior to inception of Policy by imposing clause No.4.1. Thus Respondent rejected claim of incisional hernia operation of 2006.

The complainant pleaded that the incisional hernia operation was done out of complication arose from previous LSCS legation.

As per Clause 4.1 for exclusion of pre-existing operation and as per 4.12 for exclusion of complication of previous operation would have been imposed by Respondent, had the material fact disclosed at inception amounting to No claim.

Since the incisional hernia operation was done out of previous LSCS which is prior to inception of policy the complaint fails to succeed.

Thus case was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0001-09

Mr.Prashant N.Pandya Vs. New India Assurance Co.Ltd.

Award dated 16.07.08

A mediclaim for dental treatment of fractured teeth was repudiated on the exclusion clause i.e. dental treatment is in the nature of “Corrective cosmetic or Aesthetic procedure”.

The material on record confirms that the patient was treated as OPD patient.

In this, accident of insured remitted in dental treatment but period of hospitalization was lower than minimum stipulated admissibility as such could not be considered.

The Respondents decision was upheld and case was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0016-09

Shri Mahendrabhai B.Patel Vs. National Insurance Co.Ltd.

Award dated 29.07.08

Mediclaim lodged for insured's fracture in left ring finger costing Rs.4,793/- was repudiated as per exclusion clause No.1.2 by which to land of surgery under local anesthesia does not require hospitalization.

On medication, the Respondent was asked if claim could be settled at agreed Sum of Rs.4,000/- on compromise, the Respondent consented and complainant agreed to accept in full and final settlement of claim.

Thus the case was disposed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.14-004-0394-08

Ms.Janki Janatkumar Sheth Vs. United India Insurance Co.Ltd.

Award dated 29.07.08

The mediclaim lodged for operation on Morbid Obesity was repudiated on the grounds of Cosmetic Surgery as per Clause 4.5.

The complainant's plea, supported by the Sergeant's report, was that the Morbid Obesity is Laparoscopic Gastric Bypass Surgery is variant of Bar iatric Surgery which is approved by W.H.O. This is required for avoiding future high risk complications like diabetic, IHD. This Surgery is life saving surgery and not cosmetic surgery. The material on record shows that insured had BMI 41.3 Kg/M2 and the health condition and physical particulars of insured were apparent for surgery which involves Gastric Bypass to reduce size of reservoir to limit intake. This does not involve removal of Fats.

The Respondent cannot bring up any plea to contradict the above.

The complaint succeeded and Award was given directing Respondent to settle claim for admissible amount.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0051-09

Mr.Baldevbhai Narottamdas Patel Vs. National Insurance Co. Ltd.

Award dated 29.07.08

A mediclaim was lodged for Rs.74,060/- by the complainant for hospitalization of insured due to scald burns between 28-10-2007 to 08-11-2007 against the Sum Insured of Rs.60,250/-(including CB of Rs.10,250/-). The claim was settled by the Respondent for Rs.48, 380/- due to sub limits.

Subsequently, the claim was lodged for same ailment for hospitalization during 06-12-2007 to 08-12-2007. This time claimed amount was Rs.49,260/-. Against this Respondent's TPA settled the claim only for Rs.1600/- out of balance sum insured of Rs.11, 870/-.

Respondent pleaded that the TPA was unaware of the cumulative bonus of Rs.10,250/- and was not considered while settling claim.

On mediation by this forum, the Respondent and complainant mutually agreed as a claimed amount of Rs.7687/- as full and final settlement of claim.

The dispute resolved mutually by joint agreement.

Award directed the Respondent to settle the claim for Rs.7,687/- . Case thus disposed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0040-09

Mr.Pragnesh D.Shah Vs. Oriental Insurance Co.Ltd.

Award dated 31.07.08

A mediclaim for hospitalization during 11-01-2007 to 13-01-2007 was lodged for treatment of Right Knee injury/Meniscus Tear. The claim was lodged after 116 days hence repudiated by the Respondent.

The complainant pleaded by submitting treating surgeons letter marking delay in claim submission. But this did not save the purpose in delay. The complainant argued for delay on the ground that he was unaware about policy conditions instead of condo nation. The surgery also given an OPD patient for the ailment.

Though strictly speaking the claim is not payable but as a goodwill gesture, the Respondent keeping in view long standing relationship offered to settle the claim on Ex-gratia basis for an amount equal to 60% of admissible claim amount during the course of Hearing.

Taking into account, Respondent's offer of Ex-gratia settlement the 60% of admissible claim appears to be reasonable and just and Forum concerns this settlement and accordingly Respondent is directed to settle the same.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0035-09

Mrs. Sharmishthaben R.Thakkar Vs. United India Insurance Co. Ltd.

Award dated 30.07.08

Mediclaim lodged for hospitalization of the insured which was repudiated by the Respondent as the grounds of Clause 4.10 as admission in hospital was for physiotherapy only, which does not require hospitalization.

The Respondent's plea was that the insured suffered paralytic attack in USA and on landing in India he was admitted in the hospital as a case of "Hemiplegia Lt. Side with Myasthenia Gravis with Pneumocephalus with mild diabetes". Respondent submitted that patient suffered from age related degenerative process and only possible treatment is to reduce discomfort was physiotherapy which can be given at residence.

Since the patient was admitted as per Doctor's advice for Myasthenia Gravis which is due to Hypertension. This comply the principal clause of policy as such the hospitalization was for valid reason. As the insured sum is restricted to Rs.1.5 Lacs, the award given directed the Respondent to settle claim for Rs. 1.50 lacs.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0021-09

Mr. Kirtikumar N.Shah Vs. United India Insurance Co.Ltd.

Award dated 31.07.08

Mediclaim was lodged for hospitalization of the insured was repudiated as "Pre-existing disease" invoking Clause 4.1.

The Complainant pleaded that complainant is insured since 1996. Hospitalization reveals that insured was admitted for pain in legs, swelling and pigmentation of legs and ulceration eczema. Final diagnosis was Varicose veins in 2003 the insured was operated for Bilateral varicosities with S.F and claim was admitted by United India Insurance Co.

The Policy has been renewed in continuation since 1997.

Respondent could not submit any evidence to confirm that disease is pre-existing which thus is not established.

The award directing the Respondent to settle the claim as complaint succeeds.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0004-09

Mr.Dilip C. Prajapati Vs. United India Insurance Co.Ltd.

Award dated 31.07.08

The mediclaim lodged for hospital treatment was repudiated on the grounds that hospitalization was for treatment of acute pancreatitis with septicemia.

The Respondent pleaded that as per the medical referee's opinion this treatment involves frequent Ultra Sound Sonography even CT scan of abdomen in view of its serious nature in this case the hospital record could not prove the single investigation being done and results in doubt about malafide intention.

The complainant's plea that he was admitted as per physician's advice. However Respondent's plea of not undertaking Sonography and CT scan is unanswered.

The surreptitious Modus Operandi of treating physician, his hospital, his laboratory and also medical store in several cases cited by the Respondent backs the repudiation of claim.

Thus, the complaint was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-002-0053-09

Mr. Bhadreshkumar Naik Vs. New India Assurance Co.Ltd.

Award dated 31.07.08

The mediclaim lodged for insured's hospitalization was repudiated on the grounds of hospitalization for treatment of tear ear due to entanglement of ear ring in car window and earlobe was stretched under clause 2.3.

Complainant's plea was as the earlobe tore in car window required treatment in hospital under plastic and cosmetic surgeon.

The surgical operation was done on local anesthesia. The Respondent pleaded that this becomes from OPD case and does not require hospitalization.

Since it was informed that hospital does not have any bed for admission and treatment is done an OPD process with local anesthesia. Complaint was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0058-09

Mr.Narendra J.Shah Vs. Oriental Insurance Co.Ltd.

Award dated 31.07.08

In a mediclaim policy, an insured, claim lodged for dental treatment was repudiated on the grounds of exclusion clause 4.7 as the dental treatment is excluded.

Complainant pleaded that due to accidental injury it was required hospitalization for more than 24 hours.

From the record it is observed that treatment took place in dental clinic equipped with Dental Clinic and patient was treated on OPD basis.

Since there has been no hospitalization and treatment given was on OPD basis case does not qualify for reimbursement due to non compliance of basic policy requirement. Thus, the case was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0062-09

Mr.Rameshkumar Agrawal Vs. National Insurance Co.Ltd.

Award dated 31.07.08

Claim under mediclaim policy was lodged for treatment of Oral Chemo Therapy for Breast Cancer of Insured.

The Respondent argued that in the treatment of Oral Chemotherapy the hospitalization for minimum 24 hours was not involved and claim is not acceptable.

In the course of hearing, it was confirmed by the Respondent that there is no other infirmity in claim except that hospitalization not required for Oral Chemotherapy.

Chemotherapy could be administered only on hospitalization is in early days. However technical advancement and progress in medical sciences it has been rendered possible to have chemotherapy to be administered orally without hospitalization provided the stipulated medical precautions are taken.

Taking into these entire circumstances award was given directing Respondent to settle the claim.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 08-08-2008

Case No. 11-004-0027-09

Mr. Kamalkant K Raval vs. United India Insurance Co.Ltd.

Mediclaim Policy. Claim lodged for Insured's hospitalization was repudiated for late submission of claim form.

Insured was operated for Cataract on 21-07-2007 and discharged on same date. Claim form was submitted on 21-09-2007 (after 2 months) the operating surgeon confirmed that post operative treatment lasted till 28th September 2007.

As per Respondent, the claim was to be submitted within 7 days after discharge as per clause 5.4. However, if there is post operative treatment, it has to be submitted within 7 days after such treatment (limited to 60 days). The Respondent failed to observe post operative provisions.

Considering the facts that the treatment lasted till 28-09-2007 and papers were submitted on 21-09-2007 the clause 5.4 becomes inoperative.

The Respondent was directed to settle the claim.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 12-08-2008

Case No.11-009-0043-09

Mr.Amit V.Modi vs. Reliance General Insurance Co.Ltd.

The Individual Mediclaim lodged for hospitalization and treatment in January 2008 was repudiated on the grounds of exclusion clause for Pre-existing disease. The point to be discussed was if Respondent could prove that the ailment is pre-existing. The Respondent's doctor's statement is based on 2 noting made by Dr.Jayesh Patel's letterhead which is undated and unsigned giving history of patient's complaint of pain in Lt. hip is more than 3 months.

The definition of pain makes it clear that pain is not disease, it is symptom only and as such Doctor's contention that disease was pre-existing is incorrect. The treating doctor's mentions "No illness or history on record". The insured was covered since 2004. If the disease was Pre-existing, he would have preferred treatment instead of suffering.

Thus the complaint succeeds. Respondent was directed to settle the claim within 15 days.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0342-08

Mrs.Kalaben B.Amin Vs. New India Assurance Co.Ltd.

Award dated 30.06.08

Mediclaim repudiated

The case was repudiated an invoking policy clause 1.1.

Expenses incurred were for pathological exam and medicines only.

Analysis of document on records show that, 11 Prescriptions, 22 Reports and 25 bills are not the bills of injection related to Horman therapy and all are related to diagnostic tests.

The case was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 20-08-2008

Case No.11-005-0059-09

Mr.Shirishkumar N.Shah Vs. Oriental Insurance Co.Ltd.

Mediclaim for hospitalization for acute psychosis was repudiated on exclusion clause 4.8 for psychiatric treatment.

The clinical history and certificate of attending psychiatrist indisputably confirm that insured was suffering from acute psychosis and psychiatric disorder.

The exclusion clause 4.8 is expressly stating that above treatment is not reimbursable in the Mediclaim.

The complaint fails to succeed and was dismissed

AHMEDABAD OMBUDSMAN CENTRE

Award dated 21-08-2008

Case No.11-003-0071-09

Mr.Rajeshkumar H.Dham vs. National Insurance Co.Ltd.

Mediclaim Policy. Claim for hospitalization and treatment expenses was lodged in October 2006, was repudiated an exclusion clause 5.3 – late submission.

The insured was admitted to hospital on 11-10-2006 and then was transferred to other hospital on 12-10-2006 for treatment of acute viral + HTN+ joint pain and discharged on 24-10-2006.

The claim however was lodged on 07-04-2007. No prior intimation was given to Respondent.

Since the papers submitted confirmed the fact of delayed submission the invoking clause 5.3 was correct for repudiation for inordinate delay in submission.

The case thus was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 22-08-2008

Case No.11-002-0034-09

Mr.N.J.Bhesania – Vs. New India Assurance Co.Ltd.

Mediclaim for hospitalization expenses incurred lodged by complainant was repudiated on the grounds by invoking clause 4.8 and 4.10 as the opinion was that admission to hospital was for diagnosis purpose.

Complainant pleaded that accident occurred while alighting from the train on platform and could not stand. The visitors/relatives drover her to hospital as per the advice of the doctor and underwent treatment.

Looking to the facts Respondent agreed to settle the claim on negotiation basis offering 75% of claim. After mediation by the forum the respondent and complainant mutually agreed for the same.

The case was thus disposed.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 22-08-2008

Case No.11-004-0036-09

Mr.Arvindkumar N.Shah vs. United India Insurance Co.Ltd.

A mediclaim for hospitalization expenses incurred for operation of Inguinal Hernia was repudiated by the Respondent invoking clause 4.1 on the grounds that patient had already operated for Rt. Inguinal Hernia earlier in 2001 and thus disease becomes pre-existing because the policy incepted from 1996 had a break/gap in 2002-03 and exclusion clause was put while remaining the policy in 2003-04.

The complainant pleaded that there was no break in continuation of renewal. Even in 2003-04 all requirements were completed for renewal well in time including cheque for premium payment. However due to Bank strike during first fortnight of May 2002 and on checking the bank account and finding that cheque has not been encashed. The 7 days time required for fresh cheque due to above was beyond anybody's control. The same 8 days was treated as break by the Respondent.

The complaint succeeded on merit and Award was given directing the Respondent to settle the claim.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 22-08-2008

Case No.11-002-0048-09

Mr.Snehalsamir K.Frank Vs. New India Assurance Co.Ltd.

Mediclaim for knee injury was repudiated by the Respondent invoking clause 4.10 that hospitalization was not required as the treatment given like bandage, braces and oral medicines can be done an OPD basis.

The complainant pleaded that as per the doctor's advice for acute knee injury with haemarthrosis which was severely painful admission is required. The patient may have suffered variety of injuries like ACL tear, Meniscus tear, PCL tear or vascular injuries. This compelled hospitalization.

On persuasion and mediation by the Forum, the Respondent and Complainant mutually agreed for an amount of Rs.3007/- as full and final settlement to resolve the grievances.

The case was thus disposed.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 22-08-2008

Case No. 11-005-0074-09

Mr.Ratilal D. Patel - Vs. Oriental Insurance Co.Ltd.

Mediclaim Policy. The Claim lodged for expenses incurred in hospitalization was repudiated by Respondent on the grounds of invoking clause No.4.10 as the hospitalization for diagnosis purpose and not treatment.

The Complainant pleaded that he was admitted for accelerated hypertension + BHP as consultation for B.P.

The document on record proved that accelerated hypertension may be associated either Pappiloedama or acute Coronary event on Renal failure which require admission for adjusting dosage and investigation to know the cause.

The Respondent agreed for the above and offered to settle the claim for Rs.20,000/- in full and final settlement. The complainant agreed and accepted the offer.

The case thus was resolved on mutual agreement to resolve the issue and was disposed.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 25-08-2008

Case No.11-002-0066-09

Mr.Jaydeep R.Patel Vs. New India Assurance Co.Ltd.

Mediclaim. The Insured member was hospitalized and claim for incurred expenses was lodged which was repudiated on the grounds of invoking clause 4.1 being pre-existing disease and clause 4.3 excluding expenses for Hysterectomy in fibroid.

The Respondent submitted discharge card of the hospital mentioning treatment for Accessory breast Axilla, multiple big size fibroid both breast (which is lump for 2 months gradually increasing in size, no fever no pain). The history does not go prior to inception of the policy and cannot be concluded as pre-existing.

The Respondent's decision to treat this pre-existing is not supported by observation in its last para where while comparing the fibroadenoma of breast with fibroid of Uterus and mixed two different things which is incorrect Clause 4.3 (which excludes Hysterectomy for fibroid) is not applicable and in this case there was no hysterectomy at all but for breast.

The complaint succeeded. The award directed the Respondent to pay claim in full and final settlement.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 25-08-2008

Case No.11-002-0068-09

Mr.Nimish A.Acharya Vs. New India Assurance Co.Ltd.

Mediclaim policy, claim lodged was repudiated by the Respondent invoking clause No.5.3 for not sending the claim within 7 days from the date of hospitalization (Claim lodged after 1 month).

The Complainant pleaded that he was hospitalized and since it was Group Mediclaim of his Employer, send the claim paper to his employer (LIC of India) for onward transmission to Respondent as the date of admission itself. Actual delay is only for 14 days. He further represented the case to Respondent for waiver/condonation of delay which was turned down.

In this case the complainant accepted delay and asked for waiver and delay of 14 days cannot be inordinate delay which is fit for condo nation in terms of Clause 5.4 (Discretionary Element). On the other hand since it Group Mediclaim of P.S.U when member has no choice to opt out of scheme deserve special consideration.

The complaint thus succeeds. Award directed Respondent to review the case and settle the claim.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 27-08-2008

Case No.11-004-0037-09

Mr.Vishnubhai A.Patel Vs. United India Insurance Co.Ltd.

Mediclaim Policy. A claim was lodged by the complainant for expenses incurred during hospitalization of insured for Diabetes Mellitus and Hypertension was not settled by the Respondent.

During the hearing when the complainant was absent, the Respondent informed and documents on record confirmed that in spite of letter from TPA for submitting the hospital papers and discharge summary the complainant did not arrange for submission. Instead he has sent the hospital letter mentioning that hospital record cannot be given as per practice of hospital and that concerned authority can come to hospital to peruse the papers.

Since submission of related papers from hospital is mandatory requirement for processing the claim and all the hospitals are submitting their record's Xerox as requirement the claim process could not move further.

The case was turn dismissed and directed complainant to submit the papers for which Respondent will reopen the case for subsequent settlement.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 27-08-2008

Case No.11-004-0003-09

Mrs. Bhartiben P.Patel Vs. United India Insurance Co.Ltd.

Mediguard Policy. The claim was lodged by the complainant, was repudiated by Respondent on the grounds that hospitalization for Diabetes Mellitus and Hypertension was not required.

During hearing the Respondent looking to the facts of the case and on mediation of the Forum agreed to settle the claim for Rs.10,000/- in full and final settlement to which the complainant agreed.

Since the dispute was resolved by mutual agreement in the case it was disposed.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 27-08-2008

Case No. 11-004-0073-09

Mr.Ashok J.Prajapati Vs. United India Insurance Co.Ltd.

Mediclaim Policy. The insured was hospitalized and claim for reimbursement of expenses was repudiated by the Respondent on the grounds that the disease was Pre-existing and clause 4.1 was involved for the same.

The Respondent pleaded that insured underwent operation for Trans Urethral Resection of Prostate (TURP), bilateral Orchiectomy and Hernioplasty which was prior to inception of the policy. After close examination of documents on records showed that out of above 3 operation only Hernia was pre-existing since 1997 as reported by health check-up records of the hospital and Respondent's medical referee's opinion that insured was a case of obstructive voiding symptoms – 6-7 years which form the basis of repudiation is not corroborated by the papers on record.

Taking into account the above facts the Respondent was directed to reopen the case and settle claim for TURP and Orchiectomy only (and not for hernia).

AHMEDABAD OMBUDSMAN CENTRE

Award dated 27-08-2008

Case No. 11-002-0042-09

Mr.Bhaskarbhai K Desai Vs. New India Assurance Co.Ltd.

In Mediclaim Policy, the insured was hospitalized for Ischemic Heart Disease. The claim was repudiated invoking Clause No.4.1 which excludes pre-existing disease.

The policy incepted from 2001 subject to exclusion of diabetes and related disorder. The complainants plea was that he was admitted for Ischemic Heart Disease and Coronary Angioplasty as such the diabetes cannot be treated as related disorder for the ailment.

Respondent confirmed that diabetes of the insured is for 7-8 years and policy also excluded this and claim is for heart disease with diabetes, HTN for which angioplasty was done. Diabetes being high risk factor repudiation is justified.

Since the material on record confirmed these facts, case was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 1st September 2008

Case No.11-002-0015-09

Ms. Harshadaba C. Jadeja Vs. New India Assurance Co.Ltd.

In Mediclaim Policy the insured was hospitalized but claim was repudiated invoking clause 5.4 as the claim was not submitted within 30 days and permissible time limit expired.

The material on record confirmed that respondent vide their letter dated 23-06-2008 informed the complainant that subject repudiation will be revoked of the complaint is withdrawn.

After bringing the facts to the notice of the respondent, the agreed to settle the claim and dispute was resorted mutually without formal award.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 01-09-2008.

Case No. 11-004-0028-09

Mr.Hasmukhbhai K.Vithlani Vs. United India Insurance Co.Ltd.

A mediclaim was lodged by complainant for expenses for hospitalization for chest pain.

This was repudiated invoking clause No.4.10.

However after hearing the respondent in-view of the fact that policy has been renewed for last 13 years in chain without break and this being the first claim, agreed to settle the claim.

Dispute was mutually resolved on settlement after mediation as such formal award was not pronounced.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 04-09-2008

Case No.11-002-0067-09

Mr.Bhadrik N.Kikani Vs. New India Assurance Co.Ltd.

Mediclaim was lodged for expenses incurred for hospitalization for Viral Hepatitis and Hemolytic Anemia. The claim was repudiated invoking Clause 4.3 defining ailment as pre-existing one.

The complainant submitted the supporting documents of his doctor and argued that his congenital D6PD disorder from childhood is not related to the disease for which he was hospitalized.

Respondent submitted his panel doctor's opinion as well as medical journal which proved that congenital disorder of D6PD of insured makes it vulnerable to ailment like jaundice Hepatosplenomegaly and Gall Bladder calculi and said that for this insured underwent blood transfusion in 1993.

On enquiry that if this is congenital then how diagnosis is made as Viral Hepatitis but Respondent could not add any material to merit his stand.

The case was awarded only for claim of Viral Hepatitis and rest repudiating was upheld.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 04-09-2008

Case No.21-003-0045-09

Mr.Jentilal Jiva Charania Vs. Tata AIG Life Ins.Co.Ltd.

Health Protector Plan with rider of critical illness benefit was taken by complainant.

The claim lodged for hospitalization for Coronary Artery Bypass Grafting (CABG) was repudiated under the clause that in respect of critical illness the signs or symptoms of which first occurred within 180 days from commencement/reinstatement has to be disallowed.

The material on record confirmed that though the policy incepted earlier the same was discontinued due to nonpayment of premium and was reinstated after health statement.

The period elapsed from reinstatement of policy and ailment operated for was less than 180 days and indisputably established that claim arisen within 180 days is not payable.

Case was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 08-09-2008

Case No.11-005-0092-09

Mr.Rajeshkumar V.Patel Vs. Oriental Insurance Co.Ltd.

Mediclaim policy. Claim was lodged for hospitalization for operation of Adhesiolysis and was repudiated by Respondent.

However as mediation by the forum the Respondent offered Rs.6,595/- as full and final settlement of claim to which complainant agreed.

As due to compromise by both parties the dispute was mutually resolved no formal award was given.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 08-09-2008

Case No.21-003-0038-09

Mr.Samjibhai Virjibhai Patel Vs. Tata AIG Life Ins.Co.Ltd.

Against the health Protector Plan issued by the Respondent and claim was lodged by the complainant for IHD Ischemic Heart disease which was repudiated.

Complainant's plea that claim arose after 1year of policy and policy incepted only after required medical examination by panel Doctor of the company.

The Respondent pleaded that the hospital case summary has mentioned that the patient had Chest discomfort and dyspnoea on exertion since last 5-6 months and if we go back to 5-6 month it proves that period elapsed is within 180 days of policy inception which was withheld by the party regarding health information at the time of proposal.

Since the facts confirmed the repudiation case was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 11-09-2008

Case No.11-004-0080-09

Mr.Mihir Bharatbhai Thakkar Vs. United India Insurance Co.Ltd.

The insured was covered under mediclaim which was lodged for expenses against nose surgery, was repudiated invoking clause 4.3.

The complainant pleaded that policy incepted since last 3 years without any break as such clause 4.3 is not applicable and claim be paid.

The Respondent agreed on persuasion and mediation by the forum to settle claim as per rules revoking clause 4.3 to which complainant agreed.

The complaint was resolved by mutual agreement for full and final settlement as per rules.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 12-09-2008

Case No.11-004-0072-09

Mr.Miteshkumar M.Shah Vs. United India Insurance Co.Ltd.

The insured was hospitalized for tear of meniscus and the mediclaim was repudiated on the grounds being pre-existing under clause 4.1, on the basis of medical referee's opinion that Discord Latual meniscus is pre-existing condition.

The Respondent submitted that rule to cover the pre-existing disease after 3 claim free renewal was not acceptable to this policy as the claim occurred was under Mediguard policy cover and subject claim is in the first year.

The facts in the case revealed that policy incepted and renewed without break and the Respondent's plea to be in first year is not acceptable even the new policy is issued under Mediguard policy for first year that medical referee's opinion is one sided.

The complaint succeeds and award directed Respondent to settle the claim.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 12-09-2008

Case No.11-002-0086-09

Mr.Bhagwanbhai M. Prajapati Vs. New India Assurance Co.Ltd.

Mediclaim lodged for hospital expenses for ailment covered but was repudiated by the Respondent defining that hospital admission was only for diagnostic purpose and not for treatment which was based on the investigation by the Respondent's panel doctor.

The complainant argued that the admission was only done as per the advice of treating physician and has submitted original bills/receipts for the same.

On persuasion and mediation by the forum the Respondent agreed to settle claim equal to 75% of claimed amount to which complainant agreed.

The dispute was resolved mutually and Respondent was directed to settle 75% of claimed amount as full and final settlement of claim.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 17-09-2008

Case No.11-002-098-09

Mr.Atulbhai Nai Vs. New India Assurance Co.Ltd.

The complainant lodged a claim for hospital expenses of his insured son for the treatment of Urinary Tract Infection (UTI) was repudiated by the Respondent invoking Pre-existing disease as per Exclusion Clause 4.1 of Mediclaim Policy.

The Respondent pleaded that the policy incepted on 30th July 2007 and insured had consulted Dr.Dinesh Patel of Devasya Hospital on 4th July 2007. On perusal of the Doctor's prescription dated 4-7-2007, it is proved the patient was diagnosed for Oedema on face + cry on urination + Turbid urine+ Dysuria fever since (2 months). As per Discharge Summary dated 16-01-2008, The insured was hospitalized for the treatment of UTI at Ankur Institute of Child Health, Ahmedabad.

The complainant insisted that his son was hospitalized in the month of July 2007 when he was fully cured, therefore claim is genuine.

Going through the records submitted by both the parties and materials on record, the Respondent's decision to repudiate the claim as Pre-existing disease under Exclusion Clause 4.1 is found genuine and no other relief to the complainant.

Thus the case was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 25-09-2008

Case No.11-002-0083-09

Mr.Kavyen Ajitbhai Shah Vs. New India Assurance Co.Ltd.

The Complainant covered under Mediclaim and lodged claim for expenses against insured member's breast abscess.

Claim was repudiated invoking the exclusion clause relating to ailment arising from or traceable to pregnancy, childbirth etc. vide clause No.4.12.

Complainant pleaded giving medical reference that the breast abscess was not due to Clause 4.12 but was result of infection.

The Respondent contradicted with reference of his panel doctor.

However as mediation by this forum, Respondent agreed to settle the claim which was agreed by complainant.

The Complaint was resolved by mutual understanding and thus disposed.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 25-09-2008

Case No.11-005-099-09

Mr.Jayantilal N.Patel Vs. Oriental Insurance Co.Ltd.

The mediclaim policy covering the complainant, who was hospitalized for operation for prolapsed piles, against which a claim was lodged and was repudiated under Clause 4.8.

The Respondent pleaded that complainant is known case of cirrhosis of liver (Portal Hypertension) and due to this it resulted in prolepses of piles and repudiation is qualified.

On mediation by this forum, the Respondent agreed to settle the claim for Rs.8,500/- in full and final settlement to which complainant agreed.

The Case was resolved by mutual agreement and thus disposed.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 25-09-2008

Case No.11-005-0133-09

Mr.Jaykumar N.Shah Vs. Oriental Insurance Co.Ltd.

The Complainant was hospitalized for Fistula in Ano with abscess and Piles and claim was repudiated by the Respondent invoking Clause 2.1 as the treatment was taken in Ayurvedic hospital which was not Government Hospital.

The facts on record confirmed that operation was done by M D (Ayurv.) in the hospital which was not government hospital but a private hospital.

The case was dismissed upholding the Respondent's repudiation.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 26-09-2008

Case No.14-002-119-09

Mr. Harendra J. Thanki Vs. New India Assurance Co.Ltd.

A claim for treatment of Major Depressive Disorder of insured was repudiated by the Respondent invoking clause 4.8 as treatment of this disease was excluded.

The Complainant submitted that the major depressive disorder was not any mental debility but was due to major family mishap due to which the insured was shocked and for that treatment was given.

The Respondent submitted that all such mental disorders are already excluded as per policy conditions 4.8 and cannot have discretion to admit claim.

The analysis of the material on record confirmed that treatment was given for mental depression. The history of patient also recorded about sadness poor apatite and several suicidal tendency amounts to major depressive disorder and invoking clause 4.8 is justified. The complaint was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 29-09-2008

Case No.11-002-0102-09

Mr.Jitendra O.Shah Vs. New India Assurance Co.Ltd.

A mediclaim lodged by the complainant for hospitalization expenses of the insured for treatment of High B.P and CV Hemorrhage was repudiated by the Respondent invoking clause 4.1 i.e., the ailment was pre-existing.

The Complainant pleaded that the policy was incepted since 1998 and renewed in chain without any break and the Respondent's plea about Pre-existing ailment is based on Neurologist's noting as prescription. The notification cannot be relied upon because the insured was brought to neurologist as she suffered brain hemorrhage.

It was pertinent to note that the Respondent has relied only on note of Neurologist when the patient was not able to think/talk and they ignored the noting of physician treating for MMR. Moreover the clause 4.1 becomes inoperative if the period of 3 claim free year is passed.

The award directing Respondent to settle the claim was given setting aside repudiation.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 29-09-2008

Case No.11-002-0120-09

Mr.Jayesh M. Patel Vs. New India Assurance Co.Ltd.

Mediclaim for hospitalization of Insured member for treatment of Viral hepatitis was repudiated as the intimation was not provided along with claim papers submitted to TPA.

The complainant submitted that he had sent intimation to TPA only with proof of submission.

The Respondent submitted that they did not have sufficient papers on record to comment on the matter.

On mediation by this Forum, the Respondent agreed to open the file and settle the claim for admissible amount which was converted by the Complainant.

The complaint was mutually resolved by both the parties.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 29-09-2008

Case No. 11-002-0112-09

Mr.Siddharth A. Shah Vs. New India Assurance Co.Ltd.

The insured member was hospitalized for Surgery of intestinal obstruction due to intra abdominal small intestinal strangulation. The mediclaim lodged was repudiated invoking clause No.4.1 pre-existing ailment on the basis of history recorded that HT 5 years, LSCS 10 years back and incisional hernia since 10 years.

The complainant pleaded that policy was incepted from 1992 till 2008 and history goes prior to inception of policy.

Respondent argued that present ailment relates to previous surgery as the policy was incepted from 2001.

Give the inception since 1992 was confirmed and forum mediated the Respondent agreed to settle the claim for Rs.81,868/- and complaint was mutually resolved.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 29-09-2008

Case No.11-004-0127-09

Smt. Sunanda C.Kanira Vs. United India Insurance Co.Ltd.

Mediclaim was lodged for treatment for mouth/dental injury and reimbursement of expenses of Rs.31,333/- which was repudiated as per exclusion clause 4.7 of dental treatment.

The Respondent pleaded that there is no hospitalization for accidental injury as such the claim is excluded as per policy condition.

It was confirmed from records that insured was having genuine dental problem as per Orthopantogram reveals that periodontal disease and periapical lucency.

This treatment does not require hospitalization.

The case was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 29-09-2008

Case No.11-002-0101-09

Mrs. Sangita H.Mehta Vs. New India Assurance Co.Ltd.

A mediclaim for hospitalization of insured for treatment of Bipolar Mood disorder, Depression H.T, Diabetes, IHD was lodged by complainant and was repudiated invoking clause 4.1 and 4.8 – Pre-existing disease and Run Down condition respectively.

The document on records confirmed that the patient had history of Bipolar Mood disorder and history of Psychosis.

The police panchanama confirmed that the insured patient drank acid to commit suicide and was suffering from psychiatric disorder for last 7 years.

Thus the Respondent's decision to repudiate the claim was justified and complaint dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 30-09-2008

Case No.11-005-0082-09

Mr.Nanjibhai G.Parmar Vs. Oriental Insurance Co.Ltd.

The insured who was covered under Mediclaim was hospitalized for treatment of Bipolar Disorder. The claim lodged was repudiated invoking clause 4.8 excluding treatment for mental treatment.

The Complainant pleaded that the insured was admitted for examination fever and there was no mental disorder.

On Respondent's pleading and documents on record confirmed that insured was diagnosed for Bipolar Disorder which is a mental treatment and exclusion clause 4.8 is justified for repudiation of claim.

The complaint was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 30-09-2008

Case No. 11-003-091-09

Mr. Narottam S. Patel Vs. Oriental Insurance Co.Ltd.

The complainant lodged mediclaim for expenses of hospitalization for plural effusion and renal disorder was repudiated invoking clause of 'Late submission' under clause 5.4.

The material on record and pleading of both the sides following facts was revealed.

The admission in hospital was for chronic renal failure with right plural effusion. The delay in submission of claim had not been marginal and was beyond 11 months.

The reasons for late submission were not given nor requested the condonation of delay.

This is a case where the claim was exorbitantly delayed without convincing reason violating clause 5.4.

The complaint was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 30-09-2008

Case No. 11-005-0087-09

Mr. Pradipbhai B. Joshi Vs. Oriental Insurance Company Ltd.

The Complainant lodged mediclaim for reimbursement of hospitalization expenses incurred for treatment of back pain. The claim was repudiated on the grounds that hospitalization was not required for treatment.

The Complainant pleaded that the back pain was severe and get admitted for treatment for two days and as per the advice of orthopediation he had done MRI for Lumber Spine.

The Respondent pleaded that the MRI for Lumber spine was done after discharge and that during hospitalization no treatment or injectibles were administered. Further that an investigation, the doctor had orally confirmed that patient was treated an OPD only but did not give in writing.

From the documents on record and views of both parties, it cannot be positively concluded that hospitalization was necessary or actually it took place. Most of the diagnostic tests have been carried out after so called discharge from hospital and patient was advised physiotherapy for treatment which is OPD process. Thus Repudiation is justified, Complaint was dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 30-09-2008

Case No.11-005-0110-09

Mr.Naresh T.Prajapati Vs. Oriental Insurance Co.Ltd.

The Mediclaim was lodged for hospitalization for chest pain, acute chest syndrome with respiratory tract infection. The claim was repudiated invoking clause 4.3.

The Complainant submitted that he was admitted in hospital for above ailment as per the advice of medical adviser.

Respondent pleaded that as per the medical referee, the insured was admitted for Acute Coronary Syndrome (ACS) and was having High Blood Pressure and treated for HBP and ACS.

From documents on records, it is confirmed that patient was admitted after medical advice and case history mentions that there is no past history of HBP. The opinion of treating doctor always assume greater credibility and precedence over medical referee's opinion and that during admission the patient was treated for ACS and RTI and not HBP.

The award directed Respondent to settle claim keeping aside the repudiation.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 30-09-2008

Case No.11-005-0094-09

Mr.Jayesh M.Shah Vs. Oriental Insurance Co.Ltd.

The insured member was hospitalized for Phimosis and Balanoposthitis. The claim was repudiated invoking clause 4.8 as the ailment was congenital and not covered in policy as the patient's age is 7 years.

On perusal of records and documents submitted, it is pertinent to note that Insured was suffering from Balanoposthitis which is inflammation of foreskin and glance of pains and occur over a wide age range and may have multiple Bacterial or fungal origins.

The Respondents invoking clause 4.8 is not justified because the hospitalization and Surgery were not due to congenital disease but due to pathological disease.

The award directed Respondent to set aside the repudiation and settle the claim for Rs.7, 203/-.

Thus the complaint was disposed.

Delay in settlement

AHMEDABAD OMBUDSMAN CENTRE

Case No.14-005-0387-08

Mr.Chandrakant M.Shah V/s. Oriental Insurance Co.Ltd.

Award dated 29.04.08

Mediclaim Case. Dispute was raised under RPG Rules 1998 for delay of claim payment.

The following facts were observed after perusal of material on record and personal hearing of both sides.

The claim for Rs.1.05 Lacs was submitted against Sum Insured including CB for Rs.75,000/-. The papers and bills were submitted and agreed. The Respondent called for original bills of hospitalization and called for bifurcation of bill amount.

There was inordinate delay in settlement of claim for which the Respondent could not prove reason. Complainant pleaded that bills were called but not bifurcation, similarly the claim is for 1.15 lacks and Insured sum 75000/- (within limit). As there is package with hospital, the hospital has issued consolidated bill. It was proved that there was no reply non settlement equal approach from Insured to Insured was absent. There is no lapse on complainant hence delay is not justified.

Award directed respondent to settle claim of Rs.75000/- with interest Rs.6000/- within 15 days.

AHMEDABAD OMBUDSMAN CENTRE

Case No.14-004-0061-09

Shri Nipunchandra B.Shah Vs. United India Insurance Co.Ltd.

Award dated 29.07.08

The claim lodged under 5(Five) Bhavishya Arogya Policies for Rs.1,00,000/- was delayed by the Respondent besides non-issue of two policy documents taken two years back.

The complainant pleaded that despite lodgment of claim for Rs.20, 000/- each under this 5 policies and subsequent reminders the claim is not settled. Besides this two policy documents in two cases are yet to be issued.

The Respondent agreed for delay and informed that claim under 3 policies each @ Rs.20,000/-, totaling to Rs.60,000/- has been admitted and will be paid as soon as the discharge form is received from insured (This was returned undelivered). As the other two policies were incepted subsequent to claim the claim is not admissible for Rs.40, 000/-.

Complainant consented to this and case was mutually resolved.

Partial Repudiation

AHMEDABAD OMBUDSMAN CENTRE

Case No. 14-002-0298-08

Mr. Gaurav Oza vs. New India Assurance Co.Ltd.

Award dated 07.04.08

Mediclaim partially disallowed. The dispute raised under RPG Rules 1998, when the Complainant- Gaurav Oza lodged Mediclaim of Rs.66, 672/- and the Respondent Insurer disallowed the claim partially for Rs.5, 295/-.

On verification of the documents on record and hearing of both the sides, it was revealed as under:

The amount was disallowed on the charges claimed were of non medical nature as per Respondent's plea viz. Surcharge Rs.4, 295/-, Admission fee Rs.100/-, HIV Test Rs.250/-and Certificate charge Rs.50/- defining it an administrative charges.

It was seen from the documents that charges like visit of doctor, O.T. charges, Anesthesia and Surgical charges are involved which are normally 10% of medical expense which is mentioned in the bill.

The award was given to settle the amount (as it cannot be clarified as non medical expenses) to the Respondent.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0364-08

Mr.Ashvin K. Shah vs. United India Insurance Co.

Award dated08.04.08

Mediclaim. Dispute under RPG Rules 1998 was raised for disallowing Mediclaim partially for Rs.4, 508/- against bill of Rs.97, 316/-.

The documents on record and personal hearing of both the sides revealed facts as under:

The claim of complainant's father for treatment of Alzheimer's disease was lodged claim which includes Rs.141/- (Nebulizer kit) Rs.2003/- (Diapers) Rs.1800/- (for recourse vanilla) was disallowed under "no reason", nor any justification was given by respondent for query letter of complainant.

It was held that out of the disallowed item, the external disease like

Nebulizer Ryle's tube and diapers etc by the Respondent is correct, but amount spent on Echo report for Rs.500/- only because bill is not supported is not valid as the report was received and agreed by the Respondent.

Award was given upholding the decision of Respondent for Rs.4,008/- but directed them to settle Rs.500/- for Echo Report.

AHMEDABAD OMBUDSMAN CENTRE

Case No.14-005-0192-08

Smt.Hiraben B.Brahmbhatt Vs.Oriental Insurance Co.Ltd.

Award dated 03.06.08

Mediclaim Policy. Dispute raised for disallowing claim for Rs.10,800/- as against Rs.19,058/-. On perusal of documents and hearing the things revealed are:

The policy was incepted in 2000 without any excess. Renewed without break, in continuation Respondent imposed an excess of Rs.10,000/- w.e.f. 2004-2005 till 2005-06 without informing the complainant and was

reduced to Rs.5,000/- from 2006-07. Respondent did not give reason for imposing excess. Thus it becomes unjustifiable. The plea that complainant did not object for this was ruled out.

The complaint succeeds on merit and Award was given to settle the claim.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0030-09

Shri Ashok V.Mehta Vs. New India Assurance Co.Ltd.

Award dated 26.06.08 Mediclaim Policy

The dispute was raised for partially admitting the claim.

The facts came on record after verification of documents and hearing are :

The claim for operation for Cystoscopy + TUR-BT was advised by doctor for BCG therapy for 6 weeks after surgery. This is substitute to chemotherapy (for patient suffering from cancer and has to be carried out in hospital through hospitalization for 24 hrs) is not required for BCG.

As per Clause 3.2 the respondent admitted relevant medical expenses of Rs.6, 441/- and disallowed Rs. 12,485/-.

As Respondent agreed to consider the case on submission of proof of treatment taken after operation the award was given directing respondent to process the claim.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0017-09

Mr.Ashit R.Bhow Vs. National Insurance Co.Ltd.

Award dated 26.06.08

Mediclaim partially settled disallowing Rs.34, 652/-.The facts revealed after verification of documents on record and hearing of both sides are :

In this case the insured was admitted for fibroid uterus and operated for hysterectomy (LAVH). As per respondent's medical referee (for opinion), the justification of expenses as also duration of hospitalization was suspected. While analyzing the material on record, it was observed that Respondent, while making arbitrary deduction from claim relied upon opinion of referee who is not specialized in this case and not gynecologist. Thus award was given directing the respondent to settle claim parties disallowed.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 18-08-2008

Case No.11-005-0063-09

Mr.Manoharbhai J Bhatia Vs. Oriental Insurance Co.Ltd.

Mediclaim for hospitalization of insured was partially settled, deducting a Sum of Rs.6423/-.

The complainant's plea that claim for Rs.35,361/- was settled for Rs.28938/- deducting Rs.6423/-.

The Respondent argued that the deduction were correct and reasonable.

However a mediation of this forum both the parties agreed to resolve as mutual basis and Respondent agreed to pay difference.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 27-08-2008

Case No.11-003-0070-09

Mrs.Jyotiben V.Patel Vs. National Insurance Co.Ltd.

Mediclaim. A claim was lodged for reimbursement of hospital expenses was settled partially as the Respondent changed the terms and conditions with cap an individual heads of expenses.

The complainant pleaded that the change in the terms and conditions were not informed along with the policy.

It was pointed out to the Respondent that TPA had offered the amount on cashless basis on hospitalization. The Respondent as mediation of this Forum agreed to settle the Sum of Rs.61500/- as cashless basis even though terms and conditions of policy allows only Rs.47,525/-. The TPA's offer was based an estimate only.

The actual bills were higher than estimates and was payable as per terms and conditions of policy.

The award directing the Respondent to settle the claim for full amount was given in full and final settlement.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 25-09-2008

Case No.11-002-0122-09

Mr.Bhogilal D.Bhavsar Vs. New India Assurance Co.Ltd.

A mediclaim of the insured was partially settled for Inguinal Hernia surgery.

The Complainant pleaded that he incurred Rs.39,690/- for the hospitalization and surgery but the Respondent settled only Rs.25,000/- invoking clause 4.7.

On mediation, the Respondent agreed to settle the balance amount and dispute was resolved.

AHMEDABAD OMBUDSMAN CENTRE

Award dated 29-09-2008

Case No.11-004-0115-09

Mr.Minesh B. Thakkar Vs. United India Insurance Co.Ltd.

Mediclaim lodged by the Complainant for hospitalization & treatment for lump in Breast incurring expenses of Rs.50,000/- which was settled for lesser amount of Rs.35,000/- even though the sum insured was Rs.50,000/-.

Complainant pleaded for full payment of Rs.50,000/-.

The Respondent submitted that the policy was incepted from 01-01-2008 and treated as fresh insurance under Individual Health Plan which restricts the payment to 70% of Sum Insured if the treatment is for Cancer/Major surgery and claim is settled for correct amount only.

On enquiry it was informed that changed conditions are incorporated in policy document only and informed to the complainant and confirmed that settlement is correct.

The complaint was dismissed.

BHOPAL

Total Repudiation

BHOPAL OMBUDSMAN CENTER

Ms. Kavita Karnavat V/s The New India Assurance Co. Ltd., Bhopal

Order No.: BPL/GI/08-09/03 Case No.: GI/NIA/0208/176
Award Dtd.22.4.08

Brief Background

Ms. Kavita Karnavat had obtained **Mediclaim** policy No. 451404/34/06/20/00000042 for the period from 06.03.07 to 05.03.08 for S.I. Rs. 70000/- from The New India Assurance Co. Ltd., Bhopal. As per the Complainant she was admitted in National Hospital, Bhopal on 22.06.2007 due to swelling & pain in her right knee & leg as per the advices of attending doctor who referred various investigations relating to

her ailment. Accordingly various investigations were done for evaluation and effective treatment. She was admitted for the period 22.06.07 to 24.06.07 and the claim for was preferred with the Respondent's TPA which was repudiated on the ground that the expenses incurred for the investigations and treatment was not required hospitalization and it could be done as outdoor patient.

The Respondent in its reply-dated 08.04.2008 stated that the Complainant had lodged a claim for the treatment of her multiple joint pain. The patient was investigated & evaluated during hospitalization and treated conservatively with oral medication only. The investigations could have been done on outdoor patient basis without necessity of admission. In view of the fact that the hospitalization was not necessary for the treatment availed or the investigations undergone and the same could have been taken and undergone as an outdoor patient, the claim was repudiated.

Findings: - It was observed that complainant was suffering with severe pain in her right knee & leg with swelling. Looking to her condition, the attending doctor Dr. P.K. Rai (MS, Ortho) advised hospitalization. As per doctor's advice, various investigations were carried out where medical expenditure incurred by complainant and claim for Rs. 9900.00 was preferred. At the time of hearing the Respondent presented Discharge Summary dated 21.09.2004 of National Hospital, Bhopal

Decision: -

Held that the attending doctor is competent & suitable authority to justify the admission for hospitalization depending upon the condition/requirement of patient hence, the decision taken by the

Respondent to repudiate the above claim is unfair and unjust. Therefore, the Respondent directed to pay the claim amount of Rs. 9990/- within 15 days from the receipt of consent letter from the Complainant failing which it will attract a simple interest of 6% p.a. from the date of this order to the date of actual payment.

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BHOPAL OMBUDSMAN CENTRE

Shri Vivek Banzal V/s The New India Assurance Co. Ltd. Indore

Order No.: BPL/GI/08-09/09 Case No.: GI/NIA/0408/05

Order Dated: 25/06/2008

Brief Background

Mr.Vivek Banzal had obtained **Mediclaim** policy No. 450800/48/06/20/70002758 for S.I of Rs. 50000/- for the period 25.01.07 to 24.01.08 from The New India Assurance Co. Ltd., Indore

As per the Complainant he himself admitted in Choithram Hospital, Indore for the period 08.09.07 to 9.9.07 for the treatment of in growing toe nail. He was surgically treated under local anesthesia which was confirmed vide certificate dated 13.10.2007 of attending Dr. S.S. Chamaniya. The Complainant preferred a claim for Rs. 3817/-, which was repudiated on the ground that the treatment could have been taken as an outpatient. He made an appeal to their higher offices but there was no response from Respondent. Aggrieved with the decision of the Respondent, he approached this office for necessary settlement of his claim.

The Respondent in its reply-dated 16.05.2008 stated that the Complainant had lodged a claim for the treatment of a "in growing toe nails" which was surgically done under local anesthesia for the period 08.09.07 to 09.09.07 in Choithram Hospital, Indore. The claim was preferred to their TPA M/s Family Health Plan Ltd, which was repudiated on the ground that the treatment/investigations could have been done on out patient basis without the necessity of admission for the same. As per technical/medical opinion of Dr. Syed Mazhar, Dep. Manager of FHPL, neither the line of treatment given nor the condition of the patient required hospitalization and out patient treatment is sufficient in this case. Hence the claim was rejected under Exclusion Clause No. 4.10 appended below: -

"Charges incurred at Hospital or Nursing Home primarily for diagnostic, X-Ray or laboratory examinations not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any ailment, sickness or injury for which confinement is required at a Hospital/Nursing Home."

Observations:

There was no dispute that the Complainant was covered under the above-mentioned policy.

As per the certificate dated 13.10.07 of Dr. S.S. Chamania, of Choithram Hospital who himself treated the patient and confirmed that the complainant was admitted for consideration of safety and inject able pain killer and the patient genuinely required

hospitalization for his surgery. He preferred a claim for Rs. 3817/- for the said treatment. In medical case, the attending doctor is sufficient one to decide the case whether it requires hospitalization or not. In the instant case, the patient was treated as per advice of attending doctor and since these charges are not related to primarily for diagnostic, the exclusion clause 4.10 does not apply on the case. Since the patient was suffering from acute pain with his disease and treated in the hospital as per the advice of attending doctor, the Respondent is liable to pay admissible claim of Rs. 3817/- as per Mediclaim Policy conditions.

Decision: -

Held that the decision of the Respondent to repudiate the claim is unfair and unjust. Since the attending doctor himself advised for hospitalization, the Respondent is directed to settle the claim for Rs. 3817/- as per medical papers submitted by the Complainant within 15 days from the date of receipt of consent letter from the Complainant failing which it will attract a simple interest of 6% p.a. from the date of this order to the date of actual payment.

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Bhopal Ombudsman Center

Shri S.N. Saraf……. V/s…….. The New India Assurance Co. Indore
Order No.: BPL/GI/08-09/10 Case No.: GI/NIA/0408/13

Order Dated: 26/06/2008

Brief Background

Mr. S.N. Saraf and his wife Smt. Urmila Saraf were covered under **Mediclaim** policy No. 450800/48/06/20/70001062 for S.I of Rs. 110000/- for the period 17.08.06 to 16.08.07 from The New India Assurance Co. Ltd., Indore

As per the Complainant he himself admitted in Medicare Center, Indore for the period 21.05.07 to 22.05.07 for the treatment of **UTI with DM**. He was taking mediclaim policy since 1999 without any break. He is renewing his policy with the Respondent under exclusion of all heart and cardio vascular disease. After the treatment of his present ailment, he preferred a claim with M/s Family Health Plan Ltd., TPA of the Respondent for mediclaim claims. On 14th June, 2007, he was asked the certificate of

treating doctor since when he is a case of DM. He submitted the said certificate to the Respondent TPA on 4.10.2007. In turn TPA repudiated his claim on the ground that the treatment could have been taken as an outdoor patient. Aggrieved with the decision of the Respondent, he approached this office for settlement of his claim.

The Respondent in its reply-dated 16.05.2008 stated that as per the technical/medical opinion of Dr. Syed Mazhar of TPA, FHPL, the patient was diagnosed as a case of UTI with DM. During the hospitalization, the patient was treated conservatively with oral medication only where those investigations could have been done on as outpatient basis without necessity of admission for the same illness. Hence the claim has been rejected under policy conditions exclusion clause 4.10

Observations:

There was no dispute that the Complainant was covered under the above-mentioned policy.

The Policy was issued under exclusion of all heart and cardio vascular disease for the period 17.08.06 to 16.08.07. On going through the medical opinion of Dr. Syed Mazhar, Dy. Manager, Medical Management & Claims of TPA Family Health Plan Ltd where he confirmed that the patient was admitted in Medicare Center, Indore with complaints of burning Micturation along with frequency of urine and dysuria and the patient was diagnosed as UTI with DM. The patient was treated conservatively with oral medication only. He further reiterated that neither the line of treatment given nor the condition of the patient required hospitalization and out patient treatment is sufficient in this case. As per the first prescription dated 21.05.07 of attending Dr. Rajendra Kumar Lahoti of Medicare Centre, Indore who clearly advised the patient for admission and to start the treatment as per his guidance. In Medical case, the attending doctor is the best judge to decide whether the patient requires hospitalization or not. In the instant case, attending doctor has physically inspected the patient and advised necessary treatment during hospitalization looking to the necessity and condition of the patient. Since the patient was treated during hospitalization as per the advice of attending doctor, the Respondent cannot deny its liability under exclusion clause 4.10 of the mediclaim policy.

Decision: -

Held that the decision of the Respondent to repudiate the claim is unfair and unjust. Since the attending doctor himself advised for hospitalization, the Respondent is directed to settle the claim for Rs. 7805/- as per medical claim form/papers submitted by the Complainant within 15 days from the date of receipt of consent letter from the Complainant failing which it will attract a simple interest of 6% p.a. from the date of this order to the date of actual paym

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Bhopal Ombudsman Centre

Shri Ram Gopal Sodani… V/s The New India Assurance Co. Ltd Indore

Order No.: BPL/GI/08-09/11 Case No.: GI/NIA/0408/03

Order Dated: 27/06/2008

Brief Background

Mr. Ram Gopal Sodani had obtained **Mediclaim** policy No. 450800/34/06/20/00000040 for S.I of Rs. 25000/- covering his wife Smt. Ganga Devi aged 70 years for the period 27.02.2007 to 26.02.2008 from The New India Assurance Co. Ltd., Indore.

As per the Complainant his wife Smt. Ganga Devi was admitted in Choith Ram Hospital, Indore for the period 23.04.07 to 28.04.07 due to complaints of "SOB (on exertion) & Cough". On Discharge from the hospital, he preferred a claim for Rs. 12000/- with TPA of Respondent who asked previous history of the disease which was provided to them. The TPA M/s Family Health Plan Ltd repudiated the claim on the ground that the present hospitalization is for the management of an ailment, which is related to a pre-existing condition. The Complainant made an appeal to higher offices of the Respondent vides his letter-dated 5.02.08 but there was no response from their side. Aggrieved with the decision of the Respondent's TPA, he approached this office for necessary settlement of his claim.

The Respondent in its reply-dated 03.06.2008 stated that the Complainant holds renewal mediclaim policy since 27th February 2005. As per medical record, the patient was diagnosed as a case of "Old Pulmonary Tuberculosis (PTB)/ILD." On demand of previous history of ailment, the complainant submitted earlier treatment papers of 1998, which are prior to the policy inception. Based on the facts that the

present ailment/s exist prior to the commencement of the mediclaim policy coverage, the claim falls under exclusion clause of 4.1 it repudiated the claim in full. In support of its contention, the Respondent submitted technical opinion of Dr. N.V. Ramana, Manager, Medical Management and claims of TPA Family Health Plan Ltd. along with other relevant documents.

Observations:

There was no dispute that the Complainant was covered under the above-mentioned policy.

The present Policy enjoying cumulative bonus of 30% which itself reveals that there was no claim since 2001 i.e. inception of the policy. During hearing the complainant & Respondent confirmed that the policy was in force since 2001. As per the discharge card of earlier treatment where the patient was admitted for the period 09.02.98 to 22.02.98 in S.K. Hospital, Indore for the treatment of Tuberculosis. At the time of hearing the copy of proposal form was asked from the Respondent who shown his inability to produce the same. Proposal Form is the only document, which could decide the fact. At the time of inception, the proposer should have disclosed the facts that the person is suffering from the particular disease. On the other hand, the Tuberculosis is not a severe disease in the present scenario. If the complainant had the intention to get the money from the Respondent, he will not suppose to produce the previous documents of illness before the Respondent. Further, there were no complications for a long period of seven years and the complainant for the present illness did also not produce claims. There is no relation with past illness of 8-9 years back. Respondent cannot deny its liability on the mere point of earlier illness, which had taken place before 8-9 years. The complainant and his wife were covered under Mediclaim Policy from 2001 without any break.

Decision: -

Held that the decision of the Respondent to repudiate the claim is unfair and unjust. The Respondent is directed to settle the admissible claim as per medical claim form/papers submitted by the Complainant within 15 days from the date of receipt of consent letter from the Complainant failing which it will attract a simple interest of 6% p.a. from the date of this order to the date of actual payment.

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Bhopal Ombudsman Cetnre

Shri Harish Shrivastava… V/s …The New India Assurance Co. .Shahdol

Order No.: BPL/GI/08-09/12 Case No.: GI/NIA/0108/165

Order dtated 27/06/2008

Brief Background

Mr. Harish Shrivastava had obtained **Mediclaim** policy No. 452001/48/06/20/70000011 for the period 17.08.2006 to 16.08.2007 from The New India Assurance Co. Ltd., Shahdol

As per the Complainant he was admitted in Sir Ganga Ram Hospital, New Delhi for the period 20.02.07 to 21.02.07 for treatment of Heterogeneous Growth involving Left Lateral Nasal Wall Extending into the Orbit. He was holding insurance policy since last two years. But till today he was not provided cash card from the TPA of the Respondent i.e. E-Meditek Solutions Ltd., Indore. After the discharge from the hospital, he preferred a claim for Rs. 24446.75 with TPA who asked policy copy since 2004 and ECG, X-ray report with film vide their letter dated 21.08.07 which was received by him on 10th December, 2007. In reply, he sent the required papers vide his letter-dated 30.12.07. His letter was received by the TPA on 15.01.08 as confirmed by the Department of Posts vide their letter dated 10.04.08. He was in touch with the TPA several times but there was no response from the TPA. As per letter-dated 21.08.07, the TPA closed the claim as no claim for want of necessary documents. Aggrieved with the decision of the Respondent's TPA, he approached this office for necessary settlement of his claim.

The self contained note was not submitted by respondent even after the lapse of 5 month but as per letter-dated 21.08.07 of TPA, which was originally written to the complainant, the claim was closed as no claim for want of necessary documents.

For the sake of natural justice hearing was held on 24.06.2008 at Bhopal. The Complainant was present in person and the Respondent was **absent**. The complainant was heard and copies of claim papers were received at the time of hearing.

Observations:

There was no dispute that the Complainant was covered under the above-mentioned policy.

The present Policy is a renewal of earlier policy No. 452 001/48/05/75008. The complainant explained during hearing that he did not receive letter dated 11.06.07, 10.07.07 and 21.06.07 mentioned in the letter dated 21.08.07 received on 11.12.07 by the complainant. Further, he reiterated that desired papers/medical report i.e. policy copy since 2005, ECG report & x-ray film with report were delivered to the TPA on 15.01.08 but there was no response from their side even after several reminders. Further, the Respondent should submit the desired reply asked by this forum within stipulated time. The complaint cannot be kept pending for inordinate delay for want of reply from the Respondent. Since the Respondent could not present to submit its contention, the complaint is hereby decided as ex-party.

Decision:-

Held that the decision of the Respondent to repudiate the claim is arbitrary and unjust. The Respondent is directed to process and settle the claim for Rs. 24446.75 as per medical papers submitted by the Complainant within 15 days from the date of receipt of consent letter from the Complainant failing which it will attract a simple interest of 6% p.a. from the date of this order to the date of actual payment.

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BHOPAL OMBUDSMAN CENTER

Shri Manoj Jain V/s The New India Assurance Co. Ltd.D.O.2,., Indore..

Order No.: BPL/GI/08-09/15 Case No.: GI/NIA/0208/175

Order dated 17/07/2008

Brief Background

Mr. Manoj Jain had obtained Mediclaim policy No. 450800/48/06/20/70000847 for the period from 21.07.06 to 20.07.07 covering his sister Mrs. Monika Jain for Rs. 50,000/- from The New India Assurance Co. Ltd., Indore.

As per the Complainant his sister Smt. Monica Jain was admitted in Recovery Hospital, Indore for the period 28.06.07 to 01.07.07 due to complaints of "Excess Bleeding". On Discharge from the hospital, he preferred a claim for Rs. 10219/- with TPA of Respondent M/s Family Health Plan Ltd which repudiated the claim on the ground that the treatment arising from or traceable to pregnancy and childbirth is not covered as per the given standard mediclaim policy. The Complainant made an appeal to higher offices of the Respondent vide his letter dated 03.01.08 but the claim was not settled from their side. The Complainant again made a reminder-dated 03.02.2008 to higher offices but again there was no response. Aggrieved with the decision of the Respondent's TPA, he approached this forum for necessary settlement of his claim.

For the sake of natural justice, hearing was held on 15.07.2008 at Bhopal. The Complainant was absent and the Respondent was represented by Mr. P.M. Rekhade, Asstt. Manager of The New India Assurance Co. Ltd., DO-2, Indore.

Observations:

There is no dispute that the Complainant was covered under the above-mentioned policy.

On going through the copy of claim form and certificate from attending doctor/nursing home, It is found that the patient was diagnosed as **Threatened Abortion** occurred due to excess bleeding and admitted in The Recovery Hospital, Indore for the period 28.06.07 to 01.07.07. Further I have gone through the above said policy which was an Individual Mediclaim Policy and as per exclusion clause No. 4.12 treatment arising from or traceable to pregnancy and child birth including caesarian section is not covered under existing Individual Mediclaim Policy.

Decision: -

Held that the decision of the Respondent to repudiate the claim on the ground mentioned above is fair & justified. Therefore, I found no reason to interfere with the decision taken by the Respondent. The complaint is dismissed without any relief.

BHOPAL OMBUDSMAN CENTRE

Shri Kalyan Bhangdia Vs The New India Assurance Co. Ltd. Indore.

Order No.: BPL/GI/08-09/16 Case No.: GI/NIA/0408/22

Order dated: 17/07/2008

Brief Background

Mr. Kalyan Bhangdia had obtained **Mediclaim** policy No. 450800/48/06/20/70002565 for S.I of Rs. 50000/- covering his wife Smt. Madhu Bhangdia aged 47 years for the period 10.01.07 to 09.01.08 from The New India Assurance Co. Ltd., Indore.

As per the Complainant his wife Smt. Madhu Bhangdia was admitted in Suyash Hospital, Indore for the period 02.05.07 to 06.05.07 and diagnosed as "Para Umbilical Hernia". After discharge from the hospital, he preferred a claim of Rs. 54252/- with TPA of the Respondent, which repudiated the claim on the ground that the present hospitalization is for the management of an ailment, which related to a pre-existing condition. He made a representation to their higher office vide his letter-dated 07.03.08 but there was no response from their side. Aggrieved with the repudiation of his claim, the complainant approached this office for justice.

The Respondent in its reply-dated 03.06.2008 stated that the patient was diagnosed as "Para Umbilical Hernia" in Suyash Hospital Pvt. Ltd., Indore. As per discharge summary of hospital, the patient was having history of Hysterectomy. Accordingly, the complainant was asked to submit previous history of abdominal surgery LSCS. In reply the complainant submitted discharge summary of Bombay Hospital, Indore for the admission of October 2005. As per Discharge Summary, the patient was having

history of Hysterectomy since 5 years back. The policy was continued since 2001 but the Hysterectomy was since 2000 i.e. prior to taking insurance cover. Based on the facts that the present ailment/s exist prior to the commencement of the mediclaim policy coverage, the claim falls under exclusion clause 4.1, it repudiated the claim in full. In support of its contention, the Respondent submitted technical opinion of Dr. Syed Mazhar, Deputy Manager, Medical Management and claims of TPA Family Health Plan Ltd. along with other relevant documents.

Observations:

During hearing the complainant reiterated that there were no symptoms of Hernia when his wife was treated in Bombay Hospital, Indore in October 2005 and diagnosed as Left Parietal Extradural Tubercular Abscess. The Respondent concluded that as per expert medical opinion, the present ailment is for the management of an ailment, which was existed before taking Mediclaim Policy. In support of its contention, it produced the medical opinion of its TPA M/s Family Health Plan Ltd.

It is true that the patient was diagnosed as Para Umblical Hernia in Suyash Hospital Pvt. Ltd. Indore. But the brief history says that the disease was since 15 days. Further, the history of Bombay Hospital, Indore says that the patient was H/o Hysterectomy 5 years back. It simply reflects that the hysterectomy was 5 years back but did not show that the present ailment was due to hysterectomy. I have also observed that the expert opinion was of M/s Family Health Plan Ltd. who is also processing the claim? There is no independent expert opinion of any surgeon. The Respondent cannot assume that the present ailment was due to hysterectomy. There was no concrete evidence found to prove that the present hospitalization is for the management of an ailment, which was existed prior to taking insurance policy. The complainant is in the books of Respondent since 2001 without any break of policy, hence the question of pre-existing disease does not arise.

Decision: -Held that the decision of the Respondent to repudiate the claim is unfair and unjust. The Respondent is directed to settle the claim for total S.I. Rs. 51250/- as per mediclaim policy submitted by the Complainant within 15 days from the date of receipt of consent letter from the Complainant failing which it will attract a simple interest of 6% p.a. from the date of this order to the date of actual payment.

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BHOPAL OMBUDSMAN CENTRE

Shri Anoop Thakur **V/s** The Oriental Insurance Co. Ltd., Indore

Order No.: BPL/GI/08-09/17 Case No.: GI/OIC/0208/171

Order dated: 22/07/2008

Brief Background

Mr. Anoop Thakur had obtained Mediclaim policy No. 151400/48/2007/2573 for S.I of Rs. 100000/- covering his wife Smt. Priti Thakur aged 34 years for the period 31.03.07 to 30.03.08 from The Oriental Insurance Co. Ltd., Indore (hereinafter called Respondent).

As per the Complainant his wife Smt. Priti Thakur was admitted in Choith Ram Hospital, Indore for the period 28.05.07 to 28.05.07 due to complaints of "diminished of vision". On Discharge from the hospital, he preferred a claim for Rs. 25393/- with TPA of Respondent who asked previous history of the disease which was provided to them. The TPA M/s E-Meditek Ltd. who repudiated the claim imposing Exclusion Clause 4.5 that the 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 Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident), vaccination inoculation or change of life or cosmetic or aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness. The Complainant made an appeal to higher offices of the Respondent vides his letter-dated 24.08.07 but there was no response from their side. Aggrieved with the decision of the Respondent's TPA, he approached this office for necessary settlement of his claim.

The Respondent in its reply-dated 20.02.2008 received in this forum on 16.07.08 stated that its TPA M/s E-Meditek Solutions Ltd. Repudiated the claim considering mediclaim policy exclusion clause 4.6 i.e. "Surgery for correction of eye sight, cost of spectacles, contact lenses, hearing aids etc." It further stated that As per hospitalization record of Choithram Hospital & Research Center, the patient having glasses from 20 years and she was using contact lenses from 13 years. Patient referred OPD basis for correction of eyesight in Choith Ram Hospital & Research Center i.e. on 28.05.07. This falls under Mediclaim Policy exclusion condition No. 4.6. Hence its TPA repudiated the claim.

Observations:

There is no dispute that the Complainant was covered under the above-mentioned policy.

It was noted that the policy was continued since 2003 and the complainant's wife was quite fit before taking insurance policy. As per certificate of Dr. S.P. Vyas, M.S. Hon. Sr. Ophthalmologist of M/s Choith Ram Hospital & Research Center, Indore, this particular disease occurred on 09.05.07 when she had complaints of diminished of vision in Contact Lens along with intolerance to Contact lens for past two months. Her Corneal Topography revealed Contact Lens Warpage and hence she was asked to discontinue contact lens. The treating Doctor planned for Lasik Park in both the eyes to save the vision of eyes. She was operated on 28.05.07 and discharged on the same day. The forum gone through with the terms & condition of Group & Individual Mediclaim Policy of M/s National Insurance Co. Ltd which shows that the Claim may be paid for Keratotomy of insured having more than 7 refractive error, if refractive error develops after issuance of policy. Further It is observed from the exclusion clause 4.5 of the Insurance Policy issued to the complainant and the grounds of rejection of claim that the 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 circumcision vaccination inoculation or change of life or cosmetic or aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness. The condition imposed by the TPA of the Respondent is baseless and does not stand for repudiation. During hearing the respondent argued that the patient having glasses from 20 years and she was using contact lenses from 13 years, which falls under the policy exclusion clause 4.6 of the Policy. There was a contradictory statement of the TPA as well as the

Respondent, which are not tenable in this particular case. The LASIC Park was done to save the vision of the patient; hence the Respondent is liable to pay the claim amount.

Decision: -

Held that the decision of the Respondent to repudiate the claim is unfair and unjust. The Respondent is directed to settle the admissible claim as per medical claim form/papers submitted by the Complainant within 15 days from the date of receipt of consent letter from the Complainant failing which it will attract a simple interest of 6% p.a. from the date of this order to the date of actual payment.

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BHOPAL OMBUDSMAN CENTRE,

Shri Yogesh Kumar Mathur…V/s The New India Assurance Co. Ltd.,

Order No.: BPL/GI/08-09/20 Case No.: GI/NIA/0608/47

Order dated:- 08/08/2008

Brief Background

Mr. Yogesh Kumar Mathur (hereinafter called Complainant) had obtained **Mediclaim Policy** No. 450200/48/04/20/70051009 for the period 26.02.05 to 25.02.06 for S.I. of Rs. 25000/- covering his son Mst. Pratyush Mathur from The New India Assurance Co. Ltd. D.O., Ujjain.

As per the Complainant his son Mst. Pratyush Mathur aged 11 years suffered from drug reaction (Stevenson Johnson Syndrome) in the month of June 2005. He was hospitalized in the CHL-APPOLO Hospital, Indore where he started recovering and later he underwent treatment at Shankar Netralaya, Chennai for management of his eye problem. His son was underwent many surgeries till October 2006 at Shankar Netralaya Chennai and is still under process of recovery. His son was insured for S.I. of Rs. 25000/- and the policy earned cumulative bonus of Rs. 1250/- for claim free years. Further, he renewed his policy for corresponding period 2006-07 as Policy No.

450200/48/05/20/70051333 for enhancement of S.I. Rs. 30000/- for his son. He preferred a claim for Rs. 14987/-, which was not settled by the Respondent although there was a balance of Rs. 12383/- in the existing policy. He made various reminders to the Respondent but there was no response. Aggrieved with the delay in settlement of his claim, he approached this forum for necessary settlement of his claim.

The Respondent vide its letter dated 19.06.08 submitted that the complainant's son Mst. Pratyush Mathur was covered for S.I. of Rs. 26250/- including cumulative bonus of Rs. 1250/-for the policy period 26.02.05 to 25.02.06. He renewed this policy with enhanced S.I. of Rs. 30,000/- without disclosing the above disease in the proposal form, which is violation of policy condition No. 5.7. Had he mentioned the same in the proposal form, the policy would have been issued with exclusion clause depriving his right for the above claim. He preferred three claims amounting to Rs. 43867/- with their TPA, which were settled. In support of its contention, copy of proposal form along with policy condition 5.7 was sent to this office.

Observations:

There is no dispute that the Complainant was covered under the above-mentioned policy.

On going through the claim docket, It is found that the policy No. 450200/48/04/20/70051009 was for S.I. of Rs. 25,000/- with the cumulative bonus of Rs. 3750/- for which the claim was settled for Rs. 28554/- under cashless services of the Respondent's TPA. The Complainant renewed the policy for enhanced S.I. of Rs. 30,000/- for corresponding year 2006-07. In the proposal form, which was placed before me during hearing, there was no mention of previous history of disease, which the complainant's son is facing. In spite of the above facts the Respondent settled three claim amounting to Rs. 43867/- for current policy year. By this way the Respondent liability is restricted up to old S.I. with cumulative bonus for the disease originated in previous policy year. Since the claim was already settled up to the limit of S.I., there is no reason found to interference in the complaint.

Decision: -

Held that the decision of the Respondent to repudiate the claim on this ground mentioned above is fair & justified. Therefore, I found no reason to interfere

with the decision taken by the Respondent. The complaint is dismissed without any relief.

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BHOPAL OMBUDSMAN CENTRE

Shri V.K. Jain V/s The Oriental Insurance Co. Ltd.,. Bhopal

Order No.: BPL/GI/08-09/21 Case No.: GI/OIC/0408/07

Order dated: 20/08/ 2008

Brief Background

Mr. V.K. Jain had obtained **Mediclaim** policy No. 152100/48/2007/00466 for S.I of Rs. 50000/- covering his wife Smt. Asha Devi Jain aged 28 years for the period 11.01.07 to 10.01.08 from The Oriental Insurance Co. Ltd., D.O.-I, Bhopal.

As per the Complainant his wife Smt. Asha Devi Jain was admitted in Anant Shree Hospital, Bhopal for the period 14.04.07 to 22.04.07 due to diabetic mellitus, Chest pain and ghabarahat. He was having insurance policy with the Respondent since 12.01.2004 without any break. On Discharge from the hospital, he preferred a claim for Rs. 22995/- with TPA of Respondent who asked previous history of the disease which was provided to them. The TPA M/s E-Meditek Solutions Ltd. who repudiated the claim imposing Exclusion Clause 4.1 that the 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 all disease pre & post hospitalization. The Complainant made an appeal to higher offices of the Respondent vide his letter dated 06.02.08 but there was no response from their side. Aggrieved with the decision of the Respondent's TPA, he approached this office for necessary settlement of his claim.

Finally this forum has fixed the date of hearing on 06.08.2008 where Divisional Manager, D.O.-I had requested for one week time to submit self contained note. The

request was considered and this forum has decided to fix a hearing on 18.08.2008. Unfortunately, this forum was not represented with self-contained note from the Respondent. Prescribed forms were issued to the complainant, which were received on 07.04.2008. The Complainant was present in person and the Respondent was represented by Mr. G.C. Richhariya, Asstt. Manager of the Oriental Insurance Co. Ltd., DO-I, Bhopal who was not conversant with the present case. He was not able to put any documentary evidence to this forum, which proves that the claim was not payable.

Observations:

There is no dispute that the Complainant was covered under the above-mentioned policy.

It was noted that the policy was continued since 2004 and there is no evidence that the complainant's wife was having similar disease before taking insurance policy. The present disease occurred in the third year of the policy. Repudiation letter dated 17th July, 2007 from the TPA of the Respondent mentioned that the claim was casually dealt without any concrete proof that the disease was pre-existing before taking insurance cover which is not tenable. Further, the Respondent had not even responded to the notice of this forum also. This forum has taken a serious view on this casual approach from the side of Respondent. Since there was no self contained note from the side of Respondent, the plea that the disease was pre-existing at the time of taking insurance cover is not tenable in this forum and the benefit of doubt will definitely go to the Complainant, hence the Respondent is liable to pay the claim amount.

Decision: -

Held that the decision of the Respondent to repudiate the claim is unfair and unjust. The Respondent is directed to settle the claimed amount of Rs. 22995/- as per medical claim form/papers submitted by the Complainant within 15 days from the date of receipt of consent letter from the Complainant failing which it will attract a simple interest of 6% p.a. from the date of this order to the date of actual payment.

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BHOPAL OMBUDSMAN CENTRE

Shri V.K. Agrawal V/s The New India Assurance Co. Ltd.,.Indore

Order No.: BPL/GI/08-09/23 Case No.: GI/NIA/0408/23

Order dated: 06/09/2008

Brief Background

Mr. V.K. Agrawal had obtained **Mediclaim** Policy No. 450800/48/06/20/70001102 from Indore D.O.-II of The New India Assurance Co. Ltd. (hereinafter called Respondent) for the period 26.08.2006 to 25.08.2007 covering his family members.

As per the Complainant his daughter Ms. Suchita Agrawal was hospitalized in Saibaba Hospital for the period 26.07.07 to 30.07.07 due to acute intestinal obstruction followed with the admission in Bhatia Hospital, Mumbai for the period 30.07.2007 to 08.08.2007. He preferred the claim with TPA M/s Family Health Plan Ltd. Indore but the claim was not settled for 8 months in spite of submission of desired document. The Complainant made necessary appeal to higher authorities of the Respondent but there was no satisfactory reply. Aggrieved with the delay in settlement of his claim, he approached this forum for necessary settlement of his claim.

As per reply of the Respondent dated 29.08.08, they approved one claim under subject-referred policy for Rs. 10995/- and issued the claim settlement voucher to the insured and they will release the cheque as and when received the discharge voucher. For the second claim, it is stated that the S.I. of Ms. Suchita Agrawal is Rs. 35000/- (with exclusion on S.O. of Rs. 20000/- being enhanced on subject referred policy).

Observations:

There is no dispute that the Complainant was covered under the above-mentioned policy.

On going through the claim docket, It is found that two claims were placed with the Respondent for the period from 26.07.07 to 30.07.07 and 30.07.07 to 08.08.07 of different hospital. The patient was suffering with Acute Intestinal obstruction. Further the policy was renewed with enhanced sum insured of Rs. 20,000/- with the

Respondent for the period 26.08.06 to 25.08.07, which was subject to exclusion clause as applicable in first year policy. I found as per Discharge Summary of Bhatia Hospital, Mumbai that the patient was admitted with complaints of "Intestinal Obstruction post emergency appendectomy for perforation 2 ½ years ago. Further it was noted that the claim was preferred for Rs. 11045/- and 91547/- respectively of both the hospitals. The Respondent processed first claim for Rs. 10995/- and the second claim was pending for want of desired documents on the part of the complainant. Further complainant reiterated that he had already submitted the desired claim papers with the TPA on 22.01.08, which were acknowledged by them. Since the enhanced S.I. of Rs. 20000/- was excluded as applicable on first year policy, the liability of the Respondent restricted to the original S.I. i.e. Rs. 15,000/-

Decision:-

Held that the inordinate delay in settlement of the claim for Rs. 15000/- on the part of Respondent is unfair and unjust. The Respondent is directed to settle the claim of Rs. 15000/- with 9% annual interest on the claim amount from the date of 22.01.08 i.e. the date of submission of claim papers with the TPA till the date of actual payment of claim within 15 days from the date of receipt of consent letter from the Complainant.

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CHANDIGARH

Total Repudiation

Chandigarh Ombudsman Center

CASE NO. GIC/190/OIC/11/09

Daljinder Singh Vs. Oriental Insurance Co. Ltd.

Order dated 29.08.08

FACTS: Shri Daljinder Singh had taken a mediclaim policy. for himself. It has been stated by the complainant that he preferred a mediclaim for Rs. 59937/-. However, the same has been rejected by the

insurer. It has been stated in the said letter that the disease regarding which claim has been preferred has resulted from consumption of alcohol and the same is not payable as per the exclusion clause 4.8 of the individual mediclaim policy. The insured again represented the insurer to reconsider his case. The insured in its representation has stated that the reason alleged for rejection of claim is not based on the fact. The rejection has been made on wrong interpretation of the exclusion clause. Further, such clause was never supplied to him. Feeling aggrieved, he has approached this forum for settlement of his mediclaim. Parties were called for hearing on 29.08.08.

FINDINGS: During the course of hearing the insurer stated that in the record of National Kidney Hospital and the diagnosis of Dr. Randhir Sud, the diagnosis was mentioned as ALD – cirrhosis of liver. In the discharge summary of Ganga Ram Hospital, it was mention as CLD – Chronic liver disease. They had taken expert opinion, which stated that the case was of ALD and was excluded under exclusion clause 4.8 of the Terms and Conditions of the policy.

DECISION: Held that on going through the definition of cirrhosis carefully, I am of the opinion that it has not been established beyond a shadow of doubt that the present treatment is as a result of alcoholism. Hence giving the benefit of doubt to the complainant, the claim is payable. Repudiation of case is not in order. It is hereby ordered that the admissible amount of claim should be paid by the insurer to the complainant.

Chandigarh Ombudsman Centre

CASE NO. GIC/139/NIC/14/09

M.S. Tandan Vs National Insurance Co. Ltd.

Order dated 17.07.08

FACTS: Shri M.S. Tandan had taken a Mediclaim policy bearing no. 420401/48/07/850000165 for a period covering 15.07.2007 to 14.07.2008 for a sum insured of Rs. 2 lakh each for himself and his wife.

As per the complainant he is 40 years old customer of the company and is aged about 70 years. Further, he was having Health Insurance Policy for last 12 years from Ambala City office of the insurer. He got operated for Bye-Pass Surgery on 02.02.08 at Fortis Hospital, Mohali and filed his claim papers with the insurer on 13.02.2008. Parties were called for hearing on 17.07.2008.

FINDINGS: During the course of hearing the insurer clarified the position by stating that there was a break of one day at the time of renewal in 2004-05. The TPA had opined that since the patient was a known case of 'CHRONIC ISCHAEMIC HEART DISEASE', the disease was considered as a pre existing disease and hence came under exclusion Clause 4.1.

DECISION: Held that the insurer showed copies of circulars regarding Exclusion Clause in respect of pre-existing diseases but nothing could be produced in respect of break periods. However, a circular of 1998 issued by the insurer which was available in this office reads as

" Now, if there is a break , a fresh policy should be issued after obtaining a fresh proposal form and this policy will be subject to exclusion of the disease contracted during the expiring period and during break period"As per this circular, a fresh proposal is required if the period of delay in renewal is to be treated as a break. On a query whether a fresh proposal form was obtained from the complainant and a fresh policy was issued, the insurer replied in the negative. I am of the opinion that a delay in renewal can be considered as a break only if a fresh proposal form is filled up and a fresh policy is issued. Since no such steps were taken by the insurer, the policy should be treated as having been renewed without break. The claim therefore is payable. However, the claim will be limited to Rs 1.00 lakhs plus accessed bonus in case of Angiography Report of 1996 was positive but if the report of Angiography Test carried out in 1996 is negative, the enhanced amount of Rs. 2.00 lakhs plus accessed bonus is payable.

Chandigarh Ombudsman Centre

CASE NO. GIC/105/NIC/11/09

Parvinder Singh Vs. National Insurance Co. Ltd.

Order dated 08.07.08

FACTS: Shri Parvinder Singh had taken a Mediclaim Policy No. 401803/48/06/8500000097 insuring himself and his family members. The complainant's son Sh. Avneet Singh was hospitalized and he submitted all the documents to insurer on 24.01.2007. On 21.03.2007 certain questions were raised/ documents demanded by the insurer/ TPA, which were replied/ submitted by the insured on 03.11.2007. On 24.11.2007, the TPA, Park Mediclaim Consultant (P) Ltd. wrote to insured that in absence of necessary clarification and report of investigation and X-ray film, the estimate of TPA's earlier stands for 'No Claim' remains unchanged. Parties were called for hearing on 08.07.08.

FINDINGS: During the course of hearing the insurer clarified the position by stating that TPA had asked for clarification regarding history, type of hospital, investigation report etc. which the complainant had not submitted. Hence the case was made as no claim by TPA on 31.07.07 and again on 24.11.07.

DECISION: Held that the hospitalization for 9 days without any treatment record is not justified. The making of the claim as no claim by the insurer is in order. However, if the complainant gives clarification as required by the TPA the case should be reopened and settled by the insurer / TPA on merits.

Chandigarh Ombudsman Centre

CASE NO. GIC/104/NIC/11/09

Prabhat Bhushan Vs National Insurance Co. Ltd.

Order dated 01.07.08

FACTS: Shri Prabhat Bhusan had taken a Mediclaim policy in 2006-07 which was further renewed vide Policy bearing no. 361102/48/07/8500001898 for the period 11.09.07 to 11.09.08. At the time of issuing the Mediclaim policy, a guide book edition 2006 was handed over by insurer, a All India Hospital Network List to the insured. In Sept. 2007, the insured became sick and took treatment from Lal Nursing Home, Faridabad. The doctor advised him for the operation of Calculus of Kidney and Ureter. As per the advise of doctor, the applicant was admitted on 24.09.07 in Hospital and discharged on 30.09.07 after

operation. He submitted all the relevant papers to the insurer. The TPA sent a letter dt. 04.12.07 to insurer and copy of the same was forwarded to the applicant thereby the claim of the applicant was repudiated as per clause 2.1 of the Mediclaim policy. On 30.01.08, the applicant personally met the officials of insurer and was informed that the reason for repudiation of claim was that Lal Nursing Home is not covered in Mediclaim Policy. It is stated by the complainant that at the time of issuing Mediclaim Policy, the hospital Lal Nursing Home was shown at Code No. 10187 of All India Hospital Network List and the claim was wrongly repudiated by the insurer / TPA. Parties were called for hearing on 01.07.08.

FINDINGS: During the course of hearing the insurer clarified the position by stating that the hospital had been taken off their panel in the list published in Jan. 2007. On a query, if the revised list was made available to the complainant with Lal Nursing Home being deleted, the insurer could not give a satisfactory reply. He stated that the hospital was informed about the change of status.

DECISION: Held that the insurer has been revising the list of panel hospitals from time to time. However, there is no streamlined procedure of informing the insured about the change of the list of panel hospitals, thus, keeping them in the dark. In this case also, the complainant appears to have not been aware of the revised list, otherwise he would not in the normal course have gone to the hospital for treatment. Hence in my view merely on the strength of 11-bedded hospital, the claim should not be rejected. The claim, therefore, is payable.

Chandigarh Ombudsman Centre

CASE NO. GIC/125/OIC/11/09

Rajesh Kumar Sood Vs. Oriental Insurance Co. Ltd.

Order dated 08.07.08

FACTS: Shri Rajesh Kumar Sood had taken a Mediclaim policy for himself and his family for the period of 01.04.06 to 31.03.2007 which was further renewed vide policy No. 233905/2008 for a period of one year w.e.f. 01.04.07 to 31.03.08. As per the complaint, the complainant had some problem in his knee and admitted at Satguru Partap Singh Apollo Hospital for a period of 2 days from 29.04.07 to 30.04.07.

He submitted all the claim papers to the insurer but his claim was rejected on the ground that he was treated primarily for observations. As per TPA letter dt. 30.08.07 addressed to insurer and insurer's letter dt. 03.09.07 to insured, it is mentioned that as per terms and conditions of the policy, hospitalization primarily for observation and investigation is not admissible. Hence the claim could be repudiated under clause 4.10 of Mediclaim policy. Parties were called for hearing on 08.07.08.

FINDINGS: During the course of hearing the insurer clarified the position by stating that the hospitalization was for diagnosis purposes only, which is not payable as per exclusion clause 4.10 of the terms and conditions of the policy.

DECISION: Held that on going through the discharge summary carefully, I find that the complainant was treated for knee aspiration and the extract was sent for analysis and culture. This, in my view, is a treatment and not only diagnostic test. He was also advised to contact the hospital in case of any discharge from operative wound, which shows that there was a treatment of a would from where discharge could take place. Taking above factors into consideration, the claim is payable. It is hereby ordered that the admissible amount of claim as per the terms and conditions of the policy should be paid by the insurer to the complainant.

Chandigarh Ombudsman Centre

CASE NO. GIC/249/NIA/11/09

Suman Gupta Vs. New India Assurance Co. Ltd.

Order dated 10.09.08

FACTS: Smt. Suman Gupta had been covered under Mediclaim Policy for the last more than 9 years. During the currency of last policy no. 360700/34/07/11/00000221 which is for the period 13.09.07 to 12.09.08, she was hospitalized from 07.04.08 to 16.04.08 in Sir Ganga Ram Hospital, New Delhi for the treatment of Post-traumatic secondary arthritis left hip. She had incurred an expenditure of Rs. 3,19,323/- for her treatment and all the claim documents were submitted to M/S Vipul MedCorp TPA Private Ltd on 14.04.08. The TPA after three months

repudiated the claim on following ground:-"There is a break in the policy twice in 2004 and 2006. The date of commencement of the policy will be considered as 13.09.06 and the duration of the complaints is five years, so disease is pre-existing. The claim in not payable under condition no. 4.1 of the policy". Parties were called for hearing on 10.09.08.

FINDINGS: During the course of hearing the insurer clarified the position by stating that the TPA had repudiated the claim under Exclusion Clause 4.1 of the terms and conditions of the policy on the ground that there was a gap of 171 days when the policy was renewed on 13.9.06. Hence it was a fresh policy. As per discharge summary of Sir Ganga Ram Hospital, New Delhi, the complainant came with complaint of pain for fives year and surgery was performed accordingly.

DECISION: Held that on going through the discharge summary carefully, I find that discharge summary reveals that the patient was having pain from last 5 years in both the hips. However, there is no documentary proof to show that she had undergone any treatment during the last 5 years. Moreover, while the pain was in both the hips, the treatment was only for left hip which indirectly shows that the pain and the surgery do not have nexus with each other. If the pain was acute, the patient would not have waited for 5 years for the surgery. The present disease can be considered as falling within the purview of the present policy period which has been continuous since 13.09.06. In view of the above, the benefit of doubt regarding pre-existing disease goes to the complainant and the claim is accordingly payable. It is hereby ordered that the admissible amount of claim should be paid by the insurer to the complainant.

Chandigarh Ombudsman Centre

CASE NO. GIC/087/NIC/11/09

Vinod Kundra Vs. National Insurance Co. Ltd.

Order dated 08.07.08

FACTS: Sh. Vinod Kundra had taken a Mediclaim policy for the family for last so many years. He had taken a mediclaim policy No. 401100/48/06/850000326 for the period of 24.11.06 to 23.11.07 covering himself, his wife and his son. The complainant's son Mr. Lokesh Kundra was under treatment and

hospitalized due to depression on 01.11.07 to 11.11.07 in Kala Nursing Home, Ludhiana. He incurred the expenses of Rs. 32159/- and applied for reimbursement on 29.02.2008 to the insurer. However, the claim was rejected by saying that Psychiatric diseases are not covered. The complainant received a letter No. 401100/TPA/08/4433 DT. 17.03.08 in this regard from the insurer which states that the said claim falls under exclusion clause 4.8 of Mediclaim insurance policy and hence the claim was not payable. The complainant has further stated that it is never mentioned in the policy that Psychiatric treatment is not covered and while collecting the premium from insured he has been kept in the dark as he was never informed by the insurer in this regard. Parties were called for hearing on 08.07.08.

FINDINGS: During the course of hearing the insurer clarified the position by stating that the treatment was for a Psychiatric disorder, which is not covered as per exclusion clause 4.8 of the terms and conditions of the policy. On a query, whether terms and conditions of the policy were made available to the policy holder, the insurer stated that this need to be checked up as the relevant documents were not available with him.

DECISION: Held that the case hinges on the availability of terms and conditions of the policy with the complainant at the time of insurance. The insurer stated that as per their understanding the terms and conditions of the policy were sent to the complainant. However, documentary proof was not available. The complainant restated that the terms and conditions of the policy were not available with him. I am of the opinion that the contention of complainant that terms and conditions of the policy were not available seems more plausible as he was the affected party. Giving benefit of doubt to complainant, the claim is payable albeit through default.

Chandigarh Ombudsman Centre

CASE NO. GIC/604/OIC/14/08

Abhyudai Singh Vs. Oriental Insurance Co. Ltd.

Order dated 24.04.08

FACTS: Shri Abhyudai Singh is the holder of Mediclaim Policy for a sum of Rs. 3 lakhs. He was hospitalized & underwent surgery on his right leg in July 2007 at Ruby Hall Clinic, Pune. On 08.10.2007 all the relevant papers along with the claim Form duly filled in were sent to the TPA M/s Paramount Health Services for reimbursement of an amount of Rs. 37,687/-. Since then he had been making innumerable calls to the B.O. V to the office of PHS but he has not been informed of the action taken although more than six months have elapsed since the papers were sent. Parties were called for hearing on 15.04.08.

FINDINGS: During the course of hearing the insurer clarified the position by stating that the admission in the hospital was to remove a rod which was planted when the complainant was having Mediclaim policy with National Insurance Company. Accordingly, this was the first year of the policy with them. As per terms and conditions of the policy, the treatment was treated as pre-existing disease by the TPA and a letter was written to him on 12.01.2008. On a query whether the terms and conditions of the policy were available with them, both the insurer and the complainant replied in the negative. On a query whether the letter dated 12.01.08 was received by him the complainant replied in the negative.

DECISION: Held that the claim cannot be repudiated on the term 4.1 of terms & conditions of the policy in the absence of copy of terms & conditions of the policy available with the complainant, he is bound by the declaration given by him on his proposal form. It is hereby ordered that there may be a deficiency of service in not giving copy of the proposal form to the complainant but the claim is not payable in view of false declaration about the earlier operation carried out. The repudiation of the claim is therefore justified. No further action is called for. The case is closed.

Chandigarh Ombudsman Center

CASE NO. GIC/668/NIC/11/08

Kamlesh Kuthiala Vs. National Insurance Co. Ltd.

Order dated 08.05.08

FACTS: Smt. Kamlesh Kuthiala had taken a Mediclaim Policy risk of self and her husband. She was hospitalized from 29.01.08 to 30.01.08 in CMC, Chandigarh and took her treatment. After this she submitted her claim to the insurer. The insurer has rejected the claim on the ground that hospitalization was less than 24 hours and as per definition no. 2.3 of the Mediclaim Policy Expenses as hospitalization for minimum period of 24 hours are admissible. Parties were called for hearing on 08.05.08.

FINDINGS: During the course of hearing the insurer clarified that as per clause 2.3 of the terms and conditions of the policy, expenses on hospitalization are admissible of the hospitalization is for a minimum period of 24 hours. In the instant case, the patient was admitted at 14-15 hours on 29.01.08 and discharged at 12.00 hours on 30.01.08. Hence the hospitalization was for less than 24 hours and the claim was therefore repudiated under clause 2.3 of the terms and conditions of the policy.

DECISION: Held that on going through clause 2.3 of terms and conditions of the policy, there are some exclusion given in clause 2.3 regarding minimum period of hospitalization. These relate to expenses in respect of specific treatments like Dialysis Chemotherapy, Radiotherapy, Eye-surgery, Dental-surgery, Lithotripsy (Kidney stone removal), tonsillectomy D& C taken in the Hospital/Nursing Home which do not required hospitalization for minimum period of 24 hours. If this exclusion is read in a general context it has to be construed that these exclusion relate to those treatments for which there is a specific treatment, which can be carried out in less than 24 hours. So fixing of knee-braces, though not specifically mentioned in the exclusion clause, should also be treated under this category. The total period spent in the hospital was 21 hours and 45 minutes as per the computerized receipts, which is on the closer proximity to 24 hours. Therefore, the exclusion clause should be read in the spirit in which it is given and not specifically by the letter alone. The claim is payable. The repudiation of claim is not in order. It is hereby ordered that admissible amount should be paid by the insurer to the complainant.

Chandigarh Ombudsman Center

CASE NO. GIC/058/OIC/11/09

Lalit Saluja Vs. Oriental Insurance Co. Ltd.

Order dated 26.05.08

FACTS: Shri Lalit Saluja was insured with insurer since 1993 by paying premium for the maximum cover offered from time to time. As per cover note no. 388698 dated 22.11.06 for the period 23.11.06 to 22.11.07, covering the complainant and his wife Smt. Anita Saluja clearly mention about 50% cumulative bonus on Insurance Cover of Rs. 5.00 Lakh making the total value of cover to be Rs. 7.50 Lakhs. As per the complainant, he was admitted in Sir Ganga Ram Hospital on 27.08.07 to 05.09.07 for Total Knee Replacement. He was allowed cash less facility for a sum of Rs. 3.00 Lakhs from TPA. He incurred a total expenses from hospitalization and post hospitalization amount of Rs. 4,76,090/-. He submitted all the papers to TPA M/s Paramount Health Services Pvt. Ltd. on 29.10.07 requesting for balance payment of Rs. 1,76,090/-. However, he was informed by TPA vide the letter dated 14.02.08 that "On scrutiny of documents it is observed that the sum insured for the ailment is exhausted. Hence this claim stands repudiated." Parties were called for hearing on 26.05.08.

FINDINGS: During the course of hearing the insurer clarified the position by stating that the complainant had a knee problem before the enhancement in 2003-2004. As per terms and conditions of the policy the limit of reimbursement of medical cost in respect of any pre-existing disease is to be limited to the pre-enhancement sum assured. Hence the TPA had restricted the claim to Rs. 3.00 Lakhs. On a query whether any cumulative bonus was earned by the complainant on the pre-enhancement sum assured, the insurer replied that it needed to be confirmed with the reference to the date of commencement of the policy as the record was not available with them at present.

DECISION: Held that the contention of the insurer that the treatment for pre-existing disease should be restricted to pre-enhanced assured amount is in order. However, the amount to be disbursed should take into account the total amount including cumulative bonus earned if any. The insurer is

advised to ascertain the cumulative bonus earned upto 2002-2003 and reimburse the difference in amount after taking into account the amount paid and the total amount payable after adding the cumulative bonus upto 2002-2003.

Chandigarh Ombudsman Center

CASE NO. GIC/001/NIC/14/09

Dr. R.C. Garg Vs. National Insurance Co. Ltd.

Order dated 27.05.08

1. FACTS: Dr. R.C. Garg was covered under Mediclaim Policy. The complainant claimed three claims, in which two claims have been paid to the complainant by the company. He has further stated that the expenses spent on third claim regarding Angiography etc., has not been paid to him. Parties were called for hearing on 27.05.08. at Jalandhar.

FINDINGS: During the course of hearing the insurer clarified the position by stating that the TPA had written to the complainant that the earlier policy was not Mediclaim. Pre-existing disease can be covered under 4.1 unless it is a 4 year claim free policy. On a query whether a proposal form was filled by the complainant. The insurer showed the proposal form filled by the complainant. As per terms and conditions of the policy, the claim is not payable under exclusion clause 4.1 of the policy as the complainant had taken claims with the previous insurer and the disease was therefore treated a pre-existing disease.

DECISION: Held that on going through the proposal form which has a lacuna like keeping some columns blank and issuing a Pariwar policy against a proposal made for Mediclaim policy. No queries were raised regarding relevant columns of pre-existing disease which was left blank in the proposal form. Moreover, the complainant stated he had not received the terms and conditions of the policy. While agreeing with the insurer that the claim was not payable as per terms and conditions of the policy but non availability of terms and conditions of the policy goes in his favour. Hence, payment of an ex-gratia amount outside of terms and conditions of the policy under RPG rule 16(2) read with Rule 18

would be sufficient compensation to the complainant. An ex-gratia amount of Rs. 50,000/- against an expenditure of Rs. 1.84 Lakhs should be sufficient compensation to meet the end of justice. Accordingly it is hereby ordered that an amount of Rs. 50,000/- should be paid as ex-gratia under RPG rule 16(2) read with Rule 18 by the insurer to the complainant.

Chandigarh Ombudsman Center

CASE NO. GIC/610/NIC/11/08

Raj Kumar Sharma Vs. National Insurance Co. Ltd.

Order dated 15.04.08

FACTS: Shri Raj Kumar Sharma was covered under Mediclaim Policy. He was hospitalized in DMC, Ludhiana for surgery of heart. He filed a claim for Rs. 1,67,714/- in respect of the treatment undergone. He stated that his claim had not been settled despite having submitted all the documents. It is reported that he has mediclaim cover with the insurer since the last 5 years. Parties were called for hearing on 15.04.08.

FINDINGS: During the course of hearing the insurer clarified the position by stating that initial insurance was for Rs. 25,000/- which was got enhanced to Rs. 1 lakh. However since the sum insured for Rs. 1 lakh and above did not fall within the power of the Branch Manager, the complainant was informed that his insurance cover cannot go beyond Rs. 50,000/- as financial authority vested with Branch Manager was limited to Rs. 50,000/-. The claim papers in the meantime were referred to the TPA who informed that a cheque for Rs. 24,750/- had been issued by the TPA in favour of the complainant on the presumption that it was a case of pre-existing disease and any enhancement of the sum insured in respect of pre-existing disease cannot be considered for payment. On a query whether a policy document for Rs. 1 lakh was available, the complainant replied in the affirmative and showed the original policy document. On a query whether a policy for Rs. 50,000/- was issued, the insurer stated that no such policy had been issued.

DECISION: Held that the policy available with the complainant for sum insured of Rs. 1 lakh is a valid legal document for the purpose of settling the claim. Whether it was issued with the consent of the competent authority or not is not the fault of the complainant. As far as pre-existing disease is concerned no document was available on the basis of which it could be inferred that any treatment was taken by the complainant for heart problem before the commencement of the policy. The claim should therefore be paid on the basis of existing policy where the sum insured is Rs. 1 lakh.

Chandigarh Ombudsman Center

CASE NO. GIC/673/NIC/11/08

Raj Kumar Verma Vs. National Insurance Co. Ltd.

Order dated 13.05.08

FACTS: Shri Raj Kumar Verma had taken Parivar Mediclaim Policy for the period 23.04.07 to 22.04.08 for the sum insured of Rs. 2,00,000/-. He had been having mediclaim policy since 2001 without any break. He was hospitalised for treatment of his heart ailment and Rs. 1,78,199/- was spent on the treatment. He applied for cash less facility he was harrassed and hardly 50,000/- were paid. At the time of taking insurance policy it was told that the limit for one or more hospitalisation of all or any member of the family during the entire period of one year of the said policy, the claim amount shall be Rs. 2,00,000/- but when the claim arose it was told that only 50% of the S.I. is entitled to each member of family per hospitalisation.

FINDINGS: During the course of hearing the insurer clarified the position by stating that the original insurance was for Rs. 50,000/- from 2001 to 2005. In 2003, there was a claim relating to heart disease. After enhancement, the treatment relating to heart disease was treated an existing disease and hence, as per clause 5.12 of the Terms and Conditions of the policy, treatment for heart related problems was limited to Rs. 50,000/- alone.

DECISION: Held that clause 5.12 of the terms and conditions of the policy reads as under.

"Sum Insured under this policy can be enhanced only at the time of renewal up to next higher slab if Sum Insured under expiring policy is up to Rs.

1,00,000/- and next two higher slabs if Sum Insured under expiry policy is above Rs. 1,00,000/- subject to satisfactory medical check up with regard to health of the insured person and acceptance of additional premium for the enhanced sum Insured. However, continuing or recurrent nature of disease/complaints which the insured has ever suffered will be excluded from the scope of cover so far as enhancement of Sum Insured is considered. "

In view of this clause, the action taken by the insurer to limit the claim to Rs. 50,000/- is as per terms & conditions of the policy and hence, is in order.

Chandigarh Ombudsman Center

CASE NO. GIC/609/NIC/11/08

Satish Kumar Vs. National Insurance Co. Ltd.

Order dated 06.05.08

FACTS: Shri Satish Kumar was covered under Mediclaim Policy for the period from 04.05.2007 to 03.05.2008. He remained admitted in Sir Ganga Ram Hospital from 30.06.2007 to 08.07.2007 and incurred an expenditure of Rs. 2,88,263/-. His legal heir requested for cashless treatment but was rejected on 04.07.2007. Again vide TPA letter dated 05.07.2007 he was informed that claim is not payable due to history but can be considered on merits. He submitted his bills to TPA but as per insurer letter dated 28.12.2007 addressed to insured the claim was rejected under the exclusion clause 4.1 of the policy i.e. Pre-existing. Parties were called for hearing on 06.05.08 at New Delhi.

FINDINGS: During the course of hearing the insurer clarified the case by stating that the TPA had rejected the claim as in the discharge summary it had been stated that he was suffering from pain for the last 15 years.

DECISION: Held that on going through the discharge summary carefully, nothing is mentioned about the disease against *past history* column. In the diagnosis, it has been mentioned pain for 15 years which the complainant clarified was due to a fall 15 years back which was treated. He also clarified that he was leading a normal life for the last 15 years and no claim was lodged since 2000 when the policy was taken initially. If the present surgery was done to a 15 year old problem there would have been some record of treatment in the last 15 years. Since no claim was lodged in the last 7 years of the continuation of the policy, the contention of the complainant that the earlier pain was temporary one seems more justified. The repudiation of claim on account of pre-existing disease is not in order. The claim is payable. It is hereby ordered that the admissible claim amount should be paid by the insurer to the complainant.

CHENNAI

Total Repudiation

Chennai Ombudsman Centre

Case No.IO(CHN) 11.03.1483/2007 – 08

Mrs. Mercy George

vs

The National Insurance Co. Ltd

Award No.010 dated 29T.05.08

The Complainant Mrs. Mercy George and her spouse Mr. George Abrham were covered under Parivar Mediclaim Policy of the Insurer. The spouse of the complainant underwent PTCA with stenting of RCA and Plain Ballon Angioplasty at the hospital and submitted the bills to the insurer. The claim of the insured was rejected by the insurer on the grounds that the same falls under exclusion of hospitalization within 30 days of taking of the policy.

Though the insurer had collected the premium for covering diabetes and hypertension, still 30 days waiting period under the policy is applicable and treatment taken by the insured is for CAD. From the hospital records, it is revealed that the insured was suffering from diabetes for the past 15 years. As per policy condition 4.2, hospitalization expenses claimed for other than the one relating to accidents are not payable within first 30 days of taking the policy. The insured claimed for hospitalization 22 days after commencement of the policy.

Hence the rejection of the claim by the insurer is in order and the complaint was dismissed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.05.1438/2007 – 08

Mrs. Mary Jessintha

Vs

The Oriental Insurance Co. Ltd

Award No.016 dated 30.05.08

The Complainant, Mrs. Mary Jesintha had taken a mediclaim policy for the first time from 14/03/2006 to 13/03/2007 and renewed for a further period of one year from 14/03/2007 to 13/03/2008. During the second y6ear of the policy, the insured was operated for Fibroid in uterus. TPA/Insurer repudiated the claim on the ground of condition relating to two years exclusion of certain ailments.

As per the wordings of the 2006/07 policy, hysterectomy was an exclusion under the first year of the policy. The policy was renewed without break and during the second year of the policy, the insured reported claim for hysterectomy. Had there been no change in the policy condition, the claim would have been payable. But, the revision of policy terms of the insurer during 2007/08 excluded hysterectomy for two years. Based on the same the claim of the insured was rejected.

As per the administrative instructions of the insurer, '**renewal of existing policies of the company, the waiting period will continue to be the one specified under the existing policy'.** Hence, the insured is entitled to have the benefit of waiting period of one year as per the 2006/07 policy terms since her policy was a continuous renewal with the same Company. The insurer is directed to process and settle the claim subject to other terms and conditions of the policy.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.05.1505/2007 – 08

Dr. S.K. Gupta

vs

The Oriental Insurance Co. Ltd

Award No.019 dated 30/06/2008

The Complainant Dr. S.K. Gupta 's spouse who was covered under the Mediclaim policy was hospitalized for bilateral osteoarthritis of knee right > left and surgery was carried out for correction of varus deformity and cemented total knee arthroplasty right knee. The insurer/TPA rejected the claim on grounds of pre existing condition.

The present claim for knee replacement surgery of both knees has arisen in the 3rd year of the policy. The TPA also declined pre authorization on the grounds based on x Ray report that there were severe osteo-arthritic changes of both knees cannot have developed within the policy period of two years and three months. It is a known fact that osteo arthritic changes require considerable time to develop and surgery is resorted to only when the condition becomes acute. Until that time, the same can be treated with conservative medical management. Surgery is resorted to only as the last option. For the disease to progress from joint pains, which can be treated conservatively to a condition, which necessitates the replacement of the body part itself, takes considerable time. The same cannot happen within a short span of time.

It is also possible that the twisting of he right knee in May 2007 aggravated the situation and warranted immediate medical intervention. Expert medical opinion obtained by the insurers is that the condition necessitating total knee replacement of both knees cannot have developed within the policy period. As per the discharge summary of Kottakkal Arya Vaidya Sala in March 2006, the onset of the disease had been gradual .

Hence, it is observed that the ailment is a result of gradual onset over a period of time and from the records, it is evident that it dates back to more than 3 years during which period there was no insurance cover. Hence, the decision of the insurer in rejecting the claim as due to pre existing condition is upheld and the complaint is dismissed.

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.04.1522/2007 – 08

Mr.Mr. Sushil Kumar Chordia

Vs

United India Insurance Co. Ltd

Award No.021 dated 30/06/2008

The Complainant had covered himself and his family members under the Mediclaim policy for the past 7 years. His daughter had Excimer Laser Operation and lodged a claim with the insurer. The insurer rejected the claim on the ground that their policy did not provide coverage for "Errors of Refraction".

The laser surgery was performed for correction of refractive error. As per the details furnished in the claim form, the disease was first detected on 01/09/2007 and surgery was performed on 05/10/2007. The contention of the complainant that the defective power suffered by his daughter is a disease and of very recent origin had not been established through consultation papers, details of trauma etc. Hence, the case had to be treated as a normal case of myopia or refractive error. In cases where the power exceeds (-7), when it would become a medical necessity there is provision in the insurer's guidelines for considering the claim. In the instant case, the insured had not produced any evidence to establish that the condition had arisen out of any disease and the power of the eyes are greater than (-7)

Hence, the contention of the insurer that laser surgery was not conducted for a medical purpose or emergency is found to be in order and the decision of the insurer to reject the claim on the grounds that the power was below (-7) could not be faulted. The complaint is dismissed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.14.1506/2007 – 08

Mr. C. Sugumar vs Cholamandalam MS General Insurance Co. Ltd

Award No.025 dated 16.07.08

The complainant, Mr. C. Sugumar has been covered along with his wife Rajeswari and two children under Chola Family Health Plan for the period 16.03.06 to 15.03.07 for a sum insured of Rs.2lacs. Mrs. Rajeswari was hospitalized and was operated for Direct closure of Ostium Atrial Septal Defect in May 2006. The insurer denied the claim under their policy condition C-24, stating that the ailment is congenital internal disease. Besides, since the policy was in the first year of operation, the insurer held that the ailment is a pre-existing one and an exclusion under clause C-1. It has to be ascertained whether the insurer is justified in rejecting the claim on the ground of pre existing ailment and congenital disease.

The insured underwent cardio pulmonary bypass for direct closure of heart valve defect on 2/06/2006 that is within 3 months from the date of inception of the policy on 16/03/2006. The discharge summary mentions that the insured had history of frequent respiratory infections and breathlessness on exertion since 10 months, which is prior to the date of taking the insurance policy on 16/03/2006.

The insurer has also produced the copy of the indoor case papers where it has been mentioned that Heart defect was detected one year back and has been referred to the hospital for surgery.

In the circumstances, the pre-existence of the disease, which is also a congenital defect, having been established and the claim lodged within 3 months of inception of the policy, the repudiation of the claim as per policy conditions is in order and the complaint is dismissed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.02.1519/2007 – 08

Mrs. Kamala Ramakrishnan

vs

The New India Assurance Co. Ltd

Award No.030 dated 29.07.08

Smt Kamala Ramakrishna insured under Mediclaim policy issued by New India assurance Company, had preferred a claim for Rs.75000/- for a surgery she underwent during Mar 2007.She had taken the policy in 2003 from Indiranagar branch in Chennai of the insurer. The claim was rejected by the insurer on the grounds that the treatment was for acid peptic disease she was suffering from the past 4 years which was earlier to the date of proposal and as such the claim was not payable as per exclusion clause 4.1 of the policy. The insured says she was suffering from minor symptoms like eructation and discomfort in stomach which was diagnosed as irritable bowel syndrome which is quite common in South India and for this she was not given any treatment.

It is seen that at the time of proposing for insurance Mrs. Kamala Ramakrishnan has been subjected to medical examination and the Doctor has certified that she did not suffer from any physical and/or mental diseases or infirmity or medical complaints or any previous surgery. Based on this report the policy had been issued and the only disease excluded was cataract.

It is likely that the patient may be having dyspeptic symptoms, but the insurer has not proved with any clinching evidence that it existed earlier to the date of the proposal 4 years ago and is the root cause for the ailment for which she had to undergo surgery. Therefore the total repudiation of the claim by the insurer is not in order. At the same time

it cannot be totally ruled out that the complainant never suffered from pre-existing disease which might have lead to the subsequent surgery she underwent.

To ensure that justice is done to both the parties to the dispute and keeping in mind the merits of the case, a sum of **RS.30000/- is awarded as Ex-gratia.**

Chennai Ombudsman Centre

Case No.IO(CHN) 11.08.1008/2007 – 08

Mr.M.R. Ketharam

vs

The Royal Sundaram Alliance Insurance Co. Ltd

Award No.032 dated 29.07.08

The complainant, Mr. M.R. Ketharam has been covered along with his wife and two children under Health Shield Insurance Chola Family Health Plan for the period 26.10.06 to 25.10.07 for a sum insured of Rs.1lacs. He was hospitalized for treatment of Cervical Spondilitis and SHT between 3.09.07 and 4.09.07. The insurer denied the claim stating that the ailment for which treatment had been taken was pre-existing.

It is seen there is nothing on record as per the hospital records or documents produced by the insurers to establish that the acute condition, which warranted hospitalisation of the insured had been pre-existing before 11 months when the policy was issued to him by virtue of his being a credit card holder. Even the policy that has been issued on renewal for the year 2007-08 speaks only of “hypertension” as being pre-existing disease.

In the circumstances, on perusal of all the records submitted as above, it is found that the insurer has not conclusively established with records that the complainant was treated on for the condition of pre existing disease of cervical spondylitis. A sum of Rs.6,000/- is awarded as Exgratia.

Chennai Ombudsman Centre
Case No.IO(CHN) 11.02.1015/2008-09
Smt. Y. Jayalakshmi
vs
The New India Assurance Co. Ltd
Award No.037 dated 13.08.08

The complainant Smt Jayalakshmi was covered under individual Mediclaim Policy of the insurer for a sum insured of Rs.1 lac and cumulative bonus of Rs.15,000/. She had the policy continuously for 3 years. During the policy year 2007-08, the insured had fallen down from the cot at her home and was hospitalized for headache and uneasiness. The TPA repudiated the claim on the ground of non-disclosure of Pre-Existing diseases at the time of taking the policy.

To have more clarity about the illness, the Forum has obtained the views of an expert who has opined that, "the hospitalisation was due to the progression of symptoms resulting from a fall a few weeks earlier. Her hypertension and diabetes have not caused the subdural haematoma. Absence of any indication that she was on anticoagulants or asprin, along with a report that clotting parameters are normal, would negate even this cause. By elimination of all causes, we are left with trauma as the cause. The absence of reference to this fall could be due to absence of any immediate consequences of injury."

Taking into account all of the above, it is reasonably felt that the hospitalization was due to Trauma which is the proximate cause, and not contributed by pre existing ailments or the medication which was being taken for the same. Hence the decision of the TPA/insurer to reject the claim under the condition of pre-existing illness and non-disclosure of material facts is not tenable and the insurer was directed to process and settle the claim as per the other terms and conditions of the policy. The Complaint was allowed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.02.1525/2007 – 08

Mr. N.P. Rajkumar

Vs

The New India Assurance Co. Ltd

Award No.041 dated 14.08.08

Sri.N.P.Rajkumar was covered under Mediclaim policy issued by

the insurer. He took treatment for giddiness and neck pain during the policy period and preferred a claim. The TPA had rejected his claim quoting the treatment taken was for Pre existing disease. He requested the TPA to return his original bills so that he can claim the reimbursement from his employer. In spite of his repeated E-mails they took nearly 90 days to return the bills by which time the deadline set by his employer was over and he could not get the reimbursement from his employer also. His further appeals to the insurer did not yield any result.

The TPA contended that the insured was diagnosed for Cervical Disc Herniation Right Radiculopathy/HTN and they note from the Discharge summary that insured had past history of Neck pain for 5 years. The consultant orthopedic surgeon who treated the patient certifies that the patient was suffering from the complaints since 4 weeks which is not prior to proposal date. The patient was compelled to get hospitalized only after not getting cured through domiciliary treatment .The Doctor who attended on him is the best judge to certify the patient's past history. Further, there is service deficiency on the part of the TPA/ Insurer in delaying the return of the medical records resulted in the forfeiture of reimbursement from the employer as time barred. The approach of TPA/Insurer in repudiating the claim and rendering service to the complainant appears to be casual in nature. Considering all these aspects, the insurer is directed to settle the claim as per the other terms and conditions of the policy and the complaint was allowed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.02.1130 /2008-09

Mrs. Manjula bai

vs

The New India Assurance Co. Ltd

Award No.043 dated 27.08.08

The complainant and her spouse were covered under Individual Health Insurance Policy for a sum insured of Rs.3,25,000/- each. During the policy period, the spouse of the complainant underwent angioplasty surgery and afterwards the patient died due to heart attack. The insured claimed Rs.3,25,000/- out of which, the insurer settled the claim for Rs.2,00,000/- only. The insured took up with the insurer for payment of remaining amount of Rs.1,25,000/-. The insurer informed that the maximum amount payable for major surgeries were limited to Rs.2,00,000/- only as per the revised Gold Policy terms and conditions.

Since the terms “pre and post hospitalization” expenses clearly envisages a period of compulsory hospitalization to become eligible for a hospitalization claim, it is clearly established that what is envisaged is restricting the amount of pre and post hospitalization expenses to be paid along with the any hospitalization claim. If the intention of the insurer was to restrict the expenses on major ailments claims to only 70% of sum insured, including pre and post hospitalization, then the same should have been stated in unambiguous terms on the policy. In case of ambiguity, it is an established fact that the interpretation would not be in favour of the drafter.

Since the treatment meted out to the deceased insured cannot be classified only as angioplasty, the decision of the insurer to restrict the claim to Rs 2.00 lacs is unjust and in view of the extra ordinary circumstances which included the unfortunate demise of the insured, the insurer is directed to pay a further amount of Rs 75,000/- towards pre hospitalization expenses and post angioplasty expenses as Exgratia subject to submission of relevant original bills by the insured. The complaint is partly allowed on **Ex-Gratia** basis.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.02.1100/2008-09

Mr. Kuzhandaivelu

vs

The New India Assurance Co. Ltd

Award No.045 dated 27.08.08

The complainant and his spouse were covered under the Mediclaim policy of the insurer. The complainant’s spouse underwent surgery for incisional hernia prolene mesh repair, hysterectomy, appendicectomy, ovarian cyst excision etc. Her claim was rejected under clause 4.1 as a pre-existing ailment with related complications.

As per the first discharge summary, the patient was admitted with complaints of swelling on left side of abdomen since 2 years and with history of occasional pain. This is quite different from the conclusion of the TPA/insurer that the insured has had a history of swelling in the abdomen with associated pain since 2 years. The point to be noted is that the discharge summary does not say that she was suffering from pain for two years, if at all it only says she had swelling for two years. The insurer rejected the claim based on the discharge summary mentioning the swelling on the left side of abdomen since two years.

The insurer has been unable to submit the copy of the proposal form to ascertain if the insured had declared the fact that she had had 4 deliveries and the laproscopic sterilization. The insurer had also not stated whether the proposal if any collected, at the time of commencement of cover mention the surgery carried out 13 years ago. It therefore appears that there is no clinching evidence produced by the insurer to establish that the insured was suffering from the ailment before the policy was taken.

Hence, the insurer is directed to process and settle the claim as per other terms and conditions of the policy and the complaint is allowed.

Chennai Ombudsman Centre

Shri M Harihara Mahadevan

Vs

The New India Assuarance Co. Ltd.

Case No.IO(CHN) 11.02.1133 / 2008-09

Award No. 048 dated 30.09.08

The Complainant had covered his wife and daughter under the Mediclaim policy of the insurer. During the year 2005-06, the complainant's wife was hospitalized for suspected chikungunya fever. She was not having any pre-existing disease when the policy was taken for the first time at her 37 years of age. She developed mild diabetes in 2000 and due to which she was not having any sort of complications. In September 2006 she was affected by Chikun -gunya and developed complications due to that and she expired within a week. During admission, when he asked for the cashless facility the Vijaya Hospital advised him to pay the bills first and claim reimbursement The patient passed away on 18/09/06.

The insurer rejected the claim under condition No.4.1 on the grounds that the insured was suffering from pre existing disease of Diabetes Mellitus before commencement of the policy for the first time.

The representative of the TPA stated that death of the insured was due to severe brain stem dysfunction. She was suffering from Diabetes Mellitus, which was pre-existing. She had developed severe hypoglycemia. Blood sugar level has gone so much lower without food and she must have taken diabetes tablets when she had vomiting. Her brain was not able to function with low oxygen supply. Hence she went into hypoglycemic coma. Hypoxic Encephalopathy was also due to low blood sugar level. Renal failure was also a result of low blood supply to the kidneys. Chikun Gunya could not cause these problems.

Though some of the ailments mentioned in the discharge summary can be attributed to diabetes, the insurer depended on the discharge summary for concluding that diabetes as pre-existing from the year 2000. The contracting of the disease during 2000 was also as per the version of the attendants of the insured since the insured was admitted to the hospital in an unconscious state and treated for chickengunia fever as well as host of other complications as mentioned in the death summary. There were no exact details available to pin point that the disease existed from

the year 2000, supported by either doctor's prescription/test report etc. The complainant also could not produce any records to establish that the deceased contracted diabetes only after the inception of the policy.

Preexisting disease not having been proved with any clinching evidence, an amount of Rs 30,000/- was awarded as Ex Gratia and the complaint is partly allowed..

Chennai Ombudsman Centre

Case No.IO(CHN) 11.02.1480/2007 – 08

Mr. Lala Mathai

vs

The New India Assurance Co. Ltd

Award No.02 dated 22.05.08

The Complainant Sri Lala Mathai was covered under the Mediclaim policy of New India Assurance Co. Ltd . The insured was treated for Follicular Lymphoma and the claim for the same was settled by the insurer. After six months of treatment, on reference from the Hospital the insured underwent PET-CT procedure as on out-patient which was rejected by the insurer as out-patient treatment falls under policy exclusions. The insured contended that the procedure was part of the treatment and has to be allowed under the policy.

As per the treating doctor at Vellore, the PET-CT was done for evaluation and not as part of the treatment. The policy condition stipulate minimum of 24 hours stay in the hospital as an in-patient for claiming under the policy. Further, the test undertaken is for purely diagnostic purpose and has not resulted in any active treatment.

In view of the non fulfillment of conditions of the policy relating to minimum period of stay as an in-patient in the hospital and tests conducted are only of diagnostic nature without any active treatment, the complaint was dismissed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.08.1457/2007 – 08

Mr. K.L. Bhaskaran

vs

The United India Insurance Co. Ltd

Award No.09 dated 29.05.08

Mr. K.L. Bhaskaran had taken a Mediclaim Policy from the insurer. During the policy period, the insured underwent heart surgery. The insurer rejected the claim on the grounds of pre existing condition.

The continuous cover was available from 17/04/2003. As per ECG report dated 03/10/1996, the condition of the heart of the complainant is stated to be "Hypertensive Heart Disease".

It is evident that the complainant was suffering from the disease well before the commencement of the policy and falls under the exclusions of Pre Existing Diseases.

The complaint was dismissed .

Chennai Ombudsman Centre

Case No.IO(CHN) 11.03.1448/2007 – 08

Mr. B. Kantilal

vs

The National Insurance Co. Ltd

Award No.011 dated 29.05.08

The insured along with his family members were covered under Mediclaim Insurance and the insured was hospitalized for giddiness and unsteadiness while walking and found to be suffering from anxiety. Diagnostic tests were conducted. The insurer rejected the claim on the grounds of condition No.4.10 of the mediclaim policy relating to exclusion of expenses incurred only for evaluation and not or any active line of treatment based on the findings of the evaluation.

It was found from the records that the insured was not only administered diagnostic tests, but his ailment had been diagnosed and given treatment for which he tested positive and confinement at the hospital was required. As per the indoor case sheets, the patient was administered psychiatric drugs which requires constant monitoring. The best persons to decide whether the patient needs to be hospitalized are the treating doctors. The TPA/Insurer have made no efforts to check with the hospital

whether the patient's condition require hospitalization or not. In view of the same, the rejection of the claim by the insurer is not justified and the complaint was allowed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.02.1473/2007 – 08

Mr. J. Nambu Ganesan

Vs

The New India Assurance Co. Ltd

Award No.015 dated 30.05.08

The Complainant Sri J. Nambu Ganesan was covered under the Mediclaim policy of New India Assurance Co. Ltd . The insured met with an accident and underwent treatment for Post Traumaic Subrachnoid Haemorrhage with Obstructive Hydrocephalus. The insurer rejected his claim on the grounds of non submission of required documents and misrepresentation of facts.

There were different versions of the accident like accident fall, head injury due to falling on a stone, alleged attempt to suicide etc. It is evident from the records that the insured sustained grievous injuries resulting in prolonged treatment. The sustaining of injuries and consequent treatment were not disputed. Since, the accident was not registered with the police and not mentioned in the hospital accident register, the furnishing of Medico Legal Certificate did not arise. Attempt to suicide by insured was also not proved and investigation reports submitted were also email correspondence and no efforts had been made to visit the accident site or obtain statements from the witness to the fall. Again, the e-mails of HR Manager on whom the TPA relied for rejecting the claim had requested for ignoring the same. As such, the insurer/TPA had failed to substantiate the grounds on which they had rejected the claim. Hence, the insurer was directed to settle the claim in full in accordance with the other terms and conditions of the policy.

Chennai Ombudsman Centre

Case No. No.IO(CHN) 11.03.1481/2007 – 08

Mrs. M. Sivagami

Vs

The National Insurance Co. Ltd

Award No.017 dated 10/06/2008

The Complainant Mrs. M. Sivagami and her daughter had been covered under the mediclaim policy of the insurer for a sum insured of Rs.1,50,000/-. The insured was hospitalized for Multiple Sclerosis. The insurer/TPA rejected the claim on grounds of pre existing condition.

Though the complainant was suffering from various symptoms and the diseases were progressing inside her body, she may not be aware of the exact diagnosis. Expert medical opinion obtained by the Forum also confirm that as per the 2005 records, the insured had been diagnosed as sero.neg.Rh.arthritis and treated for the same. Even, during this period, she had faced restriction of neck movement, inability to walk and also suffering from joint pain, mobility problems, urinary problems etc. The complainant had been getting treatment for the multiple symptoms and ailments under alternate therapies and it is likely that she was not aware of the exact diagnosis till February 2007.

Hence, it is observed that though the insured was suffering from different types of ailments, multiple sclerosis was diagnosed during February 2007 and took treatment for the same and the disease cannot be conclusively categorized as pre existing. The complaint is allowed and Rs.50,000/- awarded as **Ex-Gratia.**

Office of Insurance Ombudsman, Chennai

Complaint No.IO(CHN) 11.08.1502/2007 – 08

Mr. M.R. Nandakumar

vs

The Royal Sundarm Alliance Insurance Co. Ltd

Award No.023 dated 16.07.08

The complainant, Mr. M.R. Nandakumar has been covered under Health Shield Insurance Policy issued by Royal Sundaram Alliance Insurance Ltd., for the period from 27.10.06 to 2610.07. The insured was diagnosed as having 'Moderately differentiated (Grade III) ADENOCARCINOMA – RECTUM and Hypertension. His claim was rejected on the grounds of pre existing condition since as per the doctors opinion the carcinoma suffered by the insured requires more than 18 months to fully develop which was prior to commencement of the policy.

As per the "pre-existing" conditions of the insurer, policy excludes from its cover, "Such diseases/injury which have been in existence at the time of proposing this insurance. Pre/existing condition also means any sickness or its symptoms, which existed prior to the effective date of this insurance, whether or not the insured person had knowledge that the symptoms were relating to the sickness.

In the circumstances considering the gravity of the disease, ie complete encirclement, it appears that the advanced stage would have been reached after a considerable period of time, which is definitely prior to the inception of the policy, which was five months earlier and hence the complaint was dismissed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.02.1016/2007 – 08

Mr. Bhagirath D. Sheth

vs

The New India Assurance Co. Ltd

Award No.026 dated 18.07.08

The complainant has covered himself and his family under Mediclaim Policy for the period 30.03.2006 to 29.03.2007. Ms. Kruthi B Seth, insured's daughter has been covered under the policy for a sum insured of Rs.75,000/- with cumulative bonus of Rs.26,250/-. Ms. Kruthi B Seth underwent treatment, under TA –LASIK LASER for MYOPIA – BOTH EYES on 8.12.06 at Rajan Lasik Pavilion, Chennai.. The TPA had repudiated the claim under the exclusion clause 4; sub clause 4.5 of the Mediclaim policy relating to cosmetic or aesthetic treatment.

The point to be considered is whether the rejection of the claim by the insurer as per the terms and conditions of the policy is in order.

Under Exclusion 4.5 of the Mediclaim policy, 'Cosmetic or aesthetic treatment of any description' are excluded under the scope of the policy. The internal circular quoted by the insurer appears to be guidelines for waiver of Exclusion 4.5 as a special case, only in cases where the power exceeds (–7), when it would become a medical necessity.

In the instant case, however medical opinion indicates that myopia with more than (-) 7 only falls under **"HIGH MYOPIA"** and hence the rejection of the claim by the insurer on the grounds that the power was below (–) 7 is in order and the complaint is dismissed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.03.1030/2008 – 09

Mr. Packiaraj Gunasekar

vs

National Insurance Co. Ltd

Award No.034 dated 11.08.08

The complainant was having the mediclaim policy with National Insurance Co. Ltd continuously for 8 years. The sum insured under the policy was Rs.50,000/-. During the policy period, the insured underwent surgery for Total Proctocolectomy with permanent Ileostomy for Familial Adenomatous Polyposis. The insurer on the grounds of Pre Existing Disease rejected the insured's claim.

The TPA/Insurer have proved through records that the insured was having symptoms even before obtaining the policy for the first time and hence as per the terms and conditions of the policy, the same falls under pre existing condition. Therefore the decision of the insurer to reject the claim on the grounds of pre existing condition can not faulted with. The complaint is dismissed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.03.1103/2008-09

Mr. Saraswathi Viswanathan

vs

National Insurance Co. Ltd

Award No.036 dated 11.08.08

The complainant was having Mediclaim Policy from the insurer since September 2004 and renewing the same without break. During the policy period, the insured had treatment for Scar Sarcoidosis **and steroid induced** Myopathy**. The insured took the treatment at the Apollo Hospitals and submitted the claim. The insurer/TPA rejected the claim on the grounds of pre existing condition.**

Although the disease may have been cured as per the insured, it is seen that the present recurrence is on the site of the scar relating to the earlier operation. The reports of tests submitted by the insured as pre-hospitalisation expenses relate to evaluation of the sarcoidosis problem. This is confirmed by the follow up sheets of the hospital dated 10/09/2007, which speaks of "sarcoidal flare up." While it is a fact that the complainant was reviewed for the effect of the steroids, the insurer has established with clinching evidence in the form of indoor case sheets, follow up notes of the hospital etc that the present treatment and hospitalisation is related to treatment of

sarcoidosis which the patient had suffered in the past and had resurfaced on the earlier scar. This had necessitated use of steroids.

Hence, the decision of the insurer to reject the claim on the grounds of pre existing condition exclusion is in order and the complaint is dismissed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.02.1539 D/2007 – 08

Mr. Ved Prakash Agarwal

vs

The New India Assurance Co. Ltd

Award No.042 dated 22.08.08

The complainant and his wife were insured under Mediclaim policy issued by New India Assurance Company. The insured had preferred two claims totaling Rs.31,355/- for treatment taken by his wife at the hospital. The TPA rejected his claims quoting Exclusion Clause 4.1 that the treatment taken was for Pre existing disease.

The claim has been repudiated under clause 4.1 due to Pre-existing diabetes and coronary disease since 1996. The complainant contends that since a claim in respect of his spouse which occurred in 1998 ie in the second policy year was paid, the insurer is bound to pay the claims that have arisen in 2007. While it is a fact that the TPA and insurer have a duty to seek clarification from treating doctors whenever they find records that are contradictory, the primary duty rests on the insured who has obtained these reports from the treating doctor and submitted the same to the insurer. In the instant case, the insurer has submitted copy of the indoor case sheets relating to the hospitalisation of complainant's spouse where it has been recorded that the said patient is a known case of Diabetes for 15 years. As such, the insurer has provided clinching and irrefutable evidence in support of their stand that the patient was having pre-proposal illness of diabetes. In the light of the above facts, the rejection of the claim by the insurer under clause 4.1 of the policy relating to pre existing diseases is in order and the complaint is dismissed**.**

Chennai Ombudsman Centre

Case No.IO(CHN) 11.04.1130/2008-09

Mr. N.Kuppiah

vs

United India Insurance Co. Ltd

Award No.044 dated 27.08.08

The complainant and his family members are covered under the Mediclaim Policy of United India. The mother of the complainant, was covered for a sum insured of Rs.35,000/-. During the policy period, she underwent surgery for piles. The insurer rejected the claim on the grounds that the ailment the insured was suffering falls under first year exclusion as per the terms of the policy.

The policy under which the claim has been made is not the continuous renewal of the earlier policy because the policy had a break of 9 days due to cheque dishonour. The claim has arisen on the 14th day after inception of the policy after the break of 9 days. The policy is treated as a fresh contract because the Cheque was dishonoured and the cash remittance was received after the due date. When the insurer has received the notice of dishonour they have immediately informed the insured. There is no deficiency in service on the part of the insurer. The dishonour of the Cheque was not on account of any technical reasons but due to "insufficiency of funds" .If adequate balance was not available in the bank, the insured should not have issued a cheque. The issuance of Cheque without sufficient funds in the account is not legal. The insured has not taken enough care to keep the policy as a continuous renewal without break rendering the policy as a fresh one. Hence, the decision of the insurer to treat the policy, as a fresh one for applying first year exclusion is in order and the complaint is dismissed.

Chennai Ombudsman Centre

Shri N K Gupta Vs National Insurance Co. Ltd

Case No.IO(CHN) 11.03.1142 / 2008-09

Award No. 049 dated 30.09.08

Shri N K Gupta had taken a mediclaim policy for himself and his wife in 2005 after a medical examination. In 2008 he was hospitalized for heart ailment and underwent bypass surgery. The total expenses was over Rs 2.00 lacs but he preferred a claim for Rs 1,90,000/- which was the sum insured under the policy. The claim was repudiated on the grounds of pre-existing disease. The insured contended that at the time of proposing for insurance he had been subjected to medical examination at which point of time it was found he was not suffering from any disease. On that basis only the policy was issued to him. He stated that the recording in the discharge summary that he had diabetes for 12 years was incorrect and was asked to bring the first prescription of the treating doctor when the disease had been diagnosed.

The insurer rejected the claim under sec 4.1 on the grounds that as per the discharge summary, the insured was having pre existing condition of diabetes for the past 15 years and also the same was not declared at the time of obtaining the insurance cover for the first time during 2005. The insurer and the TPA contended that they had refused to give cashless facility because the ailment of coronary heart disease was a complication of diabetes which was pre existing. They stated that they had

repudiated the claim for breach of utmost good faith as he had suppressed the information regarding the positive existence of diabetes and taking treatment for the same prior to commencement of policy. He had increased the sum insured in January 2008 without mentioning diabetes.

It was found that the complainant was suffering from severe triple vessel coronary artery disease and long standing diabetes. Pathological reports furnished at the time of proposing for insurance did not have any adverse features. A reading of the hospital records establishes that the diabetic status of the complainant has been recorded differently in three different hospital records. The insurer had not obtained any clarification from the hospital regarding the incorrect recording in the discharge summary as "12 years" in one place and "15 years" in another The complainant also did not produce any records to establish exactly when he had been diagnosed. But it is seen that the complainant had a three-vessel disease, which means the onset of the disease was much earlier. The diseases may have been present and the complainant might be unaware of the same. Though the coronary artery disease might have been aggravated by diabetes, it cannot be the sole reason for the onset of the heart disease.

Further, it cannot be categorically stated that all persons with diabetes will have heart ailments, although diabetes does predispose a person to coronary disease. Also, the reference is only to diabetes and not coronary artery disease. Policy had been issued in 2005 after medical examination. Since preexistence of coronary artery disease was not established with any clinching records, an amount of Rs 75,000/- is awarded as Exgratia.and the complaint was partly allowed..

Chennai OmbudsmanCentre

Mrs. M.C. Nalini

Vs

United India Insurance Co. Ltd

Case No.IO(CHN) 11.04.1115 / 2008-09

Award No. 046 dated 27.08.08

The complainant and her spouse had been covered under Mediclaim policy of United India Insurance CO. Ltd. During the third year of the policy, she was hospitalized for chest pain. An angiogram was taken and was advised medication. The insurer rejected the claim on the grounds of pre existing condition 4.1 as per policy terms.

As indicated by the hospital records, the insured has been indifferent to sustained treatment. The complainant has not produced any records to establish that she did not have the condition prior to taking the insurance policy or actual period of time when she was diagnosed as having

systemic hypertension. It is also relevant to note that the present hospitalisation was for evaluation and control of the hypertension per se. Since the complainant has challenged the validity of statements in records submitted by her to the insurer, the onus is on the complainant to establish the facts by providing authentic documents in support of her claim.

Since the complainant has produced no such evidence, the rejection of the claim by the insurer is in order as per the terms of the policy and the Complaint is dismissed.

Partial payment

Chennai Ombudsman Centre

Case No.IOCHN) 11.04.1517/2007 – 08

Mrs. Geetha Gopalaswamy

vs

United India Insurance Co. Ltd

Award No.020 dated 30/06/2008

The Complainant Mrs Geetha Gopalaswamy had been covered under the Mediclaim policy since year 2000 for SI of Rs.75,000 + Cumulative Bonus and Sum insured was increased to Rs.2 lacs effective from year 2005 renewal. The insured was hospitalized for total knee replacement and claimed the entire expenses. The insurer settled the claim restricting the payment to Rs.97,500/- only which was the sum insured inclusive of cumulative bonus prior to enhancement of Sum Insured effected in 2005. Insured contended to consider the entire amount up to the revised SI.

Considering the nature of the ailment, it is possible that the disease may not have been diagnosed when the sum insured was increased. But the symptoms would have been present which necessitated treatment in 2005 at Mumbai or through alternative therapies. The insured had not furnished the details of treatment taken at Mumbai to the insurer as required under policy conditions.

Total knee replacement surgery would clinically need many years to develop and not a couple of months. In the absence of any details of the first consultation, and because the major disease was diagnosed within two months of the increase of the sum insured, the decision of he insurer to restrict the claim to the original sum insured cannot be faulted with. Hence, the decision of he insurer to restrict the claim to the original sum insured does not warrant intervention at the hands of the Ombudsman.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.04.1007/2007 – 08

Mr.V.S. Kesavan

vs United India Insurance Co. Ltd

Award No.031 dated 29.07.08

The complainant was covered under mediclaim policy continuously since 1997 for a sum insured of Rs.3.00 lacs. During the year 2007-08, he underwent Aortic Valve Replacement and submitted a claim for Rs 2,42,038/-. The insurer restricted the claim to Rs.2.00 lacs stating that from the 2007-08 onwards, he was covered under a new policy called "Gold Policy". As per the revised policy conditions maximum amount payable for major illnesses is 70% of the sum insured subject to a maximum of Rs 2.00 lacs. The insured contended that the new policy conditions were not brought to his notice at the time of the renewal or did he submit any fresh proposal form. He was not aware of the changes in the terms and conditions of the revised policy.

The point to be decided is whether the insurer is justified in restricting the claim amount to Rs 2.00 lacs as per the terms of the revised policy when the insured was unaware of the restriction because he had not been given a copy of the revised terms and conditions.

In the present case, since there are significant changes in policy conditions, the revised terms and conditions should have necessarily been enclosed with the policy schedule. The existing entitlement of a customer who had been insured from 14/07/1998 without a break had been reduced. The entitlement of the insured for all ailment was Rs. 2,57,500/- in 2006-07 but it had been reduced to Rs 2.00 lacs in 2007-08, even though his sum insured has been increased to Rs 3.00 lacs. In the circumstances, to meet the ends of justice to both parties, a sum of Rs 20,000/- is awarded as Exgratia.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.02.1043/2008-09

Mr. E. Guruswamy

vs

The New India Assurance Co. Ltd

Award No.038 dated 13.08.08

The complainant took the mediclaim policy for a sum insured of Rs.50,000/- for the period 2006-07. The policy was renewed for the period 2007-08 during which period; the sum insured under the policy was fixed at Rs.1 lac due to revision in the terms and conditions brought by the insurer. During the policy period, the insured was hospitalized for treatment of **Pituitary Tumor** and submitted a bill for Rs.1,04,438/-. The TPA settled the claim for Rs.52,500/- only, which was the sum insured prior to revision of the sum insured to Rs.1 lac under 2007-08 policy. He contended that the settlement of the claim should be as per the revised sum insured. The insurer rejected the same citing that the complainant is not eligible for the benefit of revised sum insured during the current year.

It is observed that the diagnosis had been made on 26/07/07 and insured was aware of the ailment during policy period 2006-07 i.e. during the time when the sum insured under the policy was Rs.50,000/-. Although the mediclaim scheme of the insurer underwent a revision, by which the minimum sum insured was stipulated as Rs 1,00,000/-, on perusal of the policy schedule the intentions of the insurer to restrict the cover is seen because they have clearly bifurcated the sum insured as Rs.50,000/- + Rs.50,000/- even at the time of renewal of the policy on 06/09/2007, when they had no information regarding the ailment of the insured and the proposed surgery.

In view of the above facts, the decision of the insurer to restrict the claim to the sum insured that was available when the disease was first diagnosed is in order and the complaint was dismissed.

DELHI

Mediclaim Policy

Delhi Ombudsman Centre

Case No. GI/493/RSA/07

In the matter of Shri Gaurav Thaper

Vs

Royal Sundaram Alliance Insurance Company Limited

AWARD

The complaint was heard on 02.07.2008. The complainant, Shri Gaurav Thaper, was present. The Insurance Company was represented by Shri Piyush, Manager (Claims).

Shri Gaurav Thaper has lodged a complaint with this forum on 15.06.2007 that he had taken a health shield insurance policy from the Royal Sundaram Alliance Insurance Company Limited from 27.07.2006. The Company has rejected his claim on the ground that the disease was pre-existing as the disease could not have developed within a period of 7 months after taking the policy which is not

covered under policy. He has mentioned that as per the discharge summary and doctor's report, there is no pre-existing disease and he has requested the Forum that his claim may be paid.

At the time of hearing, Shri Gaurav Thaper informed the Forum that his father Shri Ajay Thaper was admitted in Sant Permanent Hospital on 06.03.2007 and discharged on 07.03.2007 with complaints of chest pain. On examination at Sant Permanent Hospital, he was referred to Delhi Heart and Lung Institute for angiography and further management. After going through the test, doctors advised him that his father should be operated for by-pass surgery. However, on consultation with his family doctor, he was advised that his father was not suffering from any major cardiac problem and could be cured by taking certain medicines which were prescribed by Dr.C.K.Parikh. As per the discharge summary of both the hospitals, it has been mentioned that he was non-diabetic, non-hypertensive, non-smoker and his Blood Pressure at the time of admission was only 120/80 which clearly states that it was not a case of pre-existing disease and requested the Forum that his claim may be paid.

The representative of the Insurance Company informed that as per their in house doctor, the discharge summary states that the patient was admitted for CAD which takes longer time to develop and should not have developed during the period of 7 months of taking the policy. Hence it was a pre-existing disease which is out of the scope of the policy. They have, therefore, rightly repudiated the claim.

After hearing both the parties and on examination of the documents submitted, it is observed that Shri Ajay Thaper had complaint of chest pain and was admitted at Sant Permanent Hospital from where he was referred to Delhi Heart and Lung Institute where angiography was performed. The Insurance Company rejected the claim on the ground that the disease was pre-existing. However, Shri Gaurav Thaper, the complainant, informed the Forum that there was no pre-existing disease as per the discharge summary where it is clearly mentioned that Shri Ajay Thaper was non-diabetic and was not suffering from hypertension. He was diagnosed for CAD however, he had consulted his family doctor who advised him that it is not a case where by-pass surgery was required and he was treated medically. He has contested during the time of hearing that since there was no pre-existing disease as per the discharges summary, claim has wrongly been repudiated by the Insurance Company. I have examined the discharge summary of both the hospitals, that is, Sant Permanent Hospital and Delhi Heart and Lung Institute, and find that Shri Ajay Thaper was non-diabetic, non hypertensive and his Blood Pressure was 120/80 at the time of admission which clearly establishes that there was no pre-existing disease and the Insurance Company has wrongly repudiated the claim.

I, therefore, pass the Award that Shri Ajay Thaper be paid for pre and post hospitalization expenses along with hospitalization expenses incurred by him when he was admitted at Sant Permanent Hospital and Delhi Heart and Lung Institute.

Shri N.N.S.Rana

Vs

Oriental Insurance Company Limited

ORDER

The complaint was heard on 05.05.2008. The complainant, Shri N.N.S.Rana, was present. The Insurance Company was represented by Smt. Promila, Administrative Officer and Smt. Gurmmet Kaur, Administrative Officer.

Shri N.N.S.Rana has lodged a complaint with this Forum on 11.12.2007 that he had taken a mediclaim policy No.271900/48/2008/345 from 12.05.2007 to 11.05.2008. Shri Rana has mentioned that he had applied for mediclaim health insurance policy for himself and his wife in May, 2004 for Rs.3,00,000/- each to Oriental Insurance Company Limited. He had duly submitted medical certificate both for himself and his wife showing that they were in perfect health and had no pre-existing disease like heart problem high B.P. or any other problems even though he had been operated for appendicitis in January, 1967 and his wife had been operated for gall bladder stones in April,2003 as shown in the medical certificate. They were issued a mediclaim Health Insurance policy No.2005/136 giving them an insurance cover of only Rs.2,00,000/- each saying it is due to their age. In addition to reducing the amount for which they were insured an unnecessary clause as "Excess Clause Rs.10000/-"was also illegally and (without even asking or talking or informing them), put as a condition both for him and his wife even though their medical examination and medical certificate did not show any health problem in both of them or any pre-existing disease in them. He met the Divisional Manager and also wrote to the Chairman of the Insurance Company stating how could such a clause be introduced when the insurance cover given had already been reduced to Rs.2,00,000/- each from Rs.3,00,000/- due to their age in spite of them being in best of health but this "Excess Clause Rs.10000/-" was not removed from their policy by telling that it was due to their age. It is surprising that when all medical reports were perfect, why such a clause should have been put just because of their age, apart from reducing the insurance cover. There was no claim made by him or his wife during the currency of this policy from 12.05.2004 to 11.05.2005 which itself showed that they were in perfect health When this policy was extended for next year from 12.05.2005 to 11.05.2006, this unnecessary illegal clause was again put in the extended policy in spite of his earlier protest as explained above and in spite of no claim having been made in earlier year policy. During the policy period 12.05.2005 to 11.05.2006, no claim was made by them which also proved their excellent health as no claim had been made for the first two year of their policy. In the next extension of policy from 12.05.2006 to 11.05.2007, this clause was modified for him and for his wife, "Pre-existing disease: Compulsory Excess of Rs.10000/-. This modified clause surely meant that only for pre-existing disease, they will have to pay first Rs.10,000/- themselves and not for any new sickness. Unfortunately, in October,2006, he fell ill because of "Dengue Viral" fever and was admitted in Amar Leela Hospital from 16.10.2006 to 21.10.2006. The total cost of treatment was Rs.24795/-. In this hospital, there is arrangement with Oriental Insurance Company for cashless treatment. "Dengue Viral" fever was prevalent in Delhi in October,2006 due to mosquito menace and this was not a pre-existing disease for

him. However, in spite of the fact that condition in mediclaim policy for the period 12.05.2006 to 11.05.2007 was that first Rs.10,000/- was to be paid by him only for pre-existing disease, the company through its TPA, the Medsave Healthcare Limited did not illegally pay Rs.10,000/- out of this claim of Rs.24795/- made by Amar Leela Hospital and he was illegally made to pay Rs.10000/- himself. Again when the policy has been extended from 12.05.2007 to 11.05.2008, this illegal and unnecessary clause of "Pre-existing disease: Compulsory Excess of Rs.10000/" has been put in the policy No.271900/48/2008/345 both for him and his wife. For this policy, premium has also been increased tremendously to Rs.14703/- compared to Rs.8443/- in previous year. He again wrote to the Chairman of the Insurance Company on 16.06.2007 for paying him Rs.10000/- which has been wrongly debited from his claim in October,2006 for his admission in Amar Leela Hospital due to "Dengue Viral" fever as this disease was not pre-existing. He also requested that the pre-existing disease was not existed and he had not made any claim during the last two years. It is proved and confirmed that both he and his wife had no pre-existing disease and there is no reason why this condition was put in his policy. They received a reply from the Head Office of the Company that the matter has been sent to the concerned office and would get reply from them. No further reply has been received either from the Head Office or from the concerned Divisional Office. He again requested the Insurance Company for (i) refund of Rs.10000/- and (ii) to remove the unnecessary and illegal clause from his current policy effective from 12.05.2007 to 11.05.2008. A copy of this letter has been sent to the Divisional Office but it was returned back as the office has shifted due to sealing. NO reply was received from the Chairman Office either. He has sought a relief from the Insurance Company (i) Refund of Rs.10000/- which has not been wrongly and illegally paid by him out of his claim of Rs.24795/- for treatment of "Viral Dengue" fever since it was not a pre-existing disease, and as per condition in policy during the period 12.05.2006 to 11.05.2007, only for pre-existing disease, he was required to pay Rs.10000/- himself. (ii) The insurance company is also be asked to pay 18% interest per annum on the amount of Rs.10000/- wrongly not paid to him from October,2006 till the time this payment of Rs.10000/- is made to him. (iii) The Insurance Company is asked to remove the clause "pre-existing disease: "Compulsory excess of Rs.10000/"from his current policy and not to put any such condition or put any other load in future extension of policy also as already more than three and half years have passed since he first took this policy on 12.05.2004 and they have not made any claim for any pre-existing disease during this period nor they even had any problem due to any pre-existing disease. (iv)The Insurance Company may be ordered to pay an ex-gratia payment also due to mental torture, tension and unnecessary harassment caused to them, compelling them to make so many representations, without any effect and wasting of such much time by them in making these representations and spends money thereon. (v) Any other relief which the forum may deem and permissible under the circumstances.

At the time of hearing, Shri N.N.S.Rana reiterated the issues raised in his complaint letter dated 11.12.2007 wherein he has mentioned that he had submitted a proposal along with the medical certificate for himself and for his wife for a sum insured of Rs.3,00,000/- each to the Oriental Insurance Company Limited for a mediclaim policy. The Insurance Company has not only reduced the sum insured to Rs.2,00,000/- but also put a compulsory excess of Rs.10000/- for each and every claim. He contested that there cannot be two penalties and was a violation of constitution.

The Fourm advised Shri Rana that it is a contract of insurance based on the Contract Law and he being very well aware of the basic principle of Contract Act, he should have cancelled the policy with the Insurance Company and should have tried to avail the cover from other insurance companies if he felt that he was not agreed to the conditions imposed by the Insurance Company. Shri Rana contested that he was comfortable in taking insurance from Public Sector Insurance Companies and the Government as a social measure introduced this class of insurance and the Insurance Company cannot act as an arbitrary manner. The Forum advised that mediclaim insurance is not required to fulfill any statutory requirements like Motor policy where 3rd party liability is mandatory which is required as per Motor Vehicle's Act. To encourage medical insurance, the Government has considered rebate under tax laws but it is not a statutory requirement. Shri Rana requested the Forum that the Insurance Company be directed to remove the excess clause as it is applicable to pre existing disease only and the Insurance Company has wrongly deducted this amount from his hospitalization in Amar Leela Hospital on 16.10.2006. The Forum drew the attention that the column of pre-existing disease was supposed to name the disease which is to be excluded and no quantum is required to be mentioned since the disease is excluded as per clause 4.1 of the policy. At the time of insurance if the disease is declared by the proposer then it is mentioned otherwise the column is left blank and only at the time of hospitalization when it is discovered that the disease is pre-existing then the claim would not be payable. But in the case of Shri Rana, there is no pre-existing disease was mentioned in the column based on the medical certificate submitted by him. The excess clause has been typed for Rs.10000/- which is deductible from each and every claim.

The representative of the Insurance Company contested that Shri Rana was issued a policy in the year 2004 based on the medical certificate he had submitted for Rs.2,00,000/- each for himself and his wife and in view of his advance age, a compulsory excess of Rs.10000/- be incorporated in the policy for each and every claim. There has been a misalignment of printing of the schedule and the TPA has, therefore, rightly deducted a sum of Rs.10000/- at the time of claim of Shri Rana'a hospitalization at Amar Leela Hospital. He further contested that in case Shri Rana desires that the terms and conditions of the policy do not meet his requirement, he could request the insurance company to cancel the policy.

After hearing both the parties and on examination of the documents submitted, it is observed that Shri N.N.S.Rana had approached the Oriental Insurance Company Limited for a mediclaim policy for Rs.3,00,000/- each for himself and for his wife and submitted medical reports with the proposal. The Insurance company has granted him a cover of Rs.2,00,000/-each and imposed an excess clause of Rs.10,000/- for each and every claim. Shri Rana has contested that there cannot be two penalties at the same time. The Forum has already advised Shri Rana that based on the Contract Act, it was for him at the time of receipt of the policy whether he wanted to continue the policy with the terms and conditions prescribed in the policy and if not, he could have cancelled the policy. But having accepted the terms and conditions, it cannot be challenged at this stage. Further Shri Rana was hospitalized on 16.10.2006 and discharged on 21.10.2006 from Amar Leela Hospital. He preferred a claim of Rs.24795/- whereas the TPA has settled the claim of Rs.14795/- and Rs.10000/- was to be paid by Shri N.N.S.Rana. Shri Rana has, therefore, requested that Rs.10000/- be refunded to him as the Insurance Company has wrongly deducted the amount because there was no pre-existing disease and this excess clause was meant to pre-existing disease. Pre-existing disease is normally mentioned and in the case of Shri N.N.S.Rana, no disease has been mentioned in the column. Excess clause is applicable to any

hospitalization claim and Shri Rana has to bear the first Rs.10000/- of the claim and the Insurance Company has to pay the balance amount. In this case the Insurance Company has therefore rightly deducted Rs.10000/- for his claim when he was hospitalized at Amar Leela Hospital.

I, therefore, uphold the decision taking by the Oriental Insurance Company Limited deducting the compulsory excess of Rs.10000/- from the claim amount of Rs.24795/- and has rightly paid Rs.14795/- to Shri N.N.S.Rana. No relief can be given to Shri Rana as sought by him in his complaint dated 11.12.2007. This Forum cannot direct the Insurance Company for removal of the excess of Rs.10000/- as the same is a business proposal and the Insurance Company is to manage its business and this Forum cannot direct the Insurance Company how the business should be run by the Insurance Company. Hence no direction is given to the Insurance Company for removal of compulsory excess of Rs.10000/-. Keeping in view the above facts, the complaint of Shri N.N.S.Rana stands dismissed and no relief is given as sought by him in his complaint dated 11.12.2007.

GUWAHATI

BEFORE THE OFFICE OF THE INSURANCE OMBUDSMAN AT GUWAHATI CENTRE

Complaint No. 11-005-0100/07-08

Sri Gopal Tibrewal …….. Complainant/Insured

- Vs -

The Oriental Insurance Co. Ltd. …….. Opposite Party/Insurer

Award Date : 30.04.2008

Mr. Gopal Tibrewal procured the Mediclaim Policy from the Oriental Insurance Co. Ltd. insuring himself and three other members of his family covering the period form 20.04.2005 to 19.04.2006. The Insured Gopal Tibrewal, was hospitalized in the Calcutta Medical Research Institute on 25.07.2005 for the treatment of Tumour of Middle Finger over the Palmor aspect and after an operation under general anaesthesia, he was discharged on the same day. The Insurer / TPA - M/s. MedSave Healthcare Ltd. repudiated the claim on the ground that he was hospitalized for less than 24 hours and as per policy condition such claim is not admissible.

Being aggrieved the Complainant approached this forum.

The Insurer, in their Self Contained Note, stated that the Discharge Certificate clearly shows that the Complainant was admitted in the Calcutta Medical Research Institute, Kolkata on 25.07.2005 and discharged on 25.07.2005 itself. Thus the period of stay is less than 24 hours and it does not satisfy the policy condition No. 3.5 of the Mediclaim policy for admissibility of the claim.

The Policy Condition in Point Nos. 3.6 & 3.7 provides benefits for reimbursement of the expenses incurred during pre and post hospitalization period. Although, as per policy condition in point No. 3.5, the minimum period prescribed for hospitalization shall be for 24 hours but that appears to be not mandatory. The policy condition in point No. 2.3 (A) shows that the above limit of 24 hours hospitalization will not be applicable in case of certain treatments taken in the Networked Hospital / Nursing home (even where the insured is discharged on the same day) and such treatments will be considered to be taken under hospitalization benefit. Any surgery under general anaesthesia is one of the kind of such treatments falling under such exception category. As per policy condition in point No. 3.4, the Networked Hospital means the hospital which has been approved by the TPA to participate for providing Cashless Health Services to the Insured persons. Thus, it is not compulsory that hospitalization for 24 hours is a must for becoming a claim admissible under the mediclaim policy. On 28.07.2006, the Insurer had written to the TPA – M/s. MedSave Healthcare Ltd. for considering the policy conditions as laid down in point Nos.2.3, 2.3(A) & 2.3 (B) of the Mediclaim policy which has been referred to above even though the hospitalization period was less than 24 hours. But the TPA did not pay any attention in this regard.

Under the above facts and circumstances, the Insurer is directed to reconsider the matter and process the claim and in case claim is admissible under the above conditions, settled the claim allowing penal interest @ 8%

BEFORE THE OFFICE OF THE INSURANCE OMBUDSMAN AT GUWAHATI CENTRE

Complaint No. 11-003-0033/08-09

Mr. Raj Sharma …….. Complainant

- Vs -

The National Insurance Co. Ltd. …….. Opposite Party/Insurer

Award dated : 12.09.2008

Mr. Rathin Sharma, father of the Complainant, is a mediclaim policyholder of National Insurance Co. Ltd. since 2002. The claim arose under policy No.200800/48/05/8500001657 during the period from 10.07.2005 to 09.07.2006. He was admitted in the International Hospital, Guwahati on 18.01.2006 for treatment of his diseases wherefrom he was discharged on 21.02.2006. The diagnosis made at the Hospital was "Left MCA Ischaemic Stroke with Right Hemiplegia and Aphasis - ? Embolic, Type 2 DM, HTN. CAD and Atrial Fibrillation with controlled Ventricular Rate." After hospitalization, a claim was lodged before the Insurer through TPA which was ultimately repudiated by the TPA – M/s Med Save Health Care Ltd. and communicated the decision vide letter dated 18.03.2006. The claim was repudiated on the ground that the diseases for which the treatment was provided were pre-existing at the time of taking the policy for the first time on 10.07.2005 applying the Exclusion Clause No. 4.1 of the policy. In the meanwhile, the Complainant, Mr. Raj Sharma being constituted attorney of the Insured, approached the Insurance Ombudsman for intervention in the matter.

The analysis of the case reveals that Rathin Sharma was admitted in the International Hospital on 18.01.2006 wherein he was treated till 21.02.2006 as an indoor patient and the diagnosis was "Left MCA Ischaemic Stroke with Right Hemiplegia and Aphasis - ? Embolic, Type 2 DM, HTN. CAD and Atrial Fibrillation with controlled Ventricular Rate." In the Clinical Summary, the Hospital Authority has observed that "71 years old obese male with history of ethanol intake and smoking, hypertensive type 2 diabetes mellitus (on OHA) coronary artery disease (history of MI 1994) Presented with a history of inability to get up from bed, inability to move the right side of the body, which the family members noticed in the morning of 18.01.2006. He was immediately brought to the hospital and on examination was found to have irregular pulse of 78/min B P of 160/90. Eye opening spontaneously with gaze preference toward left." Dr. Hameed Uddeen Ahmed, Panel Doctor of the Insurer, observed that there is not a single document to suggest that Rathin Sharma was suffering from heart disease prior to taking his mediclaim policy. The report contained that the Insured has denied having any heart disease even prior to 10.07.2002 while taking the policy for the first time. Dr. Ahmed has also observed that there is no chest X-ray nor ECG report available in the mediclaim policy neither there was any effort on the part of the Insurance Company to obtain a consulting physician's opinion

BEFORE THE OFFICE OF THE INSURANCE OMBUDSMAN AT GUWAHATI CENTRE

Complaint No. 11-008-0155/07-08

Mrs. Papri Das …….. Complainant/Insured

- Vs -

Royal Sundaram Alliance Insurance Co. Ltd. …….. Opposite Party/Insurer

Award Date : 12.05.2008

The Insured / Complainant obtained a mediclaim policy from M/s. Royal Sundaram Alliance Insurance Co. Ltd. The original policy was obtained covering the period from 17.02.2006 to 16.02.2007 which was subsequently renewed covering the period from 17.02.2007 to 16.02.2008. The Insured was hospitalized on 14.03.2007 and discharged on 15.03.2007 after an operation and necessary treatment. The Insured submitted the claim before the Insurer. The Insurer repudiated the claim on the ground that disease was pre-existing.

Being aggrieved the Complainant approached this forum.

The Insurer repudiated the claim on the opinion of panel of Doctors who, on examination of the treatment particulars of the Insured, had cited that the patient was on tab danazol since May, 2006. This means that the patient was already on treatment for Endometriosis within 3 months of policy inception. The ailment is pre-existing since endometriosis cannot develop within 3 months of policy and hence the claim is not payable. The expert further opined that the condition was probably pre-existing as she was on Danazol from May, 2006.

The above opinion of the expert clearly indicates that using the word "probably" means that the expert was not sure and confirmed. It appears that the complainant was not aware about her sufferings from the disease for which she was hospitalized on 14.03.2007 but record shows and it is fact that she was on medication since May, 2006. The policy was taken originally covering the period from 17.02.2006 and renewed in time covering the period upto 16.02.2007. Even if it is treated that she was suffering from the disease w.e.f. May, 2006 even then it would be within the policy coverage. There is no treatment particulars and the opinion of the expert obtained by Insurer to establish that the disease pre-existed prior to inception of the policy. Hence, the view taken by the Insurer that the complainant was hospitalized and treated for a pre-existing disease is not at all justified. The claim is to be settled in terms of the policy document as there is no proof that she was hospitalized and treated for a pre-existing disease.

Hon'ble Ombudsman directed the Insurer to pay the amount of claim to the Complainant within 15 days from the date of receipt of this Order. Thereafter the complaint is treated as closed.

BEFORE THE OFFICE OF THE INSURANCE OMBUDSMAN AT GUWAHATI CENTRE

Complaint No. 11-004-0217/07-08

Mr. Siromoni Rajkhowa …….. Complainant

- Vs -

Royal Sundaram Alliance Ins. Co. Ltd. …….. Opposite Party/Insurer

Award Date : 23.06.2008

Facts :- Mr. Sirmoni Rajkhowa, his wife and his mother were covered under "Health Shield & Hospital Cash Insurance Policy" for the period from 29.06.2006 to 28.06.2007 & 14.09.2006 to 13.09.2007. The Insured / Mother of the Complainant Smt. Sarna Prava Rajkhowa was hospitalized at Guwahati Medical College Hospital during the period from 13.02.2007 to 18.02.2007 for the treatment of Adeno Carcinoma Sigmoid Colon and being referred she was admitted at CMC, Vellore on 22.02.2007 wherein she was treated as an indoor patient till 19.03.2007. The Complainant informed the Insurer for Cashless Treatment which was refused. Subsequently, the claim for Rs.95,139/- lodged by him for expenses incurred for hospitalization and treatment of his mother was also rejected on the ground that the disease for which she was treated was pre – existing. The prayer for reconsideration was also not considered.

Findings :- The Insurer rejected the Cashless benefit under the policy considering the fact that the policy was nine months old and carcinoma colon with liver metastasis was detected on the person of the Insured at that stage. It was further observed that annular growth was partially obstructing the lumen on colonoscopy and such a thing could not have developed over nine months and hence pre- existing. The Insurer repudiated the claim applying Clause - D (1) of the Health Shield Policy.

Reasons and Decisions : - According to the Complainant, the Insured was not suffering from any kind of symptoms of the disease before taking the policy. She felt pain just before hospitalization and thereafter the disease was detected only when she was hospitalized. The claim form clearly indicates that the insured, for the first time suffered pain on 10.02.2007 and not earlier to that. Sufferings from carcinoma required her hospitalization and treatment which was only detected after few months of procuring the above two policies. There is however, no records before the Insurer like Prescriptions, Laboratory findings etc. to establish the fact that the disease was diagnosed prior to inception of the policy or treatments were taken by her before taking the policies. The Insurer has observed that annular growth was obstructing the lumen on colonoscopy and such a thing could not have developed over nine months and hence, the disease detected was held to be pre-existing whether she was aware or not. This shows that it was presumed to be pre-existing without having any other basis for taking such a view. The decision of repudiation of the claim is found to be not justified.

The Hon'ble Ombudsman directed the Insurer to settle the claim within 15 days on receipt of the copy of the Order and report compliance thereafter. The complaint is accordingly treated as closed.

HYDERABAD

Office of Insurance Ombudsman
Hyderabad
Complaint No. G 11.05.0481

AWARD NO. 5 Dated : 30.04.2008

Sri Mohd. Hassnuddin Vs. Oriental Insurance Co.Ltd

Sri Hassnuddin and his family were insured under a mediclaim policy of Oriental Insurance Co.Ltd. for the period 10.05.2007 to 09.05.2008. His wife who was suffering from cervical and lumbar spondylitis was admitted to Kerala Sanjeevani Ayurvedic Centre. A claim for Rs. 37,451/- was lodged which was repudiated stating that the ayurvedic treatment taken was not in a Govt. Hospital.

Decision: The insurers stated that as per clause 2.1 of the policy, the expenses for ayurvedic treatment are covered only when taken in a Govt or Medical College hospital. The insurers submitted that the mediclaim policy was revised from August 2006 and the present policy was taken subsequent to the revision. The complainant submitted that the hospital was recognized. But in view of the clarity in the policy clause, it is held the insurers decision to repudiate the claim needs no interference. Complaint was dismissed.

KOLKATA

Total Repudiation of claim

Case No. 229/11/003/NL/07/2007-08

Shri Gobardhan Roy

Vs.

National Insurance Company Ltd.

Order Dated : 03.04.2008

Facts & Submissions :

This petition was filed against repudiation of a mediclaim on the ground of 'pre-existing disease.

The petitioner, Shri Gobordhan Roy in his petition dated 11.07.2007 stated that he along with her wife was covered under Mediclaim Policy No. 153500/48/04/8502768. He was admitted to CMC Hospital, Vellore on 04.07.2005 with acute abdominal pain under the advice of Dr. P.B.Ghosh. The problem for abdominal pain was diagnosed as liver with dilated Bileduct with inflammation, fibrosis and Hepatholithiasim after different examination before operation. He was operated on 06.07.2005 at CMC Hospital for excision of Choledoehal cyst, Hepaticojejunostomy (Radiology) and excision of segment III of liver. He submitted a claim for Rs.45,148/- to the insurance company on 26.08.2005 but the claim was repudiated by the TPA of the insurance company stating that the documents reflected that the present disease condition was directly related to previous surgery since 1980 (multiple surgery related to gall stone & CBD stone). They also stated that the insured enjoyed a CB (Cumulative Bonus) of only 15% and hence the disease in question was pre-existing. The complainant represented against such repudiation on 06.07.2006 stating that the disease was not pre-existing and he was ready to face any medical examination. The insurance company against this representation reviewed the claim and informed the complainant vide their letter dated 12.03.2007 expressed their inability to alter the above decision.

On the other hand the representative of the insurance company submitted a self-contained note just before the hearing. According to the self-contained note the claim was treated as 'No Claim' as the complainant underwent an operation in 1980. They further submitted medical report in which the medical history indicated apart from Appendicectomy operation in 1980, he had number of

operations in 1990, 1991, 1994, 2000 and 2001.According to them those operations were before 2000 and inception of the policy as the policy was taken in the year 1999-2000.

Decision:

This office considered the facts and submissions of the case as well as the materials available on records.

Medical history from the medical report given by Christian Medical College, Vellore indicated as under:-

"He had undergone cholecystectomy with appendicectomy in 1980 (for jaundice and lower abdominal pain), ERCP and stone extraction for choledocholithiasis in 1990, endoscopic sphincterotomy in 1991, ERCP with sphincterotomy in 1994 and 2000, inguinal hernia repair right side in 2001".

It was clear that the complainant took a policy in the year 1999-2000 and had been continuously renewing the same in time. The history indicated that certain procedures were done in 1990, 1991 and 1994. These procedures should have been mentioned in the proposal form before the inception of the policy in 1999-2000. Therefore, the proposal form became paramount in this case. This office found that the insured did not disclose in his proposal form before taking the mediclaim policy in 1999, any of the procedures that took place in 1990, 1991 and 1994. This clearly indicated that there was suppression of material facts. Since the proposal form had been signed by him his claim that he did not have the knowledge to indicate the previous illnesses could not stand the test of appeal. Therefore, Hon'ble Ombudsman did not have any other alternative but to reject the explanation given by the insured. Hence, this office upheld the decision of the insurance company with regard to the repudiation of the claim. However, keeping in view the advanced age of the insured and the last procedure in 1994 was nearly 5 years before taking the policy, Hon'ble Ombudsman proposed to grant an ex-gratia payment of Rs.10,000/- which would meet the ends of justice..

Kolkata Ombudsman Centre

Case No. 295/11/005/NL/08/2007-08

Shri Dibyendu Dutta

Vs.

The Oriental Insurance Company Ltd

Order Dated: 02.04.2008

Facts & Submissions:

This petition was against repudiation of mediclaim on the ground of 'Pre-existing Disease' under Mediclaim Insurance Policy.

The petitioner, Shri Dibyendu Dutta in his petition dated 07.08.2007 stated that he along with his family members were covered under Mediclaim policy No. 311202/2007/1137 for the period 27.07.06 to 26.07.2007. He consulted Dr. Partha Biswas, Eye Surgeon for his son Shri Arijit Dutta on 06.01.2007 for treatment of his long sightedness. Dr. Biswas after examination prescribed that he had refractive error which was called Myopia and was intolerant to contact Lenses and/or glasses. Lasik surgery was done as per advice of the doctor and a claim for Rs.28,995.75 was lodged with the insurance company, but the TPA of the insurance company rejected the claim on the ground of pre-existing disease. They mentioned in their letter dated 09.04.2007 that Myopia was present prior to inception of the policy. Shri Dutta represented against the decision of the insurance company asking how Myopia could be pre-existing when he had the policy in operation for the last 4 years.

The insurance company in their self-contained note dated 14.12.2007 stated that they referred the matter to their panel doctor, Dr. Vineet Kumar Mittal who opined that the Insured had Myopia and was on glasses. According to them the clinical documents clearly noted that it was the insured who wished that LASIK surgery and it was not advised by the doctor himself. Secondly the insured underwent this particular surgery for correction of his myopia and hence getting rid of his glasses, for he was intolerant to contact lens that too when his refractive error was only (-1) and this was purely for cosmetic purpose.

Decision:

As the representative of the insurance company did not attend in response to a notice of hearing, we proceed to deal with the matter on ex-parte basis.

The insurance company stated that their TPA had made the claim as not payable, stating that myopia was pre-existing and therefore invoked condition no. 4.1. The insurance company observed that the surgery that had been done on the patient was cosmetic in nature and therefore invoked the policy condition no. 4.5.

On going through the evidences available, this office held that simply invoking policy condition 4.1 could not be possible in this case as the insurance cover did not extend to eye sight problems as 4.6 excluded reimbursement of any expenses on lenses and spectacles. Obviously eye surgery could not be treated as pre-existing as specific provisions in the policy condition 4.6 were made for correcting the eye sight. With regard to invoking policy condition 4.5, it was observed that correction of eye sight through surgery was not cosmetic as it would reduce the discomfort and inconvenience to the patient. Perhaps it might be called Cosmetic surgery only if some person got it done for a squint in the eye. Therefore, Hon'ble Ombudsman was unable to agree with the arguments of the TPA or the insurance company. Further, it came to this office knowledge that condition 4.6 had been changed w.e.f. September 2006 in which they clearly added further exclusion of any surgery to correct the eye sight. So, by implication it was clear surgery for correcting eye sight was not excluded for the policies that had been taken before September 2006.

Keeping in view the above, this office held that the insurance company wrongly repudiated the claim.

Case No. 325/11/003/NL/08/2007-08

Shri Amal Ranjan Chakraborty

Vs.

National Insurance Company Ltd.

Order Dated: 03.04.2008

Facts & Submissions:

This petition was against repudiation of mediclaim on the ground that "investigations and treatment did not support the necessity for hospitalisation".

The petitioner Shri Amal Ranjan Chakraborty in his petition stated that his daughter was covered under Policy No. 154201/48/06/8500001076 for the period 04.08.2006 to 03.08.2007. His daughter Kumari Anusua Chakraborty was hospitalized in A.M.R.I Hospital from 08.11.2006 to 12.11.2007 with severe pain in abdomen. He preferred a claim for Rs.23,741/- which was repudiated by the insurance company's TPA, on 10.04.2007 on the ground that there was no active treatment taken from the hospital. He made a representation to the insurance company on 06.07.2007, but there was no response from the insurance company.

The insurance company in their self-contained note dated 20.12.2007 stated that the patient was hospitalised after 3 months from the inception of the policy. In the Discharge Certificate against final diagnosis it was mentioned that "pain in abdomen for investigation" clinical investigations like LET, USG, Stool, Blood etc was done and result was normal. The result of clinical investigation did not show any positive existence of ailment and therefore, it did not satisfy the condition written in the preamble of the policy. Secondly, it was repudiated on the ground of exclusion No. 4.10 of the policy i.e., there was no positive existence of any disease.

Decision:

On going through the treatment summary given by AMRI hospitals it was clear that they diagnosed it as a pain in the abdomen and it was clear that she was having continuous pain in the abdomen for 3 days along with vomiting before the doctor advised her to be admitted in the hospital. The insurance authorities were unable to state whether any of the investigations and tests done were not consistent with the final diagnosis. Therefore, Hon'ble Ombudsman was of the firm opinion that the complainant admitted his daughter on the advice of a doctor and investigations and tests confirmed the pain in the abdomen. Therefore, it could be said that all these investigations concluded that there was a pain in the abdomen.

However, the doctors could not find out the reason why she was suffering from such pain/ ailment. The insurance authorities could not say that these investigations would have been done as OPD as the complainant was advised to admit his daughter by a doctor.

Under these circumstances, this office did not have other alternative to hold that the insurance company was not correct in repudiating the claim. The claim was exigible.
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Kolkata Ombudsman Centre

Case No. 337/11/003/NL/08/2007-08

Smt. Jyoti Agarwalla

Vs.

National Insurance Company Ltd.

Order Dated: 02.04.2008

Facts & Submissions:

This petition was filed against repudiation of a claim on the ground of "Cosmetic Surgery" under exclusion clause 4.6 of the Mediclaim policy.

The petitioner Smt. Jyoti Agarwalla in her petition dated 17.08.2007 stated that she along with her family members was covered under Policy No. 101700/48/06/8500000341 for the period 12.06.2006 to 11.06.2007. She stated that due to discomfort in nose and due to constant use of spectacles, Lasik surgery was suggested by Dr. Mahesh Maskara for complainant's husband Shri Bharat Kumar Agarwalla for removal of spectacles. Accordingly, she underwent Lasik surgery on 08.11.2006 in both the eyes in Sankar Nethralaya, Chennai. She lodged a claim for Rs.49,857.95 on 07.12.2006 with National Insurance Company Ltd., but the TPA of the insurance company M/s Genins India Ltd. vide their letter dated 17.01.2007 rejected the claim on the ground that the operation was purely for cosmetic purpose. She made representation to the insurance company but did not yield any favourable reply.

The insurance company in their self-contained note dated 06.12.2007 stated that from Dr. Mahesh Maskara's certificate, it revealed that Lasik surgery was recommended to remove the eye power which resulted in withdrawal of glasses. The insurance company held that Lasik surgery was a vision corrective (refractive surgery) and they submitted evidence in support of their argument.

Decision:

Later it was found that the policy condition 4.6 which was enclosed by the insurance authorities does not pertain to the policy for the year 12.06.2006 to 11.06.2007 taken by the insured. The original policy condition 4.6 read as under:

"Cost of spectacles and contact lenses, hearing aids which are excluded from the cover".

This condition has been changed with effect from the policy taken after September 2006 which reads as under:

"Cost of surgery for correction of eye sight, cost of spectacles contact lenses hearing aids should be excluded from the cover".

Therefore, this office had to apply the former condition.

However, the insurance authorities argued that Lasik surgery was a type of cosmetic surgery. According to the insurance company 4.5 excluded cosmetic or aesthetic treatment of any description etc. was excluded from the cover of the policy. According to the above conditions, which clearly indicated that surgery for the eyes was not excluded originally and the same was prohibited later from September 2006. Therefore the insurance company could not invoke policy condition 4.5 as Lasik surgery was a surgery to correct the eye sight and not cosmetic. It might perhaps be cosmetic if squint eye with perfect eye sight is corrected. Moreover, in this case the patient was suffering extreme discomfort due to wearing of the spectacles which means that there was some ailment and to treat that ailment Lasik surgery was resorted to. Therefore, Hon'ble did not agree that this claim for Lasik surgery fell under policy conditions 4.5 & 4.6. Hence this office held that the insurance company was not correct in repudiating the claim.

Under these circumstances, Hon'ble Ombudsman directed the insurance company to pay the claim as per policy terms and conditions.

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Kolkata Ombudsman Centre

Case No. 345/11/004/NL/08/2007-08

Shri Tarkeshower Sah

Vs.

United India Insurance Company Ltd.

Order Dated: 15.04.2008

Facts & Submissions:

This petition was filed against repudiation of a claim on the ground of Exclusion clause No. 4.12 & 4.3 under Individual Medi Guard Policy issued by United India Insurance Company Ltd.

The petitioner, Shri Tarkeshwar Sah in his petition dated 28.08.2007 stated that he along with his wife was covered under Policy No. 031901/48/04/12/00001920 for the period 28.02.2005 to 27.02.2006 and not from 28.01.2005 to 27.01.2006 as mentioned in the self-contained note. The complainant's wife Smt. Usha Gupta Sah was admitted in Anandaloke Hospital & Neurosciences Centre, Siliguri on 22.01.2006 and discharged on 25.01.2006 and subsequently on 28.01.2006 in Sunrise Nursing Home Pvt. Ltd. Siliguri and discharged on 02.02.2006 for T.O. Mass. A claim for Rs.26,254/- was lodged with United India Insurance Company Ltd., but the same was repudiated on the ground that treatment was for pregnancy prevention and subsequent Minilap was for ligation. He represented to the insurance company that T.O. Mass formation was independent of ligation which arose after ligation. His representation was turned down and therefore, he approached this forum for redressal of his grievance seeking relief of Rs.26,264/-.

The insurance company in their self-contained note dated 15.01.2008 stated that the disease for which treatment was undergone was a case of disease process of menorrhagia caused due to treatment being taken for pregnancy prevention. Also subsequent Minilap was for ligation done on 24.12.2005 resulted in complication T.O. Mass. As per opinion of Dr. Soma Bhattacharjee, the patient underwent ligation on 24.12.2005 following which her complication started. It appears to be a case where the disease for which treatment was sought was related to pregnancy prevention.

Decision:

On going through the policy condition 4.3, it was clear that an operation should have taken place for removal of uterus in case of menorrhagia. Since no hysterectomy operation was done and as per the Discharge Certificate there was no removal of uterus and only the Minilap operation was done for Ligation could be treated as Hysterectomy for menorrhagia, therefore clearly 4.3 was not applicable. Invoking of condition 4.12 was also not correct as the patient was not pregnant as per the Discharge Certificate. The condition clearly stated that any procedure traceable to pregnancy is excluded and not any procedure traceable to prevention of pregnancy. The condition 4.12 read as under.

"Treatment arising from or traceable to pregnancy (including voluntary termination of pregnancy) and childbirth (including caesarean section)".

Therefore, the interpretation of the insurance authorities that the condition 4.12 applicable was not correct as the insured was not pregnant at the time of procedure adopted above. In fact the Discharge Certificate clearly stated that she was not pregnant.

Under these conditions, Hon'ble Ombudsman did not agree with the reasons given by the insurance company for repudiating the claim. These reasons were not tenable. Therefore, this office held that the claim was exigible and directed the insurance company to pay the claim.

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Kolkata Ombudsman Centre

Case No. 353/14/003/NL/09/2007-2008

Shri Prasanta Kumar Dey

Vs.

National Insurance Co. Ltd.

Order Dated: 20.05.2008

Facts & Submissions:

This complaint was filed against delay in settlement of claim under Mediclaim Insurance Policy.

The petitioner, Shri Prasanta Kumar Dey in his petition dt. 31.08.2007 stated that he was having a Mediclaim Policy with National Insurance Co. Ltd., Midnapore Divisional Office since December 2005 (13.12.2005). On 5.8.2006, he got spinal injury and had to consult with local physicians. As per advice of the physician he got admitted at Apollo Hospital, Chennai for better treatment. After completion of treatment, the entire treatment papers were submitted to the TPA of the Insurance Company on 25.11.2006. Since then he followed up the matter with the TPA as well as the Insurance Company for reimbursement by sending number of reminders, but did not yield any result. He even took up the matter with the Head Office of National Insurance Co. Ltd. for settlement of the claim on 25.5.2007. After that he received a letter through his agent asking some clarifications which was also replied to vide his letter dt.25.6.2007. He again received a letter from the Midnapore Divisional Office on 20.7.2007 in reply to his letter dt.17.7.2007 through his agent which was properly complied with on 23.7.2007. Even after one month from the date of submission of his last letter i.e. 23.7.2007, he did not get any response either from the Divisional office or from the Head office of National Insurance Co. Ltd. Being aggrieved, he approached this forum for relief of Rs.75,000/-.

(b) Insurer:

In the self-contained note dt.23.11.2007, the Insurance Company stated that they issued an individual mediclaim policy to cover Shri Prasanta Kumar Dey and his wife Smt. Priya Dey for Sum Insured of Rs.75,000/- and Rs.50,000/- respectively which was subsequently renewed in the next year commencing from 13.12.2006. The complainant got admitted at Appolo Hospitals, Chennai on 19.10.2006 for surgery of Lumber Canal Stenosis and submitted the claim papers to TPA on 27.l11.2006. The insurance company was informed that the complainant had fallen in the bathroom on 5.8.2006 and he was under the treatment of Dr. M. Chakraborty who prescribed him medicines and advised for an X-ray which was not submitted in the claim papers. He again consulted Dr. Chakraborty on 3.9.2006 who advised him for MRI of L/S spine and admission in the hospital for better management. He also changed some medicines which

the complainant purchased and waited up to 18.10.2006. Finally he got admitted at Appolo Hospitals, Chennai and he was operated upon for Lumber Canal Stenosis. The Discharge Summary itself revealed that he had a past history of "low back pain" for 6 months. After scrutinizing the papers, TPA, Genins India Ltd asked for some more documents pertaining to low back pain which the complainant complied with on 7.3.2007 denying he did not have such experience. The insurance company also took the opinion of their panel doctor, Dr. K. K. Arora. According to him, it was a clear case of suppression of fact. He also opined that fall in the bathroom was not the prime cause of "low back pain". Low back pain caused was due to "chronic degenerative disc" and there was no trauma. So, the insurance company asked for past history documents from the complainant to arrive at a decision.

Decision :

This office considered the facts and submissions of the case as well as the materials available on records. In view of the above, it was clear that the insurance company did not take any decision regarding settlement of the claim. This office did not have jurisdiction unless a decision was taken by the insurance company and the same was conveyed to the insured. In this case, the Insurance Company sought for doctor's advice for conducting MRI and registration certificate from Apollo Hospital. Therefore, Hon'ble Ombudsman suggested that the complainant should comply with those documents, as sought for by the insurance company and at the same time the insurance company was directed to take decision with regard to settlement of the claim after examining the documents that were to be provided by the complainant. The insurance company was directed to complete all the formalities after receiving the required documents and come to a conclusion with regard to the settlement of the claim.

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Kolkata Ombudsman Centre

Case No. 354/11/003/NL/09/2007-2008

Shri Asit Kumar Pal

Vs.

National Insurance Co. Ltd.

Order Dated: 09.04.2008

Facts & Submissions:

This complaint was filed against repudiation of a claim on the ground that Incision Hernia operation was done before inception of the policy by invoking the Exclusion Clause No.4.1 of the Mediclaim Insurance Policy.

The petitioner, Shri Asit Kumar Pal in his petition DT. 04.09.2007 stated that he was having a Mediclaim Policy with National Insurance Co. Ltd., Midnapore Divisional Office since July 2003 (i.e.29.07.2003) and got the same renewed from time to time without any break. On 12.8.2006, the complainant's wife felt sudden abdominal pain and had to consult with local physician where detection of the disease was done and referred to a surgeon. On 25.1.2007, he consulted Dr. OM Tantia who advised operation. On 11.2.2007, his wife was admitted to a Nursing Home at Kolkata for operation and subsequently discharged from the nursing home on 21.02.2007 after operation of incision hernia. He submitted all the relevant papers to the TPA of the insurance company for reimbursement. He received a repudiation letter from the said TPA in the month of April, 2007, as she had operation in the past, as per Discharge Summary from which the patient had developed incision hernia. Representation against repudiation was made to the Divisional Manager of the Insurance Company on 26.4.2007. After reviewing the matter the insurance company upheld the decision of repudiation. He immediately informed the matter to the Manager of the concerned insurance company posted at Head Office, but did not get any reply. The complainant also stated that his wife did not have such knowledge of the disease at the time of making proposal and not even before 12.8.2006 when she felt sudden abdominal pain and forced to take consultation with local physician and the disease was detected by the said doctor at that time. He pointed out that policy condition no. 4.2 against exclusion clause could not be applied when there were no symptoms or existence of the disease at the time of making proposal. He contended that the insurance company did not exclude anything from the scope of the policy coverage although he disclosed everything at the time of filling the proposal form of his wife's past history of ailment/treatment/ operation column. Being aggrieved, he approached this forum for relief of Rs.49,722/-.

In the self-contained note dt.23.11.2007, the Insurance Company stated that they issued an individual mediclaim policy covering Shri Asit Kumar Pal, self, his wife Smt.Chhanda Pal and son Shri Aritra Pal against sum insured of Rs.50,000/- each since July 2003 and had been continuing without any break. At the time of commencement of the policy the insured declared/disclosed clearly that his wife underwent gall-bladder stone operation way back in 2001 and hysterectomy operation was performed in the year 2003 for which these diseases had been excluded from the scope of the policy. On 11.2.2007 Smt. Chhanda Pal was admitted to ILS multi hospitality clinic, Salt Lake for the problem of "large incision hernia and hypothyroid" and submitted the relevant documents to their TPA, MD India Health Care Services (P) Ltd. The past history of the patient showed the above surgical operation including caesarian section of child birth and exploratory laparactomy for over ion cyst 15 years back. On the basis of the past history of ailment, the TPA repudiated the claim on 14.4.2007 and on 12.6.2007 on the ground of pre-existing disease since the past operation like LUCS, abdominal hysterectomy or ovarian cyst caused such incision hernia. Regarding hypothyroid, the patient had a past history of suffering as per doctor's prescription dt.17.12.2001 attached to the proposal from and Smt. Chhanda Pal at the time of commencement. The insurance company opined that cause of incision hernia could happen due to previous abdominal operation.

Decision:

This office considered the facts and submissions of the case as well as the materials available on records. From Butterworth's Medical Dictionary, "Hernia means a protrusion of an internal organ through a defect in the wall of the Anatomical Cavity in which it lies or into subsidiary compartment of that Cavity. Incision Hernia means, which may happen through an operational scar". It was clear that the scar was pre-existing, but hernia took place later. There was no proof to suggest that hernia took place before the inception of the policy. Obviously hernia might occur at any time due to the existence of an internal scar. It was not necessary that hernia should occur previously when the scar was in existence. Similarly, it was possible that hernia might happen again at the same place; even it was operated upon once. Therefore, Hon'ble Ombudsman opined that Hernia was also not a disease. It was a peculiar anatomical event which took place due to a cavity or due to a scar that was inflicted due to an operation. Keeping in view of the above, Hon'ble Ombudsman did not agree with the views of the insurance company in repudiating the claim by invoking exclusion clause no.4.1 of the policy condition in this case and held that the claim was exigible. Therefore, the expenses incurred due to hernia operation were payable and it could not be treated as pre-existing disease.

Kolkata Ombudsman Centre

Case No. 356/11/012/NL/09/2007-08

Shri Dilip Mehra

Vs.

ICICI Lombard General Insurance

Order Dated: 09.04.2008

Facts & Submissions:

This petition was in respect of repudiation of an own damage claim under Private Car Package Policy issued by ICICI Lombard General Insurance Company Ltd.

The petitioner, Shri Dilip Mehra in his petition dated 03.09.2007 stated that his private car bearing no. WB 02U 3286 was insured under Motor policy No. 3001/50066422/00/000 for the period 26.07.2006 to 25.07.2007. On 29.09.2006 at about 2 A.M his car was burnt, local police was informed and a claim was lodged with the insurance company, but the insurance company repudiated the claim by their letter dated 09.10.2006 mentioning that the burning of the vehicle was not caused by any accident or malicious act. According to them the cause could be attributed to electrical/mechanical breakdown which was not covered under the policy. The insured sent representation to the insurance company on 27.07.2007 expressing his non-acceptance on the repudiation decision and requested the insurance company to pay the claim. As he did not get any favourable reply he approached this forum for redressal of his grievance seeking relief of Rs.2 lakhs on total loss basis.

The insurance company in their self-contained note sent on 05.04.2008 stated that the complainant took a Private Car Policy and the insured vehicle caught fire on 28.09.2006 and the same was intimated to the insurance company. Accordingly, a surveyor was appointed to assess the loss. As per the surveyor's report the vehicle caught fire due to fixing of non-standard music system of high amperage. Therefore, the surveyor requested the complainant to get the vehicle inspected by the manufacturer as the same fell under the manufacturing warranty. Further the insurance company submitted that the vehicle was a new vehicle and there was no accident or external hazard due to which the vehicle caught fire. According to them there was a possibility that the vehicle could have caught fire due to electrical breakdown as confirmed by the surveyor. According to them electrical breakdown came under the General Exceptions as per the policy terms and conditions. Therefore, they felt that the claim was not payable.

Decision:

This office was unable to agree with the arguments of the insurance company. The surveyor did not give any reason for electrical breakdown excepting stating that the complainant used a non standard music system of high amperage. This office did not understand how there would be a spark due to a short circuit when the music system was not in use and when the car was parked in the night at 2.00 A.M. We were also not sure how even if a short circuit occurred the fire took place unless the wiring used was inferior. There were no answers for such questions in the surveyor's report excepting the fact that the manufacturer had recalled all the vehicles in a particular lot for fresh wiring as there was a defective wiring in that lot. In fact the complainant was not in the knowledge that there was such a recall from the manufacturer with regard to the particular lot to which this vehicle which caught fire belonged. There were many questions that had not been answered by the insurance company with regard to above. Therefore, Hon'ble Ombudsman felt that the insurance company should appoint another independent surveyor and get a report conclusively with regard to the reasons for the fire in the vehicle and take a review of the repudiation decision already made. The complainant was also advised to communicate with the manufacturer regarding the manufacturing defects of his vehicle which caught fire.

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Kolkata Ombudsman Centre

Case No. 229/11/003/NL/07/2007-08

Shri Gobardhan Roy

Vs.

National Insurance Company Ltd.

Order Dated : 03.04.2008

Facts & Submissions :

This petition was filed against repudiation of a mediclaim on the ground of 'pre-existing disease.

The petitioner, Shri Gobordhan Roy in his petition dated 11.07.2007 stated that he along with her wife was covered under Mediclaim Policy No. 153500/48/04/8502768. He was admitted to CMC Hospital, Vellore on 04.07.2005 with acute abdominal pain under the advice of Dr. P.B.Ghosh. The problem for abdominal pain was diagnosed as liver with dilated Bileduct with inflammation, fibrosis and Hepatholithiasim after different examination before operation. He was operated on 06.07.2005 at CMC Hospital for excision of Choledoehal cyst, Hepaticojejunostomy (Radiology) and excision of segment III of liver. He submitted a claim for Rs.45,148/- to the insurance company on 26.08.2005 but the claim was repudiated by the TPA of the insurance company stating that the documents reflected that the present disease condition was directly related to previous surgery since 1980 (multiple surgery related to gall stone & CBD stone). They also stated that the insured enjoyed a CB (Cumulative Bonus) of only 15% and hence the disease in question was pre-existing. The complainant represented against such repudiation on 06.07.2006 stating that the disease was not pre-existing and he was ready to face any medical examination. The insurance company against this representation reviewed the claim and informed the complainant vide their letter dated 12.03.2007 expressed their inability to alter the above decision.

On the other hand the representative of the insurance company submitted a self-contained note just before the hearing. According to the self-contained note the claim was treated as 'No Claim' as the complainant underwent an operation in 1980. They further submitted medical report in which the medical history indicated apart from Appendicectomy operation in 1980, he had number of operations in 1990, 1991, 1994, 2000 and 2001.According to them those operations were before 2000 and inception of the policy as the policy was taken in the year 1999-2000.

Decision :

This office considered the facts and submissions of the case as well as the materials available on records.

Medical history from the medical report given by Christian Medical College, Vellore indicated as under:-

"He had undergone cholecystectomy with appendicectomy in 1980 (for jaundice and lower abdominal pain), ERCP and stone extraction for choledocholithiasis in 1990, endoscopic sphincterotomy in 1991, ERCP with sphincterotomy in 1994 and 2000, inguinal hernia repair right side in 2001".

It was clear that the complainant took a policy in the year 1999-2000 and had been continuously renewing the same in time. The history indicated that certain procedures were done in 1990, 1991 and 1994. These procedures should have been mentioned in the proposal form before the inception of the policy in 1999-2000. Therefore, the proposal form became paramount in this case. This office found that the insured did not disclose in his proposal form before taking the mediclaim policy in 1999, any of the procedures that took place in 1990, 1991 and 1994. This clearly indicated that there was suppression of material facts. Since the proposal form had been signed by him his claim that he did not have the knowledge to indicate

the previous illnesses could not stand the test of appeal. Therefore, Hon'ble Ombudsman did not have any other alternative but to reject the explanation given by the insured. Hence, this office upheld the decision of the insurance company with regard to the repudiation of the claim. However, keeping in view the advanced age of the insured and the last procedure in 1994 was nearly 5 years before taking the policy, Hon'ble Ombudsman proposed to grant an ex-gratia payment of Rs.10,000/- which would meet the ends of justice..

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Kolkata Ombudsman Centre

Case No. 295/11/005/NL/08/2007-08

Shri Dibyendu Dutta

Vs.

The Oriental Insurance Company Ltd

Order Dated: 02.04.2008

Facts & Submissions:

This petition was against repudiation of mediclaim on the ground of 'Pre-existing Disease' under Mediclaim Insurance Policy.

The petitioner, Shri Dibyendu Dutta in his petition dated 07.08.2007 stated that he along with his family members were covered under Mediclaim policy No. 311202/2007/1137 for the period 27.07.06 to 26.07.2007. He consulted Dr. Partha Biswas, Eye Surgeon for his son Shri Arijit Dutta on 06.01.2007 for treatment of his long sightedness. Dr. Biswas after examination prescribed that he had refractive error which was called Myopia and was intolerant to contact Lenses and/or glasses. Lasik surgery was done as per advice of the doctor and a claim for Rs.28, 995.75 was lodged with the insurance company, but the TPA of the insurance company rejected the claim on the ground of pre-existing disease. They mentioned in their letter dated 09.04.2007 that Myopia was present prior to inception of the policy. Shri Dutta represented against the decision of the insurance company asking how Myopia could be pre-existing when he had the policy in operation for the last 4 years.

The insurance company in their self-contained note dated 14.12.2007 stated that they referred the matter to their panel doctor, Dr. Vineet Kumar Mittal who opined that the Insured had Myopia and was on glasses. According to them the clinical documents clearly noted that it was the insured who wished that LASIK surgery and it was not advised by the doctor himself. Secondly the insured underwent this particular surgery for correction of his myopia and hence getting rid of his glasses, for he was intolerant to contact lens that too when his refractive error was only (-1) and this was purely for cosmetic purpose.

Decision:

As the representative of the insurance company did not attend in response to a notice of hearing, we proceed to deal with the matter on ex-parte basis.

The insurance company stated that their TPA had made the claim as not payable, stating that myopia was pre-existing and therefore invoked condition no. 4.1. The insurance company observed that the surgery that had been done on the patient was cosmetic in nature and therefore invoked the policy condition no. 4.5.

On going through the evidences available, this office held that simply invoking policy condition 4.1 could not be possible in this case as the insurance cover did not extend to eye sight problems as 4.6 excluded reimbursement of any expenses on lenses and spectacles. Obviously eye surgery could not be treated as pre-existing as specific provisions in the policy condition 4.6 were made for correcting the eye sight. With regard to invoking policy condition 4.5, it was observed that correction of eye sight through surgery was not cosmetic as it would reduce the discomfort and inconvenience to the patient. Perhaps it might be called Cosmetic surgery only if some person got it done for a squint in the eye. Therefore, Hon'ble Ombudsman was unable to agree with the arguments of the TPA or the insurance company. Further, it came to this office knowledge that condition 4.6 had been changed w.e.f. September 2006 in which they clearly added further exclusion of any surgery to correct the eye sight. So, by implication it was clear surgery for correcting eye sight was not excluded for the policies that had been taken before September 2006.

Keeping in view the above, this office held that the insurance company wrongly repudiated the claim.

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Kolkata Ombudsman Centre

Case No. 325/11/003/NL/08/2007-08

Shri Amal Ranjan Chakraborty

Vs.

National Insurance Company Ltd.

Order Dated: 03.04.2008

Facts & Submissions:

This petition was against repudiation of mediclaim on the ground that "investigations and treatment did not support the necessity for hospitalisation".

The petitioner Shri Amal Ranjan Chakraborty in his petition stated that his daughter was covered under Policy No. 154201/48/06/8500001076 for the period 04.08.2006 to 03.08.2007. His daughter Kumari Anusua Chakraborty was hospitalized in A.M.R.I Hospital from 08.11.2006 to 12.11.2007 with severe pain in abdomen. He preferred a claim for Rs.23,741/- which was repudiated by the insurance

company's TPA, on 10.04.2007 on the ground that there was no active treatment taken from the hospital. He made a representation to the insurance company on 06.07.2007, but there was no response from the insurance company.

The insurance company in their self-contained note dated 20.12.2007 stated that the patient was hospitalised after 3 months from the inception of the policy. In the Discharge Certificate against final diagnosis it was mentioned that "pain in abdomen for investigation" clinical investigations like LET, USG, Stool, Blood etc was done and result was normal. The result of clinical investigation did not show any positive existence of ailment and therefore, it did not satisfy the condition written in the preamble of the policy. Secondly, it was repudiated on the ground of exclusion No. 4.10 of the policy i.e., there was no positive existence of any disease.

Decision:

On going through the treatment summary given by AMRI hospitals it was clear that they diagnosed it as a pain in the abdomen and it was clear that she was having continuous pain in the abdomen for 3 days along with vomiting before the doctor advised her to be admitted in the hospital. The insurance authorities were unable to state whether any of the investigations and tests done were not consistent with the final diagnosis. Therefore, Hon'ble Ombudsman was of the firm opinion that the complainant admitted his daughter on the advice of a doctor and investigations and tests confirmed the pain in the abdomen. Therefore, it could be said that all these investigations concluded that there was a pain in the abdomen. However, the doctors could not find out the reason why she was suffering from such pain/ ailment. The insurance authorities could not say that these investigations would have been done as OPD as the complainant was advised to admit his daughter by a doctor.

Under these circumstances, this office did not have other alternative to hold that the insurance company was not correct in repudiating the claim. The claim was exigible.
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Kolkata Ombudsman Centre

Case No. 337/11/003/NL/08/2007-08

Smt. Jyoti Agarwalla

Vs.

National Insurance Company Ltd.

Order Dated: 02.04.2008

Facts & Submissions:

This petition was filed against repudiation of a claim on the ground of "Cosmetic Surgery" under exclusion clause 4.6 of the Mediclaim policy.

The petitioner Smt. Jyoti Agarwalla in her petition dated 17.08.2007 stated that she along with her family members was covered under Policy No. 101700/48/06/8500000341 for the period 12.06.2006 to 11.06.2007. She stated that due to discomfort in nose and due to constant use of spectacles, Lasik surgery was suggested by Dr. Mahesh Maskara for complainant's husband Shri Bharat Kumar Agarwalla for removal of spectacles. Accordingly, she underwent Lasik surgery on 08.11.2006 in both the eyes in Sankar Nethralaya, Chennai. She lodged a claim for Rs.49,857.95 on 07.12.2006 with National Insurance Company Ltd., but the TPA of the insurance company M/s Genins India Ltd. vide their letter dated 17.01.2007 rejected the claim on the ground that the operation was purely for cosmetic purpose. She made representation to the insurance company but did not yield any favourable reply.

The insurance company in their self-contained note dated 06.12.2007 stated that from Dr. Mahesh Maskara's certificate, it revealed that Lasik surgery was recommended to remove the eye power which resulted in withdrawal of glasses. The insurance company held that Lasik surgery was a vision corrective (refractive surgery) and they submitted evidence in support of their argument.

Decision:

Later it was found that the policy condition 4.6 which was enclosed by the insurance authorities does not pertain to the policy for the year 12.06.2006 to 11.06.2007 taken by the insured. The original policy condition 4.6 read as under:

"Cost of spectacles and contact lenses, hearing aids which are excluded from the cover".

This condition has been changed with effect from the policy taken after September 2006 which reads as under:

"Cost of surgery for correction of eye sight, cost of spectacles contact lenses hearing aids should be excluded from the cover".

Therefore, this office had to apply the former condition.

However, the insurance authorities argued that Lasik surgery was a type of cosmetic surgery. According to the insurance company 4.5 excluded cosmetic or aesthetic treatment of any description etc. was excluded from the cover of the policy. According to the above conditions, which clearly indicated that surgery for the eyes was not excluded originally and the same was prohibited later from September 2006. Therefore the insurance company could not invoke policy condition 4.5 as Lasik surgery was a surgery to correct the eye sight and not cosmetic. It might perhaps be cosmetic if squint eye with perfect eye sight is corrected. Moreover, in this case the patient was suffering extreme discomfort due to wearing of the spectacles which means that there was some ailment and to treat that ailment Lasik surgery was resorted to. Therefore, Hon'ble did not agree that this claim for Lasik surgery fell under policy conditions 4.5 & 4.6. Hence this office held that the insurance company was not correct in repudiating the claim.

Under these circumstances, Hon'ble Ombudsman directed the insurance company to pay the claim as per policy terms and conditions.

Kolkata Ombudsman Centre

Case No. 345/11/004/NL/08/2007-08

Shri Tarkeshower Sah

Vs.

United India Insurance Company Ltd.

Order Dated: 15.04.2008

Facts & Submissions:

This petition was filed against repudiation of a claim on the ground of Exclusion clause No. 4.12 & 4.3 under Individual Medi Guard Policy issued by United India Insurance Company Ltd.

The petitioner, Shri Tarkeshwar Sah in his petition dated 28.08.2007 stated that he along with his wife was covered under Policy No. 031901/48/04/12/00001920 for the period 28.02.2005 to 27.02.2006 and not from 28.01.2005 to 27.01.2006 as mentioned in the self-contained note. The complainant's wife Smt. Usha Gupta Sah was admitted in Anandaloke Hospital & Neurosciences Centre, Siliguri on 22.01.2006 and discharged on 25.01.2006 and subsequently on 28.01.2006 in Sunrise Nursing Home Pvt. Ltd. Siliguri and discharged on 02.02.2006 for T.O. Mass. A claim for Rs.26,254/- was lodged with United India Insurance Company Ltd., but the same was repudiated on the ground that treatment was for pregnancy prevention and subsequent Minilap was for ligation. He represented to the insurance company that T.O. Mass formation was independent of ligation which arose after ligation. His representation was turned down and therefore, he approached this forum for redressal of his grievance seeking relief of Rs.26,264/-.

The insurance company in their self-contained note dated 15.01.2008 stated that the disease for which treatment was undergone was a case of disease process of menorrhagia caused due to treatment being taken for pregnancy prevention. Also subsequent Minilap was for ligation done on 24.12.2005 resulted in complication T.O. Mass. As per opinion of Dr. Soma Bhattacharjee, the patient underwent ligation on 24.12.2005 following which her complication started. It appears to be a case where the disease for which treatment was sought was related to pregnancy prevention.

Decision:

On going through the policy condition 4.3, it was clear that an operation should have taken place for removal of uterus in case of menorrhagia. Since no hysterectomy operation was done and as per the Discharge Certificate there was no removal of uterus and only the Minilap operation was done for Ligation could be treated as Hysterectomy for menorrhagia, therefore clearly 4.3 was not applicable. Invoking of condition 4.12 was also not correct as the patient was not pregnant as per the Discharge Certificate. The condition clearly stated that any procedure traceable to pregnancy is excluded and not any procedure traceable to prevention of pregnancy. The condition 4.12 read as under.

"Treatment arising from or traceable to pregnancy (including voluntary termination of pregnancy) and childbirth (including caesarean section)".

Therefore, the interpretation of the insurance authorities that the condition 4.12 applicable was not correct as the insured was not pregnant at the time of procedure adopted above. In fact the Discharge Certificate clearly stated that she was not pregnant.

Under these conditions, Hon'ble Ombudsman did not agree with the reasons given by the insurance company for repudiating the claim. These reasons were not tenable. Therefore, this office held that the claim was exigible and directed the insurance company to pay the claim.

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Kolkata Ombudsman Centre

Case No. 354/11/003/NL/09/2007-2008

Shri Asit Kumar Pal

Vs.

National Insurance Co. Ltd.

Order Dated: 09.04.2008

Facts & Submissions:

This complaint was filed against repudiation of a claim on the ground that Incision Hernia operation was done before inception of the policy by invoking the Exclusion Clause No.4.1 of the Mediclaim Insurance Policy.

The petitioner, Shri Asit Kumar Pal in his petition DT. 04.09.2007 stated that he was having a Mediclaim Policy with National Insurance Co. Ltd., Midnapore Divisional Office since July 2003 (i.e.29.07.2003) and got the same renewed from time to time without any break. On 12.8.2006, the complainant's wife felt sudden abdominal pain and had to consult with local physician where detection of the disease was

done and referred to a surgeon. On 25.1.2007, he consulted Dr. OM Tantia who advised operation. On 11.2.2007, his wife was admitted to a Nursing Home at Kolkata for operation and subsequently discharged from the nursing home on 21.02.2007 after operation of incision hernia. He submitted all the relevant papers to the TPA of the insurance company for reimbursement. He received a repudiation letter from the said TPA in the month of April, 2007, as she had operation in the past, as per Discharge Summary from which the patient had developed incision hernia. Representation against repudiation was made to the Divisional Manager of the Insurance Company on 26.4.2007. After reviewing the matter the insurance company upheld the decision of repudiation. He immediately informed the matter to the Manager of the concerned insurance company posted at Head Office, but did not get any reply. The complainant also stated that his wife did not have such knowledge of the disease at the time of making proposal and not even before 12.8.2006 when she felt sudden abdominal pain and forced to take consultation with local physician and the disease was detected by the said doctor at that time. He pointed out that policy condition no. 4.2 against exclusion clause could not be applied when there were no symptoms or existence of the disease at the time of making proposal. He contended that the insurance company did not exclude anything from the scope of the policy coverage although he disclosed everything at the time of filling the proposal form of his wife's past history of ailment/treatment/ operation column. Being aggrieved, he approached this forum for relief of Rs.49,722/-.

In the self-contained note dt.23.11.2007, the Insurance Company stated that they issued an individual mediclaim policy covering Shri Asit Kumar Pal, self, his wife Smt.Chhanda Pal and son Shri Aritra Pal against sum insured of Rs.50,000/- each since July 2003 and had been continuing without any break. At the time of commencement of the policy the insured declared/disclosed clearly that his wife underwent gall-bladder stone operation way back in 2001 and hysterectomy operation was performed in the year 2003 for which these diseases had been excluded from the scope of the policy. On 11.2.2007 Smt. Chhanda Pal was admitted to ILS multi hospitality clinic, Salt Lake for the problem of "large incision hernia and hypothyroid" and submitted the relevant documents to their TPA, MD

India Health Care Services (P) Ltd. The past history of the patient showed the above surgical operation including caesarian section of child birth and exploratory laparactomy for over ion cyst 15 years back. On the basis of the past history of ailment, the TPA repudiated the claim on 14.4.2007 and on 12.6.2007 on the ground of pre-existing disease since the past operation like LUCS, abdominal hysterectomy or ovarian cyst caused such incision hernia. Regarding hypothyroid, the patient had a past history of suffering as per doctor's prescription dt.17.12.2001 attached to the proposal from and Smt. Chhanda Pal at the time of commencement. The insurance company opined that cause of incision hernia could happen due to previous abdominal operation.

Decision :

This office considered the facts and submissions of the case as well as the materials available on records. From Butterworth's Medical Dictionary, "Hernia means a protrusion of an internal organ through a defect in the wall of the Anatomical Cavity in which it lies or into subsidiary compartment of that Cavity. Incision Hernia means, which may happen through an operational scar". It was clear that the scar was pre-existing, but hernia took place later. There was no proof to suggest that hernia took place before the inception of the policy. Obviously hernia might occur at any time due to the existence of an internal scar. It was not necessary that hernia should occur previously when the scar was in existence. Similarly, it was possible that hernia might happen again at the same place; even it was operated upon once. Therefore, Hon'ble Ombudsman opined that Hernia was also not a disease. It was a peculiar anatomical event which took place due to a cavity or due to a scar that was inflicted due to an operation.

Keeping in view of the above, Hon'ble Ombudsman did not agree with the views of the insurance company in repudiating the claim by invoking exclusion clause no.4.1 of the policy condition in this case and held that the claim was exigible. Therefore, the expenses incurred due to hernia operation were payable and it could not be treated as pre-existing disease.

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Kolkata Ombudsman Centre

Case No. 379/11/008/NL/09/2007-08

Ms. Gloria V. Higginson

Vs.

Royal Sundaram Alliance

Order Dated: 28.04.2008

Facts & Submissions:

This petition was in respect of repudiation a claim on the ground of pre-existing disease under Health Shield Insurance policy issued by Royal Sundaram Alliance Insurance Company Ltd.

The petitioner, Ms. Gloria V. Higginson in her petition dated 12.09.2007 stated that she was covered under Health Shield Insurance policy No. HE00043975000101 for the period 24.09.2005 to 23.09.2006. She was hospitalised in Woodlands Medical Centre Limited, Kolkata from 12.06.2006 to 19.06.2006 for treatment of Ischaemic Heart Disease, Single Vessel Disease (block 90%). Angioplasty was done on 15.06.2006. She lodged a claim for Rs.1,60,140/- to the insurance company on 09.08.2006, but the claim was repudiated by the insurance company on 25.10.2006 on the ground of pre-existing disease mentioning that during the first year of the policy any heart, kidney and circulatory disorders were not payable for insured persons suffering from hypertension/diabetes. They also mentioned that single vessel disease could not develop within 8 ½ months. She represented against this decision with the insurance company stating that she had no HTN or diabetes and submitted a certificate from Dr. R.Sadique, her family physician to this effect. In spite of reminders she did not get any favourable reply and accordingly she approached this forum for redressal of her grievance seeking relief of Rs.1.50,000/-.

The insurance company in their self-contained note dated 06.12.2007 stated that as per policy pre-existing condition meant such disease/injury which existed at the time of proposal. It also meant that sickness or symptoms which existed prior to the effective date of the insurance whether known or unknown for the insured person that the symptoms were related to sickness. They also stated that any heart, kidney and circulatory disorders were not payable for all insured persons suffering from HTN/ Diabetes during the first year operation of the policy.

Decision:

The policy condition D-1 read as under:-

The Company should not be liable to make any payment under the policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of :

During the first year of the operation of the policy the expenses on treatment of:

B. any heart, kidney and circulatory disorders are not payable for all Insured Persons suffering from hypertension/ diabetes.

According to the policy condition persons suffering from Hypertension or Diabetes would not be covered if they have a disease pertaining to heart, kidney and circulatory disorders during the first year of cover. If that is so the insurance company should not have any objection for payment of the treatment for the above disease in the second year onwards. However, phrase suffering from 'Hypertension, Diabetes' clearly indicates that it pertains to those persons who were having Hypertension/ Diabetes before the commencement of the policy and not if the same is detected during the cover of the policy. However, according to the representative of the insurance company Hypertension or Diabetes suffered during the period of hospitalisation also excludes them from claiming during the first year.

However, on going through the Discharge Summary it was clear that the hospital authorities did not mention anything with regard to Diabetes or Hypertension at the time of treatment. The case history of Woodlands Medical Centre Limited states that the patient was recently diagnosed as hypertensive and was having

tablet – Dilgem. They clearly stated that she was not known to be Diabetic. Keeping in view the above, the arguments that policy condition D-2 was applicable in her case was not tenable.

The policy condition D-1 read as under:

The 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 :

"Such diseases/injury which have been in existence at the time of proposing the insurance, pre-existing condition also means any sickness or its symptoms, which existed prior to the effective date of this insurance, whether or not the insured person had knowledge that the symptoms were relating to the sickness. Complications arising from pre-existing disease will be considered part of that pre-existing condition".

The authorities of the insurance company merely interpreted on the strength of the opinion given by the doctor that she might be having a blockade in the artery before the inception of the policy and therefore according to them IHD was existing. Hon'ble Ombudsman opined that though blockade existed it was not necessary that the disease called IHD had manifested. The percentage of heart blockade might not have been critical and IHD might not have developed. Therefore, question of treating that the disease manifested itself before the inception of the insurance policy was not acceptable. However, coming to the next part of the condition mentioned above it was stated that the pre-existing condition also meant sickness or symptoms which existed prior to the effective date of insurance, whether or not the insured person had knowledge that the symptoms were relating to the sickness.

From the above, it was clear that there should be existence of sickness or its symptoms before the inception of the policy. The insurance company should have proof of the same. For that the insurance company must have got medical reports before granting the insurance cover. Medical reports would have definitely given any symptoms which are likely to manifest into a sickness later. In addition to that the insurance company has obtained replies from the attending physician on a questionnaire in which the attending physician has stated that IHD is not always related to HTN or Dyslipidemia and both and he also stated that it would be unwise to comment with certainty on the duration of the disease process,

especially if there is no record of the insured's requirement of medical aid prior to her current one.

From the above it was clear that the insured patient did not have any existing sickness or its symptoms before inception of the policy and therefore question of the patient knowing whether such sickness or its symptoms that were existing did not arise.

Therefore, Hon'ble Ombudsman held that the reasons that the insurance company invoked policy condition D-1 were not tenable. Finally he held that there was no symptom of HTN before the inception of the policy and the sickness manifested only during the cover of the period. It is a well known fact that even though blockades occur the body did not give signals or symptoms until the blockade reaches a critical stage.

Keeping in view the above arguments, Hon'ble Ombudsman that invoking policy conditions D-1 and D-2 to repudiate the claim, was not correct. The claim was exigible. Therefore, he directed the insurance company to pay the claim as per policy terms and conditions.

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Kolkata Ombudsman Centre

Case No. 354/11/003/NL/09/2007-2008

Shri Asit Kumar Pal

Vs.

National Insurance Co. Ltd.

Order Dated: 09.04.2008

Facts & Submissions:

This complaint was filed against repudiation of a claim on the ground that Incision Hernia operation was done before inception of the policy by invoking the Exclusion Clause No.4.1 of the Mediclaim Insurance Policy.

The petitioner, Shri Asit Kumar Pal in his petition DT. 04.09.2007 stated that he was having a Mediclaim Policy with National Insurance Co. Ltd., Midnapore Divisional Office since July 2003 (i.e.29.07.2003) and got the same renewed from time to time without any break. On 12.8.2006, the complainant's wife felt sudden abdominal pain and had to consult with local physician where detection of the disease was done and referred to a surgeon. On 25.1.2007, he consulted Dr. OM Tantia who advised operation. On 11.2.2007, his wife was admitted to a Nursing Home at Kolkata for operation and subsequently discharged from the nursing home on 21.02.2007 after operation of incision hernia. He submitted all the relevant papers to the TPA of the insurance company for reimbursement. He received a repudiation letter from the said TPA in the month of April, 2007, as she had operation in the past, as per Discharge Summary from which the patient had developed incision hernia. Representation against repudiation was made to the Divisional Manager of the Insurance Company on 26.4.2007. After reviewing the matter the insurance company upheld the decision of repudiation. He immediately informed the matter to the Manager of the concerned insurance company posted at Head Office, but did not get any reply. The complainant also stated that his wife did not have such knowledge of the disease at the time of making proposal and not even before 12.8.2006 when she felt sudden abdominal pain and forced to take consultation with local physician and the disease was detected by the said doctor at that time. He pointed out that policy condition no. 4.2 against exclusion clause could not be applied when there were no symptoms or existence of the disease at the time of making proposal. He contended that the insurance company did not exclude anything from the scope of the policy coverage although he disclosed everything at the time of filling the proposal form of his wife's past history of ailment/treatment/ operation column. Being aggrieved, he approached this forum for relief of Rs.49,722/-.

In the self-contained note dt.23.11.2007, the Insurance Company stated that they issued an individual mediclaim policy covering Shri Asit Kumar Pal, self, his wife Smt.Chhanda Pal and son Shri Aritra Pal against sum insured of Rs.50,000/- each since July 2003 and had been continuing without any break. At the time of commencement of the policy the insured declared/disclosed clearly that his wife underwent gall-bladder stone operation way back in 2001 and hysterectomy operation was performed in the year 2003 for which these diseases had been excluded from the scope of the policy. On 11.2.2007 Smt. Chhanda Pal was admitted to ILS multi hospitality clinic, Salt Lake for the problem of "large incision hernia and hypothyroid" and submitted the relevant documents to their TPA, MD India Health Care Services (P) Ltd. The past history of the patient showed the above surgical operation including caesarian section of child birth and exploratory laparactomy for over ion cyst 15 years back. On the basis of the past history of ailment, the TPA repudiated the claim on 14.4.2007 and on 12.6.2007 on the ground of pre-existing disease since the past operation like LUCS, abdominal hysterectomy or ovarian cyst caused such incision hernia. Regarding hypothyroid, the patient had a past history of suffering as per doctor's prescription dt.17.12.2001 attached to the proposal from and Smt. Chhanda Pal at the time of commencement. The insurance company opined that cause of incision hernia could happen due to previous abdominal operation.

Decision :

This office considered the facts and submissions of the case as well as the materials available on records. From Butterworth's Medical Dictionary, "Hernia means a protrusion of an internal organ through a defect in the wall of the Anatomical Cavity in which it lies or into subsidiary compartment of that Cavity. Incision Hernia means, which may happen through an operational scar". It was clear that the scar was pre-existing, but hernia took place later. There was no proof to suggest that hernia took place before the inception of the policy. Obviously hernia might occur at any time due to the existence of an internal scar. It was not necessary that hernia should occur previously when the scar was in existence. Similarly, it was possible that hernia might happen again at the same place; even it was operated upon once. Therefore, Hon'ble Ombudsman opined that Hernia was also not a disease. It was a peculiar anatomical event which took place due to a cavity or due to a scar that was inflicted due to an operation.

Keeping in view of the above, Hon'ble Ombudsman did not agree with the views of the insurance company in repudiating the claim by invoking exclusion clause no.4.1 of the policy condition in this case and held that the claim was exigible. Therefore, the expenses incurred due to hernia operation were payable and it could not be treated as pre-existing disease.

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Kolkata Ombudsman Centre

Case No. 375/11/003/NL/09/2007-08

Shri Nanda Dulal Ghosh

Vs.

National Insurance Company Ltd.

Order Dated: 07.04.2008

Facts & Submissions:

This petition is against repudiation of mediclaim under exclusion clause 4.2 of the Mediclaim Insurance Policy.

The petitioner, Shri Nanda Dulal Ghosh in his petition dated 17.09.2007 stated that he along with his wife and children were covered under Policy No. 153600/48/06/8500002640 for the period 26.10.2006 to 25.10.2007.His daughter Poulami Ghosh was hospitalised in West Bank Hospital, Howrah on 18.11.2006 and discharged on 09.12.2006 for high fever and intensive rash all over the body. He lodged a claim for Rs.1 lakh to the insurance company but the same was repudiated by the TPA of the

insurance company M/s Medsave Health Care Services, Kolkata as per exclusion clause 4.2 (as the claim is within 30 days of the policy) of the policy. The complainant represented to the insurance company that clause 4.2 was not applicable here as his daughter was in good health when the proposal was signed on 25.10.2006 and she attended the college on 25.10.2006 and also on 11.11.2006 when she had fallen ill. As he did not get any favourable reply from the insurance company he approached this forum for redressal of his grievance seeking monetary relief of Rs.1 lakh plus interest.

The insurance company submitted their self-contained note DT. 27.03.2008, the contents of which are as under:

i) The complainant took a hospitalisation and domiciliary hospitalisation policy for self, wife and
Two children for a sum insured of Rs.1,50,000/- w.e.f. 26.10.2006 to 25.10.2007;

ii) His daughter Ms. Poulami Ghosh was ill on 11.11.2006 and was admitted to West Bank Hospital, Howrah for treatment for the period 18.11.2006 to 09.12.2006 as indoor patient;

iii) He lodged a claim for Rs.2,64,000/- for reimbursement of expenditure incurred towards hospitalization;

iv) According to mediclaim policy under exclusion as per policy condition 4.2, any expenses incurred on treatment of disease occurring within first 30 days

from the commencement of the policy are not reimbursable;

v) According to them the TPA M/s MedSave Health Care, Kolkata correctly repudiated the claim invoking the policy condition 4.2.

Decision:

The policy condition 4.2 read as under :-

"Any disease other than those stated in clause 4.3, contracted by the Insured Person during the first 30 days from the commencement date of the Policy. This exclusion shall not however, apply if in the opinion of panel of Medical Practitioners constituted by the Company for the purpose, the Insured Person could not have known of the existence of the Disease or any symptoms or complaints thereof at the time of making the proposal for insurance to the Company. This condition 4.2 shall not however apply in case of

the insured person having been covered under the scheme or group insurance scheme with any of the Indian Insurance Companies for a continuous period of preceding 12 months without any break".

The representatives of the insurance company were asked at the time of hearing whether the rider to the exclusion clause 4.2 which stated as above whether it had been applied or not.

"If in the opinion of panel of Medical Practitioners constituted by the Company for the purpose, the Insured Person could not have known of the existence of the Disease or any symptoms or complaints thereof at the time of making the proposal for insurance to the Company" whether it had been applied it or not.

In reply the representatives of the insurance company stated that the above rider to the policy condition 4.2 had not been applied.

From the description given by the complainant it could be seen that his daughter suffered illness and rash which suddenly occurred and such an ailment, it was felt would not have occurred before the inception of the policy and it was not possible that the insured's family was having any knowledge of such disease. However, in the interest of justice, Hon'ble Ombudsman directed the insurance company to appoint a panel of doctors and obtain their opinion with regard to the rider mentioned above. If the panel opines that the insured person could not have the knowledge of the existence of the disease then obviously the claim was payable.

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Kolkata Ombudsman Centre

Case No. 390/11/003/NL/09/2007-08

Shri Biswadeb Chatterjee

Vs.

United India Insurance Company Ltd.

Order Dated: 19.05.2008

Facts & Submissions:

This petition was in respect of repudiation of a claim under Individual Mediclaim Insurance Policy issued

by United India Insurance Company Ltd. on the ground of pre-existing disease.

The petitioner Shri Biswadeb Chatterjee in his petition DT. 28.09.2007 stated that he and his family members were covered by a mediclaim policy from 09.05.2006 to 08.05.2007 and previous policy was valid from 09.06.2005 to 08.05.2006. His wife Smt. Shamayita Chatterjee developed Menorrhagia around June 2006 as confirmed by the doctor/USG on 14.11.2006. After prescribing medicines for 4 months the doctor advised Hysterectomy on 14.12.2006 and the operation was done on 20.12.2006 in Apollo Nursing Home, Burdwan where she was hospitalised from 19.12.2006 to 26.12.2006. He lodged a claim for Rs.20,388/-, but the claim was repudiated by the insurance company on the ground of pre-

existing disease. He represented to the insurance company for reconsideration based on doctor's opinion but did not receive any reply from the insurance company. Finding no other alternative he approached this forum for redressal of his grievance.

The insurance company in their self-contained note dated 12.03.2008 stated that on 14.11.2006 Dr. Amitava Pal in his prescription noted that the patient had history of Menorrhagia for one year. Therefore, it had been observed that she had the disease since first year or it might be prior to the policy inception. Hysterectomy for Menorrhagia was excluded during first year of policy and as per exclusion clause no. 4.1 it was a pre-existing disease.

Decision:

On reading the policy condition 4.1, 4.2 and 4.3 it was clear that there were certain ailments and diseases which were excluded for reimbursement of claim, such as Cataract operation, Hysterectomy for Menorrhagia, Hernia etc. in the first year of the cover. Therefore, even if a person suffered these diseases in the first year of the cover but got them operated during the second year of the cover the benefit could not be denied by invoking policy condition 4.3.

The panel doctors' opinioned that Fibroid Uterus could not have developed in a short span of first year of cover had not been allowed to be contradicted by the patient as no opportunity had been given to him and therefore invoking policy condition 4.1 was not acceptable. Further there was no irrefutable evidence that Menorrhagia occurred before the inception of the policy.

Hon'ble Ombudsman's observation was that the above conditions which indicated that condition 4.1 and 4.3 were mutually exclusive and unless there was an irrefutable proof that an ailment or disease existed prior to the inception of the policy the insurance company had no right to invoke both the conditions, simultaneously. This was so because the Hysterectomy for Menorrhagia was done in second year and that there is no irrefutable proof for existence of Menorrhagia before the inception of the policy.

Under these circumstances, Hon'ble Ombudsman held that the reasons given by the insurance company for taking a decision of repudiation were not tenable.

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Kolkata Ombudsman Centre

Case No. 379/11/008/NL/09/2007-08

Ms. Gloria V. Higginson

Vs.

Royal Sundaram Alliance

Order Dated: 28.04.2008

Facts & Submissions:

This petition was in respect of repudiation a claim on the ground of pre-existing disease under Health Shield Insurance policy issued by Royal Sundaram Alliance Insurance Company Ltd.

The petitioner, Ms. Gloria V. Higginson in her petition dated 12.09.2007 stated that she was covered under Health Shield Insurance policy No. HE00043975000101 for the period 24.09.2005 to 23.09.2006. She was hospitalised in Woodlands Medical Centre Limited, Kolkata from 12.06.2006 to 19.06.2006 for treatment of Ischaemic Heart Disease, Single Vessel Disease (block 90%). Angioplasty was done on 15.06.2006. She lodged a claim for Rs.1,60,140/- to the insurance company on 09.08.2006, but the claim was repudiated by the insurance company on 25.10.2006 on the ground of pre-existing disease mentioning that during the first year of the policy any heart, kidney and circulatory disorders were not payable for insured persons suffering from hypertension/diabetes. They also mentioned that single vessel disease could not develop within 8 ½ months. She represented against this decision with the insurance company stating that she had no HTN or diabetes and submitted a certificate from Dr. R.Sadique, her family physician to this effect. In spite of reminders she did not get any favourable reply and accordingly she approached this forum for redressal of her grievance seeking relief of Rs.1.50,000/-.

The insurance company in their self-contained note dated 06.12.2007 stated that as per policy pre-existing condition meant such disease/injury which existed at the time of proposal. It also meant that sickness or symptoms which existed prior to the effective date of the insurance whether known or unknown for the insured person that the symptoms were related to sickness. They also stated that any heart, kidney and circulatory disorders were not payable for all insured persons suffering from HTN/ Diabetes during the first year operation of the policy.

Decision:

The policy condition D-1 read as under :-

The Company should not be liable to make any payment under the policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of :

During the first year of the operation of the policy the expenses on treatment of :

b. any heart, kidney and circulatory disorders are not payable for all Insured Persons suffering from hypertension/ diabetes.

According to the policy condition persons suffering from Hypertension or Diabetes would not be covered if they have a disease pertaining to heart, kidney and circulatory disorders during the first year of cover. If that is so the insurance company should not have any objection for payment of the treatment for the above disease in the second year onwards. However, phrase suffering from

'Hypertension, Diabetes' clearly indicates that it pertains to those persons who were having Hypertension/ Diabetes before the commencement of the policy and not if the same is detected during the cover of the policy. However, according to the representative of the insurance company Hypertension or Diabetes suffered during the period of hospitalisation also excludes them from claiming during the first year.

However, on going through the Discharge Summary it was clear that the hospital authorities did not mention anything with regard to Diabetes or Hypertension at the time of treatment. The case history of Woodlands Medical Centre Limited states that the patient was recently diagnosed as hypertensive and was having tablet – Dilgem. They clearly stated that she was not known to be Diabetic. Keeping in view the above, the arguments that policy condition D-2 was applicable in her case was not tenable.

The policy condition D-1 read as under :

The 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 :

"Such diseases/injury which have been in existence at the time of proposing the insurance, pre-existing condition also means any sickness or its symptoms, which existed prior to the effective date of this insurance, whether or not the insured person had knowledge that the symptoms were relating to the sickness. Complications arising from pre-existing disease will be considered part of that pre-existing condition".

The authorities of the insurance company merely interpreted on the strength of the opinion given by the doctor that she might be having a blockade in the artery before the inception of the policy and therefore according to them IHD was existing. Hon'ble Ombudsman opined that though blockade existed it was not necessary that the disease called IHD had manifested. The percentage of heart blockade might not have been critical and IHD might not have developed. Therefore, question of treating that the disease manifested itself before the inception of the insurance policy was not acceptable. However, coming to the next part of the condition mentioned above it was stated that the pre-existing condition also meant sickness or symptoms which existed prior to the effective date of insurance, whether or not the insured person had knowledge that the symptoms were relating to the sickness.

From the above, it was clear that there should be existence of sickness or its symptoms before the inception of the policy. The insurance company should have proof of the same. For that the insurance company must have got medical reports before granting the insurance cover. Medical reports would have definitely given any symptoms which are likely to manifest into a sickness later. In addition to that the insurance company has obtained replies from the attending physician on a questionnaire in which the attending physician has stated that IHD is not always related to HTN or Dyslipidemia and both and he also stated that it would be unwise to comment with certainty on the duration of the disease process, especially if there is no record of the insured's requirement of medical aid prior to her current one.

From the above it was clear that the insured patient did not have any existing sickness or its symptoms before inception of the policy and therefore question of the patient knowing whether such sickness or its symptoms that were existing did not arise.

Therefore, Hon'ble Ombudsman held that the reasons that the insurance company invoked policy condition D-1 were not tenable. Finally he held that there was no symptom of HTN before the inception of the policy and the sickness manifested only during the cover of the period. It is a well known fact that

even though blockades occur the body did not give signals or symptoms until the blockade reaches a critical stage.

Keeping in view the above arguments, Hon'ble Ombudsman that invoking policy conditions D-1 and D-2 to repudiate the claim, was not correct. The claim was exigible. Therefore, he directed the insurance company to pay the claim as per policy terms and conditions.

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Kolkata Ombudsman Centre

Case No. 390/11/003/NL/09/2007-08

Shri Manish Bakshi

Vs.

National Insurance Company Ltd

Order Dated: 22.05.2008

Facts & Submissions:

This petition was against repudiation of a claim on the ground of pre-existing disease under Individual Mediclaim policy.

The petitioner, Shri Manish Bakshi in his petition dated 14.09.2007 stated that he was insured with National Insurance Company Ltd. under Mediclaim Policy No. 170200/48/05/8500000011 for the period 30.05.2005 to 29.05.2006. He was hospitalized from 19.12.2005 to 20.12.2005 in Abdur Razzzaque Ansari Memorial Weavers Hospital, Ranchi. He was diagnosed as RHD, severe MS, PAH, PVH Normal LV function in NSR, PTMC done on 19.12.2005. He lodged a claim for Rs.42,751/- to the insurance company which was rejected by the insurance company on the ground of pre-existing disease. He made a representation to the insurance company but it was not considered. Therefore, the complainant approached this forum for monetary compensation of Rs.42,751/-.

The insurance company in their self-contained note dated 27.03.2008 stated that Rheumatic Heart Disease with Class-II symptom and tight MS develops only after a number of years of Rheumatic fever and could not develop in 6 months, 19 days. Hence this disease was pre-existing prior to start of policy i.e. 30.05.2005 and was not admissible.

Decision:

On going through the Discharge Summary it was found that the patient was only 30 years old and the investigations revealed normal parameters with respect to Blood, urine etc. However, they detected a small clot for which Ballon Surgery was done which was known as BMB. Excepting the interpretation that Rheumatic Heart Disease could not have developed in a short span of 6 months, there was no proof to establish that the disease actually existed prior to the inception of the policy. It was absolutely clear that insured patient did not have any symptoms which indicated Rheumatic Heart Disease before the inception of the policy and obviously he could not have mentioned it in the proposal form. Rheumatism of heart occurs as per Butterworths Medical Dictionary due to a rheumatic fever. It might often result in permanent valvular deformity. From this definition it would be very difficult to interpret that Rheumatic Heart Disease occurred before the inception of the policy. Therefore Hon'ble Ombudsman was unable to agree with the interpretation that Rheumatic Heart Disease was existed prior to the inception of the policy. Further, it was clear that the insured patient did not know about the disease existing before the inception of the policy. Therefore, he also did not agree with the reasons given by the insurance company for taking a decision of repudiation of the claim and held the reasons as untenable.

Under these circumstances, Hon'ble Ombudsman directed the insurance company to settle the claim as per policy terms and condition and pay the same.

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Kolkata Ombudsman Centre

Case No. 392/11/003/NL/09/2007-08

Shri Ajit Kumar Kejriwal

Vs.

National Insurance Company Ltd

Order Dated: 28.04.2008

Facts & Submissions:

This petition was against repudiation of mediclaim under exclusion clause 4.1 (pre-existing disease) of the Mediclaim Insurance Policy.

The petitioner Shri Ajit Kumar Kejriwal in his petition dated 05.09.2007 stated that he and his wife were insured by a mediclaim policy since 1999, but in the year 2000 there was break as could not renew the same on time due to his illness. His policy was renewed from 11.11.2000 (previous policy expired on 03.11.2000) and since then there was no break up to 10.11.2006. His wife Smt. Renu Devi Kejriwal was hospitalised from 26.09.2006 to 03.10.2006 in Apollo Hospitals, Chennai, where surgery for Posterior decompression and stabilization L3 – L5 with pedicle screws and rods (Depuy) and postero lateral fusion was done. He lodged a claim for Rs.1,99,586.72 to the insurance company which was rejected by the TPA of the insurance company M/s Family Health Plan Limited on the ground of pre-existing disease. He represented to the insurance company stating that the disease first came to the notice in October 2001

after she fell down being assaulted by somebody. He also made three claims earlier which were paid and submitted some documents as evidence. However, he did not receive any favourable reply from the insurance company and therefore approached this forum for redressal of his grievance seeking monetary compensation of Rs.1,50,000/-.

The insurance company in their self-contained note dated 03.12.2007 stated that as per Discharge Summary of the hospital the patient had a history of low back pain for last 7 years off and on. The policy was incepted on 11.11.2000, hence the claim was repudiated as the disease was pre-existing at the time of inception of the policy.

Decision :

The representative of the insurance company did not attend; Hon'ble Ombudsman proposed to deal with the matter on an ex-parte basis.

Mere history of back pain for last 7 years off and on could not be reason to treat the disease in the back as pre-existing. The insurance company should have irrefutable proof that there was a disease in the back before the inception of the policy. It was also not clear whether the insurance company took a fresh proposal to issue the policy with effect from 11.11.2000. Thereafter it had been continuous. The policy condition with regard to delay of 7 days was generally condoned by the insurance company. In this case, the delay was exactly 7 days though they had not initially condoned the delay, Hon'ble Ombudsman did not agree to accept the argument that the policy was only fresh from 11.11.2000, as the insured would be precluded from all the benefits of the continuous insurance policy. Condoning the delay, it was presumed that the policy was held to be continuous.

Keeping in view that there was no proof that diseases having manifested before the inception of the policy in 1999 and that having held that the policy should be treated as continuous, Hon'ble Ombudsman held that the claim was exigible.

Under these circumstances, Hon'ble Ombudsman directed the insurance company to pay the claim as per policy terms and conditions.

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Kolkata Ombudsman Centre

Case No. 393/11/003/NL/09/2007-08

Shri Satindra Krishna De

Vs.

National Insurance Company Ltd

Order Dated: 28.04.2008

Facts & Submissions:

This petition is in respect of repudiation of a claim under Individual Mediclaim Insurance Policy on the ground of pre-existing disease.

The petitioner Shri Satindra Krishna De in his petition dated 20.09.2007 stated that he was covered by a mediclaim policy No. 154200/48/05/8500010034 for the period 30.03.2006 to 29.03.2007 which was a second year policy. He was hospitalised in Rabindra Nath Tagore International Institute of Cardiac Sciences (RTIICS) from 16.02.2007 to 17.02.2007 and again from 05.03.2007 to 17.03.2007 for the treatment of Coronary Artery Disease and underwent by-pass surgery. He lodged a claim for Rs.1,50,000/- to the insurance company which was repudiated by the TPA of the insurance company M/s MD India Healthcare Services (P) Ltd. on the ground of pre-existing disease. They mentioned that as per IPD papers he was suffering from Hypertension since 15 years and chest pain since 3 years. The complainant represented against this repudiation stating that his chest pain was actually 3 months old and not 3 years old. Without getting any favourable reply from the insurance company he approached this forum for redressal of his grievance seeking monetary compensation of Rs.1,50,000/-.

The insurance company in their self-contained note dated 05.12.2007 stated as under :-

The subject policy under which claim lodged by the insured patient was 2nd year policy effective from 30.03.2006 to 29.03.2007. It revealed from the Case History Form of hospital that the insured was suffering from HTN since 15 years and chest pain since 3 years, that is, before the inception of policy. Hence it was held that the claim was not payable on the ground of pre-existence.

Finally they have reiterated the stand taken by their TPA.

Decision :

As the representative of the insurance company did not attend, Hon'ble Ombudsman proposed to deal with the matter on an ex-parte basis.

From the above record of the insurance policies, the insured patient had almost continuous policy from 28.03.1998 and even if the break was considered he had been directed to give medical tests and reports which clearly indicate that he was non-diabetic and normotensive. He had also not claimed any hospitalisation expenses during the long years of mediclaim.

Even if HTN was existed, it was only a symptom and not a disease. It was not possible that he was having chest pain for 3 years and did not get checked yup for 3 years at the advanced age i.e., about 68 years before this claim with regard to CABG.

Keeping in view the above it was held that the reasons given for repudiation of the claim could not be tenable on the ground of pre-existing disease when there was no irrefutable proof with regard to

existence and manifestation of disease before the inception of the policy. Since there was no claim for a long time and since the policy was almost continuously existed, it was proved enough that he did not have any manifestation of the disease.

Under these circumstances, Hon'ble Ombudsman directed the insurance company to pay the claim as per policy terms and conditions.

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Kolkata Ombudsman Centre

Case No. 376/11/005/NL/09/2007-08

Shri Sandip Kumar Bose

Vs.

The Oriental Insurance Company Ltd.

Order Dated: 16.04.2008

Facts & Submissions:

This petition was in respect of repudiation of a claim under Individual Mediclaim Insurance Policy due to

pre-existing disease.

The petitioner, Shri Sandip Kumar Bose in his petition dt. 03.09.2007 stated that he initially took a mediclaim policy in Mary 1998 which was renewed up to 06.05.2007 under which he was hospitalised in Nightingale, Kolkata from 06.11.2006 to 14.11.2006 for treatment of Ventral Hernia with LRTI and operation was done. He lodged a claim to the insurance company which was rejected by the TPA of the insurance company, M/s Medicare Services on the ground of pre-existing disease as per doctor's observation of the hospital that there was a prior operation of umbilical hernia in 1997. He made a representation to the insurance company but did not receive any reply from them. Therefore, he approached this forum for redressal of his grievance seeking relief of Rs.50, 000/-.

The insurance company in their self-contained note dt. 28.03.2008, the contents of which were as under:

The complainant took a mediclaim policy which was called a family package policy comprising self, his wife and son. According to the self-contained note the policy was continuing since 1998-99 with Cumulative Bonus of Rs.14,000/- in the case of the complainant. The TPA of the insurance company repudiated the claim with regard to the cost incurred in connection with hernia operation as it was held that hernia existed prior to the inception of the policy. According to them the complainant underwent a

first hernia operation in 1997 before the inception of the policy. The insurance company also requested that they were directed to obtain an opinion of the independent specialist doctor, if the Hon'ble Ombudsman was not satisfied with the report given by Dr. Pinaki Banerjee.

Decision :

Since the representatives of the insurance company did not attend, it was proposed to deal with the matter on an ex-parte basis.

It was clear from the documentation that this was a type of incision hernia due to a scar that occurred because of a prior hernia operation in 1997 and hernia took place once again after 8 years. In several cases with regard to incision hernia, this office held that the scar was pre-existing and hernia occurred later. It is also clear that hernia occurred at any time due to the existence of an internal scar. It was also possible that hernia might once again occur even if it was operated at the same place as hernia happened due to an organ caught in the scar existing in the body.

Further the mediclaim policy clearly stated that if the insured had a continuous mediclaim policy for more than 4 years in existence any disease prior to the inception of the policy did not get excluded.

The request made by the insurance company for reference to a specialist doctor could not accede to as it was amply clear that hernia could not be treated as pre-existing disease as it occurred only if there was a pre-existing scar. Further, the policy condition was changed, as mentioned above, for the benefit of the insured, so that some pre-existing diseases were covered.

Keeping in view the above, Hon'ble Ombudsman held that the reimbursement for expenditure of hernia was exigible. The insurance company was directed to pay the claim.

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Kolkata Ombudsman Centre

Case No. 424/11/002/NL/10/2007-08

Shri Biplab Basu Thakur

Vs.

The New India Assurance Company Ltd.

Order Dated: 22.05.2008

Facts & Submissions:

This petition was against repudiation of a claim on the ground of pre-existing disease under Individual Mediclaim policy.

The petitioner Shri Biplab Basu Thakur in his petition dated 08.10.2007 stated that his wife Smt.Gowri Basu Thakur who was covered under Mediclaim Policy from December 2001 which was renewed up to 30.12.2006. Smt. Thakur was hospitalised in Apollo Hospital, Chennai from 21.03.2006 to 31.03.2006 for treatment of incision hernia. A surgery was done on 24.03.2006. He lodged a claim for Rs.1,50,508.25 which was repudiated by the TPA of the insurance company M/s E-Meditek Solutions Limited on the ground of pre-existing disease. He represented to the insurance company against such repudiation but he did not get any favourable reply from the insurance company. Therefore, he approached this forum for a monetary compensation of Rs.1,20,000/-.

The insurance company in their self-contained note stated that she had a hysterectomy operation in 1993 which was responsible for this present hernia. Therefore, the claim was repudiated.

Decision:

It was clear that the person was operated upon for hernia due to incision scar that was existed since 1993 after a hysterectomy operation. On the basis of the opinion of Butterworth's Medical Dictionary, Hon'ble Ombudsman opined that due to scar the above ailment was existed and he also opined that hernia was not at all a disease. Therefore, he was unable to agree with the arguments that hernia existed before the inception of the policy and therefore, the clause 4.1 would not be applicable. In a similar case this office held that incision hernia was not a pre-existing disease and therefore policy condition 4.1 could not be invoked.

Under these circumstances, he did not agree with the reasons given by the insurance authorities for invoking policy condition 4.1 and therefore directed the insurance company to settle the claim as per policy terms and conditions.

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Kolkata Ombudsman Centre

Case No. 425/11/003/NL/10/2007-08

Shri Biswajit Bhowmick

Vs.

National Insurance Company Ltd

Order Dated: 20.05.2008

Facts & Submissions:

This petition was against repudiation of mediclaim on the ground of Investigation expenses under Individual Mediclaim Policy.

The petitioner Shri Biswajit Bhowmick in his petition dated 10.10.2007 stated that he was covered under a mediclaim policy no. 100900/48/06/8500002834 for the period 28.06.2006 to 27.06.2007. He was hospitalized in The Sherwood Nursing Home from 13.11.2006 to 17.11.2006 for treatment of Duodonal Ulcer with gastritis. He lodged a claim with the insurance company for Rs.20,454/- which was repudiated by the insurance company on 26.03.2007 as the admission to the hospital was purely for investigation and the treatment could be done in OPD. The complainant wrote to the insurance company that investigation was done on doctor's advice and the internal examination papers might be collected by the insurance company, but he did not get any favourable reply from the insurance company. Therefore, he approached this forum for redressal of his grievance seeking monetary compensation of Rs.20,454/-.

The Insurance company in their self-contained note dated 14.05.2008 gave the following details:-

The insured took a mediclaim policy for self and his family for the period 28.06.2006 to 27.06.2007. The insured patient was hospitalized on 13.11.2006 and confined up to 17.11.2006, the claim was rejected by the insurance company on the ground that the prescription dated 13.11.2006, it was mentioned that the patient was suffering from Flatulence, and pain in the neck and at the same time

it was mentioned that the patient was not having any Nausea nor pain in the abdomen and did not have any chest pain. Therefore, according to them the investigations and tests done could have been taken up on OPD basis and therefore the claim was not sustainable and by invoking the policy condition 4.10 the insurance company repudiated the claim.

Decision:

As per the policy condition 4.10 investigations and tests which were not necessary for diagnosing a disease and which could be done on OPD basis were excluded for reimbursement. In this case the insured patient was directed by the doctor to be admitted in the hospital due to pain in the neck and due to Flatulence. In fact the patient stayed in the hospital for 5 days and Discharge Summary clearly stated that he was diagnosed as having Duodonal Ulcer, Fatty Liver and Cervical Spondylosis. This clearly indicated that the investigations and tests were definitely culminated in diagnosing the disease due to which the patient was having pain, therefore, Hon'ble Ombudsman did not agree with the reasons that had been adduced to invoke the provision of condition 4.10 and therefore, held them as untenable.

Keeping in view the above, he directed the insurance company to settle the claim as per policy terms and conditions.

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Kolkata Ombudsman Centre

Case No. 427/11/002/NL/10/2007-08

Shri Abhijit Sil

Vs.

The New India Assurance Company Ltd.

Order Dated: 29.05.2008

Facts & Submissions:

This petition was against repudiation of mediclaim in respect of two sons of the complainant due to alleged false statement in respect of their injury.

The petitioner Shri Abhijit Sil in his petition dated 09.10.2007 stated that his two sons covered under a medicalim policy No. 512202/48/06/20/70001045 for the period 22.06.2006 to 21.06.2007 with the New India Insurance Company Ltd. His two sons got injured while playing football and both were hospitalised in Belle Vue Clinic from 10.07.2006 to 14.07.2006 for treatment of ACL deficiency for which operation was also done. He lodged a claim for Rs.89,880/- (for his son Abhiran Sil) and Rs.87,726/- (for his son Abhidev Sil). He stated that his sons were injured while playing in school sometimes in the year 2005. The treatment was taken from different doctors since relief was not being achieved. The exact date of injury was not given much importance by doctors although he reported correctly. Therefore, the date of injury varied in different prescriptions of the doctors. He also stated that his policy was continuing for 4/5 years and both of his sons have enjoyed Cumulative Bonus. The TPA of the insurance company M/s Medicare TPA Service (I) Pvt. Ltd. repudiated the claim as different dates of injury were mentioned by different doctors. The complainant explained that the dates of injury reported by various doctors pertain to the aggravation of the initial injury with the passage of time resulting in a fresh visit to a particular doctor and hence a fresh date. Thus the dates of injury as recorded in the prescriptions were not false or mis-statements. He requested the insurance company to review the matter but they did not change their decision of repudiation. The complainant then approached this forum for monetary compensation as under:

i) Rs.89,880.50 + Rs.12,000/- for mental pain and suffering for Abhiron Sil + 9% interest for undue delay in payment for a genuine claim.

ii) Rs.87,726.50 + Rs.12,000/- for mental pain and suffering for Abhidev Sil + 9% interest for undue delay in payment for a genuine claim.

The TPA of the insurance company, M/s Medicare TPA Services (I) Pvt. Ltd. stated in their repudiation letter that in different dates of injury had been mentioned in the prescriptions and Discharge Summary of different doctors and Belle Vue Clinic. Therefore, they concluded that "as per declaration given by the claimant in the claim form if any statement made by the insured is found false or untrue, then insured's right to claim reimbursement of the expenses shall be absolutely forfeited and accordingly the aforesaid claim is repudiated and file is closed as 'No Claim'. However, we have not received the self-contained note from the insurance company.

Decision:

Merely because there were certain discrepancies in fixing the date of risk, the insurer did not have the right to invoke a clause that was not existed in the policy condition. It was merely mentioned in the claim form that claim was not payable, if there were certain wrong statements in those forms. Here, it was a case of injury that was conservatively treated for a long time before an operation was necessitated. It was abundantly clear from the chronological order of events as described by the parents that the injuries to both the children were treated from July 2005 to the date of operation somewhere between 10.07.2006 to 14.06.2006. The policy was incepted 4/5 years before the claim as per the Cumulative Bonus granted. The mere interpretation that the injury could have happened even before the inception of the policy without having an irrefutable proof did not hold any test of appeal.

Keeping in view the above, giving benefit of doubt in favour of the complainant that the injury took place during the policy cover and keeping in view that a prolonged treatment was undergone for both the children, Hon'ble Ombudsman held that the reasons adduced by the insurance company for taking a decision of repudiation was not tenable.

Under these circumstances, he directed the insurance company to settle the claims as per policy terms and conditions. However, the claim of damages for mental pain etc. was not exigible as they were outside the purview of the Redressal of Public Grievances Rules, 1998

Kolkata Ombudsman Centre

Case No. 424/11/002/NL/10/2007-08

Shri Biplab Basu Thakur

Vs.

The New India Assurance Company Ltd.

Order Dated: 22.05.2008

Facts & Submissions:

This petition was against repudiation of a claim on the ground of pre-existing disease under Individual Mediclaim policy.

The petitioner Shri Biplab Basu Thakur in his petition dated 08.10.2007 stated that his wife Smt.Gowri Basu Thakur who was covered under Mediclaim Policy from December 2001 which was renewed up to 30.12.2006. Smt. Thakur was hospitalised in Apollo Hospital, Chennai from 21.03.2006 to 31.03.2006 for treatment of incision hernia. A surgery was done on 24.03.2006. He lodged a claim for Rs.1,50,508.25 which was repudiated by the TPA of the insurance company M/s E-Meditek Solutions Limited on the ground of pre-existing disease. He represented to the insurance company against such repudiation but he did not get any favourable reply from the insurance company. Therefore, he approached this forum for a monetary compensation of Rs.1,20,000/-.

The insurance company in their self-contained note stated that she had a hysterectomy operation in 1993 which was responsible for this present hernia. Therefore, the claim was repudiated.

Decision:

It was clear that the person was operated upon for hernia due to incision scar that was existed since 1993 after a hysterectomy operation. On the basis of the opinion of Butterworth's Medical Dictionary, Hon'ble Ombudsman opined that due to scar the above ailment was existed and he also opined that hernia was not at all a disease. Therefore, he was unable to agree with the arguments that hernia existed before the inception of the policy and therefore, the clause 4.1 would not be applicable. In a similar case this office held that incision hernia was not a pre-existing disease and therefore policy condition 4.1 could not be invoked.

Under these circumstances, he did not agree with the reasons given by the insurance authorities for invoking policy condition 4.1 and therefore directed the insurance company to settle the claim as per policy terms and conditions.

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Kolkata Ombudsman Centre

Case No. 425/11/003/NL/10/2007-08

Shri Biswajit Bhowmick

Vs.

National Insurance Company Ltd

Order Dated: 20.05.2008

Facts & Submissions:

This petition was against repudiation of mediclaim on the ground of Investigation expenses under Individual Mediclaim Policy.

The petitioner Shri Biswajit Bhowmick in his petition dated 10.10.2007 stated that he was covered under a mediclaim policy no. 100900/48/06/8500002834 for the period 28.06.2006 to 27.06.2007. He was hospitalized in The Sherwood Nursing Home from 13.11.2006 to 17.11.2006 for treatment of Duodonal Ulcer with gastritis. He lodged a claim with the insurance company for Rs.20,454/- which was repudiated by the insurance company on 26.03.2007 as the admission to the hospital was purely for investigation and the treatment could be done in OPD. The complainant wrote to the insurance company that investigation was done on doctor's advice and the internal examination papers might be collected by the insurance company, but he did not get any favourable reply from the insurance company. Therefore, he approached this forum for redressal of his grievance seeking monetary compensation of Rs.20,454/-.

The Insurance company in their self-contained note dated 14.05.2008 gave the following details:-

The insured took a mediclaim policy for self and his family for the period 28.06.2006 to 27.06.2007. The insured patient was hospitalized on 13.11.2006 and confined up to 17.11.2006, the claim was rejected by the insurance company on the ground that the prescription dated 13.11.2006, it was mentioned that the patient was suffering from Flatulence, and pain in the neck and at the same time it was mentioned that the patient was not having any Nausea nor pain in the abdomen and did not have any chest pain. Therefore, according to them the investigations and tests done could have been taken up on OPD basis and therefore the claim was not sustainable and by invoking the policy condition 4.10 the insurance company repudiated the claim.

Decision:

As per the policy condition 4.10 investigations and tests which were not necessary for diagnosing a disease and which could be done on OPD basis were excluded for reimbursement. In this case the insured patient was directed by the doctor to be admitted in the hospital due to pain in the neck and due to Flatulence. In fact the patient stayed in the hospital for 5 days and Discharge Summary clearly stated that he was diagnosed as having Duodonal Ulcer, Fatty Liver and Cervical Spondylosis. This clearly indicated that the investigations and tests were definitely culminated in diagnosing the disease due to which the patient was having pain, therefore, Hon'ble Ombudsman did not agree with the reasons that had been adduced to invoke the provision of condition 4.10 and therefore, held them as untenable.

Keeping in view the above, he directed the insurance company to settle the claim as per policy terms and conditions.

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Kolkata Ombudsman Centre

Case No. 427/11/002/NL/10/2007-08

Shri Abhijit Sil

Vs.

The New India Assurance Company Ltd.

Order Dated: 29.05.2008

Facts & Submissions:

This petition was against repudiation of mediclaim in respect of two sons of the complainant due to alleged false statement in respect of their injury.

The petitioner Shri Abhijit Sil in his petition dated 09.10.2007 stated that his two sons covered under a medicalim policy No. 512202/48/06/20/70001045 for the period 22.06.2006 to 21.06.2007 with the New India Insurance Company Ltd. His two sons got injured while playing football and both were hospitalised in Belle Vue Clinic from 10.07.2006 to 14.07.2006 for treatment of ACL deficiency for which operation was also done. He lodged a claim for Rs.89,880/- (for his son Abhiran Sil) and Rs.87,726/- (for his son Abhidev Sil). He stated that his sons were injured while playing in school sometimes in the year 2005. The treatment was taken from different doctors since relief was not being achieved. The exact date of injury was not given much importance by doctors although he reported correctly. Therefore, the date of injury varied in different prescriptions of the doctors. He also stated that his policy was continuing for 4/5 years and both of his sons have enjoyed Cumulative Bonus. The TPA of the insurance company M/s Medicare TPA Service (I) Pvt. Ltd. repudiated the claim as different dates of injury were mentioned by different doctors. The complainant explained that the dates of injury reported by various doctors pertain to the aggravation of the initial injury with the passage of time resulting in a fresh visit to a particular doctor and hence a fresh date. Thus the dates of injury as recorded in the prescriptions were not false or mis-statements. He requested the insurance company to review the matter but they did not

change their decision of repudiation. The complainant then approached this forum for monetary compensation as under:

i) Rs.89,880.50 + Rs.12,000/- for mental pain and suffering for Abhiron Sil + 9% interest for undue delay in payment for a genuine claim.

ii) Rs.87,726.50 + Rs.12,000/- for mental pain and suffering for Abhidev Sil + 9% interest for undue delay in payment for a genuine claim.

The TPA of the insurance company, M/s Medicare TPA Services (I) Pvt. Ltd. stated in their repudiation letter that in different dates of injury had been mentioned in the prescriptions and Discharge Summary of different doctors and Belle Vue Clinic. Therefore, they concluded that "as per declaration given by the claimant in the claim form if any statement made by the insured is found false or untrue, then insured's right to claim reimbursement of the expenses shall be absolutely forfeited and accordingly the aforesaid claim is repudiated and file is closed as 'No Claim'. However, we have not received the self-contained note from the insurance company.

Decision:

Merely because there were certain discrepancies in fixing the date of risk, the insurer did not have the right to invoke a clause that was not existed in the policy condition. It was merely mentioned in the claim form that claim was not payable, if there were certain wrong statements in those forms. Here, it was a case of injury that was conservatively treated for a long time before an operation was necessitated. It was abundantly clear from the chronological order of events as described by the parents that the injuries to both the children were treated from July 2005 to the date of operation somewhere between 10.07.2006 to 14.06.2006. The policy was incepted 4/5 years before the claim as per the Cumulative Bonus granted. The mere interpretation that the injury could have happened even before the inception of the policy without having an irrefutable proof did not hold any test of appeal.

Keeping in view the above, giving benefit of doubt in favour of the complainant that the injury took place during the policy cover and keeping in view that a prolonged treatment was undergone for both the children, Hon'ble Ombudsman held that the reasons adduced by the insurance company for taking a decision of repudiation was not tenable.

Under these circumstances, he directed the insurance company to settle the claims as per policy terms and conditions. However, the claim of damages for mental pain etc. was not exigible as they were outside the purview of the Redressal of Public Grievances Rules, 1998

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Shri Manish Bakshi

Vs.

National Insurance Company Ltd

Order Dated: 22.05.2008

Facts & Submissions:

This petition was against repudiation of a claim on the ground of pre-existing disease under Individual Mediclaim policy.

The petitioner, Shri Manish Bakshi in his petition dated 14.09.2007 stated that he was insured with National Insurance Company Ltd. under Mediclaim Policy No. 170200/48/05/8500000011 for the period 30.05.2005 to 29.05.2006. He was hospitalized from 19.12.2005 to 20.12.2005 in Abdur Razzzaque Ansari Memorial Weavers Hospital, Ranchi. He was diagnosed as RHD, severe MS, PAH, PVH Normal LV function in NSR, PTMC done on 19.12.2005. He lodged a claim for Rs.42,751/- to the insurance company which was rejected by the insurance company on the ground of pre-existing disease. He made a representation to the insurance company but it was not considered. Therefore, the complainant approached this forum for monetary compensation of Rs.42,751/-.

The insurance company in their self-contained note dated 27.03.2008 stated that Rheumatic Heart Disease with Class-II symptom and tight MS develops only after a number of years of Rheumatic fever and could not develop in 6 months, 19 days. Hence this disease was pre-existing prior to start of policy i.e. 30.05.2005 and was not admissible.

Decision :

On going through the Discharge Summary it was found that the patient was only 30 years old and the investigations revealed normal parameters with respect to Blood, urine etc. However, they detected a small clot for which Ballon Surgery was done which was known as BMB. Excepting the interpretation that Rheumatic

Heart Disease could not have developed in a short span of 6 months, there was no proof to establish that the disease actually existed prior to the inception of the policy. It was absolutely clear that insured patient did not have any symptoms which indicated Rheumatic Heart Disease before the inception of the policy and obviously he could not have mentioned it in the proposal form. Rheumatism of heart occurs as per Butterworth's Medical Dictionary due to a rheumatic fever. It might often result in permanent valvular deformity. From this definition it would be very difficult to interpret that Rheumatic Heart Disease occurred before the inception of the policy. Therefore Hon'ble Ombudsman was unable to agree with the interpretation that Rheumatic Heart Disease was existed prior to the inception of the policy. Further, it was clear that the insured patient did not know about the disease existing before the inception of the policy. Therefore, he also did not agree with the reasons given by the insurance company for taking a decision of repudiation of the claim and held the reasons as untenable.

Under these circumstances, Hon'ble Ombudsman directed the insurance company to settle the claim as per policy terms and condition and pay the same.

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Kolkata Ombudsman Centre

Case No. 392/11/003/NL/09/2007-08

Shri Ajit Kumar Kejriwal

Vs.

National Insurance Company Ltd

Order Dated: 28.04.2008

Facts & Submissions:

This petition was against repudiation of mediclaim under exclusion clause 4.1

(pre-existing disease) of the Mediclaim Insurance Policy.

The petitioner Shri Ajit Kumar Kejriwal in his petition dated 05.09.2007 stated that he and his wife were insured by a mediclaim policy since 1999, but in the year 2000 there was break as could not renew the same on time due to his illness. His policy was renewed from 11.11.2000 (previous policy expired on 03.11.2000) and since then there was no break up to 10.11.2006. His wife Smt. Renu Devi Kejriwal was hospitalised from 26.09.2006 to 03.10.2006 in Apollo Hospitals, Chennai, where surgery for Posterior decompression and stabilization L3 – L5 with pedicle screws and rods (Depuy) and postero lateral fusion was done. He lodged a claim for Rs.1,99,586.72 to the insurance company which was rejected by the TPA of the insurance company M/s Family Health Plan Limited on the ground of pre-existing disease. He represented to the insurance company stating that the disease first came to the notice in October 2001 after she fell down being assaulted by somebody. He also made three claims earlier which were paid and submitted some documents as evidence. However, he did not receive any favourable reply from the insurance company and therefore approached this forum for redressal of his grievance seeking monetary compensation of Rs.1,50,000/-.

The insurance company in their self-contained note dated 03.12.2007 stated that as per Discharge Summary of the hospital the patient had a history of low back pain for last 7 years off and on. The policy was incepted on 11.11.2000, hence the claim was repudiated as the disease was pre-existing at the time of inception of the policy.

Decision :

The representative of the insurance company did not attend; Hon'ble Ombudsman proposed to deal with the matter on an ex-parte basis.

Mere history of back pain for last 7 years off and on could not be reason to treat the disease in the back as pre-existing. The insurance company should have irrefutable proof that there was a disease in the back before the inception of the policy. It was also not clear whether the insurance company took a fresh proposal to issue the policy with effect from 11.11.2000. Thereafter it had been

continuous. The policy condition with regard to delay of 7 days was generally condoned by the insurance company. In this case, the delay was exactly 7 days though they had not initially condoned the delay, Hon'ble Ombudsman did not agree to accept the argument that the policy was only fresh from 11.11.2000, as the insured would be precluded from all the benefits of the continuous insurance policy. Condoning the delay, it was presumed that the policy was held to be continuous.

Keeping in view that there was no proof that diseases having manifested before the inception of the policy in 1999 and that having held that the policy should be treated as continuous, Hon'ble Ombudsman held that the claim was exigible.

Under these circumstances, Hon'ble Ombudsman directed the insurance company to pay the claim as per policy terms and conditions.

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Kolkata Ombudsman Centre

Case No. 393/11/003/NL/09/2007-08

Shri Satindra Krishna De

Vs.

National Insurance Company Ltd

Order Dated: 28.04.2008

Facts & Submissions:

This petition is in respect of repudiation of a claim under Individual Mediclaim Insurance Policy on the ground of pre-existing disease.

The petitioner Shri Satindra Krishna De in his petition dated 20.09.2007 stated that he was covered by a mediclaim policy No. 154200/48/05/8500010034 for the

period 30.03.2006 to 29.03.2007 which was a second year policy. He was hospitalised in Rabindra Nath Tagore International Institute of Cardiac Sciences (RTIICS) from 16.02.2007 to 17.02.2007 and again from 05.03.2007 to 17.03.2007 for the treatment of Coronary Artery Disease and underwent by-pass surgery. He lodged a claim for Rs.1,50,000/- to the insurance company which was repudiated by the TPA of the insurance company M/s MD India Healthcare Services (P) Ltd. on the ground of pre-existing disease. They mentioned that as per IPD papers he was suffering from Hypertension since 15 years and chest pain since 3 years. The complainant represented against this repudiation stating that his chest pain was actually 3 months old and not 3 years old. Without getting any favourable reply from the insurance company he approached this forum for redressal of his grievance seeking monetary compensation of Rs.1,50,000/-.

The insurance company in their self-contained note dated 05.12.2007 stated as under :-

The subject policy under which claim lodged by the insured patient was 2nd year policy effective from 30.03.2006 to 29.03.2007. It revealed from the Case History Form of hospital that the insured was suffering from HTN since 15 years and chest pain since 3 years, that is, before the inception of policy. Hence it was held that the claim was not payable on the ground of pre-existence.

Finally they have reiterated the stand taken by their TPA.

Decision :

As the representative of the insurance company did not attend, Hon'ble Ombudsman proposed to deal with the matter on an ex-parte basis.

From the above record of the insurance policies, the insured patient had almost continuous policy from 28.03.1998 and even if the break was considered he had been directed to give medical tests and reports which clearly indicate that he was

non-diabetic and normotensive. He had also not claimed any hospitalisation expenses during the long years of mediclaim.

Even if HTN was existed, it was only a symptom and not a disease. It was not possible that he was having chest pain for 3 years and did not get checked yup for 3 years at the advanced age i.e., about 68 years before this claim with regard to CABG.

Keeping in view the above it was held that the reasons given for repudiation of the claim could not be tenable on the ground of pre-existing disease when there was no irrefutable proof with regard to existence and manifestation of disease before the inception of the policy. Since there was no claim for a long time and since the policy was almost continuously existed, it was proved enough that he did not have any manifestation of the disease.

Under these circumstances, Hon'ble Ombudsman directed the insurance company to pay the claim as per policy terms and conditions.

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Kolkata Ombudsman Centre

Case No. 356/11/012/NL/09/2007-08

Shri Dilip Mehra

Vs.

ICICI Lombard General Insurance

Order Dated: 09.04.2008

Facts & Submissions:

This petition was in respect of repudiation of an own damage claim under Private

Car Package Policy issued by ICICI Lombard General Insurance Company Ltd.

The petitioner, Shri Dilip Mehra in his petition dated 03.09.2007 stated that his private car bearing no. WB 02U 3286 was insured under Motor policy No. 3001/50066422/00/000 for the period 26.07.2006 to 25.07.2007. On 29.09.2006 at about 2 A.M his car was burnt, local police was informed and a claim was lodged with the insurance company, but the insurance company repudiated the claim by their letter dated 09.10.2006 mentioning that the burning of the vehicle was not caused by any accident or malicious act. According to them the cause could be attributed to electrical/mechanical breakdown which was not covered under the policy. The insured sent representation to the insurance company on 27.07.2007 expressing his non-acceptance on the repudiation decision and requested the insurance company to pay the claim. As he did not get any favourable reply he approached this forum for redressal of his grievance seeking relief of Rs.2 lakhs on total loss basis.

The insurance company in their self-contained note sent on 05.04.2008 stated that the complainant took a Private Car Policy and the insured vehicle caught fire on 28.09.2006 and the same was intimated to the insurance company. Accordingly, a surveyor was appointed to assess the loss. As per the surveyor's report the vehicle caught fire due to fixing of non-standard music system of high amperage. Therefore, the surveyor requested the complainant to get the vehicle inspected by the manufacturer as the same fell under the manufacturing warranty. Further the insurance company submitted that the vehicle was a new vehicle and there was no accident or external hazard due to which the vehicle caught fire. According to them there was a possibility that the vehicle could have caught fire due to electrical breakdown as confirmed by the surveyor. According to them electrical breakdown came under the General Exceptions as per the policy terms and conditions. Therefore, they felt that the claim was not payable.

Decision:

This office was unable to agree with the arguments of the insurance company. The surveyor did not give any reason for electrical breakdown excepting stating that the complainant used a non standard music system of high amperage. This

office did not understand how there would be a spark due to a short circuit when the music system was not in use and when the car was parked in the night at 2.00 A.M. We were also not sure how even if a short circuit occurred the fire took place unless the wiring used was inferior. There were no answers for such questions in the surveyor's report excepting the fact that the manufacturer had recalled all the vehicles in a particular lot for fresh wiring as there was a defective wiring in that lot. In fact the complainant was not in the knowledge that there was such a recall from the manufacturer with regard to the particular lot to which this vehicle which caught fire belonged. There were many questions that had not been answered by the insurance company with regard to above. Therefore, Hon'ble Ombudsman felt that the insurance company should appoint another independent surveyor and get a report conclusively with regard to the reasons for the fire in the vehicle and take a review of the repudiation decision already made. The complainant was also advised to communicate with the manufacturer regarding the manufacturing defects of his vehicle which caught fire.

Kolkata Ombudsman Centre

Case No. 373/11/002/NL/09/2007-08

Shri Amal Kumar Nandi Roy

Vs.

The New India Assurance Company Ltd.

Order Dated: 07.04.2008

Facts & Submissions:

This petition was against repudiation of a claim on the ground of Exclusion of Heart disease under Individual Mediclaim Policy issued by the said Insurance Company.

The petitioner, Shri Amal Kumar Nandy Roy in his petition dt. 12.09.2007 stated that he was covered under mediclaim policy No. 510300/48/05/91789 from 20.01.2005 to 19.01.2006 and renewed up to 19.01.2008. He was admitted to Ruby General Hospital on 14.05.2006 and discharged on 28.05.2006 with complaint of problem in walking with left leg associated with headache. The final diagnosis as per Discharge Summary dated 28.05.2006 as "RIGHT FRONTOPARIETAL SUBACUTE SUBDURAL HAEMATOMA BURRHOLE & EVACUATION DONE". He lodged a claim with the insurance company for Rs.74,616.28 on 21st July 2006, but the claim was rejected by the TPA of the insurance company, M/s Heritage Health Services Pvt. Ltd. stating that "as per policy condition heart diseases have been excluded from the coverage, so the claim is non-admissible". He represented against the decision of the insurance company on 20.12.2006 stating that he did not suffer from any heart disease, as detected as "Subacute Subdural Haematoma in right Frontoparietal region". After review the TPA of the insurance company vide their letter dated 22.03.2007 concluded that based on doctor's opinion the claim was found inadmissible since the disease was opined as complication of HTN, which related to heart problem. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking relief of Rs.74, 616.28.

The insurance company in their self-contained note dated 02.04.2008 which inter-alia stated as under:-

The insured was covered under a Mediclaim Policy for Rs.1 lakh with Cumulative Bonus of 5%. The insured submitted the claim documents on 21.07.2006 for his treatment of cerebral as mentioned in claim papers. On scrutiny of the documents the TPA of the insurance company M/s Heritage Health Services Pvt.

Ltd. requested the insured to provide medical history sheet at the time of admission. The insured submitted doctor's certificate given by Dr. Dilip Bhattacharya of Ruby General Hospital, Kolkata and he mentioned that the insured was found to be hypertensive and diagnosed as CVA. The TPA adjudged the claim was not payable as heart disease was excluded from the inception of the mediclaim policy. However, on a review the TPA stated that the Discharge Summary dated 28.05.2006 indicated "Right Frontiparietal Subacute Subdural Haematoma Burrhole & Evacuation Done", and based on the opinion of the panel doctors the disease suffered by the insured resulted due to complication of HTN which was related to the heart problem.

Decision:

The questioning exclusion of heart disease from the inception of the policy by the insurance company was not the subject matter. However interpreting that he was suffering from HTN before the inception of the policy and therefore he had the abovementioned ailment in the brain was not tenable. The insurance company had to prove that the above ailment was existed at the time of inception of the policy. The policy was incepted from 20.01.2005 to 19.01.2006 and then renewed from 20.01.2006 to 19.01.2007 with a C.B. of 5%. Therefore, it was clear that the above problem was suffered by the insured in the second year of the policy. Connecting that the above ailment was due to HTN before the inception of the policy without knowing the insured was having HTN before the inception of the policy was not acceptable. Even if it had HTN before the inception of the policy, the insurance company had to prove that the above ailment was existing prior to the inception of the policy, there was no such proof.

Under these circumstances, Hon'ble Ombudsman did not to agree with the argument of the insurance company. This office held that the decision of

repudiation was wrong and directed the insurance company to pay the claim as per policy terms and conditions.

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Kolkata Ombudsman Centre

Case No. 375/11/003/NL/09/2007-08

Shri Nanda Dulal Ghosh

Vs.

National Insurance Company Ltd.

Order Dated: 07.04.2008

Facts & Submissions:

This petition is against repudiation of mediclaim under exclusion clause 4.2 of the Mediclaim Insurance Policy.

The petitioner, Shri Nanda Dulal Ghosh in his petition dated 17.09.2007 stated that he along with his wife and children were covered under Policy No. 153600/48/06/8500002640 for the period 26.10.2006 to 25.10.2007.His daughter Poulami Ghosh was hospitalised in West Bank Hospital, Howrah on 18.11.2006 and discharged on 09.12.2006 for high fever and intensive rash all over the body. He lodged a claim for Rs.1 lakh to the insurance company but the same was repudiated by the TPA of the insurance company M/s Medsave Health Care Services, Kolkata as per exclusion clause 4.2 (as the claim is within 30 days of the policy) of the policy. The complainant represented to the insurance company that clause 4.2 was not applicable here as his daughter was in good health when the proposal was signed on 25.10.2006 and she attended the college on 25.10.2006 and also on 11.11.2006 when she had fallen ill. As he did not get any favourable reply from the insurance company he approached this forum for redressal of his grievance seeking monetary relief of Rs.1 lakh plus interest.

The insurance company submitted their self-contained note dt. 27.03.2008, the contents of which are as under:

vi) The complainant took a hospitalisation and domiciliary hospitalisation policy for self, wife and
two children for a sum insured of Rs.1,50,000/- w.e.f. 26.10.2006 to 25.10.2007;

vii) His daughter Ms. Poulami Ghosh was ill on 11.11.2006 and was admitted to West Bank
Hospital, Howrah for treatment for the period 18.11.2006 to 09.12.2006 as indoor patient;

viii) He lodged a claim for Rs.2,64,000/- for reimbursement of expenditure incurred
towards hospitalization;

ix) According to mediclaim policy under exclusion as per policy condition 4.2, any
expenses incurred on treatment of disease occurring within first 30 days

from the commencement of the policy are not reimbursable;

x) According to them the TPA M/s MedSave Health Care, Kolkata correctly repudiated
the claim invoking the policy condition 4.2.

Decision:

The policy condition 4.2 read as under :-

"Any disease other than those stated in clause 4.3, contracted by the Insured Person during the first 30 days from the commencement date of the Policy. This exclusion shall not however, apply if in the opinion of panel of Medical Practitioners constituted by the Company for the purpose, the Insured Person could not have known of the existence of the Disease or any symptoms or complaints thereof at the time of making the proposal for insurance to the Company. This condition 4.2 shall not however apply in case of the insured person

having been covered under the scheme or group insurance scheme with any of the Indian Insurance Companies for a continuous period of preceding 12 months without any break".

The representatives of the insurance company were asked at the time of hearing whether the rider to the exclusion clause 4.2 which stated as above whether it had been applied or not.

"If in the opinion of panel of Medical Practitioners constituted by the Company for the purpose, the Insured Person could not have known of the existence of the Disease or any symptoms or complaints thereof at the time of making the proposal for insurance to the Company" whether it had been applied it or not.

In reply the representatives of the insurance company stated that the above rider to the policy condition 4.2 had not been applied.

From the description given by the complainant it could be seen that his daughter suffered illness and rash which suddenly occurred and such an ailment, it was felt would not have occurred before the inception of the policy and it was not possible that the insured's family was having any knowledge of such disease. However, in the interest of justice, Hon'ble Ombudsman directed the insurance company to appoint a panel of doctors and obtain their opinion with regard to the rider mentioned above. If the panel opines that the insured person could not have the knowledge of the existence of the disease then obviously the claim was payable.

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Kolkata Ombudsman Centre

Case No. 376/11/005/NL/09/2007-08

Shri Sandip Kumar Bose

Vs.

The Oriental Insurance Company Ltd.

Order Dated: 16.04.2008

Facts & Submissions:

This petition was in respect of repudiation of a claim under Individual Mediclaim Insurance Policy due to pre-existing disease.

The petitioner, Shri Sandip Kumar Bose in his petition dt. 03.09.2007 stated that he initially took a mediclaim policy in Mary 1998 which was renewed up to 06.05.2007 under which he was hospitalised in Nightingale, Kolkata from 06.11.2006 to 14.11.2006 for treatment of Ventral Hernia with LRTI and operation was done. He lodged a claim to the insurance company which was rejected by the TPA of the insurance company, M/s Medicare Services on the ground of pre-existing disease as per doctor's observation of the hospital that there was a prior operation of umbilical hernia in 1997. He made a representation to the insurance company but did not receive any reply from them. Therefore, he approached this forum for redressal of his grievance seeking relief of Rs.50, 000/-.

The insurance company in their self-contained note dt. 28.03.2008, the contents of which were as under:

The complainant took a mediclaim policy which was called a family package policy comprising self, his wife and son. According to the self-contained note the policy was continuing since 1998-99 with Cumulative Bonus of Rs.14,000/- in the case of the complainant. The TPA of the insurance company repudiated the claim with regard to the cost incurred in connection with hernia operation as it was held that hernia existed prior to the inception of the policy. According to them the complainant underwent a first hernia operation in 1997 before the inception of the policy. The insurance company also requested that they were directed to obtain an opinion of the independent specialist doctor, if the Hon'ble Ombudsman was not satisfied with the report given by Dr. Pinaki Banerjee.

Decision :

Since the representatives of the insurance company did not attend, it was proposed to deal with the matter on an ex-parte basis.

It was clear from the documentation that this was a type of incision hernia due to a scar that occurred because of a prior hernia operation in 1997 and hernia took place once again after 8 years. In several cases with regard to incision hernia, this office held that the scar was pre-existing and hernia occurred later. It is also clear that hernia occurred at any time due to the existence of an internal scar. It was also possible that hernia might once again occur even if it was operated at the same place as hernia happened due to an organ caught in the scar existing in the body.

Further the mediclaim policy clearly stated that if the insured had a continuous mediclaim policy for more than 4 years in existence any disease prior to the inception of the policy did not get excluded.

The request made by the insurance company for reference to a specialist doctor could not accede to as it was amply clear that hernia could not be treated as pre-existing disease as it occurred only if there was a pre-existing scar. Further, the policy condition was changed, as mentioned above, for the benefit of the insured, so that some pre-existing diseases were covered.

Keeping in view the above, Hon'ble Ombudsman held that the reimbursement for expenditure of hernia was exigible. The insurance company was directed to pay the claim.

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Kolkata Ombudsman Centre

Case No. 390/11/003/NL/09/2007-08

Shri Biswadeb Chatterjee

Vs.

United India Insurance Company Ltd.

Order Dated: 19.05.2008

Facts & Submissions:

This petition was in respect of repudiation of a claim under Individual Mediclaim Insurance Policy issued by United India Insurance Company Ltd. on the ground of pre-existing disease.

The petitioner Shri Biswadeb Chatterjee in his petition dt. 28.09.2007 stated that he and his family members were covered by a mediclaim policy from 09.05.2006 to 08.05.2007 and previous policy was valid from 09.06.2005 to 08.05.2006. His wife Smt. Shamayita Chatterjee developed Menorrhagia around June 2006 as confirmed by the doctor/USG on 14.11.2006. After prescribing medicines for 4 months the doctor advised Hysterectomy on 14.12.2006 and the operation was done on 20.12.2006 in Apollo Nursing Home, Burdwan where she was hospitalised from 19.12.2006 to 26.12.2006. He lodged a claim for Rs.20,388/-, but the claim was repudiated by the insurance company on the ground of pre-existing disease. He represented to the insurance company for reconsideration based on doctor's opinion but did not receive any reply from the insurance company. Finding no other alternative he approached this forum for redressal of his grievance.

The insurance company in their self-contained note dated 12.03.2008 stated that on 14.11.2006 Dr. Amitava Pal in his prescription noted that the patient had history of Menorrhagia for one year. Therefore, it had been observed that she had the disease since first year or it might be prior to the policy inception. Hysterectomy for Menorrhagia was excluded during first year of policy and as per exclusion clause no. 4.1 it was a pre-existing disease.

Decision:

On reading the policy condition 4.1, 4.2 and 4.3 it was clear that there were certain ailments and diseases which were excluded for reimbursement of claim, such as Cataract operation, Hysterectomy for Menorrhagia, Hernia etc. in the first year of the cover. Therefore, even if a person suffered these diseases in the first

year of the cover but got them operated during the second year of the cover the benefit could not be denied by invoking policy condition 4.3.

The panel doctors' opinioned that Fibroid Uterus could not have developed in a short span of first year of cover had not been allowed to be contradicted by the patient as no opportunity had been given to him and therefore invoking policy condition 4.1 was not acceptable. Further there was no irrefutable evidence that Menorrhagia occurred before the inception of the policy.

Hon'ble Ombudsman's observation was that the above conditions which indicated that condition 4.1 and 4.3 were mutually exclusive and unless there was an irrefutable proof that an ailment or disease existed prior to the inception of the policy the insurance company had no right to invoke both the conditions, simultaneously. This was so because the Hysterectomy for Menorrhagia was done in second year and that there is no irrefutable proof for existence of Menorrhagia before the inception of the policy.

Under these circumstances, Hon'ble Ombudsman held that the reasons given by the insurance company for taking a decision of repudiation were not tenable.

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Kolkata Ombudsman Centre

Case No. 512/11/002/NL/12/2007-2008

Shri Angshuman Kumar Saha

Vs.

The New India Assurance Co. Ltd.

Order Dated : 04.07. 2008

Facts & Submissions :

This complaint was filed against repudiation of a claim on the ground that R.C.T. (Root Canal Treatment) was not payable under Mediclaim Insurance Policy.

The petitioner, Shri Angshuman Kumar Saha stated that he was having a Mediclaim Insurance Policy with the New India Assurance Co. Ltd. covering self, wife and son for the period 22.04.2006 to 21.04.2007. He stated that his wife was admitted to Rastogi Dental Hospital & Research Centre, Allahabad on 29.11.2006 for R.C.T. She was operated upon and discharged on the same day. After that a claim was submitted to the Insurance Company on 21.12.2006 in respect of treatment of his wife, Smt. Monisha Saha. The

insurance company repudiated the claim on 5.5.2007 on the ground that the disease for which R.C.T. (Root Canal Treatment) was performed was not payable. He represented against the repudiation decision of the insurance company citing the reasons backed by the certificate, issued by the Dental Surgeon, Dr. Sushil Kumar Rastogi which clearly stated that 'RCT of Smt. Monisha Saha was done as a result of disease and not any other reason'. He requested the insurance company that on the basis of this certificate they might be able to settle the claim without further delay, as six months had already been elapsed since he lodged the claim. Being aggrieved, he has approached this forum for relief of Rs.6,533/- plus interest and compensation against harassment and mental agony.

In the self-contained note dt.11.03.2008, the insurance company stated that Smt. Monisha Saha was covered under Mediclaim Insurance Policy having sum insured Rs.50,000.00 with C.B.20% and enhancement of Sum Insured was Rs.25,000/- with 10% C.B. They further stated that a claim was submitted on 20.4.2007 for the treatment of Root Canal of the above named insured for reimbursement which was turned down by the TPA of the Insurance Company, M/s. Heritage Health Services Pvt. Ltd. with the plea that this type of treatment was not covered under the policy. The Insurance Company again stated that the repudiation was made because the treatment was taken in a clinic and not in a hospital. Root Canal treatment was not payable unless it is a consequence of a disease or injury which attracted policy exclusion Clause No.4.7.

Decision :

This office considered the facts and submissions of the case as well as the materials available on records. On going through the records, it was found that the operation was done in a dental hospital and not in a clinic, as described by the insurance authorities. According to our opinion, the certificate given by the Doctor that the R. C. T. operation was done due to a disease in the teeth and that was not cosmetic in nature.

Under the circumstances, Hon'ble Ombudsman did not agree with the arguments of the insurance company and he told that their arguments were not tenable. Therefore, he directed the insurance company to pay the claim as per the terms and conditions of the Mediclaim policy.

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Kolkata Ombudsman Centre

Case No. 571/11/003/NL/01/2007-08

Shri Sailendra Nath Malick

Vs.

National Insurance Company Ltd.

Order Dated : 11.08. 2008

Facts & Submissions :

This petition was in respect of repudiation of claim on the ground of "pre-existing" disease as per exclusion clause no. 4.1 under Individual Mediclaim Insurance Policy.

The petitioner, Shri Salindra Nath Malick stated that he along with his wife and daughter were covered under a mediclaim policy from 01.12.2005 to 30.11.2006 which was a second year policy. He was hospitalized in Life Line Nursing Home from 16.03.22006 to 19.03.2006 for treatment of CSOM with big central perforation (RE) and had undergone Tympanoplasty (RE). He lodged a claim for Rs.22,770/- to the insurance company which was repudiated by the TPA of the insurance company on the ground of pre-existing disease. He appealed to the insurance company for payment of the claim but the same was not considered by the insurance company and therefore, he approached this forum for redressal of his grievance seeking relief of Rs.22,770.01.

The insurance company did not even send their self-contained note along with consent letter, as asked for. However, the claim was repudiated by the TPA of the insurance company stating that the complainant was suffering from the disease since inception of the policy.

Decision:

It was found that the complainant was having a mediclaim insurance policy with Iffco-Tokio General Insurance Company Ltd. for about 10 years, though the details were not available. Keeping in view that Ear, Throat and Nose were connected and also keeping in view the fact that the proposer had mentioned Polyps operation and availability of mediclaim policy for 10 years Hon'ble Ombudsman did not agree with the arguments of the insurance company with regard to the decision of repudiation.

Under these circumstances, he held that the insurance company should pay the claim as per the policy terms and conditions.

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Kolkata Ombudsman Centre

Case No. 572/11/003/NL/01/2007-08

Smt. Anjali Gupta

Vs.

National Insurance Company Ltd.

Order Dated : 22.07. 2008

Facts & Submissions :

This petition was against repudiation of two claims under Individual Mediclaim Policy issued by National Insurance Company Ltd., one on the ground of admission for

investigation purpose only i.e., 4.10 and another on the ground of 'pre-existing' disease as per exclusion i.e., clause No. 4.1.

The application to Insurance Ombudsman was initially received from Smt. Anjali Gupta as her claim for hospitalization was repudiated under exclusion clause no. 4.10. She was hospitalized from 28.02.2007 to 03.03.2007 in Uma Medical Related Institute (P) Ltd. for treatment of low back pain. She was diagnosed with Lumber Spondylosis with Lumber Canal Stenosis with decreased space in L5-S1 Vertebra. She submitted a claim to the insurance company which was rejected by the TPA of the insurance company M/s MD India Healthcare Services (P) Ltd. on the ground that admission in hospital was for investigation purpose only. She appealed for a review but the insurance company upheld the decision of repudiation. Therefore, she approached this forum for a monetary compensation of Rs.14,000/- (approx).

In the 'P' form she also made a complaint against repudiation of claim in respect of her husband Shri Biswantah Gupta who was hospitalized from 25.01.2007 to 31.01.2007 in Microlap. As per Discharge card he was suffering from Prostatism under flow of urine. The patient underwent TURP in 1996 as per RAL sheet. Hence the claim was repudiated under exclusion clause 4.1 as pre-existing disease. The policy was continuing from 09.06.2005 and renewed up to 08.06.2007 with 7,500/- Cumulative Bonus. She appealed to the insurance company for a review as under flow of urine was not due to growth of prostate but due to growth of cyst in bladder neck. She also enclosed certificate of Dr. Dipankar Mukherjee dated 23.06.2007 wherein he opined that it was difficult to say whether it was a secondary Prostatism. But her appeal was not considered, hence she approached this forum for a monetary compensation of Rs.39,485/-.

The self-contained note in respect of complaint by Smt. Anjali Gupta was submitted in which the insurance company reiterated that the patient was admitted primarily to get MRI done. The self-contained note also referred to a note in the treatment sheet wherein it was clearly stated that "the insurance company had sent a denial letter, and the patient was not willing to continue hospital stay". From the statement according to the insurance company it was crystal clear that her hospital stay was not genuinely required. Hence the claim could not be entertained.

In respect of her husband's claim the insurance company did not send any self-contained note.

Decision:

As the complainant did not attend the hearing, Hon'ble Ombudsman proposed to deal with the matter on ex-parte basis.

On going through the chronological happening of events in the case of the complainant it was found that the complainant had joined the hospital for treatment of back pain on the advice of a doctor and she could not get the MRI done as no cashless facility was available. She was accordingly discharged for getting MRI done later. Thereafter, MRI was done which has clearly indicated that she was suffering from

Degenerative Lumbar Spine. Therefore, Hon'ble Ombudsman was of the opinion that had she got the MRI done at the time of hospitalization she would have been diagnosed as mentioned above at that time itself. Therefore, policy condition 4.10 could not have been applied. Therefore, merely stating that the tests could have been done on OPD basis by the insurance company was not tenable. Therefore, he directed the insurance company to pay the claim as per policy terms and conditions.

In the case of the claim with respect to the treatment of her husband, it was observed that no specialist opinion was taken whether the low flow of urine was connected with prostate disease which was existed prior to the inception of the policy. Therefore, Hon'ble Ombudsman directed the insurance company to appoint a specialist doctor outside their panel connected with the disease and obtain an opinion with regard to whether the lower flow of urine was due to a cyst in the bladder neck or whether it is due to disease in the prostate gland. The insurance company should review the claim on the basis of the specialist opinion and intimate the complainant accordingly. The opinion of the specialist doctor would be final.

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Kolkata Ombudsman Centre

Case No. 578/11/003/NL/01/2007-08

Shri Sekhar Kumar Mitra

Vs.

National Insurance Company Ltd.

Order Dated : 29.07. 2008

Facts & Submissions :

This petition was in respect of repudiation of a claim on the ground of less than 24 hours hospitalization as per exclusion clause no. 4.10 under Individual Mediclaim policy issued by the above insurance company.

The petitioner, Shri Sekhar Kumar Mitra stated that he along with his family members were covered under mediclaim for the period from 13.02.2006 to 12.02.2007. He was hospitalized in Ruby General Hospital from 04.11.2006 at 12.43 hours to 05.11.2006 at 2.55 P.M. for treatment of Type – II Diabetic Mellitus and non specific chest pain. He lodged a claim for Rs.8,203.74 to the insurance company which was rejected by the TPA of the insurance company on the following grounds :-

1. The hospitalization was for evaluation purpose
2. The hospitalization was for less than 24 hours.

He represented against decision of the insurance company stating that he felt chest pain and according to doctor's advice he was admitted to the hospital and after thorough check up he was released on the next day. But he did not receive any reply from the insurance company; hence he approached this forum for redressal of his grievance seeking monetary relief of 75% of the claimed amount.

This office wrote to the insurance company to send their self-contained note along with consent for the Insurance Ombudsman to act as a mediator between the parties on 12.02.2008 followed by a reminder dated 06/09.06.2008, but regret to mention that this office did not appear to have received the self-contained note from the insurance company. Later they filed the same on 21.07.2008 stating the reasons for rejection of the claim in their repudiation letter dated 10.03.2007.

Decision:

As the complainant did not attend the hearing, Hon'ble Ombudsman proposed to deal with the matter on ex-parte basis.

From the evidence available on record, Hon'ble Ombudsman came to a conclusion that policy condition 2.3 and exclusion clause 4.10 were clearly applicable and therefore, the insurance company was correct in repudiating the claim

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Kolkata Ombudsman Centre
Case No. 611/11/002/NL/01/2007-08

Shri Bimal Kumar Pansari

Vs.

The New India Assurance Company Ltd.

Order Dated : 28.07. 2008

Facts & Submissions :

This petition was in respect of repudiation of a claim under Individual Mediclaim Insurance Policy issued by the New India Assurance Company Ltd. on the ground that no. CT/MRI was done under the said policy.

The petitioner, Shri Bimal Kumar Pansari stated that he along with his wife was covered under a medicalim policy from 17.11.2005 which was renewed up to 16.11.2007. Shri Pansari was hospitalized from 26.12.2006 to 29.12.2006 in Bivek Nursing Home, Howrah under doctor's advice as he became senseless at home. He was treated in the hospital for Vertigo & Loss of Consciousness. He lodged a claim for Rs.15,020.50 to the insurance company on 03.01.2007 which was repudiated by the

TPA of the insurance company because no CT/MRI was done. He appealed to the insurance company for reconsideration explaining that the doctor advised for undergoing CT/MRI in case of recurrence of the attack but his appeal was not considered and therefore he approached this forum for redressal of his grievance.

We wrote to the insurance company to send the self-contained note along with their consent for the Insurance Ombudsman to act as a mediator between the parties on 13.02.2008 followed by a reminder dated 06/09.06.2008, but regret to mention that we have not received the self-contained note from the insurance company. However, the TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd. in their repudiation letter dated 16.02.2007 has mentioned that this was the first year policy and the disease was diagnosed as Vertigo with Loss of Consciousness. Although the final cause of loss of consciousness was not given. Surprisingly no CT Scan and Cardiac tests were performed. No MRI was also done. Instead of that some other tests like NCV of upper Limbs were done. They questioned the necessity of admission in the hospital.

Decision :

Since the insurance company had decided to admit the claim with expenditure of Rs.2,650/-which they did not allow earlier, Hon'ble Ombudsman proposed not to interfere any further. However, he directed the insurance company to pay the deducted amount.

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Kolkata Ombudsman Centre

Case No. 621/11/005/NL/01/2007-08

Shri Mahabir Prasad Periwal

Vs.

The New India Assurance Company Ltd.

Order Dated : 24.07. 2008

Facts & Submissions :

This petition was against repudiation of claim under Individual Mediclaim Policy issued by the Oriental Insurance Company Ltd. on the ground of exclusion pre-existing disease under exclusion clause No. 4.1.

The petitioner, Shri Mahabir Prasad Periwal stated that he was covered under a mediclaim policy since 1999 and was renewed up to 31.12.2006. He was hospitalized in B.M. Birla Heart Research centre for treatment of Coronary Artery disease, Diabetes Mellitus, Hypertension and PTCA done to LAD and RCA on 21.09.2006. He lodged a claim for Rs.3,94,356/- to the insurance company. The TPA of the insurance company M/s Heritage Health Services Pvt. Ltd. offered Rs.1 lakh only on the ground that when earlier claim was lodged the sum insured was increased. Later the insurance company took a different plea that non-disclosure of the earlier claim was the reason for limiting liabilities. He wrote to the insurance company for payment of Rs.3.50 lakhs but the insurance company justified the decision of the TPA, therefore, he approached this forum for redressal of his grievance seeking relief of Rs.3.50 lakhs.

The insurance company in their self-contained note dated 19.05.2008 stated that the complainant Shri Mahabir Prasad Periwal was covered under a Group Mediclaim Policy. He took an individual mediclaim policy w.e.f. 01.01.2002 and renewed the policy without any break of insurance with a sum insured of Rs.2 lakhs for each member. In the year 2004 he had enhanced the sum insured by Rs.3 lakhs. At the time of taking individual mediclaim policy in the year 2002, the insured did not disclose any illness/ disease sustained by him in the past in the proposal form under serial no. 15, though it was revealed later that he was paid a claim for Rs.1 lakh for treatment of heart disease in 2000. In the year 2006 he lodged a claim for Rs.3,94,356/- to Heritage Health Services Pvt. Ltd. for treatment of Coronary Artery Disease. The TPA M/s Heritage Health Services Pvt. Ltd. offered him Rs.1.20 lakhs for full as final settlement as the claim for CAD against claim amount of Rs.3,94,356/-. They explained that during the time of switching from Group Mediclaim Policy to Individual Mediclaim Policy in the year 2002 the past history of health was not disclosed. The insurance company argued that had he disclosed this fact they could have put a cap of Rs.1 lakh for any heart disease.

Decision :

Keeping in view of the facts mentioned above, this office felt that it was obligatory on the part of the complainant to mention whatever health procedures that had been undertaken by him before the conversion of the policy from Group Mediclaim Policy to Individual Mediclaim Policy. From the proposal it could be seen that the complainant did not mention any procedure with regard to heart ailment undertaken in the year 2000.Therefore, Hon'ble Ombudsman directed the insurance company to verify the extent of cover under Group Mediclaim Policy plus Cumulative Bonus at the time of conversion and accordingly directed them to pay the claim if any consisting of the cover in the Group Mediclaim Policy along with Cumulative bonus, if any.

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Kolkata Ombudsman Centre

Case No. 637/11/003/NL/02/2007-08

Smt. Alpana Samaddar

Vs.

National Insurance Company Ltd.

Order Dated : 26.08. 2008

Facts & Submissions :

This complaint was filed against repudiation of claim on the ground of belated submission of the claim i. e. beyond 90 days which fell under non-compliance of Condition No.15 of MOU held between the Insurance Company and the GMSC Ltd under Group Personal Accident policy.

The petitioner, Smt. Alpana Samaddar stated that she being the wife and nominee of late Swapan Samaddar, who happened to be one of the members of Group Personal Accident policy issued by National Insurance Co. Ltd., D.O.III, Kolkata through Golden Multi Services Club Limited, lodged a complaint stating that the said insurance company repudiated the claim of her deceased husband who died on 10.02.2006 due to a bus accident. The repudiation according to her was made on a very flimsy ground. She also contended that the belated submission of papers i.e. 9 months, 6 days took place due to collection of requisite papers from different Government Organizations. She again said the delay in submission of papers was totally unintentional. Further, according to her immediately after sudden demise of her husband she was physically sick and mentally upset. She had urged the insurance authorities, following mishap in the family she already lost her husband to consider the matter more on compassionate ground rather than on technical requirements. Being aggrieved, she has approached this forum for relief of Rs.5,00,000/- subject to maximum of Sum Insured.

In the self-contained note dt.17.06.2008, the Insurance Company stated that the deceased was covered by a Group Personal Accident Policy with sum insured of Rs.5 lacs. The nominee of the deceased, Smt. Alpana Samaddar lodged a claim after a gap of 9 months, 6 days from the date of expiry of her husband for compensation. The insurance company repudiated the claim on the ground of belated submission of the claim. Since MOU itself categorically mentioned that any claim submitted after 90 days could not be entertained and therefore the insurance company repudiated the claim.

Decision :

The complainant was explained that the office of Insurance Ombudsman had to be consistent with the decision with regard to the similar cases that had already been taken by him. Keeping in view of the decision already taken, Hon'ble ombudsman upheld the decision of the insurance company in repudiating the claim.

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Kolkata Ombudsman Centre

Case No. 651/11/003/NL/02/2007-08

Shri Nawal Kishore Bhartia

Vs.

National Insurance Company Ltd.

Order Dated : 25.08. 2008

Facts & Submissions :

This petition was in respect of repudiation of a claim on the ground that the hospitalization was for investigation and evaluation of ailment under Individual Mediclaim policy.

The petitioner, Shri Nawal Kishore Bhartia stated that his daughter was covered under mediclaim policy no. 101500/48/05/8500000670 for the period from 06.06.2005 to 05.06.2006. His daughter Miss Sweta Bhartia was admitted in the Calcutta Medical Research Institute from 26.12.2005 to 29.12.2005 with severe back pain under advice of treating doctor. He lodged a claim for Rs.27,050.90 to the insurance company which was repudiated by the insurance company stating that the treatment could have been done in the outpatient department, without the necessity of admission. He appealed to the insurance company against repudiation which was not considered by the insurance company, and then he approached this forum for redressal of his grievance seeking monetary relief of Rs.27,050.90.

The insurance company did not send any self-contained note.

Decision:

From the evidence available there was no doubt that the patient was referred to be admitted in a hospital due to severe back pain etc. and it was also true that she was diagnosed with Koch's disease. Therefore, Hon'ble Ombudsman directed the insurance company to pay the claim.

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Kolkata Ombudsman Centre

Case No. 661/11/003/NL/02/2007-08

Shri Arun Kumar Mukherjee

Vs.

National Insurance Company Ltd.

Order Dated : 26.08. 2008

Facts & Submissions :

This complaint was filed against repudiation of a claim on the ground that the treatment taken in the hospital was for investigation and evaluation only which fell under Exclusion Clause No.4.10 of the Mediclaim policy.

The petitioner, Shri Arun Kumar Mukherjee stated that he took an Individual Mediclaim Policy from National Insurance Co. Ltd., D.O.III, Kolkata for self, wife and son with Sum insured of Rs.50,000/- each commencing from 4.1.2007 to 3.1.2008. His wife, Smt. Krishna Mukherjee fell sick on 17.1.2007 and consulted Dr. Swagata Chowdhury, M. D., Consultant Physician and Cardiologist who diagnosed and advised her for hospitalization. As per advice of the said Cardiologist she was hospitalized on 18.1.2007 at Dr. B. N. Basu Memorial Clinic Apollo Nursing Home, Kolkata-29 and diagnosed there under her care and supervision. She had to confine herself in the said clinic from 18.1.2007 to 26.1.2007. After completion of treatment of his wife, he lodged claim in respect of his wife on 20.9.2007 and 27.12.2007 respectively to the insurance company amounting to Rs.29,106.26 for reimbursement. The insurance company repudiated the claim on the ground that the treatment taken in the hospital was for investigation and evaluation only and there was no positive existence or presence of any ailment. He represented against the decision of the insurance company on 27.122007. Being aggrieved, he has approached this forum for relief of Rs.29, 106.26.

The Insurance Company did not provide us with the self-contained note till date, as asked for vide our letter dt.30.6.2008.

4. **Decision :**

On going through the Discharge Summary, it was found that the patient was admitted with a diagnosis of 'SYNCOPE for evaluation'. According to Butterworth's Medical Dictionary Syncope means transient loss of consciousness due to inadequate cerebral blood flow. Consequent to such diagnosis test and investigation has been done in the hospital to evaluate the same. Therefore, the insurance company could not say that the investigations were done which were not consistent with or incidental to the diagnosis. It is clear from the above, that hospitalization was done to complete the investigation and test to evaluate the degree of Syncope.

Therefore, Hon'ble Ombudsman directed the insurance company to pay the claim as per the terms and conditions of the policy.

Kolkata Ombudsman Centre

Case No. 674/11/002/NL/02/2007-08

Shri Ramesh Chandra Jolly

Vs.

The New India Assurance Company Ltd.

Order Dated : 14.08. 2008

Facts & Submissions :

This petition was against repudiation of claim under Individual Mediclaim Policy issued by the New India Assurance Company Ltd. due to less than 24 hours hospitalization as per exclusion clause No.2.3.

The petitioner Shri Ramesh Chandra Jolly stated that he along with his wife and daughter were covered under policy No. 510200/48/06/20/70052691 for the period 26.09.2006 to 25.09.2007. He met with an accident and was admitted in Health Point a Multi – Speciality Hospital on 27.08.2007 at 4.00 P.M and released on 28.08.2007 at 12.00 Noon for repair of Lacerated wound. He submitted a claim for Rs.12,588/- to the insurance company which was repudiated by the TPA of the insurance company M/s MDIndia Healthcare Services (P) Ltd. on the ground that period of hospitalization was less than 24 hours. He appealed to the insurance company stating that this condition was not known to him hence the claim should be considered. His appeal was not considered by the insurance company. Therefore he approached this forum for redressal of his grievance seeking relief of Rs.12,588/-.

The insurance company in their self-contained note dated 17.04.2008 upheld the decision of repudiation of the TPA.

Decision :

On going through the condition 2.3, it was found that there was no mention of hospitalization due to an accident and therefore, it was not sure whether condition 2.3 was at all applicable. However, the argument that there was a separate product for insurance benefit given by the insurance companies for accidents was acceptable. It is also true that insurance company had changed the policy condition 2.3 for later mediclaim policies.

Therefore, it was clear that as the company itself had expanded the definition of 2.3 for the subsequent mediclaim policies it looked as though the previous mediclaim policies were consciously excluded hospitalization benefit under 2.3 in the case of accidents.

Keeping in view the above arguments Hon'ble Ombudsman felt that the insured should not suffer due to the definition given under policy condition 2.3. He proposed to grant an ex-gratia payment of Rs.6,000/- as the patient could have stayed little longer in the hospital for getting the benefit which probably was not in his knowledge. Therefore, he directed the insurance company to pay an ex-gratia amount of Rs.6,000/-.

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Kolkata Ombudsman Centre

Case No. 686/11/005/NL/02/2007-08

Shri Susanta Ghosh

Vs.

The Oriental Insurance Company Ltd.

Order Dated : 14.08. 2008

Facts & Submissions :

This petition was against repudiation of claim under Individual Mediclaim Policy issued by the Oriental Insurance Company Ltd. on the ground of "pre-existing disease".

The petitioner Shri Susanta Ghosh stated that he along with his family members were covered under Policy for the period 14.03.2005 to 13.03.2006. His daughter Ms Ridipta Ghosh was hospitalized in Suraksha Hospital, Kolkata from 27.09.2005 to 28.09.2005 as she suddenly lost her sense, as per advice of Dr. S.S. Chowdhury. Dr. Chowdhury advised for EEG and MRI of brain which were done in the hospital. He submitted a claim for Rs.9,841/- to the insurance company which was repudiated by the TPA of the insurance company on the ground of pre-existing disease and for investigation purpose only. He represented to the insurance company to review the matter which was not considered by the insurance company. Therefore, he approached this forum for redressal of his grievance seeking monetary relief of Rs.9,841/-.

The insurance company in their self-contained note dated 07.05.2008 stated that as per Discharge Certificate of the Hospital the patient had suffered such attacks twice, one at 1 year old and another at 5 years old. Hence they upheld the decision of the TPA.

Decision:

As the complainant did not attend, Hon'ble Ombudsman proposed to deal with the matter on ex-parte basis.

Hon'ble Ombudsman did not agree with the arguments of the representative of the insurance company with regard to non-mentioning of seizure at the age of 1 year and at the age of 5 years as the proposal form did not contain anything concerning with seizure or convulsion. There was also no evidence to show that the patient suffered this seizure due to a disease or ailment in the body because it is proved from the Discharge Summary that the convulsion was studied by conducting tests like MRI and that no diagnosis was made with regard to any disease or ailment. He inferred that similar thing must have happened at the age of 1 and 5 years.

With regard to second condition that the tests were done did not indicate any disease would fall under policy condition 4.10, which he agreed with the argument of the insurance company. Though he did not agree in invoking the policy condition 4.1, but he agreed that policy condition 4.10 was clearly attracted and therefore, he confirmed the decision of repudiation made by the insurance company. Hence the petition was dismissed without any relief to the complainant.

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Kolkata Ombudsman Centre
Case No. 688/11/002/NL/02/2007-08

Shri Dipak Kumar Shome

Vs.

The New India Assurance Company Ltd.

Order Dated : 25.08. 2008

Facts & Submissions :

This petition was in respect of repudiation of a claim on the ground of less than 24 hours hospitalization as per exclusion clause no. 2.3 under Individual Mediclaim policy issued by The New India Assurance Company Ltd.

The petitioner, Shri Dipak Kumar Shome stated that he along with his family members were covered under mediclaim policy no. 512800/48/06/20/ 7001455 for the period from 11.07.2006 to 10.07.2007. He was admitted in Christian Medical College, Vellore for treatment of low back ache and leg pain on 01.06.2007 and released on the same day. He lodged a claim for Rs.13,759/- to the insurance company which was repudiated by the TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd. dated 02.07.2007 on the ground that the treatment could have been taken as an outdoor basis and the hospitalization was for less than 24 hours. He appealed to the insurance company on 06.07.2007 for review of the repudiation decision. The insurance company reviewed the claim on 21.08.2007 and reiterated their earlier decision of repudiation. Therefore, he approached this forum for redressal of his grievance seeking monetary relief of Rs.13,759/-

The insurance company did not send the self-contained.

Decision:

On going through the letter of repudiation and Discharge Summary, it was found that the complainant was having a low back ache and leg pain for 3 years and therefore the tests and reports were done between 28.05.2007 to 31.05.2007, from which it was diagnosed that he was having L4-L5 Interverterbal Disc Prolapse. He was admitted on 01st June 2007 and discharged on the same day. Since the diagnosis needed treatment, he was treated in the operation theatre and as he was able to walk he was discharged.

It was found that this was a very peculiar and singular case where the hospitalization for more than 24 hours could not be made due to factors beyond the control of the hospital authorities. The diagnosis implied that he would have been hospitalized had he gone to any other hospital. Therefore, Hon'ble Ombudsman tented to agree with the arguments of the complainant with regard to the applicability of condition 2.3. Treating this as rarest of rare cases, he proposed to allow the claim of the complainant without invoking the policy condition 2.3. This decision was only applicable to this case as it is a rarest of rare cases and could not be quoted as a precedent.

Under these circumstances, he directed the insurance company to pay the claim.

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Kolkata Ombudsman Centre

Case No. 689/11/003/NL/02/2007-08

Shri Aroop Nath Chatterjee

Vs.

National Insurance Company Ltd.

Order Dated : 25.08. 2008

Facts & Submissions :

This petition was against repudiation of claim on the ground of "Pre-existing" disease under Individual Mediclaim Policy issued by National Insurance Company Limited.

The petitioner, Shri Aroop Nath Chatterjee stated that he along with his family members were covered under Policy for the period 16.12.2006 to 15.12.2007. As per advice of Dr. Atul B. Deokar his son Master Aditya Chatterjee was hospitalized from 27.06.2007 to 30.06.2007 in Dr. Balabhai Nanavati Hospital, Mumbai with fever and convulsion. A claim for Rs.25,083/- was submitted to the insurance company and was repudiated by the insurance company on the ground of pre-existing disease. He appealed to the insurance company with a certificate of the treating doctor which was not considered by the insurance company. In the meantime, he took back the bills for getting reimbursement from his employer. His employer paid Rs.10,000/- . Later, he approached this forum for redressal of his grievance seeking monetary compensation for the balance amount of Rs.15,083/-.

The insurance company did not send the self-contained note.

Decision:

From the evidence available it was found that the youngster was hospitalized from 27.06.2007 to 30.06.2007 at Dr. Balabhai Nanavati Hospital, Mumbai for fever and convulsion, the MRI Scan of Brain was done at the relevant time dated 29.06.2007 did not indicate any abnormality. Obviously there could not have any abnormality when the youngster was one year old. Therefore, presuming that there was a pre-existing disease without proper evidence is not acceptable. The arguments put forward by the insurance authorities were not tenable. Further mere fever and convulsion were not diseases to be mentioned in the proposal form submitted before taking the policy.

Keeping in view the above, Hon'ble Ombudsman held that the decision taken by the insurance authorities with regard to the repudiation of the claim was not correct. Accordingly, he directs the insurance company to pay the claim.

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Kolkata Ombudsman Centre

Case No. 706/11/003/NL/02/2007-08

Shri Ranjit Naskar

Vs.

National Insurance Company Ltd.

Order Dated : 14.08. 2008

Facts & Submissions :

This petition was against repudiation of claim under Individual Mediclaim Policy on the ground that the patient was suffering from back pain for the last 8 years i.e., before inception of the policy.

The petitioner, Shri Ranajit Naskar stated that he along with his wife and son were covered under a mediclaim policy from 15.07.2005 which was renewed up to 14.07.2008. His wife Smt. Saraju Naskar was hospitalized on 25.07.2007 to 30.07.2007 in Apollo Hospital, Chennai. Discectomy L5-S1and bilateral nerve roots decompression done on 26.07.2007. He lodged a claim for Rs.84,152/- to the insurance company which was repudiated by the TPA of the insurance company on the ground of pre-existing disease. He appealed to the insurance company stating that the pain was for 3 months only and not for 4 years. But his appeal was not considered. Therefore, he approached this forum for redressal of his grievance.

The insurance company in their self-contained note dated 03.06.2008 stated that the in the Discharge Summary of Apollo Hospital, Chennai, mentioned that "complaints of pain in back and right lower limb – 4 years, pain insidious onset, progressive, radiating to right lower limb". The insured did not disclose this fact in the proposal form on 15.07.2005 when the policy was first incepted. As the policy was running for 3 years and the disease was for 4 years old the decision of TPA for repudiating the claim was upheld by the insurance company.

Decision:

On going through the documents submitted by the complainant, though this was cured for the time being, but in the proposal form given on 15.07.2005 the insured should have answered question 13 (a) properly as the above impression was clearly with regard to spinal disorder or slip disc. It was clear that there was suppression of material fact in the proposal form.

Under these circumstances Hon'ble Ombudsman was not agreed with the arguments of the complainant and it was held untenable and upheld the decision of repudiation made by the insurance company.

Kolkata Ombudsman Centre

Case No. 707/11/002/NL/02/2007-08

Shri Mehul C. Vasa

Vs.

The New India Assurance Co. Ltd.

Order Dated : 25.08. 2008

Facts & Submissions :

This petition was in respect of repudiation of a claim on the ground of congenital disease as per exclusion clause no. 4.8 under Individual Mediclaim policy.

The petitioner, Shri Mehul C. Vasa stated that he along with his family members were covered under mediclaim policy for the period from 05.08.2006 to 04.08.2007. His son Master Shreyans M. Vasa was hospitalized in Bhagirathi Neotia Woman & child Care Centre from 06.02.2007 to 08.02.2007 for Bilateral Undescended Testis. Surgery was done under General Anesthesia. He lodged a claim for Rs.21,083/- to the insurance company which was repudiated by the TPA of the insurance company on the ground of exclusion clause no. 4.8 as the patient suffered from congenital external disease. He appealed to the insurance company stating that as per the attending doctor the disease was not from the birth. So the claim should be paid. His appeal was not considered and therefore, he approached this forum for redressal of his grievance seeking monetary compensation of Rs.21,083/-.

The insurance company did not send the self-contained note.

Decision:

This office did not agree with the opinion of the panel doctor that this particular condition was external congenital defect and therefore Hon'ble Ombudsman directed the insurance company to appoint a specialist doctor outside their panel and specialist in this particular discipline and allow an opportunity to be given to the complainant to defend his case before the doctor and obtain an opinion with regard to the congenital nature of the defect – whether external or internal. It might be informed here that if this specialist doctor opined that the defect was external congenital the insurance authorities were correct in repudiating the claim. However, if the specialist doctor opined that the defect was internal in nature, Hon'ble Ombudsman directed the insurance company to review their decision of repudiation and take a decision with regard to settlement of the claim.

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Kolkata Ombudsman Centre

Case No. 708/11/005/NL/02/2007-08

Shri Dilip Kumar Senapati

Vs.

The Oriental Insurance Company Ltd.

Order Dated : 21.08. 2008

Facts & Submissions :

This petition was against repudiation of claim under Individual Mediclaim Policy issued by the Oriental Insurance Company Ltd. due to delay in submission of claim documents.

The petitioner, Shri Dilip Kumar Senapati stated that he along with his family members were covered under a mediclaim policy from 28.11.2003 which was renewed up to 27.11.2005. His wife Smt. Sandhya Senapati was hospitalized in Christian Medical College, Vellore for treatment of Coronary Artery Disease from 16.11.2005 to 18.11.2005. Coronary Angiogram and PTCA with stinting was done. He submitted a claim to the insurance company which was repudiated by the TPA of the insurance company on the ground of delay in submission of claim. He represented to the insurance company stating that he already submitted the claim papers through his agent but his appeal was not considered by the insurance company. Therefore, he approached this forum for redressal of his grievance.

The insurance company in their self-contained note dated 11.04.2008 stated that the insured preferred the claim on TPA after more than 7 months on 21.06.2006 when his wife was admitted on 16.11.2005. The TPA also asked for certain clarifications which the complainant did not submit.

Decision:

Hon'ble Ombudsman was of the opinion that the decision not considering the claim due to delay of 7 months seemed to be rather harsh. Therefore, he condoned the delay and directed the insurance company to process the claim after due investigation. The complainant was requested to produce all the required documents for conducting the investigation by the insurance company. After completing the investigation he directed the insurance company to review the decision of repudiation.

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Kolkata Ombudsman Centre

Case No. 711/11/002/NL/03/2007-08

Shri Haradhan Bera

Vs.

The New India Assurance Co. Ltd.

Order Dated : 28.08. 2008

Facts & Submissions :

This petition was against repudiation of claim under Universal Health Insurance Policy issued by The New India Assurance Company Ltd. on the ground of "pre-existing" disease as well as the subject claim fell within 30 days from the inception of the policy.

The petitioner Shri Haradhan Bera stated that he along with his wife and daughter were covered under mediclaim policy for the period 15.09.2006 to 14.09.2007. He was hospitalized in Swasti Nursing Home, Belurmath, Howrah from 17.10.2006 to 23.10.2006 for acute appendicitis and appendectomy was done on 17.10.2006. He submitted a claim for Rs.11,614.48 to the insurance company which was repudiated by the insurance company on 19.01.2007 on the ground that the claim fell within waiting period of 30 days. He represented to the insurance company against such repudiation stating that the disease was not pre-existing. His appeal was not considered favourably and therefore he approached this forum for redressal of his grievance seeking relief of Rs.11,614.48.

The insurance company in their self-contained note dated 26.05.2008 stated that the patient was treated on 15.10.2006 by Dr. Nirmal Kumar Dutta following a pain in his abdomen for last 4 days. The attending doctor detected it as appendix and advised him to take admission in a nursing home. Accordingly the insurance company opined that the disease was contracted within the waiting period of 30 days. The date of commencement of the policy was 15.09.2006 and disease was contracted on 11.10.2006.

Decision:

Hon'ble Ombudsman agreed with the arguments of the complainant. The detection of likely appendicitis problem was only on the 30th day and he was actually operated on 17.10.2006 which was more than 30 days. Appendicitis was not a disease. It was only inflammation of appendix and only in acute cases the

same was operated. In this case the acuteness of appendicitis was detected only on 15.10.2006 which was exactly on 30th day, that too it was sub-acute.

Keeping in view the above facts and giving benefit of doubt of the patient that he had not contracted any appendicitis problem within first 30 days of the policy cover, Hon'ble Ombudsman direct the insurance company to settle the claim as per policy terms and conditions.

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Kolkata Ombudsman Centre
Case No. 718/11/002/NL/03/2007-08

Smt. Lachmidevi Khushalani

Vs.

The New India Assurance Co. Ltd.

Order Dated : 02.09. 2008

Facts & Submissions :

This petition was in respect of repudiation of a claim under individual mediclaim policy.

The petitioner, Smt. Lachmidevi Khushalani stated that she along with her husband was covered by a mediclaim policy with the New India Assurance Company Ltd. from 31.12.2003 which was renewed up to 30.12.2007. She was hospitalized in Ruby General Hospital, Kolkata from 22.06.2007 to 26.06.2007 for her treatment and final diagnosis was acute Pulmonary Oedema Secondary to Mild Rheumatic Mitral Stenosis precipitated by Lower Respiratory Tract Infection. She lodged a claim for Rs.32,073/- to the insurance company which was repudiated by the TPA of the insurance company on the ground of pre-existing symptom as this disease could not develop within 4 years of inception of the policy. She represented to insurance company to review the claim and the TPA upheld their earlier decision of repudiation of the claim. Being aggrieved with the decision of the insurance company she approached this forum.

The insurance company did not send the self-contained note.

Decision :

From the above, it was clear that the insurance company had decided to settle the claim as early as possible. Since the complaint had been satisfactorily redressed, Hon'ble Ombudsman felt that no further intervention was called for.

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Kolkata Ombudsman Centre

Case No. 750/11/003/NL/03/2007-08

Shri Ram Krishna Banerjee

Vs.

National Insurance Company Ltd.

Order Dated : 28.08. 2008

Facts & Submissions :

This petition was against repudiation of claim under Individual Mediclaim Policy issued by National Insurance Company Limited on the ground of "pre-existing" disease as per Exclusion Clause No.4.1.

The petitioner Shri Ram Krishna stated that he along with his wife were covered under mediclaim policy from 03.10.2003 which was renewed up to 20.10.2007 without any break and he was enjoying 15% Cumulative Bonus. He was hospitalized in Divine Nursing Home Pvt. Ltd. from 14.06.2007 to 18.06.2007 for treatment of syncope. He lodged a claim for Rs.18,858/- to the insurance company which was repudiated by the TPA of the insurance company on the ground of pre-existing disease. He represented to the insurance company on 12.12.2007 for review of their decision which was turned down by the insurance company. Aggrieved by the decision of the insurance company he approached this forum for redressal of his grievance seeking monetary compensation of Rs.18,858/- plus applicable interest.

The insurance company in their self-contained note dated 11.07.2008 stated that as per self declaration made by the insured himself he was having hypertension since last five years from the date of declaration i.e., 16.06.2007. The first policy was issued from 21.10.2003. Syncope for which the insured was hospitalized was one of the complications of HTN which was pre-existing. Hence the claim had been repudiated by them.

Decision:

It was clear that the complainant was having the policy since 21.10.2003 and that HTN was only a symptom and there was no opinion of any doctor that syncope was connected with HTN. On the other hand the Discharge Summary indicated that syncope might be due to Vertebra Bacillary Insufficiency. Keeping in view these facts Hon'ble Ombudsman was of the firm opinion that the arguments given by the insurance company for taking the decision of repudiation was not tenable.

Therefore, he held that the decision of repudiation was not correct and hence he directed the insurance company to pay the claim as per policy terms and conditions.

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Kolkata Ombudsman Centre
Case No. 002/11/003/NL/04/2008-09

Smt. Kanta Agarwal

Vs.

National Insurance Company Ltd.

Order Dated : 29.09. 2008

Facts & Submissions :

This petition was against repudiation of claim under Individual Mediclaim Policy issued by National Insurance Company Limited on the ground of "pre-existing" disease Clause as unknown case of DM & HTN since 1989.

The petitioner, Smt. Kanta Agarwal stated that she along with her husband was covered under mediclaim policy from 1998 which was renewed up to 31.05.2006. In December 2005 her husband, Shri Kamal Kishore Agarwal was hospitalized due to Pneumonia and she lodged a claim to the insurance company which was repudiated by the TPA of the insurance company on the ground of pre-existing disease as he was suffering from DM, HTN which was pre-existing. She appealed to the insurance company that he suffered from Pneumonia which was not connected with HTN or DM. Her appeal was not considered favourably and therefore she approached this forum for redressal of her grievance seeking monetary relief of Rs.78,548/-.

The insurance company did not send the self-contained note along with their consent.

Decision:

The insurance company had come to a conclusion that IHD was existed before the inception of the policy due to CABG done in 1989. However, since the proposal forms could not be traced, Hon.ble Ombudsman had to give the benefit of doubt to the complainant and therefore, he held that the claim was exigible.

He directed the insurance company to pay the claim as per the policy terms and conditions.

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Kolkata Ombudsman Centre
Case No. 003/11/003/NL/04/2008-09

Shri Rajiv Agarwal

Vs.

National Insurance Company Ltd.

Order Dated : 22.09. 2008

Facts & Submissions :

This petition was against repudiation of claim under Individual Mediclaim Policy issued by National Insurance Company Limited on the ground that as the treatment given at home which was not payable.

The petitioner, Shri Rajiv Agarwal stated that he along with his family members were covered under policy for the period 01.06.2005 to 31.05.2006. His wife Smt. Shova Agarwal was treated with Chemotherapy at home during the period 22.02.2006 to 01.04.2006 and he submitted a claim for Rs.16,975/- to the insurance company but the same was repudiated by the TPA of the insurance company as the treatment was not taken in a hospital. He represented to the insurance company that due to ill health of his parents her wife was not admitted although earlier she took Chemotherapy from AMRI. His appeal was rejected by the insurance company and therefore she approached this forum for redressal of his grievance seeking relief of Rs.16,975/-.

The insurance company in their self-contained note dated 04.08.2008 stated that Chemotherapy was not taken in the hospital and therefore, the claim had not been considered.

DECISION:

It was clear that the reimbursement of the expenditure did not come under the policy condition 2.3. On reading clause 2.3 it was clear that Chemotherapy was excluded for hospitalization, but it could only be done in a hospital, due to requirement of hospital personnel on OPD basis. Similarly the domiciliary condition clearly stated that the condition of the patient was such that she could not be taken to the hospital and or no beds were available at any hospital and this condition was also not satisfied.

However, conditions described at the time of hearing indicated to some extent the inability of the complainant to take his wife to the hospital. Therefore, to meet the ends of justice Hon'ble Ombudsman proposed to grant an ex-gratia payment, even though, Hon'ble Ombudsman agreed with the decision of the insurance company with regard to the repudiation of the claim. Therefore, he directed the insurance company to pay an ex-gratia amount of Rs.10,000/- (Ten Thousand) which would meet the ends of justice.

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Kolkata Ombudsman Centre

Case No. 004/11//008/NL/04/2008-09

Shri Sandip Kr. Bhattacharya

Vs.

Royal Sundaram Alliance Insurance Co. Ltd.

Order Dated : 29.09. 2008

Facts & Submissions :

This petition was in respect of repudiation a claim on the ground of pre-existing disease under Health Shield Insurance policy issued by Royal Sundaram Alliance Insurance Company Ltd.

The petitioner, Shri Sandip Kumar Bhattacharya stated that he was covered under Health Shield Insurance policy for the period 09.03.2005 which was renewed up to 13.03.2007. Following a heart attack on 16.02.2007 he was admitted in a nursing home on the same day and released on 22.02.2007. He lodged a claim for Rs.28,419/- with the insurance company which was repudiated by them on the ground of pre-existing disease. He represented to the insurance company stating that before the present illness he never suffered any disease, 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.30,000/- (approx).

In the self-contained note dt. 12.9.08 along with their consent the insurance company stated that in their repudiation letter they had also mentioned that during the first year of the operation of the policy the expenses on treatment of any heart, kidney and circulatory disorders were not payable for all insured persons suffering from HTN/Diabetes.

Decision:

Keeping in view the policy conditions, this office found that the insurance company did not have any irrefutable proof with regard to the existence of symptoms or disease itself. The policy was for the period 14.03.2006 to 13.03.2007 and was renewed on 16.03.2007 after 3 days delay. The delay had been condoned according to the representative of the insurance company and the policy had been deemed to be continuous from 14.03.2006 to 13.03.2008, therefore, the claim had occurred after nearly 14 months of policy cover.

In the light of the above, unless the insurance company produced any irrefutable proof of either existence of symptoms like HTN or existence of the disease itself before the inception of the policy, Hon'ble Ombudsman was not able to agree with the reasons given for repudiation of the claim. The reasons given by the insurance company were held to be untenable, therefore, Hon'ble Ombudsman directed the insurance company to pay the claim as per the policy terms and conditions.

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Kolkata Ombudsman Centre

Case No. 015/11/005/NL/04/2008-09

Smt. Aparna Bera

Vs.

The Oriental Insurance Company Ltd.

Order Dated : 23.09. 2008

Facts & Submissions :

This petition was in respect of repudiation of a claim under Individual Mediclaim Insurance Policy issued by The Oriental Insurance Company Ltd. as per exclusion clause 4.3 of the policy.

The petitioner Smt. Aparna Bera stated that she along with her family members was covered under mediclaim policy from 04.12.2001 which was renewed up to 14.12.2007. She was admitted in KKR ENT Hospital and Research Institute, Chennai from 09.04.2007 to 11.04.2007 for Functional Endoscopic Sinus Surgery under general anesthesia and operation was done on 10.04.2007. She lodged a claim for Rs.36,195/- with the insurance company which was repudiated by the TPA of the insurance company under exclusion clause 4.3 stating that the claim related to sinusitis and allied disorder was not admissible for 2 years from first commencement of risk. She represented to the insurance company for a review but her appeal was not considered. Being aggrieved by the decision of the insurance company she approached this forum for redressal of her grievance seeking monetary compensation of Rs.36,195/- plus interest.

The insurance company in their self-contained note stated that the previous policy expired on 11.12.2006 and the policy was renewed from 15.12.2006 and the policy was considered as first year policy as there was a break in policy period and therefore the claim was rejected under exclusion clause No. 4.3. Further it is found that the complainant had a continuously policy from 04.12.2001 to 04.12.2005, after that there was a break of 7 days and the policy was continued on 12.12.2005 to 11.12.2006 and later with a break of 3 days continued from 15.12.2006 to 14.12.2007.

Decision:

As the representative of the insurance company did not attend, the matter was being considered on ex-parte basis. From 04.12.2001 to 14.12.2007 there were only delays twice from 04.12.2005 to 12.12.2005 and 11.12.2006 to 15.12.2006. For the first time it was only 7 days delay and for the second time it was 3 days delay. It would be harsh on the part of the insurance company if such delay was not condoned. It was found from various other insurance companies that generally the delay of 7 days in taking the mediclaim policies was condoned wherever there was a reasonable cause, unless there was an irrefutable proof that the policy holder contracted any disease or had been through a medical or surgical procedure during the period of delay. Hon'ble Ombudsman opined that the delay was due to the negligence of the agent and

therefore, the short delay should not completely take away the benefits that accrued a policy holder if the mediclaim policy was continuous.

Keeping in view the above, Hon'ble Ombudsman condoned the delay between the periods 04.12.2005 to 12.12.2005 and also condoned between 11.12.2005 to 15.12.2005 and treated the mediclaim policies as continuous. It was decided to treat the mediclaim policy as continuous the condition 4.3 (xii) would not survive any more, i.e., the exclusion clause did not apply. He directed the insurance company to pay the claim as per policy terms and conditions

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Kolkata Ombudsman Centre
Case No. 016/11/003/NL/04/2008-09

Shri Ashis Baral

Vs.

National Insurance Company Ltd.

Order Dated : 22.09. 2008

Facts & Submissions :

This petition is against repudiation of claim under Individual Mediclaim Policy issued by National Insurance Company Limited on the ground of "pre-existing" disease under Exclusion Clause No.4.1.

The petitioner, Shri Ashis Baral stated that he along with his wife was covered under mediclaim policy from 14.11.2005 and which was renewed up to 13.11.2007. He was hospitalized in Christian Medical College, Vellore from 18.04.2007 to 11.05.2007 with the complaint of mid back pain for 2 years. He was diagnosed with T7, T8 Intradural Schwannoma. He lodged a claim for Rs.57,807/- to the insurance company which was repudiated by the TPA of the insurance company on the ground of pre-existing disease. He represented to the insurance company against such repudiation stated that earlier 2 years back he had experienced mild back pain on 3 – 4 occasions but when he initially consulted the physician, the physician advised him not to sleep on foam mattress. He was relieved of the pain after following the advice of the doctor. Since January 2007 he was again suffering from this disease and at the time of taking the policy he had no knowledge of any existing illness. His representation was not considered by the insurance company, hence he approached this forum for redressal of his grievance seeking monetary relief of Rs.57,807/-.

The insurance company did not send the self-contained note along with their consent.

Decision:

Hon'ble Ombudsman opined that if the insurance company was able to produce irrefutable proof with regard to existence of a disease before inception of the policy, in that case the only proof was the Discharge Summary in which it was mentioned that the patient was suffering from back pain since 2 years. According to us suffering of pain was only a symptom and therefore, it could not be treated as existence of a disease connected with the back pain. Further the policy was existed for nearly 18 months when the patient was hospitalized. The mention of two years in the Discharge Summary was only an approximation and therefore it could not be concluded that the disease was existing before the inception of the policy.

Hon'ble Ombudsman held that the insurance company was not correct in repudiating the claim. The reasons given by the insurance authority were not tenable. Therefore, he directed the insurance company to pay the claim as per the policy terms and conditions.

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Kolkata Ombudsman Centre

Case No. 030/11/003/NL/04/2008-09

Shri Ajoy Kumar Gupta

Vs.

National Insurance Company Ltd.

Order Dated : 16.09. 2008

Facts & Submissions :

This petition was against repudiation of claim under Individual Mediclaim Policy issued by National Insurance Company Limited on the ground of "pre-existing" disease under Exclusion Clause No.4.1.

The petitioner, Shri Ajoy Kumar Gupta stated that he along with his family members were covered under policy for the period 06.08.2006 to 05.08.2007. He was hospitalized in AMRI from 04.05.2007 to 14.05.2007 for treatment of Trisums, SM swelling, fever & dysphagia. He was diagnosed with Submandibular Sialoadenitis with lithiasis with LN Pathy. He lodged a claim for Rs.49,021/- to the insurance company which was repudiated by the TPA of the insurance company on the ground of pre-existing disease as in the Treatment Summary it was indicated that in 1997 he had a pain (right SM area). He represented to the insurance company to review the matter with the observation of the attending surgeon that the present ailment did not have any relation with previous pain in 1997. But his appeal was rejected by the insurance company. Being aggrieved by the decision of the insurance company he approached this forum for redressal of his grievance seeking relief of Rs.1,98,250/- (Rs.48,250/- claimed amount + Rs. 50,000/- financial loss due to sale of gold ornaments on spot + Rs.1,00,000/- compensation for mental harassment and interest).

The insurance company in their self-contained note dated 11.06.2008 stated that they requested the TPA to review the matter but ultimately agreed with the decision of the TPA that the disease was pre-existing.

Decision:

From the Butterworth's medical dictionary it was clear that mandibular meant horse shoe bone of the lower jaw and submandibular meant below that lower jaw. Sialoadenitis meant infection of saliva glands. Therefore, according to us there was a mere pain below the lower jaw probably due to cold and according to us this was not such a serious matter to be mentioned in the proposal form. Hon'ble Ombudsman did not agree with the arguments of the representatives of the insurance company that there was suppression of material facts with regard to health. According to us the claim was exigible. However, the complainant was informed that this forum did not have powers to reimburse financial loss suffered by him or compensation claimed by him for harassment.

Therefore, he directed the insurance company to settle the claim as per policy terms and conditions.

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Kolkata Ombudsman Centre
Case No. 038/11/002/NL/04/2008-09

Shri Durgadas Sanyal

Vs.

The New India Assurance Company Ltd.

Order Dated : 23.09. 2008

Facts & Submissions :

This petition was against repudiation of claim under Good Health Policy Certificate issued by The New India Assurance Company Ltd. as per exclusion clause 4.2 i.e., the subject claim fell within 30 days from the inception of the policy.

The petitioner, Shri Durgadas Sanyal stated that he along with his family members were covered under policy for the period 01.07.2006 to 30.06.2007. His elder brother's wife Smt. Ranjita Sanyal was hospitalized for ERCP, CBD clearance and Laparoscopic

Cholecystectomy from 15.08.2006 to 20 .08.2006. Earlier she had severe pain in abdomen one month back and was treated conservatively. He lodged a claim to the insurance company which was repudiated by the TPA of the insurance company under exclusion clause 4.2 as the disease was contracted within 30 days from the inception of the policy. He represented to the insurance company stating that the pain suffered by the patient was one month back and was relieved by treatment and she was hospitalized from 15.08.2006 to 20.08.2006 during which period she was operated. Hence she was operated well after one month of the commencement date of the policy. His appeal was not considered by the insurance company and therefore he approached this forum for redressal of his grievance seeking relief of Rs.55,000/-.

The insurance company did not send the self-contained note along with their consent.

Decision:

This office did not understand how a patient would be able to submit a first detection report when there was no such medical procedure before the hospitalization excepting pain in the abdomen which was conservatively treated. Hon'ble Ombudsman did not agree with the reason given by the TPA for repudiating the claim on the strength of non-submission of the report by invoking exclusion clause 4.2. Further, he did not agree that exclusion clause 4.2 applied as there was no irrefutable proof with the insurance company and benefit of doubt certainly favoured the insured.

In the light of above, Hon'ble Ombudsman held that the reasons given by the insurance company to deny the claim were not tenable. Therefore, he directed the insurance company to pay the claim as per policy terms and conditions.

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Kolkata Ombudsman Centre

Case No. 046/11/003/NL/04/2008-09

Shri Rajeev Tewari

Vs.

National Insurance Company Ltd.

Order Dated : 16.09. 2008

Facts & Submissions :

This petition was against repudiation of claim under Individual Mediclaim Policy issued by National Insurance Company Limited on the ground of "pre-existing" disease under Exclusion Clause No.4.1.

The petitioner, Shri Rajeev Tewari stated that he along with his wife was covered under mediclaim policy for 5 years which was renewed up to 05.11.2007. He was hospitalized in City Hospital, New Delhi from 18.11.2006 to 22.11.2006. He was admitted for TURP (Laser PPV done on 20.11.2006). He lodged a claim to the insurance company which was repudiated by the TPA on the ground of pre-existing disease. They stated in their repudiation letter that as per Discharge Summary he was known case of renal allograft recipient, date of TX, June 2000. For the present ailment he was admitted with recurrent UTI cause obstructive uropathy for TURP which was related to TX 2000. Therefore, they repudiated the claim under exclusion clause 4.1. He represented to the insurance company stating that the present operation was "prostate" operation and not related to "Kidney Transplant" but his appeal for review was rejected by the insurance company.

The insurance company in their self-contained note dated 18.06.2008 stated that the date of TX was in June 2000 but the policy was for 5 years. The present hospitalization and treatment was done during the period 18.11.2006 to 22.11.2006. Since the present ailment is due to renal allograft, the claim was repudiated on the ground of pre-existing disease.

Decision:

Keeping in view the above, it was clear that an important medical procedure had not been mentioned in the proposal form and therefore, the insurance company did not have information to correctly underwrite. Hence, Hon'ble Ombudsman held that the insurance company was correct in repudiating the claim.

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Kolkata Ombudsman Centre

Case No. 057/11/004/NL/04/2008-09

Sri Haro Prasad Das

Vs.

United India Insurance Company Ltd

Order Dated : 16.09. 2008

Facts & Submissions :

This petition was against repudiation of claim under Individual Mediclaim Policy issued by United India Insurance Company Ltd. as there was no hospitalization for Root Canal Treatment in this case.

The petitioner, Shri Haro Prasad Das stated that he along with his family members were covered under policy No. 030800/48/05/20/00005105 for the period 17.02.2006 to 16.02.2007. His wife Smt. Esha Das underwent Root Canal Treatment (RCT) on 26.01.2007 under Dr. Jayanta De at Advanced Dental Care & Implant Centre, Kolkata. He lodged a claim for Rs.5,834/- to the insurance company which was repudiated by the TPA of the insurance company M/s Heritage Health Services Pvt. Ltd. on the ground that for the treatment of the disease hospitalization was not done. He represented to the insurance company stating that the Advanced Dental Care & Implant Centre is an outdoor department of Good Hope Nursing Home and submitted a certificate from the nursing home to this effect. But his appeal was not considered favourably. Being aggrieved, the complainant approached this forum for redressal of his grievance.

The insurance company in their self-contained note dated 16.07.2008 stated that she was treated for Root Canal in Advanced Dental Care & Implant Centre. RCT should be taken in a Registered Hospital / Nursing Home under a Registered Medical Practitioner. In this case, receipt of treatment was given by the doctor and not by a hospital. The insured submitted a certificate that Advanced Dental Care and Implant Centre was the outdoor department of Good Hope Nursing Home. Since outdoor treatment was not covered under mediclaim policy, they upheld the decision of the TPA.

Decision:

Hon'ble Ombudsman did not agree with the insurance company with regard to treating Advanced Dental Care and Implant Centre as an outdoor department and not a hospital. He agreed with the representatives of the insurance company that RCT procedure that was done on the patient was for less than 24 hours and that dental treatment other than due to an accident was not allowed under the policy condition. This point was explained to the complainant. Probably the previous claim was allowed when the policy conditions were not changed w.e.f. 01.04.2007

Hon'ble Ombudsman upheld the decision of the insurance company that the repudiation was correctly done. Hence, the petition was dismissed without any relief to the complainant.

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Kolkata Ombudsman Centre
Case No. 065/11/002/NL/04/2008-09

Shri Kishan Kumar Gupta

Vs.

The New India Assurance Co. Ltd.

Order Dated : 25.09. 2008

Facts & Submissions :

This petition is against repudiation of claim under Individual Mediclaim Policy issued by The New India Assurance Company Ltd. on the ground of "pre-existing" disease as well as the subject claim falls within 30 days from the inception of the policy.

The petitioner Shri Kishan Kumar Gupta stated that he along with his wife was covered under mediclaim policy No. 510900/34/07/20/00001276 for the period 15.06.2007 to 14.06.2008. He suffered from a chest pain on 03.07.2007and hospitalized in B.M. Birla heart Research Centre, Kolkata from 04.07.2007 to 11.07.2007. He lodged a claim for Rs.62,433/- with the insurance company which was repudiated by the TPA of the insurance company. under exclusion clause 4.2 i.e., disease contracted within 30 days of a new policy. He appealed to the insurance company for the chest pain was sudden and he never had any such complication or symptoms. But his appeal was not accepted by the insurance company, therefore, he approached this forum for redressal of his grievance seeking monetary compensation of Rs.62,433/-

The insurance company did not send the self-contained note along with their consent.

Decision:

On going through the details given by B.M.Birla Heart Research Centre, it was clear that the patient was admitted to the hospital on emergency basis. There was no history of the patient mentioned in the document. In this case the question of panel doctor giving opinion whether the insured person was in the knowledge of the disease was not necessary, as the insured person was admitted to the hospital on emergency basis. In fact the insured suffered a chest pain on 03.07.2007 and he was admitted in the B.M.Birla Heart Research Centre immediately on 04.07.2007 to 11.07.2007.

Therefore, Hon'ble Ombudsman came to a conclusion that the insured was not in the knowledge of the disease prior to the inception of the policy and exception of policy condition 4.2 squarely applied. Therefore, he directed the insurance company to pay the claim as per the policy terms and conditions.

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Kolkata Ombudsman Centre

Case No. 070/11/003/NL/04/2008-09

Shri Bipad Bhanjan Chakraborty

Vs.

National Insurance Company Ltd.

Order Dated : 16.09. 2008

Facts & Submissions :

This petition was against repudiation of claim under Individual Mediclaim Policy issued by National Insurance Company Limited on the ground of "pre-existing" disease under Exclusion Clause No.4.1.

The petitioner, Shri Bipad Bhanjan Chakraborty stated that he along with his family members were covered under a policy from 01.11.2005 which was renewed up to 31.10.2007. He was hospitalized from 23.08.2007 to 24.08.2007 in Postgraduate Institute of Medical Education & Research, Chandigarh for cataract operation. Cataract was operated on 24.08.2008. He lodged a claim to the insurance company which was rejected by the TPA of the insurance company M/s MD India Health Care Services Pvt. Ltd. on the ground of pre-existing disease. He appealed to the insurance company stating that cataract was detected in April 2007 and ultimately it was operated in August 2007. He referred to policy condition 4.3 in which cataract operation in first year is excluded. Since operation was done in the second year according to him, he should get the payment. His appeal was rejected by the insurance company and therefore he approached this forum for redressal of his grievance seeking monetary relief of Rs.14,500/- .

This office received a self-contained note on 12.09.2008. According to the self-contained note cataract was held to be pre-existing as the problem of dimness of vision was existing since 2 years. Hence by invoking policy condition 4.1 the insurance company repudiated the claim.

Decision:

As the representative of the insurance company did not attend, Hon'ble Ombudsman proposed to deal with the matter on ex-parte basis.

The basis on which repudiation was done was due to mention of two years, in the admission card by the doctor with regard to existence of cataract. The insurance company had correctly repudiated the claim as the cataract was deemed to be existed before the inception of the policy. The mention of two years by the doctor in the admission card is only an approximation. Therefore, keeping in view that the operation was done nearly after 21 months, Hon'ble Ombudsman opined that benefit of doubt should go to the patient

and allow an ex-gratia amount of Rs.10,000/- (Ten Thousand) only which will meet the ends of justice. He directed the insurance company to pay the above ex-gratia amount.

Delay in settlement:

Case No. 357/14/002/NL/09/2007-08

Shri Pijush Sengupta

Vs.

The New India Assurance Company Ltd

Order Dated: 17.04.2008

Facts & Submissions:

This petition is in respect of delay in settlement of a claim under Individual Mediclaim Insurance Policy issued by the New India Assurance Company Ltd.

The petitioner, Shri Pijush Sengupta in his petition dated 03.09.2007 stated that he was covered by a mediclaim policy from 22.04.1992 and renewed his policy with the New India Assurance Company Ltd. up to 21.04.2008 without any break. He was hospitalised in Rabindra Nath Tagore International Institute of Cardiac Sciences (RTIICS) from 16.02.2007 to 20.02.2007 (continued treatment from 21.02.2007 to 29.05.2007 at home). He was admitted with the complaint of respiratory distress and upper abdomen pain and he was diagnosed as a case of Left Ventricular Failure with dilated cardimyopathy and Atrial Fibrillation and treated conservatively by RTIICS. The final claim for Rs.10,072.75 was lodged with the TPA of the Insurance Company, M/s Genins India Ltd. on 04.06.2007. The papers asked for by TPA of the insurance company were sent. But in spite of repeated requests the claim was not settled. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking relief of Rs.10,072.75 plus other expenses is about Rs.500/- approx. plus compensation for unnecessary delay & harassment.

The insurance company had sent a letter dated 15.04.2008 in which they referred to the claim of Rs.31, 789/-. According to them the amount payable out of the above amount would only come to Rs.27,515/-. They also stated that they received the previous policy copy which started from the year 1992.

However, the insurance company did not comment anything about the complaint made to this office with regard to the claim of Rs.10, 072.75 for hospitalisation at Rabindra Nath Tagore International Institute of Cardiac Sciences from 16.02.2007 to 20.02.2007.

Decision:
Since the representative of the insurance company did not attend, this office proposed to deal with the matter on an ex-parte basis.

From the letter dated 15.04.2008 sent by the insurance company, it was found that the claim that was sought to be settled was different from the claim made in the petition filed by the complainant. Probably both the claims were during the policy period 22.04.2006 to 21.04.2007. *This might please be got verified*. However, since the policy was existed from 22.04.1992 question of treating pacemaker implantation for a pre-existing disease could not arise, as the same was implanted somewhere in the year 1993. Therefore, this claim was also exigible provided the same should have been included in the claim that was ought to be settled, as per letter dated 15.04.2008.

Therefore, Hon'ble Ombudsman directed the insurance company to pay the claim, if it was different from the claim mentioned in the letter dated 15.04.2008.

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Kolkata Ombudsman Centre

Case No. 421/14/002/NL/10/2007-08

Shri Kallol Polley

Vs.

The New India Assurance Company Ltd.

Order Dated: 19.05.2008

Facts & Submissions:

This petition was in respect of delay in settlement of a claim under Individual Mediclaim policy issued by the New India Assurance Company Ltd.

The petitioner, Shri Kallol Polley in his petition dated 06.10.2007 stated that he was covered under a mediclaim policy No. 512800/48/05/79275 for the period from 15.01.2006 to 14.01.2007. There was a previous complaint requesting grant of cashless facility with this forum when he was admitted to Kamineni Hospitals, Hyderabad with complaint of intolerable neck and back pain with difficulty in walking for 3 days, and he was denied cashless facility. The cashless facility was denied by the insurance company because admission to the hospital was only for primary investigation and evaluation of suspected disease which attracted exclusion clause 4.10 of the mediclaim policy. Obviously the insurance company could grant the cashless facility only when the ultimate claim was payable for the

policy. By an order dated 07.02.2007, the Hon'ble Insurance Ombudsman held that the complaint was against refusal of grant of cashless facility and not against repudiation of claim and therefore, agreed with the action taken by the insurance company. Subsequently the petitioner lodged a claim for Rs.20,997/- with the insurance company on 21.05.2007 which had not yet been paid. He sent reminders to the insurance company, but he did not get any reply from them. Therefore, he approached this forum for monetary compensation of Rs.20,997/-.

Decision :

Since the representative of the insurance company did not attend, Hon'ble Ombudsman proposed to deal with the matter on ex-parte basis.

The policy condition 4.10 excluded any reimbursement of expenditure on investigations and tests which were not required for diagnosis of any ailment or disease and which could be done on OPD basis.

In this case the investigations and tests have been done to find out the reason for severe back pain and he was admitted to the hospital on 20.03.2006 and was discharged on 22.03.2006 as per the advice of the doctor.

The Discharge Summary clearly stated that the patient was having Cervical Spondylosis, the tests and investigations done were for diagnosing such a disease. Therefore, according to us the condition 4.10 could not be invoked.

Under these circumstances, Hon'ble Ombudsman did not have any other alternative but to hold that the reasons given by the insurance company for taking decision of repudiation of the claim were not tenable. Therefore, he directed the insurance company to settle the claim as per policy terms and conditions and pay the same.

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Kolkata Ombudsman Centre

Case No. 411/14/003/NL/10/2007-08

Shri Alok Prakash Poddar

Vs.

National Insurance Company Ltd

Order Dated: 15.05.2008

Facts & Submissions:

This petition was in respect of delay in settlement of a claim under Individual Mediclaim policy issued by

National Insurance Company Ltd

The petitioner Shri Alok Prakash Poddar in his petition dated 26.09.2007 stated that he was covered under a mediclaim policy No. 101600/48/06/8500005698 from 23.11.2006 to 22.11.2007. He was hospitalised in Belle Vue Clinic from 05.02.2007 to 11.02.2007 for treatment of Decompensated Liver Disease. He lodged a claim for Rs.1,05,181/- on 10.05.2007. He was asked to submit a certificate from the doctor giving a history of alcohol intake. He submitted a certificate from the attending doctor, Dr. B.K.Gupta on 11.06.2007 wherein it was mentioned that he was consuming alcohol twice or thrice in a month since last one year. He did not receive any letter from the TPA of the insurance company but when he enquired he was told that the claim had been repudiated. He represented to the insurance company enclosing a press release showing a Court Order by the Delhi State Consumer Disputes Redressal Commission stating that moderate drinking and a drink at social gathering would not be a reason for repudiation of a claim on the ground of taking alcohol. As he did not get any favourable reply from the insurance company he lodged a complaint to this forum for a monetary compensation of Rs.1,14,957/-.

The insurance company in their self-contained note dated 31.03.2008 stated that the patient was suffering from liver disease and the certificate from the attending doctor that too also confirmed that he used to consume alcohol twice/thrice in a month for last one year. Therefore, the claim was denied under clause no. 4.8 of Standard Mediclaim Policy.

Decision:

The insurance company invoked policy condition 4.8 without getting any irrefutable proof that Decompensated Liver Disease was caused by intake of alcohol. Mere interpretation that alcohol was responsible for the above liver disease could not be a reasonable cause for invoking the policy condition 4.8. From the above discussion in the special facts we found that liver might be functioning well but the secretions of the liver might not be sufficient for digestion of the food intake. In fact the patient was advised to control his food habits keeping in view the fact that there was no clear cut proof that the alcohol intake was responsible for Decompensated Liver Disease. Also due to the fact that there were no columns in the proposal to indicate the habit of taking alcohol, Hon'ble Ombudsman held that the reasons given by the insurance company for invoking policy condition 4.8 were not tenable.

Under these circumstances, he directed the insurance company to settle the claim as per policy terms and conditions and pay the same.

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Kolkata Ombudsman Centre

Case No. 374/14/004/NL/09/2007-08

Shri Gopal Mohan Banerjee

Vs.

United India Insurance Co. Ltd.

Order Dated: 07.04.2008

Facts & Submissions:

This petition was in respect of delay in settlement of a claim under Floater Mediclaim policy issued to United Bank of India by the United India Insurance Company Ltd.

The petitioner, Shri Gopal Mohan Banerjee in his petition dated 19.09.2007 stated that he was covered under Policy No. 030200/48/06/87/00001866 for the period 27.09.2006 to 26.09.2007. He was hospitalised for eye operation from the period 13.05.2007 to 15.05.2007 at N.B.M Eye Hospital, Garia, Kolkata. He lodged a claim for Rs.5,210.79 on 25.06.2007 with requisite vouchers and papers but did not receive any reply from the insurance company. He represented twice to the insurance company on 20.02.2007 and 09.05.2007 but without getting any reply from them and being aggrieved, the complainant approached this forum for redressal of his grievance seeking relief of Rs.5,210.79 plus interest Rs.1,500/-.

The insurance company had provided a self-contained note on the date of hearing i.e., 04.04.2008. According to them the policy had been cancelled w.e.f. 01.04.2007 at the request of the insured i.e., United Bank of India due to non-fulfillment of the agreed terms and conditions. In short, the complainant was the beneficiary of a Group Insurance policy. The claim occurred on 13.05.2007 after the cancellation of the Group Insurance Policy and according to that self-contained note refund of premium cheque was originally refused by the claimant but later accepted by him. The cheque amount was received by the complainant on 22.02.2008 as per the bank statement.

Decision :

As there was no cover at the time of occurrence of the claim, Hon'ble Insurance Ombudsman did not get the jurisdiction under the Redressal of Public Grievances Rules, 1998. Therefore, this office did not have any other alternative but to

dismiss the complaint without any relief to the complainant. Further the insurance company was advised to write an apology letter to the complainant for not replying to his correspondence.

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Kolkata Ombudsman Centre

Case No. 443/14/003/NL/10/2007-08

Shri Debudatt Khetawat

Vs.

National Insurance Company Ltd

Order Dated: 15.05.2008

Facts & Submissions:

This petition was in respect of delay in settlement of a claim under Individual Mediclaim policy issued by National Insurance Company Ltd.

The petitioner Shri Debudatt Khetawat in his petition dated 15.10.2007 stated that he was covered along with his family members under a mediclaim policy No. 101600/48/06/8500001140 from 10.05.2006 to 09.05.2007. His wife Smt. Krishna Khetawat was hospitalised from 22.11.2006 to 27.11.2006 in Belle Vue Clinic for Pelvic Floor Repair. He lodged a claim for Rs.29,571.56 on 25.04.2007, but the TPA of the insurance company M/s TTK Healthcare Services Pvt. Ltd. wanted a doctor's certificate which was sent to them but the claim was not paid. He had heard that his claim had been repudiated but he did not receive any repudiation letter from insurance company. He waited for 6 months and approached this forum for monetary compensation of Rs.32,529.56 i.e. Rs.29,571.56 claimed amount + Rs.2,958/- interest..

The insurance company in their self-contained note dated 31.03.2008 stated that the attending doctor Dr. Sudip Chakraborty mentioned in the certificate dated 25.05.2007 that the patient first consulted regarding the problem in August 2006 and she noted the problem about a month before. Moreover, the medical certificate filled in by the treating doctor, Dr. Sudip Chakraborty revealed that the patient was diagnosed as having Cystocele and Rectocele and was suffering from the said complaints from June 2006 i.e., after one month from the date of inception of the policy. As per TTK the problem for which she was operated could not have been developed in a short span of one month hence they repudiated the claim as pre-existing disease.

Decision:

The TPA of the insurance company came to a conclusion that Cystocle and Rectocele could not have developed within one month after the inception of the policy without concrete evidence. Hon'ble Ombudsman was unable to agree with the reasons given by the insurance company and held them as not tenable for taking a decision of repudiation. According to him they did not establish with irrefutable proof that disease, ailment or injury were existing before the inception of the policy.

Under these circumstances Hon'ble Ombudsman directed the insurance company to settle the claim as per policy terms and conditions. However, no interest was exigible as the insurance company took a decision of repudiation on the available material in their possession.

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Kolkata Ombudsman Centre

Case No. 453/14/003/NL/10/2007-08

Shri Sumanu Banerjee

Vs.

National Insurance Company Ltd

Order Dated: 22.05.2008

Facts & Submissions:

This petition was in respect of delay in settlement of a claim under "Shopkeepers"

Insurance Policy issued by the National Insurance Company Ltd.

The petitioner Shri Sumanu Banerjee in his petition dated 29.10.2007 stated that he took a "Shopkeepers" insurance policy for the period 25.07.2006 to 24.07.2007. He lost Rs.9,650/- along with his mobile phone while going to purchase medicine on 06.10.2006. He claimed an amount under section 3 (A) (money in transit cover). The matter was reported to Uttarpara Police Station under General Diary entry no.277 dated 06.10.2006. The insurance company asked for final police report for processing the claim. The complainant obtained an interim police report and submitted to the insurance company. The report stated that the above mobile phone and cash amount was not yet traced. He represented to the insurance company but he did not get any favourable reply. Therefore, he approached this forum for monetary compensation of Rs.9,650/- with interest for delay in settlement of the claim.

The insurance company in their letter dated 05.03.2008 addressed to the complainant asked for final police report (Certified from Local Court).

Decision:

It was felt that in a case where the loss was small, expecting a final police report was not justified. The interim police report was sufficient to settle the claim. The complainant was requested to give an indemnity bond to the insurance company. Keeping in view the above, Hon'ble Ombudsman directed the insurance company to settle the claim as per policy terms and conditions and pay the same after obtaining the indemnity bond from the complainant. However, no interest was exigible.

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Kolkata Ombudsman Centre

Case No. 411/14/003/NL/10/2007-08

Shri Alok Prakash Poddar

Vs.

National Insurance Company Ltd

Order Dated: 15.05.2008

Facts & Submissions:

This petition was in respect of delay in settlement of a claim under Individual Mediclaim policy issued by National Insurance Company Ltd

The petitioner Shri Alok Prakash Poddar in his petition dated 26.09.2007 stated that he was covered under a mediclaim policy No. 101600/48/06/8500005698 from 23.11.2006 to 22.11.2007. He was hospitalised in Belle Vue Clinic from 05.02.2007 to 11.02.2007 for treatment of Decompensated Liver Disease. He lodged a claim for Rs.1,05,181/- on 10.05.2007. He was asked to submit a certificate from the doctor giving a history of alcohol intake. He submitted a certificate from the attending doctor, Dr. B.K.Gupta on 11.06.2007 wherein it was mentioned that he was consuming alcohol twice or thrice in a month since last one year. He did not receive any letter from the TPA of the insurance company but when he enquired he was told that the claim had been repudiated. He represented to the insurance company enclosing a press release showing a Court Order by the Delhi State Consumer Disputes Redressal Commission stating that moderate drinking and a drink at social gathering would not be a reason for repudiation of a claim on the ground of taking alcohol. As he did not get any favourable reply from the insurance company he lodged a complaint to this forum for a monetary compensation of Rs.1,14,957/-.

The insurance company in their self-contained note dated 31.03.2008 stated that the patient was suffering from liver disease and the certificate from the attending

doctor that too also confirmed that he used to consume alcohol twice/thrice in a month for last one year. Therefore, the claim was denied under clause no. 4.8 of Standard Mediclaim Policy.

Decision:

The insurance company invoked policy condition 4.8 without getting any irrefutable proof that Decompensated Liver Disease was caused by intake of alcohol. Mere interpretation that alcohol was responsible for the above liver disease could not be a reasonable cause for invoking the policy condition 4.8. From the above discussion in the special facts we found that liver might be functioning well but the secretions of the liver might not be sufficient for digestion of the food intake. In fact the patient was advised to control his food habits keeping in view the fact that there was no clear cut proof that the alcohol intake was responsible for Decompensated Liver Disease. Also due to the fact that there were no columns in the proposal to indicate the habit of taking alcohol, Hon'ble Ombudsman held that the reasons given by the insurance company for invoking policy condition 4.8 were not tenable.

Under these circumstances, he directed the insurance company to settle the claim as per policy terms and conditions and pay the same.

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Kolkata Ombudsman Centre

Case No. 353/14/003/NL/09/2007-2008

Shri Prasanta Kumar Dey

Vs.

National Insurance Co. Ltd.

Order Dated: 20.05.2008

Facts & Submission

This complaint was filed against delay in settlement of claim under Mediclaim Insurance Policy.

(a)Complainant :

The petitioner, Shri Prasanta Kumar Dey in his petition dt. 31.08.2007 stated that he was having a Mediclaim Policy with National Insurance Co. Ltd., Midnapore Divisional Office since December 2005 (13.12.2005). On 5.8.2006, he got spinal injury and had to consult with local physicians. As per advice of the physician he got admitted at Apollo Hospital, Chennai for better treatment. After completion of treatment, the entire treatment papers were submitted to the TPA of the Insurance Company on 25.11.2006. Since then he followed up the matter with the TPA as well as the Insurance Company for reimbursement by sending number of reminders, but did not yield any result. He even took up the matter with the Head Office of National Insurance Co. Ltd. for settlement of the claim on 25.5.2007. After that he received a letter through his agent asking some clarifications which was also replied to vide his letter dt.25.6.2007. He again received a letter from the Midnapore Divisional Office on 20.7.2007 in reply to his letter dt.17.7.2007 through his agent which was properly complied with on 23.7.2007. Even after one month from the date of submission of his last letter i.e. 23.7.2007, he did not get any response either from the Divisional office or from the Head office of National Insurance Co. Ltd. Being aggrieved, he approached this forum for relief of Rs.75,000/-.

(b) Insurer :

In the self-contained note dt.23.11.2007, the Insurance Company stated that they issued an individual mediclaim policy to cover Shri Prasanta Kumar Dey and his wife Smt. Priya Dey for Sum Insured of Rs.75,000/- and Rs.50,000/- respectively which was subsequently renewed in the next year commencing from 13.12.2006. The complainant got admitted at Appolo Hospitals, Chennai on 19.10.2006 for surgery of Lumber Canal Stenosis and submitted the claim papers to TPA on 27.l11.2006. The insurance company was informed that the complainant had fallen in the bathroom on 5.8.2006 and he was under the treatment of Dr. M. Chakraborty who prescribed him medicines and advised for an X-ray which was not submitted in the claim papers. He again consulted Dr. Chakraborty on 3.9.2006 who advised him for MRI of L/S spine and admission in the hospital for better management. He also changed some medicines which the complainant purchased and waited up to 18.10.2006. Finally he got admitted at Appolo Hospitals, Chennai and he was operated upon for Lumber Canal Stenosis. The Discharge Summary itself revealed that he had a past history of “low back pain” for 6 months. After scrutinizing the papers, TPA, Genins India Ltd asked for some more documents pertaining to low back pain which the complainant complied with on 7.3.2007 denying he did not have such experience. The insurance company also took the opinion of their panel doctor, Dr. K. K. Arora. According to him, it was a clear case of suppression of fact. He also opined that fall in the bathroom was not the prime cause of “low back pain”. Low back pain caused was due to “chronic degenerative disc” and there was no trauma. So, the insurance company asked for past history documents from the complainant to arrive at a decision.

Decision :

This office considered the facts and submissions of the case as well as the materials available on records. In view of the above, it was clear that the insurance company did not take any decision regarding settlement of the claim. This office did not have jurisdiction unless a decision was taken by the insurance company and the same was conveyed to the insured. In this case, the Insurance Company sought for

doctor's advice for conducting MRI and registration certificate from Apollo Hospital. Therefore, Hon'ble Ombudsman suggested that the complainant should comply with those documents, as sought for by the insurance company and at the same time the insurance company was directed to take decision with regard to settlement of the claim after examining the documents that were to be provided by the complainant. The insurance company was directed to complete all the formalities after receiving the required documents and come to a conclusion with regard to the settlement of the claim.

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Kolkata Ombudsman Centre

Case No. 405/14/004/NL/09/2007-08

Shri Rajiv Keshri

Vs.

United India Insurance Co. Ltd.

Order Dated: 08.04.2008

Facts & Submissions:

This petition was in respect of delay in settlement of maternity benefit claim under Group Mediclaim policy issued to M/s Avianca Multicare Society by United India Insurance Company Ltd.

The petitioner, Shri Rajiv Keshri in his petition dated 21.09.2007 stated that he was insured with United India Insurance Company Ltd. under Group Mediclaim policy with M/s Avianca Multicare Society for the period 14.07.2006 to 13.07.2007 for a sum insured of Rs.1 lakh including maternity benefit up to Rs.25,000/-. He preferred a maternity claim in respect of his wife Smt. Priyanka Keshri on 15.02.2007. On 14.08.2007 he received a letter dated 17.07.2007 from M/s Family Health Plan Ltd., the TPA of the insurance company asking for clarification from United India Insurance Company Ltd. that whether to consider this policy as renewal policy or not. The complainant also mentioned that his policy was a renewal policy under Group insurance with all the same benefits including maternity benefit without any break. He went to United India Insurance Company Ltd. but did not get any proper reply. Hence he approached this forum

for monetary compensation of Rs.25,000/- plus 18% interest per annum for late payment and litigation cost of Rs.10,000/- and Rs.5,000/- for mental harassment and agony.

The insurance company stated in their self-contained mentioned that under maternity scheme minimum waiting period should be 9 months from inception of the policy up to date of admission. If admission related to child birth had taken on or after 20.04.2008, the claim will be admissible, otherwise will not be payable as per policy condition.

Further according to the evidence available from the documents submitted to the Ombudsman, it was found that National Insurance Company Ltd. Insured Club Asian Venture Group in which the complainant was a beneficiary member for the period 20.07.2005 to 19.07.2006 and later the beneficiary (complainant) became member of M/s Avianca Multicare Society which was insured with United India Insurance Company Ltd. by an MOU dated 10.07.2006. The certificate issued by the Club Asian Venture Group covered maternity benefit and later it was changed to M/s Avianca Multicare Society as per the certificate maternity benefits were covered but with a rider of waiting period of 9 months.

The insurance company had also given their company's consent for the Insurance Ombudsman to act as a mediator between the complainant and themselves and give his recommendation for the resolution of the complaint.

Decision:

As per the insurance company's argument maternity benefit had to be provided to the new members only after a waiting period of 9 months and accordingly the TPA of the insurance company on the ground of policy condition rejected the claim of complainant's wife as being a fresh entrant to M/s Avianca Multicare Society. However, on going through the certificate issued in the name of United India Insurance Company Ltd., it was found that the previous policy No. 101000/46/03/8500528 had been mentioned and the complainant was of the opinion that mentioning of that member had to communicate continuation of the policy cover. Hon'ble Ombudsman also found that there was no written information given to the beneficiary members of the new society that they would be treated as fresh members and the previous policy continuation would not be allowed. In the absence of such communication the individual beneficiary member was naturally under the impression that the cover granted in the new policy was in continuation of the old policy. The insurance company should take into consideration the policy condition that had not been informed to the beneficiary as vital before repudiation of the claim. The policy condition simply informed that there was a waiting period of 9 months and did not mention whether the previous policy cover continuous to the new policy under a new insurance company.

If one took into consideration the policy condition being applicable to a fresh entrant would permanently bar a person from claiming the maternity benefits for two children if the beneficiary member had continuous policy but changed the membership of the Club and the Club in turn changed the insurance company under an MOU. The changes that took place between the Clubs and the insurance company due to any reason specially due to load of premium and consequent change in policy conditions could not be detrimental to a member beneficiary who relied on them and took insurance cover continuously for 2 to 4 years and plans to claim maternity benefit for two children during the 4 years of insurance cover. This condition on which the insurance company relies goes against all canons of natural justice.

Therefore, Hon'ble Ombudsman was unable to agree with the arguments of the insurance company in support of repudiation of maternity benefit claim. No reasonable beneficiary member would like to forego the existing benefit of maternity cover by changing over to another insurance company. Here in this

case it was clear that the beneficiary member suffered due to lack of communication from the present insurance company.

In view of the above, Hon'ble Ombudsman directed the insurance company to pay the maternity claim as per the sum insured depending on whether it was a normal delivery or a caesarian delivery.

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Kolkata Ombudsman Centre

Case No. 357/14/002/NL/09/2007-08

Shri Pijush Sengupta

Vs.

The New India Assurance Company Ltd

Order Dated: 17.04.2008

Facts & Submissions:

This petition is in respect of delay in settlement of a claim under Individual Mediclaim Insurance Policy issued by the New India Assurance Company Ltd.

The petitioner, Shri Pijush Sengupta in his petition dated 03.09.2007 stated that he was covered by a mediclaim policy from 22.04.1992 and renewed his policy with the New India Assurance Company Ltd. up to 21.04.2008 without any break. He was hospitalised in Rabindra Nath Tagore International Institute of Cardiac Sciences (RTIICS) from 16.02.2007 to 20.02.2007 (continued treatment from 21.02.2007 to 29.05.2007 at home). He was admitted with the complaint of respiratory distress and upper abdomen pain and he was diagnosed as a case of Left Ventricular Failure with dilated cardimyopathy and Atrial Fibrillation and treated conservatively by RTIICS. The final claim for Rs.10,072.75 was lodged with the TPA of the Insurance Company, M/s Genins India Ltd. on 04.06.2007. The

papers asked for by TPA of the insurance company were sent. But in spite of repeated requests the claim was not settled. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking relief of Rs.10,072.75 plus other expenses is about Rs.500/- approx. plus compensation for unnecessary delay & harassment.

The insurance company had sent a letter dated 15.04.2008 in which they referred to the claim of Rs.31, 789/-. According to them the amount payable out of the above amount would only come to Rs.27,515/-. They also stated that they received the previous policy copy which started from the year 1992.

However, the insurance company did not comment anything about the complaint made to this office with regard to the claim of Rs.10, 072.75 for hospitalisation at Rabindra Nath Tagore International Institute of Cardiac Sciences from 16.02.2007 to 20.02.2007.

Decision:

Since the representative of the insurance company did not attend, this office proposed to deal with the matter on an ex-parte basis.

From the letter dated 15.04.2008 sent by the insurance company, it was found that the claim that was sought to be settled was different from the claim made in the petition filed by the complainant. Probably both the claims were during the policy period 22.04.2006 to 21.04.2007. *This might please be got verified*. However, since the policy was existed from 22.04.1992 question of treating pacemaker implantation for a pre-existing disease could not arise, as the same was implanted somewhere in the year 1993. Therefore, this claim was also exigible provided the same should have been included in the claim that was ought to be settled, as per letter dated 15.04.2008.

Therefore, Hon'ble Ombudsman directed the insurance company to pay the claim, if it was different from the claim mentioned in the letter dated 15.04.2008.

Kolkata Ombudsman Centre
Case No. 634/11/003/NL/01/2007-08

Smt. Pampa Chatterjee

Vs.

National Insurance Company Ltd.

Order Dated : 29.07. 2008

Facts & Submissions :

This petition is against repudiation of death claim due to delay in intimation and submission of claim documents and also on the ground that the deceased committed suicide as confirmed in the Police Investigation Report.

The petitioner Smt. Pampa Chatterjee the nominee of the deceased insured stated that her husband Late Arup Kumar Chatterjee was covered under Group JPA policy for the period 31.03.2003 to 30.03.2013 for a sum insured of Rs.4 lakhs. He died in a train accident on 15.08.2006. Thereafter, she lodged a claim with National Insurance Company Ltd. which was repudiated by the insurance company on the ground that the deceased committed suicide by jumping in front of a running train. She appealed to the insurance company for reconsideration of their decision but she did not get any suitable reply from the insurance company and therefore, she approached this forum for redressal of his grievance seeking monetary compensation of Rs.4 lakhs stating that there was no reason for her husband to commit suicide and there was no family problem.

The insurance company in their self-contained note dated 17.06.2008 stated that the insurance company repudiated the claim on the basis of police investigation report confirming that the deceased committed suicide due to family disturbance by jumping in front of running train on 15.08.2006.

Decision:
From the evidence available on records, it was a fact that the deceased committed suicide by jumping in front of a running train and there was no other evidence to show that the death was not due to committing of suicide.

Under these circumstances, Hon'ble Ombudsman upheld the decision of the insurance company in repudiating the claim.

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Kolkata Ombudsman Centre
Case No. 635/14/003/NL/01/2007-08

Shri Satish Kumar Gupta

Vs.

National Insurance Company Ltd.

Order Dated : 22.07. 2008

Facts & Submissions :

This petition was in respect of delay in settlement of a claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd.

The petitioner Shri Satish Kumar Gupta stated that he along with his wife and son were covered under mediclaim policy from 2001 and renewed up to 27.02.2007. His wife Smt. Santa Devi Gupta was hospitalized at Arogya Maternity and Nursing Home from 29.05.2006 to 30.05.2006 for which a claim for Rs.25,797/- was lodged with the insurance company on 27.02.2007 but as the claim amount was not received by him he took up the matter with the insurance company. But in spite of repeated reminders he did not get the cheque and therefore, he approached this forum for a monetary compensation of Rs. 25,797/- with interest.

The insurance company in their self-contained note dated 24.03.2008 stated that they had already handed over to the representative of M/s Family Health Plan Limited of their TPA, a list of 30 cases for payment. The case of Shri Satish Kumar Gupta was also in the list.

Decision:

As the complainant did not attend the hearing, Hon'ble Ombudsman proposed to deal with the matter on ex-parte basis. Since the TPA of the insurance company had promised to send another cheque by their letter dated 18.07.2008, it was felt that no further intervention was called for.

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Kolkata Ombudsman Centre

Case No. 724/14/012/NL/03/2007-08

Shri Somnath Ghosh

Vs.

ICICI Lombard General Insurance Co. Ltd

Order Dated : 29.08. 2008

Facts & Submissions :

This petition was in respect of delay in settlement of a claim under Health Care Insurance Policy issued by ICICI Lombard General Insurance Company Ltd.

The petitioner, Shri Somnath Ghosh stated that he along his family members were covered under Policy for the period 04.10.2005 to 03.10.2006. Shri Ghosh was admitted in CMRI for treatment of abscess ulcerated wound on 07th July 2006 and released on 16th July 2006 and again he was admitted to Apollo Hospital Chennai from 28.07.2006 to 06.08.2006, the disease was diagnosed as Pyoderma Gangrenosum. He submitted two claims for Rs.48,439/- and Rs.40,822/- respectively. In spite of repeated requests the claims were not settled. Hence he approached this forum for redressal of his grievance.

The insurance company did not send their self-contained note along with their consent.

Decision:

As the complaint had been satisfactorily redressed, Hon'ble Ombudsman felt that no further intervention was called for.

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Kolkata Ombudsman Centre

Case No. 054/14/003/NL/04/2008-09

Shri Hirendra Nath Bhunia

Vs.

National Insurance Company Ltd.

Order Dated : 23.09. 2008

Facts & Submissions :

This petition was against delay in settlement of claim under Varistha Mediclaim Policy for Senior Citizens issued by National Insurance Company Limited.

The petitioner Shri Hirendra Nath Bhunia stated that he along with his family member was covered under Varistha Mediclaim policy for the period 02.02.2007 to 01.02.2008. He lodged a claim for Rs.87,298/- with the insurance company on 26.04.2007 for hospitalization of his wife Smt. Papri Bhunia. In spite of several letters and telephone calls the insurance company neither responded nor taken any action in respect of settlement of the claim. Being aggrieved the complainant approached this forum for redressal of his grievance seeking relief of Rs.2.50 lakhs.

The self-contained note dated 19.09.2008 was submitted at the time of hearing on 22.09.2008by the insurance company.

Decision:

The insurance company had stated that they did not have yet decided with regard to the admissibility of the claim and therefore they pleaded that they would make efforts to complete the procedure of deciding about the settlement or repudiation of the claim immediately.

The concerned insurance authorities should apologize for the callous attitude towards various correspondences written by the complainant.

Keeping in view the above discussion, the insurance company was directed to immediately take a decision with regard to settlement or to repudiation of the claim by the Hon'ble Ombudsman.

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Kolkata Ombudsman Centre

Case No. 063/14/003/NL/04/2008-09

Smt. Aparajita Sarkar

Vs.

National Insurance Company Ltd.

Order Dated : 25.09. 2008

Facts & Submissions :

This petition was in respect of delay in settlement of a claim under Mediclaim Insurance Policy issued by National Insurance Company Ltd.

The petitioner, Smt. Aparajita Sarkar stated that her father Shri Mihir Ghosh was covered under a mediclaim policy from 28.02.2003 and renewed up to 27.02.2007. He was hospitalized in Arogya Niketan Private Limited, Uttarpara, Hooghly from 22.12.2005 to 27.12.2005 for treatment of HTN, DM, IHD and Dislipidemia. He submitted a claim to the insurance company which was not paid in spite of repeated requests. Being aggrieved by the delay the complainant approached this forum for redressal of her grievance.

The insurance company in their self-contained note dated 11.09.2008 stated that the claim was repudiated on the pre-existing disease clause. The patient was admitted in Arogya Niketan for treatment of HTN, IHD and Dislipidemia. From the prescription dated 14.12.2005 (not submitted to us) it was found by them that the patient had a previous history of CVA Infraction twice in the year 2001 & 2003.

Decision:

Since the insurance company was able to produce irrefutable proof that the policyholder was having IHD definitely in 2001, Hon'ble Ombudsman came to a conclusion that the patient was having pre-existing disease as the policy was only incepted in 2003.

He upheld the decision of the insurance company in repudiating the same.

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Partial Repudiation of claim

Kolkata Ombudsman Centre

Case No. 414/11/005/NL/10/2007-08

Shri Pijus Mukherjee

Vs.

The Oriental Insurance Company Ltd.

Order Dated: 20.05.2008

Facts & Submissions:

This petition was in respect of partial repudiation of a claim under Individual Mediclaim Insurance Policy issued by the Oriental Insurance Company Ltd.

The petitioner Shri Pijus Mukherjee in his petition dated 20.09.2007 stated that he was covered under a mediclaim policy No.311500/2007/3074/HDH with the Oriental Insurance Company Ltd. for the period 24.10.2005 to 23.10.2006. He was hospitalised in a nursing home on 14.08.2006 to 17.08.2006 for left DCR operation. He lodged a claim for Rs.20,765.50 on 11.10.2006 against which the TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd. paid Rs.13,789/- on 22.12.2006. He also complained that the list of admissible and inadmissible items given on the back of repudiation letter was quite illegible. He represented to the insurance company, subsequently the insurance company's representative told him in February 2007 over phone that another cheque for Rs.4,673/- was ready but he did not receive the cheque. Without finding no other alternative he approached this forum for monetary compensation for Rs.15,000/- including interest etc.

The insurance company in their self-contained note dated 06.03.2008 stated that they took up the matter with the TPA asking them to give reason for their deduction of Rs.4,673/- on 20.11.2007. The

TPA in reply dated 12.02.2008 that actual amount claimed was Rs.16,918/- out of which Rs.1,000/- is inadmissible, therefore the complainant is entitled to a balance amount of Rs.2,126/- i.e., (Rs.15,915/- – Rs.13,789/-). They have requested the TPA to release the amount.

Decision:

As the complainant did not attend the hearing Hon'ble Ombudsman proposed to deal with the matter on ex-parte basis.

The explanation given by the insurance company had been mentioned in the above paragraph and it was presumed that the complainant had received the cheque of Rs.2,126/-. As he did not attend the hearing it was presumed that his grievance had been satisfactorily redressed and that he was not interested in pursuing his complaint. However, no interest was exigible as the insurance company took a decision of repudiation on the available material in their possession. Therefore, Hon'ble Ombudsman found that no further intervention was required and the petition was dismissed.

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Kolkata Ombudsman Centre

Case No. 475/11/003/NL/11/2007-08

Shri Anil Kumar Kapoor

Vs.

National Insurance Company Ltd

Order Dated: 28.05.2008

Facts & Submissions:

This petition was in respect of partial repudiation of a claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd.

The petitioner Shri Anil Kumar Kapoor in his petition dated 08.11.2007 stated that he was covered under a mediclaim policy No. 101100/48/04/8500005491 from 22.02.2005 to 21.02.2006. He was hospitalized from 20.01.2006 to 24.01.2006 in St. Stephen's Hospital, Delhi. He lodged a claim for Rs.17,650/- to the insurance company and the claim was settled for Rs.7,014/-. He sent several reminders and requesting the insurance company to pay the balance amount of Rs.10,636/-, but he did not get any reply from them and therefore he approached this forum for redressal of his grievance seeking relief of Rs.10,636/-.

This office did not appear to have received the self-contained note from the insurance company.

Decision:

The complainant was requested to file all the required documents and after receiving the same the insurance authorities are directed to finalize the balance amount.

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Kolkata Ombudsman Centre

Case No. 368/11/003/NL/09/2007-08

Shri Plaban Sarker

Vs.

National Insurance Company Ltd.

Order Dated: 17.04.2008

Facts & Submissions:

This petition is against partial repudiation of a claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Limited.

The petitioner, Shri Plaban Sarkar in his petition dated 10.09.2007 stated that he was covered under Policy No. 101800/48/05/8500006192 for the period 03.01.2006 to 02.01.2007. He was admitted in St. Mary's Nursing Home (P) Ltd. from 07.10.2006 to 10.10.2006 under Dr. Tapas Chakraborty for treatment of Viral Pyrexia. He lodged a claim for Rs.8,043.49 to the TPA of the insurance company M/s Family Health Plan Limited and the claim was settled for Rs.7,418/- after deducting Rs.600/- for nursing charges. He represented to the insurance company with a certificate obtained from Dr. Tapas Chakraborty stating that private nurse was required to be appointed for his treatment. He did not receive any favourable reply from the insurance company and therefore approached this forum for monetary compensation of Rs.600/- plus travel allowance plus postage plus printing plus type plus telephone and late refund and Xerox total amounting to Rs.1,000/-.

The insurance company did not submit any self-contained note to this effect.

Decision :

The certificate mentioned above given by Dr. Tapas Chakraborty was received by the TPA, M/s Family Health Plan Limited on 17..04.2007 and therefore, it was deemed to have been received within 15 days as per the condition mentioned in the letter enclosing the cheque dated 24.03.2007. Therefore, Hon'ble Ombudsman directed the insurance company to take this certificate into consideration and pay the amount of Rs. 600/- as nursing charges. However, no interest is allowed.

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Kolkata Ombudsman Centre

Case No. 454/11/002/NL/10/2007-08

Shri Kinnar Kumar Chatterjee

Vs.

The New India Assurance Company Ltd.

Order Dated: 22.05.2008

Facts & Submissions:

This petition was in respect of partial repudiation of a claim under Individual Mediclaim policy issued by the New India Assurance Company Ltd.

The petitioner Shri Kinnar Kumar Chatterjee in his petition dated 29.10.2007 stated that he along with his wife and son were covered under a mediclaim policy No. 510300/48/05/82128 for the period from 14.02.2006 to 13.02.2007. His son Indraneel Chatterjee was hospitalized in A.M.R.I on 09.09.2006 for surgery of 4 (four) seriously infected teeth on 09.09.2006. He lodged a claim of Rs.30,712.38 to the insurance company, initially the claim was repudiated by the TPA of the insurance company M/s Heritage Health Services Pvt. Ltd., but ultimately they settled the claim for Rs.29,395/- deducting Rs.1,317.60 against his bill amounting to Rs.30,712.38. He represented to the insurance company for payment of the balance amount but he did not get any favourable reply. He, therefore, approached this forum for monetary compensation of Rs.1,317.60 with 10% interest on full claim amount for nonpayment for 7 months.

The insurance company in their self-contained note dated 15.04.2008 has explained the reasons for deduction. However, they agreed to pay Rs.400/- for X-ray charges.

Decision :

As the representative of the insurance company did not attend, Hon'ble Ombudsman proposed to deal with the matter on ex-parte basis.

The evidence produced by the complainant was satisfactory and therefore, Hon'ble Ombudsman directed the insurance company to pay Rs.1,018/- deducting only Rs.301/- as service charges which had not been disputed by the complainant. However, no interest was exigible, as the insurance company bonafide deducted such amount while paying the original amount of Rs.29,395/-.

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Kolkata Ombudsman Centre

Case No. 368/11/003/NL/09/2007-08

Shri Plaban Sarker

Vs.

National Insurance Company Ltd.

Order Dated: 17.04.2008

Facts & Submissions:

This petition is against partial repudiation of a claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Limited.

The petitioner, Shri Plaban Sarkar in his petition dated 10.09.2007 stated that he was covered under Policy No. 101800/48/05/8500006192 for the period 03.01.2006 to 02.01.2007. He was admitted in St. Mary's Nursing Home (P) Ltd. from 07.10.2006 to 10.10.2006 under Dr. Tapas Chakraborty for treatment of Viral Pyrexia. He lodged a claim for Rs.8,043.49 to the TPA of the insurance company M/s Family Health Plan Limited and the claim was settled for Rs.7,418/- after deducting Rs.600/- for nursing charges. He represented to the insurance company with a certificate obtained from Dr. Tapas Chakraborty stating that private nurse was required to be appointed for his treatment. He did not receive any favourable reply from the insurance company and therefore approached this forum for monetary compensation of Rs.600/- plus travel allowance plus postage plus printing plus type plus telephone and late refund and Xerox total amounting to Rs.1,000/-.

The insurance company did not submit any self-contained note to this effect.

Decision :

The certificate mentioned above given by Dr. Tapas Chakraborty was received by the TPA, M/s Family Health Plan Limited on 17..04.2007 and therefore, it was deemed to have been received within 15 days as per the condition mentioned in the letter enclosing the cheque dated 24.03.2007. Therefore, Hon'ble Ombudsman directed the insurance company to take this certificate into consideration and pay the amount of Rs. 600/- as nursing charges. However, no interest is allowed.

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Kolkata Ombudsman Centre

Case No. 414/11/005/NL/10/2007-08

Shri Pijus Mukherjee

Vs.

The Oriental Insurance Company Ltd.

Order Dated: 20.05.2008

Facts & Submissions:

This petition was in respect of partial repudiation of a claim under Individual Mediclaim Insurance Policy issued by the Oriental Insurance Company Ltd.

The petitioner Shri Pijus Mukherjee in his petition dated 20.09.2007 stated that he was covered under a mediclaim policy No.311500/2007/3074/HDH with the Oriental Insurance Company Ltd. for the period 24.10.2005 to 23.10.2006. He was hospitalised in a nursing home on 14.08.2006 to 17.08.2006 for left DCR operation. He lodged a claim for Rs.20,765.50 on 11.10.2006 against which the TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd. paid Rs.13,789/- on 22.12.2006. He also complained that the list of admissible and inadmissible items given on the back of repudiation letter was quite illegible. He represented to the insurance company, subsequently the insurance company's representative told him in February 2007 over phone that another cheque for Rs.4,673/- was ready but he did not receive the cheque. Without finding no other alternative he approached this forum for monetary compensation for Rs.15,000/- including interest etc.

The insurance company in their self-contained note dated 06.03.2008 stated that they took up the matter with the TPA asking them to give reason for their deduction of Rs.4,673/- on 20.11.2007. The TPA in reply dated 12.02.2008 that

actual amount claimed was Rs.16,918/- out of which Rs.1,000/- is inadmissible, therefore the complainant is entitled to a balance amount of Rs.2,126/- i.e., (Rs.15,915/- – Rs.13,789/-). They have requested the TPA to release the amount.

Decision:

As the complainant did not attend the hearing Hon'ble Ombudsman proposed to deal with the matter on ex-parte basis.

The explanation given by the insurance company had been mentioned in the above paragraph and it was presumed that the complainant had received the cheque of Rs.2,126/-. As he did not attend the hearing it was presumed that his grievance had been satisfactorily redressed and that he was not interested in pursuing his complaint. However, no interest was exigible as the insurance company took a decision of repudiation on the available material in their possession. Therefore, Hon'ble Ombudsman found that no further intervention was required and the petition was dismissed.

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Kolkata Ombudsman Centre

Case No. 598/11/003/NL/01/2007-08

Shri Lalit Kumar Bhansaly

Vs.

National Insurance Company Ltd.

Order Dated : 28.07. 2008

Facts & Submissions :

This petition was in respect of partial repudiation of a claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd.

The petitioner, Shri Lalit Kumar Bhansaly stated that he along with his family members were covered by the above insurance company for the period from 01.03.2006 to 28.02.2007. His son Shri Varun Bhansaly was hospitalized for OBSCQRE GI Bleeding in Moolchand Hospital from 11.10.2006 to 13.10.2006. He submitted a claim for Rs.35,110.84 to the insurance company but the insurance company settled the claim for Rs.29,381/- , disallowing some items.

He represented against the decision of the insurance company with the clarifications but it was not considered and therefore, he approached this forum for a monetary compensation of Rs.5,729.84 plus interest on delayed payment of Rs.3,150/- .

The insurance company did not send their self-contained note along with consent, but in the repudiation decision they have disallowed certain items.

Decision:

Hon'ble Ombudsman agreed with the arguments of the complainant that doctor's fees should be paid as the doctor was not bound to give prescription on every day of his attendance at the residence for checking the patient. Similarly the bill that did not contain the name of the patient should also be admitted if the medicine mentioned therein was the same as the medicine for which the insurance company settled the matter.

Keeping in view of the above, Hon'ble Ombudsman directed the insurance company to pay Rs.4,570/- towards doctor's fees and medicine bills.

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Kolkata Ombudsman Centre

Case No. 609/11/002/NL/01/2007-08

Shri Debi Prasad Pal

Vs.

The New India Assurance Company Ltd.

Order Dated : 24.07. 2008

Facts & Submissions :

This petition was against partial repudiation of claim on the ground of diagnostic tests during hospitalization and pre-hospitalization under Individual Mediclaim Policy issued by the New India Assurance Company Ltd.

The petitioner, Shri Debi Prasad Pal stated that he and his wife Smt. Renuka Pal were covered under a mediclaim policy for the period 06.11.2006 to 05.11.227 for sum insured of Rs.1 lakh plus 20% Cumulative bonus. His wife was admitted at Rabindra Nath Tagore International Institute of Cardiac Sciences (RTIICS) for treatment of chest pain associated with palpitation. As per advice of the doctor an angiography was done and he lodged a claim for Rs.14,191/- to the insurance company which was first rejected but later on representation a part payment for Rs.7,829/- was made by the TPA of the insurance company. Most of the expenses for hospitalization including pre and post hospitalization were paid but the expenses for Cath lab charges with medicine and consumables which constitute the charges for coronary angiogram for which hospitalization was done had not been admitted. By that way he was

deprived of Rs.6, 112/-, he wrote to the insurance company but did not receive any reply from them. Hence, he approached this forum for redressal of his grievance

The insurance company in their self-contained note dated 31.03.2008 stated that they had not been given the breakup of the amount and therefore the same was not allowed. They upheld the decision of the TPA.

Decision:

The representatives of the insurance company were informed that Cath Lab was the place where the angiogram was done and therefore the question of break-up of this expenditure did not arise. They were also told that these expenses had to be reimbursed. Therefore, Hon'ble Ombudsman directed the insurance company to pay the Cath Lab charges of Rs.5,309/- only as agreed by the complainant.

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Mediclaim Miscellaneous

Kolkata Ombudsman Centre

Case No. 394/12/004/NL/09/2007-2008

Shri Ravi Kumar Saraff

Vs.

United India Insurance Co. Ltd.

Order Dated: 29.04.2008

Facts & Submissions:

This complaint was filed against loading of premium under Mediclaim Insurance Policy.

The petitioner, Shri Ravi Kumar Saraff in his petition dt. 15.09.2007 stated that he was having a Mediclaim Policy with United India Insurance Co. Ltd., Divisional Office-IV, Kolkata since 18.2.2005 and got renewed from time to time without any break. He contended that stiff hike in premium was not at par with other insurers,

as a matter of policy decision. He also contended that in the case of Policy No.030400/48/04/20/00003753, the insurance company charged a premium of Rs.7,559/-, whereas in the next year of renewal the premium was hiked to Rs.15,117/- against Policy No. 030400/48/05/20/00004172. Simultaneously, in the next year of renewal the premium was increased to Rs.15.762/- against Policy No. 030400/48/06/12/00004408. As far as premium hike is concerned, the loading of premium from Rs.7,559/- to Rs.15,762/- (i. e. more than Rs.15,000/-) was very abnormal on the part of the insurance company. According to him, this was not fair. Being aggrieved, he approached this forum for relief of Rs.8,000/-each in last two years.

In the self-contained note dt.13.12.2007, the insurance company stated that the insured was already having two claims against policy nos. 030400/48/02/20/00002404 and 030400/48/04/20/00003753 for Rs.84,465/- and Rs.73,577/- respectively. Due to that fact and keeping in view the internal guidelines with regard to loading of premium, the insurance company increased the premium for the next two years. The Insurance Company further stated they followed up the IRDA rules/norms and accordingly imposed 100% loading was imposed on renewal premium considering the adverse claim ratio.

4. **Decision** :

Hon'ble Ombudsman was unable to agree with the views of the representatives of the insurance company at the time of hearing as well as in their self-contained note. Definitely, there were some guidelines for enhancement of premium or loading of premium when there were excessive claims under the policy in a particular year. Therefore, he was of the firm opinion that the insurance company did not have any right to increase the premium unilaterally against an insured person who did not make any claim during the policy period. Under the circumstances, this office held that there was merit in the arguments of the complainant. Therefore, he direct the insurance company to refund the premium that was charged in excess in respect of the persons who had not made any claim for both the mediclaim periods i. e. 18.2.2005 to 17.2.2006 and 20.2.2006 to 19.2.2007 and the petition was accordingly disposed of.