LIFE INSURANCE-MISC. CASES- 1-10-2013 TO 31.3.2014

AHMEDABAD OIO

LIFE INSURANCE Miscellaneous

Case No.AHD-L-029-1314:0023
Mr. Sumer Singh Rajpurohit Vs. LIC of India
Award dated 7th October 2013
Repudiation of Critical rider claim

Complainant lodged a claim of Rs.2,16,498/- for the treatment of Acute Pancreatitis under the critical illness rider policy was repudiated by the Respondent giving reason that the said disease is not under the policy.

The original hospital papers were not available for verification. Policy bond does not indicate that critical illness rider was opted or not, which was printed S.A Rs.2.00 Lacs & DAB S.A Rs.2,50,000/-.

Respondent produced the copy of their internal circular which shows the names of diseases covered under critical illness in which the subject disease is not mentioned so, Respondent's decision is upheld and complaint dismissed.

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Case No.AHD-L-017-1314:0024
Shri C.K. Mendha Vs. Future Generali India Life Insurance Co. Ltd.
Award dated 10th October 2013
Rejection of Cancellation of Policy and Refund of Premium

Complainant's request that he is not capacity to pay yearly premium of Rs.23,000/- for 10 years so compelled to cancel within free look period. But his son was an ex-employee of the Insurer as Financial Planning Associate who was fully aware of the Proposal details & Terms and conditions of the policy. Policy can not cancel issued to Insurer's employees or close relatives of the employees so Respondent rejected his request.

In the result complaint dismissed.

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Case No. AHD-L-026-1314:0054
Shri Dharmendra N. Chavla Vs. Kotak Mahendra Old Mutual Life Ins. Co. Ltd.
Award dated 17th October 2013
Rejection of Cancellation of Policy and Refund of Premium

Complainant requested to cancel his Life Insurance policy due to mis-selling by the Representative of the Respondent which was refused to accept by the Respondent because cancellation request received after free look period i.e. 8 months after issuing the policy document.

On scrutiny of documents of both the parties, the Forum advised the Respondent to cancel the policy by waiving the free look period and refund the premium as per rules as a special case.

In the result complaint succeeds.

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Case No.AHD-L-046-1314:0051
Shri Dharmendra N. Chavla Vs. TATA AIA Life Ins. Co. Ltd.
Award dated 18th October 2013
Rejection of Cancellation of Policy and Refund of Premium

Complainant requested to cancel his Life Insurance policy due to mis-selling by the Representative of the Respondent which was refused to accept by the Respondent because cancellation request received after free look period i.e. 1 year after issuing the policy document.

Complainant stated that he can not pay Rs.60,000/- premium every year for 15 years and S.A is Rs.6,38,000/-. Policy was issued to his minor girl.

On scrutiny of documents of both the parties, the Forum advised the Respondent to cancel the policy by waiving the free look period and refund the premium as per rules as a special case.

In the result complaint succeeds.

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Case No.AHD-L-019-1314:0074
Shri Rajnish D. Ahir Vs. HDFC Standard Life Insurance Co. Ltd.
Award dated 25th October 2013
Rejection of Cancellation of Policies and Refund of Premium

Complainant requested to cancel his two Life Insurance policies due to mis-selling by the Representative of the Respondent which was refused to accept by the Respondent because cancellation request received after free look period i.e. after 4 months of issuing the policy documents.

Complainant stated that he is a clerk in a Municipality and his right leg is polio affected and also having other policies for S.A Rs.10.00 Lacs and annual premium Rs.1 Lac so can not pay Rs.70,000/- premium every year for 7 years.

On scrutiny of documents of both the parties, the Forum advised the Respondent to cancel the policies by waiving the free look period and refund the premium as per rules as a special case.

In the result complaint succeeds.

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Case No.AHD-L-019-1314:0025
Shri Manmohan Johri Vs. HDFC Standard Life Insurance Co. Ltd.
Award dated 25th October 2013
Rejection of Cancellation of Policy and Refund of Premium

Complainant requested to cancel his Life Insurance policy due to mis-selling by the Representative of the Respondent which was refused to accept by the Respondent because cancellation request received after two years and three months which is beyond free look period.

Complainant stated that the Representative of the Respondent wrongly advised this is a Single premium, can be withdrawn at any time after 1 year.

On scrutiny of documents of both the parties, the Forum also denied the complainant's request to cancel the policy.

In the result complaint fails to succeed.

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Case No.AHD-L-033-1314-0075
Smt. Radhaben Patel Vs. Metlife India Insurance Co. Ltd.
Award dated 11th November 2013
Rejection of policy revival

Complainant covered a Smart Gold Plan Policy from 27-09-2008 with a monthly premium of Rs.2000/-. Complainant paid premium up to 27-03-2011 and thereafter on 16th June 2012 sent a cheque for Rs.10,000/- for partial renewal of the policy which was not accepted by the Respondent because at that time the policy was in lapsed condition.

However Respondent returned the cheqe of Rs.10,000/- and policy foreclosed without intimating the insured and refunded the amount as per policy condition No.4.7.

Complainant's request to reinstate the lapsed policy, it should be within two years from the date of last premium due date hence Respondent's decision is upheld and complaint dismissed.

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Case No.AHD-L-021-1314-0080
Mrs. & Mr.Kirtibhai R. Thakkar Vs. ICICI Prudential Life Insurance Co. Ltd.
Award dated 19th Nov. 2013
Refusal of Cancellation request for 5 policies.

Complainant had taken five Guaranteed Saving Insurance Plan Policies from the Respondent on the basis monthly pension plan misguided by the Representatives of the Respondent.

After getting the policies, Complainant requested to cancel all policies and refund the premium paid amounts beyond free look cancellation was refused by the Respondent and advised to change the product name which was not agreeable by the Complainant.

On scrutiny of available documents of both the parties, the Forum directed to cancel the policies and refund the premium paid as a special case.

In the result complaint succeeds.

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Case No.AHD-L-0019-1314-0082
Ms. Ashvini Vyas Vs. HDFC Standard Life Insurance Co. Ltd.
Award dated 20th November 2013
Refusal of Cancellation request for two policies.

Complainant misguided by representative of the Respondent and issued two policies for regular premium mode for 11 years instead of Single premium policy, so complainant requested to cancel the policy and refund of premium paid amount which was rejected by the Respondent stating that cancellation request not received within 30 days from the date of commencement of policy.

On scrutiny of available documents of both the parties, the Forum directed to cancel the policies and refund the premium paid as a special case.

In the result complaint succeeds.

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Case No.AHD-L-019-1314:0076
Shri Ramesh Ratanpara Vs. HDFC Standard Life Insurance Co. Ltd.
Award dated 20th November 2013
Rejection of Cancellation of Policy and Refund of Premium

Complainant requested to cancel his Life Insurance policy due to mis-selling by the Representative of the Respondent which was refused to accept by the Respondent because cancellation request received after five months which is beyond free look period.

Complainant stated that the Proposal Form filled in the name of his father and he is nominee of the policy but policy issued in the name of the Complainant. He is not having a permanent income so he can not pay yearly premium of Rs.97000/- for 10 years.

On scrutiny of available documents of both the parties, the Forum directed to cancel the policy and refund the premium paid as a special case.

In the result complaint succeeds.

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Case No.AHD-L-0019-1314-0088
Mr. Saurabh H. Modi Vs. HDFC Standard Life Insurance Co. Ltd.
Award dated 20th November 2013
Refusal of Cancellation request of policy.

Complainant misguided by representative of the Respondent and issued a Life Insurance policy for regular premium mode for 10 years. Complainant requested to cancel the policy and refund of premium paid amount which was rejected by the Respondent stating that cancellation request not received within 30 days from the date of commencement of policy.

On scrutiny of available documents of both the parties, the Forum directed to cancel the policies and refund the premium paid as a special case.

In the result complaint succeeds.

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Case No.AHD-L-0019-1314-0091
Mr. Dhansukhbhai M. Rangani Vs. HDFC Standard Life Insurance Co. Ltd.
Award dated 21st November 2013
Refusal of Cancellation request for two policies.

Complainant misguided by representative of the Respondent and issued two policies for regular premium mode for 10 years instead of Single premium policy. Since total yearly premium Rs.2.00 Lacs could not pay for 10 years, complainant requested to cancel the policy and refund of premium paid amount which was rejected by the Respondent stating that cancellation request not received within 30 days from the date of commencement of policy.

On scrutiny of available documents of both the parties, the Forum directed to cancel the policies and refund the premium paid as a special case.

In the result complaint succeeds.

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Case No.AHD-L-033-1314-0086
Shri Manilal C. Modi Vs. Metlife India Insurance Co. Ltd.
Award dated 22nd November 2013
Short receipt of Surrender Value

Complainant misguided by representative of the Respondent and issued two policy for annual premium Rs.60,000/-for 3 years thereafter insured can surrender the policy and get additional 12% interest. But after surrendering the policy Complainant received only Rs.1,53,977.83 instead of paid amount of Rs.1,80,000/- + interest comes to Rs.2,26,759/-.

On scrutiny of available documents of both the parties, the Forum came to know that the Respondent sold policy illegally hence directed to pay premium paid amount with interest.

In the result complaint succeeds.

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Case No.AHD-L-029-1314-0092
Shri S.H. Prajapati Vs. Life Insurance Corporation of India
Award dated 22nd November 2013
Non receipt of interest for late payment

Complainant demanded 12% interest for 17 months late receipt of maturity amount of GSLI Scheme. Complainant retired from LIC but failed to produce supporting evidences relating to his savings component.

This is a tailor made Employee-welfare scheme and revised from time to time and the exact calculation of saving portion differ from category to category and not uniform all the time so it is not possible to interfere in the decision of the Respondent.

Thus complaint dismissed.

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Case No. AHD-L-029-1314-0101
Shri Jitendra Ratilal Shah Vs. LIC of India
Award dated 29th November 2013
Non receipt of Annuity amount

Complainant's deceased mother had purchased a Annuity policy price Rs.5.00 Lacs and mode of payment of annuity was yearly.

Death occurred in the month of April, Annuity due in July hence the broken period annuity is not payable as per policy terms and conditions.

On scrutiny of documents of both the parties, the Forum also denied the complainant's request for payment of July to April.

In the result complaint fails to succeed.

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Case No.AHD-L-021-1314-0058
Shri Narendrasinh N. Gohil Vs. ICICI Prudential Life Insurance Co. Ltd.
Award dated 2nd December 2013
Repudiation of Medical expenses under Health Saver Policy

Complainant hospitalized for treatment of Infective Hepatitis with Jaundice and expense incurred for Rs.35,000/- was repudiated by the Respondent on the ground of non-disclosure of material facts. Treatment papers reveals, the complainant was a known case of Diabetes, B.P & Cholesterol prior to inception of policy.

Thus Complaint dismissed.

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Case No.AHD-L-036-1314-0105
Mr. Vasantbhai N. Chauhan Vs. Reliance Life Insurance Co. Ltd.
Award dated 6th December 2013
Refusal of Cancellation request of policy.

Complainant misguided by representative of the Respondent and issued a Life Insurance policy for regular premium mode for 5 years. Complainant requested to cancel the policy and refund of premium paid amount which was rejected by the Respondent stating that cancellation request not received within 15 days from the date of commencement of policy. On scrutiny of available documents of both the parties, the Forum directed to cancel the policies and refund the premium paid as a special case.

In the result complaint succeeds.

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Case No.AHD-L-019-1314-0126
Mrs. Hiral J.Gandhi Vs. HDFC Standard Life Insurance Co. Ltd.
Award dated 27th December 2013
Refusal of Cancellation request and refund of premium paid.

Complainant misguided by representative of the Respondent and issued policy for regular premium mode for 10 years and yearly premium Rs.25,000/-.On receipt of policy document, complainant requested to cancel the policy and refund of premium paid amount with interest which was rejected by the Respondent stating that cancellation request not received within 30 days from the date of commencement of policy.

On scrutiny of available documents of both the parties, the Forum directed to cancel the policies and refund the premium paid as a special case.

In the result complaint succeeds.

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Case No.AHD-L-019-1314-0127
Mr. Sanjay S. Hinduja Vs. HDFC Standard Life Insurance Co. Ltd.
Award dated 27th December 2013
Refusal of Cancellation request and refund of premium.

Complainant misguided by representative of the Respondent and issued policy for regular premium mode for 7 years instead of Single premium policy. Since total yearly premium Rs.1.50 Lacs could not pay for 7 years, complainant requested to cancel the policy and refund of premium paid amount which was rejected by the Respondent stating that cancellation request not received within 30 days from the date of commencement of policy.

On scrutiny of available documents of both the parties, the Forum directed to cancel the policies and refund the premium paid as a special case.

In the result complaint succeeds.

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Case No.AHD-L-019-1314-0066
Mrs. Heenaben M Dave Vs. HDFC Standard Life Insurance Co. Ltd.
Award dated 30th December 2013
Refusal of Cancellation request and refund of premium paid.

Complainant misguided by representative of the Respondent and issued policy for regular premium mode for 10 years and yearly premium Rs.25,000/-.On receipt of policy document, complainant requested to cancel the policy and refund of premium paid amount which was rejected by the Respondent stating that cancellation request not received within a stipulated period.

On scrutiny of available documents of both the parties, the Forum directed to cancel the policies and refund the premium paid as a special case.

In the result complaint succeeds.

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Case No.AHD-L-004-1314-0131
Shri Mohandas D. Balchandani Vs. Aviva Life Insurance Co. Ltd.
Award dated 6th January 2014
Repudiation of Cancellation of Policy & Refund of Total premium

Complainant covered a Life Insurance Policy for S.A Rs.4,75,000/- on regular yearly premium basis Rs.25,000/- incepted in the year of January 2008. There was no complaint about the policy within 15 days from the receipt of policy to the complainant. After 3 years, Respondent foreclosed his policy due to non payment of premium and sent a cheque to the complainant for eligible amount which is not acceptable by the Complainant.

On scrutiny of documents of both the parties, the Forum also denied the complainant's request for full payment of premium paid amount.

In the result complaint fails to succeed.

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Case No.AHD-L-008-1314-0162
Shri Dhansukhbhai V. Paghdal Vs. Bharti Axa Life Insurance Co. Ltd.
Award dated 9th January 2014
Repudiation of Cancellation of policy & Refund of premium

Complainant required a single premium policy against which Respondent issued a regular premium policy and mode of payment was yearly Rs.1,17,215/- for 15 years and period of policy is 30 years.

Complainant requested to the insurer for cancellation after 1 ½ months from the receipt of policy which is not acceptable by the Insurer. As per rules, free look cancellation period is within 15 days from the receipt of policy.

Thus complaint dismissed.

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Case No.AHD-L-021-1314-0164
Mr. Vinodkumar Agarwal Vs. ICICI Prudential Life Insurance Co. Ltd.
Award dated 21st January 2014
Repudiation of Cancellation of policy & refund of premium

Complainant requested to cancel his policy after free look period and refund of premium with interest, was repudiated by the Respondent as his demand is beyond the policy terms and conditions.

Complainant requested to the insurer for cancellation after 3 months from the receipt of policy which is not acceptable by the Insurer. As per rules, free look cancellation period is within 15 days from the receipt of policy.

Thus complaint dismissed.

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Case No.AHD-L-004-1314-0165
Shri Devilal R. Soni Vs. Aviva Life Insurance Co. Ltd.
Award dated 22nd January 2014
Repudiation of full annuity refund against Life Time annuity policy.

Respondent issued a pension plus plan policy in 2007 to the complainant and was matured on 13.3.2012. Maturity amount was Rs.49,035/- and issued a cheque in the name of LIC for annuity pension as per the instruction of the complainant. Thereafter complainant came to know that the annuity amount should be minimum Rs.1.00 Lac and there is no refund of purchase value after the death of the annuitant. However Complainant approached the Respondent again to cancel the old cheque and issue a fresh which was too late.

Hence Respondent repudiated to issue a fresh cheque is upheld and complaint dismissed.

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Case No.AHD-L-009-1314-0170
Shri Bhagwatdan P Gadhwi Vs. Birla Sun Life Insurance Co. Ltd.
Award dated 24th January 2014
Repudiation of cancellation of policy and refund premium

Respondent issued a policy on June 2012 to the complainant on regular premium basis and yearly premium of Rs.8,000/- was to cancel and refund premium paid amount after 13 months from the receipt of policy which was refused by the Respondent.

As per Insurance rules complainant have not approached for cancellation of policy within 15 days from the receipt of policy hence Respondent rejected his request.

Looking to the available documents of both the parties the Forum also denied his request hence complaint dismissed.

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Case No.AHD-L-019-1314-0194
Mr. Vimalbhai Gajjar Vs. HDFC Standard Life Insurance Co. Ltd.
Award dated 27th January 2014
Refusal of Cancellation request and refund of premium paid.

Complainant misguided by representative of the Respondent and issued policy for regular premium mode for 5 years and yearly premium Rs.99,900/-.On receipt of policy document, complainant requested to cancel the policy and refund of premium paid amount which was rejected by the Respondent stating that cancellation request not received within a stipulated period.

On scrutiny of available documents of both the parties, the Forum directed to cancel the policies and refund the premium paid as a special case.

In the result complaint succeeds.

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Case No.AHD-L-009-1314-0207
Shri Jugalkishor N. Sharma Vs. Birla Sun Life Insurance Co. Ltd.
Award dated 31st January 2014
Repudiation of cancellation of policy and refund premium

Complainant misguided by representative of the Respondent and issued policy for regular premium mode for 10 years and yearly premium Rs.50,000/-.On receipt of policy document, complainant requested to cancel the policy and refund of premium paid amount which was rejected by the Respondent stating that cancellation request not received within a stipulated period.

On scrutiny of available documents of both the parties, the Forum directed to cancel the policies and refund the premium paid as a special case.

In the result complaint succeeds.

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CHANDIGARH

CASE NO. FGI/1987/22/13/Mumbai/Mohali
Smt. Tejinder Kaur Vs FGI Life Ins. Co. Ltd.

Order dated 03.01.2014 **Miscellaneous**

Facts: **Smt. Tejinder Kaur was sold an insurance policy bearing number 1027696 for a sum of Rs.13500/- in August 2012. Her application for cancellation on 05.11.2012 due to forged signature on proposal forms was not responded by the company.**

Findings: **The insurer clarified that the policy was issued on the basis of details furnished in the proposal forms and the policy was delivered on time, but she did not opt to return the policy within free look period. In view of a delay, request for cancellation/a refund was declined.**

Decision: **Held that there is deficiency in service on the part of the company. In fact the signature of Smt. Tejinder Kaur prima facia does not tally with the signature on Aadhaar Card submitted by her. Moreover, her request was**

within reasonable time. Accordingly, an award is passed with a direction to the insurance company to refund the premium paid.

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CASE NO. Birla Sun Life/2681/Mumbai/Chandigarh/22/13
In the matter of Sh. Chhajja Singh Vs Birla Sun Life Insurance Co. Ltd.

ORDER DATED 25.11.2013

FACTS: **Sh. Chhajja Singh had filed a complaint about a purchase of policies from Birla Sun Life Insurance Co. Ltd. bearing numbers 5664664,5674428,5541720,5437664,5370445,5357577,5580042 with a false promise and his request for cancellation was not considered by the company.**

FINDINGS: **The insurer clarified that the request for cancellation was beyond free look period and it was not feasible for the company to refund. However keeping in view his age factor and being a customer centric organization, he decided to convert it into single premium with a new date of commencement subject to fulfillment of the requisite requirements. Even then, it was not agreed upon by Shri Chhajja Singh.**

DECION: **Held that Shri Chajja Singh, being an educated person, should have perused the contents of the policy within stipulated free look period. Moreover, he should not have linked home loan with insurance policies. However, keeping in view, his age and an offer of a conversion into single premium policies, the company is directed to convert these policies in to single premium.**

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CASE NO. PNB Met/82/22/14/Bangalore/Patiala
In the matter of Raj Rani Vs PNB Met Life Insurance Company Ltd,

ORDER DATED 18.11.2013

1. **FACTS:** **Smt. Raj Rani had filed a complaint against PNB Met Life Insurance Company Ltd. about a fraudulent sale of a policy for Rs. 30,000 /- bearing numbers 20697182 on 2012-2011 as fixed deposit and her application for a cancellation of policy was denied by the Company.**

2. **FINDINGS:** **The insurer clarified that a policy was issued on the basis of proposal forms given/signed by Smt. Raj Rani after understanding features of the plans. Although, the policy documents were delivered on time but Smt. Raj Rani requested on 28.09.2012 for a cancellation which was beyond free look period.**

DECION: **Held that there appears to be deficiency in service on the part of the company as Smt. Mandeep Kaur had introduced a proposal for insurance to Smt. Raj Rani in the Bank premises as fixed deposit. Later on a policy was issued and the request of Smt. Raj Rani for cancellation of policy was rejected by the company. In fact, Smt. Raj Rani had to suffer a lot being a daily wage tailor owing to misselling and rejection of her cancellation request. Keeping in view this factual position, an award is passed with a direction to the insurance company to cancel the policy since inception and refund of premium received therein.**

CASE NO. CHD-L-013-1314-0413
In the matter of Ashok Dhiman Vs DHLF Pramerica Life Ins. Co. Ltd,

ORDER DATED 05.02.2014

1. **FACTS:** **Shri Ashok Dhiman had filed a complaint against DHLF Pramerica Life Insurance Company Ltd. about a misselling of five policies from January 2012 to June 2012 bearing numbers 117004, 114661, 116419, 155548 and 155551 on false promises. Actually, signatures on the proposal forms were forged by the company and his representation for a cancellation of policies and a refund was rejected by the company. Shri Krishan Chand had filed a complaint against FGI Life Insurance Company Ltd. about a purchase of two policies in Dec., 2010 bearing No. 00729383 & 00729424 for a sum of Rs.14000/- instead of one policy and his application for a cancellation of policy and a refund was declined by the company.**

2. **FINDINGS:** **The insurer clarified that the policies were issued on the basis of proposal forms given/signed by Shri Ashok Dhiman after understanding features of the plans. Although, Shri Ashok Dhiman obtained the policy documents on time, but a request on 07.01.2013 for a cancellation after a period of almost one year was beyond free look period.**

3. **DECION:** **Held that there appears to be deficiency in service on the part of the company as the terms and conditions were not properly conveyed to Shri Ashok Dhiman. However, Shri Ashok Dhiman did not exercise an option for cancellation within stipulated period. Keeping in view this factual position, an award is passed with a direction to the insurance**

company to cancel both the policies and convert it into a new single policy without free look option.

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CASE NO. Tata AIA/CHD-L-046-1314-0087
In the matter of Shri Pardeep Kumar Dhawan Vs Tata AIA Life Ins. Co.

ORDER DATED 05.02.2014

1. **FACTS:** **Shri Pardeep Kumar Dhawan had filed a complaint in this office against the Tata AIA Life Insurance Company about a purchase of a policy bearing number C-110449506 in March 2004 for a sum of Rs.9200/- with an annual Premium wherein he could not pay premium in March 2013 due to office closing and the company terminated his policy.**

2. **FINDINGS:** **The insurer clarified that the critical illness claim was paid and the basic policy coverage was automatically terminated which was communicated to Shri Pardeep Kumar Dhawan vide letter dated 02.09.2008. Moreover, excess premiums after termination had already been refunded to him. However, on account of some system defect notice continued to be sent to policyholder and formally policy could not be terminated.**

3. **DECION:** **Held that there appears to be no deficiency on the part of the company about termination of policy. On the other hand, the company received renewal premiums after the termination of the policy since March 2009. Therefore, keeping in view this factual position/circumstances of the matter, an award is passed with a direction to the insurance company to pay 8% interest on the amount**

of premiums received after termination of the policy from a date of receipt of premium till a date of return of actual refund.

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CASE NO. FGI/2875/22/13/Mumbai/Gurgaon
In the matter of Shri Krishan Chand Vs FGI Life Insurance Company Ltd,

ORDER DATED 24.10.2013

1. **FACTS:** **Shri Krishan Chand had filed a complaint against FGI Life Insurance Company Ltd. about a purchase of two policies in Dec., 2010 bearing No. 00729383 & 00729424 for a sum of Rs.14000/- instead of one policy and his application for a cancellation of policy and a refund was declined by the company.**

2. **FINDINGS:** **The insurer clarified that the policies were issued on the basis of proposal forms given/signed by Shri Rakesh Yadav on 31.12.2010 and the policy documents were delivered in time. Although, he received the papers in time but representation on 10.03.2012 i.e. after one year and 9 months resulted into rejection by the company.**

3. **DECION:** **Held that it is a case of misselling as terms and conditions of the policies were not properly conveyed. Moreover, two policies were issued whereas Shri Rakesh Yadav was keen for one policy. When Shri Krishan Chand called on the branch office Gurgaon, as an Army official, who is posted in Jammu & Kashmir, he was not properly attended/guided. Keeping in view this factual position, an award is passed with a direction to the insurance company to cancel both the policies since inception and a refund of premium paid therein.**

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CASE NO. HDFC/758/Mumbai/Panchkula/22/14
In the matter of Shri Basant Kumar Verma Vs HDFC Life Ins. Co. Ltd,

ORDER DATED 13.12.2013

FACTS: **Shri Basant Kumar Verma had filed a complaint in this office against HDFC Life Insurance Company about a purchase of a policy bearing number 00122610 for a term of 10 years with an annual premium of Rs.10004/- maturing/vesting on 03.02.2013 for a payment of Rs.141223/-wherein surrender value was declined by the Company.**

FINDINGS: **The insurer clarified that as per terms and conditions, the policy holder has the option to surrender the policy before maturity/ vesting date followed by an alternative of annuity payments. On 26.11.2012, Shri Basant Kumar Verma was intimated about the vesting date to exercise the annuity options before the vesting date. However, he did not exercise the options and contacted for the first time on 01.03. 2013 for surrender of the policy, after vesting date which was not entertained by the Company.**

DECION: **Held that Shri Basant Kumar Verma was not conveyed about the terms and conditions. Actually, he was not aware that surrender value can be claimed only before the vesting date only. In this context, the Company might have sent the communication on 26.11.2012 instructing him to exercise the annuity options; it did not address the issues that the surrender value is admissible only if it is claimed before the vesting date. In fact, Shri Basant Kumar Verma, a retired Central Government employee receipt of a pension benefit, wanted to surrender the policy to meet the medical treatment, house construction and other social obligations, failed to file the request because of lack of clarity. In view of this factual position, an award is passed**

with a direction to the insurance company to surrender the policy and release the payment.

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CASE NO. HDFC/384/Mumbai/Chandigarh/22/14
In the matter of Smt. Dnanmeet Kaur Vs HDFC Life Insurance Co. Ltd,

ORDER DATED 13.12.2013

FACTS: **Smt. Dhanmeet Kaur had filed a complaint against HDFC Life Insurance Company about a purchase of a policy bearing number 255948 wherein reduction in term was denied to her.**

FINDINGS: **The insurer clarified that Smt. Dhanmeet Kaur deposited renewal premiums and filed a request for reduction in term from 21 years to 10 years which could not be processed due to inadequate/ incomplete data. In this context, the matter for reduction in term must be made one month prior to the following due date of premium. As application was not at a proper time, the Company did not effect the change in terms. More over Pension Plan is a special plan and requires exercise of options for any type alteration in policy/ surrender option before vesting date and annuity options. In this connection, whenever the branch personnel tried to run an option of reduction in term, the system was not accepting the command and was showing an error.**

DECION: **Held that Smt. Dhanmeet Kaur had contacted the Company for the first time on 06.12.2011for reduction in term, visited the Company's office in Sector 43, Chandigarh and even called on the Legal representative of the Company. More over, her repeated communications failed to achieve desired results.**

Naturally, there is a clear case of unprofessional behavior adopted by the Company. In view of this latest factual position, an award is passed with a direction to the insurance Company to effect reduction in term from 21 years to 13 years as per the advice of Actuarial Department.

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CASE NO. LIC/9/Amritsar/Amritsar/21/14
In the matter of Smt. Rajbans Vs Life Insurance Corporation of India

ORDER DATED 24.03.2014

FACTS: **Smt. Rajbans had filed a complaint against a Health Protection Plus policy no. 473067002 from LIC and deposited three yearly premiums upto 11.08.2012. Owing to health problem, she was hospitalized on 27.06.2012 and underwent a CABG surgery of heart on 02.07.2012 and discharged on 09.07.2012. Consequently, she lodged a claim of Rs. 2 lakhs as Major Surgical Benefit, Rs. 12,000/= as Daily Hospital Cash Benefit and Rs.7,000/= as daily room expenses to LIC of India which was rejected on 30.07.2012.**

FINDINGS: **The insurer clarified that at the time of admission to the hospital; Smt. Rajbans's attendant had disclosed that the patient had a history of DM Type II since last two years prior to taking the policy which was not reflected in the proposal form. Thus, there is suppression of details pertaining to the pre-existing disease which has a bearing to the nature of the claim being made. Naturally, this amounts to suppression of a material fact due to which the claim was not considered by the company.**

DECION: **Held that the patient's attendant's evidence does not conclusively prove that the patient had a pre-existing disease. In this context, in order to establish beyond doubt that there was a pre-existing disease, evidence in**

form of treatment records prior to commencement of policy is relevant and absolutely necessary. In the instant case, in absence of treatment records, the repudiation of the claim by the Corporation is not based on clear and unambiguous evidence. In view of this factual position, the Corporation is directed to settle the claim of Smt. Rajbans as per admissibility.

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CASE NO. CHD-I-36-1314-0006/Mumbai/Panchkula
In the matter of Shri Vinod Kumar Vs Reliance Life Insurance Company Ltd,

ORDER DATED 27.01.2014

FACTS: **Shri Vinod Kumar had filed a complaint against the Reliance Life Insurance Company about a purchase of a policy bearing number 1490071 for a term of 15years with an annual premium of Rs.10,00,000 /- wherein policy was sold by wrong commitments/allurements and his representation for a cancellation and a refund was rejected by the Company.**

FINDINGS: **The insurer clarified that the documents were delivered, but the complainant failed to exercise free look period and representation being beyond free look period was rejected by the Company.**

DECION: **Held that there is a deficiency of service as instead of a fixed deposit, a regular policy was given. Surprisingly, he got policy on 19.06.2010 and wrote for a refund on 23.06.2010. Even then, insurer failed to accede to his representation. Moreover, his financial position was not taken into consideration at the time of sale of the policy. Actually, he could not afford the policy. Award is passed to refund the premium after a cancellation of policy.**

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CASE NO. CHD-L-001-1314-0013/Mumbai/Ludhiana
In the matter of Shri Raghubir Singh Gill Vs Aegon Religare Life InsuranCompany

ORDER DATED 06.01.2014

FACTS: **Shri Raghubir Singh Gill had filed a complaint against the Aegon Religare Life Insurance Company about a purchase of policies bearing numbers 121113678893 and 121113678907 for a term of 17 years with an annual premium of Rs.3, 20,000 /- wherein policies were sold by wrong commitments/allurements and his representation for a cancellation and a refund was rejected by the Company.**

FINDINGS: **The insurer clarified that the documents were delivered, but the complainant failed to exercise free look period and representation being beyond free look period was rejected by the Company.**

DECION: **Held that there is a deficiency of services as policies were not received by the complainant being away from his residence. More over, policies were sold through misrepresentation and false allurements of obtaining bonus payment./ Award is passed to refund the premiums after a cancellation of policies.**

CHENNAI

AWARD No. L 018/2013-14 dated 27/06/2013
Complaint No. IO (CHN) / 21.003.2751 / 2012-13
N.Rajkumar Mehata Vs TATA AIA Life Insurance Co. Ltd.

The complainant, Sri N.Rajkumar Mehata, had taken a Invest Assure Health Policy from TATA AIA Life Insurance Co. Ltd., bearing Policy No. U 044959049 with Date of Commencement as 26.03.2009 covering self, his spouse Smt. R.Madumathi. and his two children. His spouse was covered for Daily Hospital Benefit (DHB)of Rs. 1000/ & Surgical Rider Benefit (SRB) –of Rs. 80000/- She was hospitalized at Apollo Speciality Hospital, Chennai from 18.03.2012 to 30.03.2012 for a surgery. The complainant, Sri.N.Rajkunar Mehata, preferred a claim of Rs. 272268/- (towards the hospital and surgical expenses incurred by him in connection with his wife's treatment) . with the Insurer. The Insurer has rejected the claim on the grounds that Smt. R.Madumathi was on medication for Atypical Lymphatic Filariasis since 19/2/2009 and Hypothyroidism for 5 years which is prior to the date of application for Insurance and these facts were not disclosed in the proposal form submitted at the time of taking the above policy. They have also informed the claimant that claim has been repudiated forfeiting the premium paid there under rescinding the coverage of Smt. R.Mathumathi from the above policy from inception.

A personal hearing of both the parties was held on 27/05/2013.
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In the certificate dated 18.02.2009 issued by Dr. G.Manokaran of Apollo Hospital, it is mentioned that she was suffering from Atypical Lymphatic Filariasis and hypothyroidism and medicines were prescribed. No other details were furnished.. In the discharge summary dated 30.03.2012 issued by Apollo Speciality Hospital, Chennai it is noted that the Surgery was performed on 20.03.2012 for Left Fronto-parietal Craniotomy and total excision of tumors. In the history of illness, it is stated as "a Known case of atypical Filariasis of bilateral upper limb and hypothyroidism". In the Certificate of Medical attendant dated 30.03.2012 completed by Apollo Specialty Hospital, Chennai, in Past medical history, it is recorded as " H/o Atypical Filariasis and hypothyroidism."

The complainant in his letter dated 14.08.2012 while preferring an appeal against the rejection of his claim has stated that he had given the all the relevant documents including health checkup report dated 01.09.2006 to the intermediary at the point of sale.. He refutes the allegation that he has willfully suppressed the material facts regarding health condition of the spouse while submitting the proposal form. The Insurer has neither confirmed nor denied having received the said documents in any of his correspondences or at the time of the hearing.

It is clear that the Insurer has not established, beyond doubt, that the exact health conditions of the spouse of the LA was deliberately suppressed in the proposal, even after the LA had categorically said that he had given the Master checkup details to the representative of the Insurer at the point of sale.. The claim has been called in question after 2 years from the commencement and hence attracts the provisions of Sec 45 of the Insurance Act 1938. . The observations made above leave a scope for providing some ex-gratia relief to the claimant.

The complaint was PARTLY ALLOWED on EX-GRATIA basis for Rs.61,000/- (Rs. Sixty one thousand only) in full and final settlement of the claim.

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Synopsis
AWARD No: IO (CHN) L- 025/ 2013-14 Dt. 15/7/2013
Complaint No. IO (CHN) /24.009.2361 /2012-13
Sri.S.Jayaraman Vs. Bajaj Allianz Life Insurance Company Ltd.

The complainant, Sri. S.Jayaraman, had taken a Invest Plus Premier policy bearing no 0194453491 for a sum assured of Rs.200000/- with date of commencement of risk as 29.01.2011 with semi- annual premium of. 4816/- (which includes premium for accident death benefit Rs.171/- , premium for Waiver of premium rider- Rs.55.20/-, premium for accidental permanent total/partial disability benefit Rs.186/-) for a term of 25 years from Bajaj Allianz Life Insurance Company Ltd. The life assured (the complainant) fell sick due to paralysis and is immobilized. He claimed disability claim under this policy from the Insurer. The Insurer has denied the disability claim informing him that as per medical records submitted by the life assured, disability is not proved due to accidental injury resulting into loss of limbs as per policy definition.

A personal hearing was held on 12/06/2013. The complainant's wife attended the hearing. Both the representative of the complainant and the Insurer presented their versions.

The Insurer has produced the Certificate dated 30.03.2012 issued by Dr. N.V.Subbarayan, Seva Clinic, Salem High Road, Nallampatti, Dharmapuri district as documentary evidence. In the certificate, it is mentioned as follows:- " S.Jayaraman, S/o Sidhan of Bodarankottai , Nallampalli is suffering from partial paralysis of ® upper limb and ® side of face It is alleged to be there for the past six months. He has 40% loss of function in his right upper limbs. He has partial impairment of speech." The life assured has admitted in his letter dated 31.03.2012 addressed to the Insurer that he had "whooping cough" all of a sudden which has led to his disability He has also confirmed the same in his letter dated 25/07/2012 addressed to this Forum.

In the policy document also, it is mentioned that premium of Rs.171/-, Rs.55.20 & Rs.186/- is collected towards accidental death benefit, waiver of premium rider & accidental permanent total/ partial disability benefit respectively.

The disability of the life assured has not arisen due to accident. "Disability" for which the complainant is claiming disability benefit is not covered under the terms and conditions of the policy.

The Insurer's decision to reject the "Accidental permanent total /partial disability benefit" claim of the complainant is fully justified.

The complaint was DISMISSED.

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SYNOPSIS
AWARD No: IO (CHN) L 0 46 / 2013-14 Dated 16/08/2013
Complaint No. IO (CHN)/21.03.2913/2012-13
P.Balasubramanian Vs Coimbatore Division, LIC of India

The complainant, Sri.P.Balasubramanian (Principal Insured) had taken a LIC's Health Plus policy bearing no. 765962433 for a sum assured of Rs.50.000/- years with date of commencement 29/12/2009 from Coimbatore Division of LIC of India. He has also included his wife, Smt.C.Shanthi, as First Insured under the above policy. The policy-holder has opted for Hospital Cash Benefit (HCB) of Rs.250/- and Major Surgical Benefit (MSB) of Rs.50, 000/- . The complainant had submitted the claim for Rs.46293/- on 14/09/2012 for the surgery undergone by his wife. The Insurer had settled Rs.275/- towards HCB and rejected the claim under MSB. TPA has rejected MSB claim informing him that that the benefits are calculated based on the Initial Daily Benefit opted in the proposal form on the life of the beneficiary and the period of hospitalization /type of surgery eligible as per the policy terms and conditions elaborated in the ' Conditions and privileges referred to in the policy document.. The claim was settled for Rs.275/-. On rejection of MSB, the complainant Sri. P.Balasubramanian, appealed to the Insurer. The Insurer has informed the complainant that the surgical operation undergone by Smt. C.Shanthi, (First Insured) does not fall under the category of the list of surgical procedures and the claim was settled as per the terms and conditions of the policy.

A personal hearing of both the parties was held on 12/07/2013.

As per the Discharge Summary dated 21.08.2012 of Kovai Medical Centre and Hospital Ltd.,, Coimbatore, Smt C.Shanthi, First Insured under the above policy was admitted on 19.08.2012 and discharged on 21.08.2012 Under the heading " Major Procedure" it is mentioned as " LAPROSCOPIC EXCISION OF LARGE LEFT CHOCOLATE CYST done on 20.08.2012." In the same Discharge summary, past History of the patient is mentioned as " H/o Laparoscopic excision of ovarian cyst – 2 years back ".

On going through the Policy conditions, it is observed that the above surgical Procedure (viz) "LAPROSCOPIC EXCISION OF LARGE LEFT CHOCOLATE CYST" performed on 20.08.2012,(surgery connected with Reproductive Organ)" is not covered under 49 types of surgeries listed for reimbursement.

In view of the fore-going, it is evident that the complainant is not eligible for Major Surgical Benefit (MSB) claim under the above policy for the above-mentioned surgery. The Insurer's decision to reject Major Surgical Benefit (MSB) claim under the above policy is fully justified.

The complaint was DISMISSED.

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SYNOPSIS

AWARD No: IO (CHN) L 060 / 2013-14 Dated 04/09/2013

Complaint No. IO (CHN)/21.04.2082/2013-14

Sri.G.Rengarajan Vs. Madurai Division , LIC of India

The complainant Sri.G.Rengarajan (Principal Insured) had taken a LIC's Jeevan Arogya policy bearing number 746995524 for a Sum assured of Rs.1,00,000/- with date of commencement as 07/12/2011 from Madurai Division of LIC of India. . The policy-holder has opted for initial daily Hospital Cash Benefit (HCB) of Rs1000/- and Major Surgical Benefit (MSB) of Rs.1,00,000/- . The complainant had submitted the claim for Rs.1,6,9686/- incurred in connection with his hospitalisation during the period 08/08/2012 to 13/08/2012 (Angiogram on 09/08/2012) and during the period 22/08/2012 to 30/08/2012 (CABG surgery on 24/08/2012). The Insurer vide their letter dated 16/02/2013 informed the complainant that that the complainant's claim cannot be considered for admission and payment as per the terms and conditions of the policy for the following reasons:- "Pre-existing illness irrespective of prior medical treatment or advise". The Insurer has denied the claim on the grounds that the Principal Insured has suppressed the details pertaining to the pre-existing diseases in the proposal which has relation to the nature of the claim made .

A personal hearing of both the parties was held on 26/07/2013.

As per the Discharge Summary dated 13/08/2012 issued by G.Kuppuswamy Naidu Memorial Hospital, Coimbatore, against presenting complaints, it is mentioned as " 42 years old male , type 2 diabetes mellitus since 7 years, systemic hypertension, smoker, history of DOE class III for which patient was evaluated outside where ECG changes with Echo…." Against course in the hospital, it is mentioned as " 42 years old gentleman, hypertensive, diabetic, reformed smoker and CAD – old AWMI(NT-2005), was admitted with features of LV dysfunction….. A CABG was advised.". Diagnosis arrived at in the hospital is mentioned as Hypertension, Diabetes Mellitus, CAD- old AWMI, Severe LVD, Mild MR, Triple Vessel Disease (date of aadmission-08/08/2012 , date of discharge-13/08/2012). In the discharge summary dated 30/08/2012 issued by

the same hospital, it is mentioned that Angiogram was done on 09/08/2012 (Triple Vessel disease done). Operative procedure executed is shown as "Off Pump Coronary Artery Bypass X1 Graft(S)". Under risk factors, it is mentioned as " Diabetic Mellitus & Hypertension since 7 years, Ex smoking 1 cigarette per day, no smoking 6 months, alcohol occasionally". (date of admission – 22/08/2012, date of discharge-30/08/2012, date of surgery- 24/08/2012).

Records submitted by the insurer clearly establish the existence of the diseases/ ailments prior to the date of proposal which has relation to the nature of the claim made. The Insurer's decision to reject daily Hospital Cash Benefit (HCB) claim and Major Surgical Benefit (MSB) claim under the above policy is fully justified.

The complaint was DISMISSED.

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SYNOPSIS

AWARD No: IO (CHN) L- 063 / 2013-14 Dated 20/09/2013

Complaint No. IO (CHN) /21.03.2320 / 2013-14

Smt.L.Eswari Vs. Coimbatore Division, LIC of India

The complainant, Smt. L.Eswari, had taken a 20 year Money Back policy(with profits) (with accident benefit) bearing no 762515357 for a sum assured of Rs.25,000/- with date of commencement as 28/03/2000 under quarterly mode with a premium of Rs. 422/- (which includes premium for accident death benefit & premium for extended permanent disability benefit due to accident) from Coimbatore division of LIC of India. The complainant, Smt.L.Eswari, the life assured under the above policy has informed in her complaint that, on 19/08/2010, she fell down while carrying tea leaves on her head and became disabled. She had further stated that she had not lodged complaint with the Police Authorities since she fell down while carrying tea leaves on her head. She claimed Extended permanent disability benefit (EPDB claim) with the Insurer on 20/02/2012 vide Form No. 5279 under the above policy. The Insurer has rejected the claim on the grounds that the disability was partial.

A personal hearing was conducted at Coimbatore on 29/08/2013..

As per the questionnaire dated 29/12/2012 (F.No. 5280) completed by Dr. P.Senthil Kumar, Deepa Hospital , Thirupur, history reported by the husband of the life assured at the time of admission is " history of fall in working place." Final diagnosis arrived at is shown as " Spondylolisthesis L5 S 1." The condition of the patient, then, is mentioned as " The patient cannot do work in standing for long time bending forward and backwards. Sondylolisthesis with nerve compression" The percentage of disability is shown as 45%. As per the Disability Assessment Certificate dated 16/02/2012 issued by Dr. P.Senthil Kumar, Deepa Hospital , Thirupur, percentage of disability assessed is 45%, nature of disability is" Partial permanent". Opinion about disablement for above stated work is given as " Not possible."(Work before accident as stated by the injured is estate coolie worker"). The doctor has mentioned that, on clinical examination, she has difficulty in

walking and climbing stairs. She cannot stand for more than 10 minutes. She cannot bend forward and backwards and she cannot stand from sitting position. She has low back ache. She has difficulty in doing activities of daily living. She has partial permanent disability. In the discharge summary dated 10/01/2011 issued by Deepa Hospital, Thirupur, under the heading" History & Presenting", it is mentioned as " History of old RTA on 19/08/2010 and low back pain. Since then, complaints of to be urinary incontinence. Bowel habits normal." Final diagnosis is mentioned as Lumbar spondylolisthesis L5 S1. (date of admission-03/01/2011 , date of discharge-10/01/2011) . In the Concession Certificate (Escort) dated 19/07/2012 issued by Dr.K.Suresh, Govt. Hospital, Gudalur, the doctor has given his opinion that the life assured requires the assistance of an escort to travel on fairly long distance by bus due to inability. In the medical certificated dated 31/08/2012 issued by Dr.B.Jeya Ganesh Moorthy, Govt. Head Quarters Hospital, Udhagamandalam it is mentioned that the life assured is suffering from left lower limbs monoperesis and she has 50% disability. It is mentioned that she is not fit to do labour work and she can only travel with escort for fairly long distance. In the Identity Card for person with disabilites dated 29/06/2012 issued to the life assured by the Govt. of Tamil Nadu, disability is mentioned as 50% and nature of disability is mentioned as " Left lower limb monoperesis".

"Disability" for which the complainant is claiming extended permanent disability benefit is" Partial Permanent" only and is not covered under the terms and conditions of the policy. The Insurer's decision to reject the" Extended permanent disability benefit" claim under the policy under dispute is fully justified.

The complaint was DISMISSED.

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SYNOPSIS

AWARD No: IO (CHN) L-067 / 2013-14 Dated 30/09/2013
Complaint No. IO (CHN) / 21.01.2423 / 2013-14
Smt.Geetha Sankar Vs. Chennai DO I , LIC of India

The complainant, Smt. Geetha Sankar, had taken a Asha Deep II policy bearing number 714110154 for Sum assured Rs.2,00,000/- for a term of 15 years with date of commencement as 28/08/2004 under yearly mode with a premium of Rs.17124/- from LIC of India , Chennai Divisional Office-I. The life assured had undergone kidney transplantation on 21/04/2011 and claimed "Benefits (B) " envisaged in the policy schedule. Premiums upto the due August 2011 stand paid.(8 yearly premiums paid). The complainant, Smt. Geetha Sankar, life assured under the policy, preferred a claim for the Benefits (B) envisaged in the policy schedule with the Insurer. The Insurer has informed the complainant vide their repudiation letter dated 30/01/2012 that the life assured was suffering from polycystic kidney disease since 1991 and this fact was not disclosed in the proposal . They have added that had this fact been disclosed, their underwriting decision would have been different.

A personal hearing of both the parties was held on 12/09/2013. During the hearing, both the parties to the dispute presented their versions.

The Ultra Sound Report of the patient, Smt. Geetha, dated 21/09/1998 issued by Vijaya Health Centre, Chennai, shows the findings as " Bilateral Polycystic Kidneys." In claim Form AD (KF)-2 (Kidney Failure Claim under Asha Deep policy) dated Nil, it is mentioned that kidney transplantation was done on 21/04/2011. The cause of renal disease is mentioned as "Polycystic Kidney disease. The approximate date on which the life assured became aware of the renal disease or other systemic disease(s) leading to renal failure is given as "1991". The Medical Attendant has also mentioned that he was the Medical Attendant of the life assured since 1991.

In claim Form AD (KF)- 3 (Kidney Failure Claim under Asha Deep policy) dated Nil, it is mentioned that the life assured has undergone kidney transplantation on 21/04/2011. Cause for primary kidney disease is mentioned as "Polycystic Kidney disease" . "Date of Onset" is mentioned as " Not known". In the discharge summary dated 09/05/2011 issued by MIOT Institute of Nephrology, diagnosis arrived at is shown as " Polycystic kidney disease, chronic kidney disease on maintenance Haemodialysis, renal transplantation done on 21/04/2011, Acute Cellular Rejection- resolved". Under the heading" History", it is mentioned as "known case of polycystic kidney disease/ hypertension/chronic kidney disease on maintenance haemodialysis for renal transplantation, husband being the donor."It is also mentioned that the life assured received induction therapy as per protocol .and she had haemodialysis and renal transplantation done on 21/04/2011.D.M.R. of the Insurer has given his opinion that polycystic kidney is directly linked to renal transplantation…….
From the records submitted by the insurer, it is very clear that the life assured was suffering from polycystic kidney disease since 1991 which is prior to the date of proposal. While taking the policy, the life assured has filled "an addendum to the proposal under Asha Deep plan which seeks specific information on renal failure or kidney diseases" for which the life assured answered in the negative. The life assured admitted during the hearing that she was having polycystic kidney since birth. Going by the above, the complainant's letter dated 21/06/2013 claiming that she was having normal health at the time of proposal for the above policy is not tenable.

Para 5 of the policy conditions in the policy document reads as follows" In case the premiums shall not be duly paid or in case any condition herein contained or endorsed hereon shall be contravened or in case, it is found that any untrue or incorrect statement is contained in the proposal / personal statement , declaration and connected documents or any material information is withheld, then and in every such case but subject to the provisions of section 45 of the Insurance Act ,1938, wherever applicable, this policy shall be void and all claims to any benefit in virtue hereof shall cease and determine and all moneys that have been paid in consequence thereof shall belong to the Corporation , excepting always in so far as relief is provided in terms of the privileges herein contained or may be lawfully granted by the Corporation."

The Insurer has made the above policy null and void and has informed the complainant vide their letter dated 30/01/2012 that all moneys paid towards premium may be forfeited to the Corporation as per policy condition. Here, the forfeiture of premiums was not categorical.

The policy has been called in question after 7 years 5 months 2 days from the commencement of the policy thereby attracting Section 45 of the Insurance Act 1938. Eight yearly premiums amounting to Rs.1,36,992/- stand paid under the above policy. Term of the policy is 15 years and premiums were paid for more than half of the policy/premium paying term. Though the repudiation of the claim for kidney transplantation cannot be questioned, the forfeiture of the premium is not fully justified. Further, the clause 10(6) gives some lee way for allowing some relief to be offered to the complainant (viz) the life assured.

The Insurer was directed to pay an ex-gratia of Rs.1,00, 000/- (Rupees one lakh only) in full and final settlement of the claim,

The complaint was partly allowed on Ex-Gratia basis.

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Chennai

SYNOPSIS
AWARD No. IO (CHN) L-068 /2013-14 dated 09/10/2013
Complaint No. IO (CHN) / 25.006.2380 /2013-14
Sri. S. Ramadurai Vs. Birla Sun Life Insurance Company Limited

The complainant, Sri. S.Ramadurai, had taken a BSLI Platinum Premier policy bearing no. 004198143 for sum assured of Rs.7,50,000/- with policy issue date as 23/06/2010 for a term of 10 years with a yearly premium of Rs.1,50,000/- (proposal dated 07/06/2010) and BSLI Saral Wealth GA FAV policy bearing No. 004207302 for sum assured of Rs.5,88,000/- with policy issue date as 28/06/2010 with a yearly premium of Rs.1,09,760/- (Proposal date 24/06/2010) for a term of 20 years from Birla Sun Life Insurance Company Limited.(Policy particulars as furnished by the Insurer in their self-contained note). The policy-holder says that he has not yet received the policy documents under the above policies. The complainant, Sri.S.Ramadurai, has informed the Insurer that he has not received the original policy documents under the above policies. The Insurer vide their letter dated 14/11/2011 had replied to the complainant that they had despatched the original policy documents as per the following details:-

Policy no.	Issue date	Delivery date	Blue Dart POD	Recipient
004198143	23/06/2010	29/06/2010	44053634704	Velu
004207302	28/06/2010	03/07/2010	44053634704	Vel

They had also informed the complainant that they are willing to issue duplicate policies subject to certain requirements being complied with. The Insurer contended in their letter dated 14/11/2011 that_the complainant approached them for cancellation of both the

policies after the free-look period. The complainant being not satisfied with this reply approached the Forum regarding non-receipt of policy documents. The complainant, once again, took up the matter with the Insurer and they in turn, vide e-mail dated 24/06/2013 have informed the complainant that they have already replied to him vide their communications date 14/06/2013 and 20/06/2013 and advised him to, if he chose to pursue the case further, approach this Forum.

A personal hearing of both the parties was held on 12/09/2013. During the hearing, the attention of the representative of the Insurer was drawn to the discrepancy (viz) of both the policy bonds being delivered on two different dates, (viz) 29/06/2010 and 03/07/2010, but through the same POD No.44053634704, he admitted that this is a mistake and assured the Forum that correct details would be furnished. However, till date, the required particulars have not been furnished. He was also advised to submit the relevant correspondence relating the change of address. He then informed the Forum that there was only a minor correction in the name of the town and that no correspondence was made in this respect.

From the correspondence of the complainant, it is observed that, The first complaint lodged with Mumbai Ombudsman through two undated (??) letters were received by them on 09/01/2012.
The paper cutting submitted by the complainant to this Forum was not bearing any date. However, during the hearing, he informed that it was dated 11-04-2011, i.e., well beyond the free-look period.
The complainant sent a letter, again un-dated, to the Insurer, (stated to have been received by the Insurer on 28-02-2011 and submitted by them marked as "Exhibit C") stating that he was contacted by a lady in Birla Sun Life promising full refund of the premium paid. He further stated that he was being contacted during the free-look period and that he did not want to continue with the Insurance company……The above letter refers to only one policy No. 004198143.
In this correspondence he never mentioned about the non-receipt of the policy documents. There is almost a year's gap between the letter to the Insurer and the complaint to the Mumbai Ombudsman.

<u>On the other hand, the Insurer has not :-</u>
Provided a copy of the policies under dispute to this Forum. This compels us to surmise that the policies were not prepared and delivered to the insured.
Submitted to this Forum, the proof of delivery (of the policy bonds), but only submitted a certificate of delivery for only one policy which cannot be taken as proof of delivery.
For the second policy, the certificate of delivery was not submitted.
Finally, it is observed that there are serious lapses on both the sides to the dispute. The Insurer was directed to issue the policy documents under both the policies to the complainant.
The Complaint was ALLOWED.
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SYNOPSIS

AWARD No: IO (CHN) L 076 / 2013-14 dated 30/10/2013
Complaint No. IO (CHN)/21.013.2493/2013-14
Smt. Vidya Veerapandian Vs. Aviva Life Insurance Company India Ltd

The complainant, Smt. Vidya Veerapandian, had taken a Aviva Health Plus policy bearing number NHP 0037522 for Sum assured of Rs.1,50,000/- for a policy term of 10 years(premium paying term-5 years) with date of commencement as 20/02/2012 under Yearly mode with a premium of Rs. 15582/- from Aviva Life Insurance Company India Ltd. The policy-holder has opted for initial daily Hospital Cash Benefit (HCB) General of Rs1750/-, ICU-Rs.3500/- and Surgical cash Benefit (SCB) of Rs.1,50,000/-(maximum annual benefit –Rs. 75,000/-). The policy also covers Accidental death and disability benefit, Sickness-only TPD (STPD) benefit and critical illness rider benefit of Rs. 1,50,000/- each. The complainant has claimed Operation expenses of Rs.75,000/- and room rent of Rs.56,500/- (23 days general room rent benefit and 3 days ICU rent benefit) incurred in connection with her hospitalisation during the period 23/06/2012 to 14/07/2012 (red blood cells transfusion on 04/07/2012, 2 units of packed cells transfused on 11/07/2012 Umbilical Hernia operated). She has also claimed critical illness rider benefit of Rs.1,50,000/-. . The Insurer has rejected the claim and cancelled the policy vide their e-mail dated 04/09/2012 due to non-disclosure of chronic kidney failure for the last 2.5 years.

A personal hearing of parties was held on 24/10/2013. The complainant was represented by her husband. During the hearing, representative of the complainant and the insurer presented their versions.

As per the Discharge Summary dated 06/06/2012 issued by St. Isabel's Hospital, Chennai, final diagnosis arrived at in the hospital is " Hypertension/ Chronic Kidney disease (patient on maintenance hemodialysis./ Dilated Cardiomyopathy/ Right Pleural Effusion(Tapping done).. Under the heading" History of present illness", it is mentioned as " .....known case of HTN.." Under the heading "Surgical history" it is shown as " Laparoscopy- Infertility treatment 15 years ago." In the discharge summary dated 14/07/2012 issued by St.Isabel's Hospital, Chennai, final diagnosis arrived at in the hospital is stated as " Hypertension/ Chronic Kidney disease(on maintenance hemodialysis)/ Umbilical Hernia – operated.." (Date of admission- 23/06/2012, date of discharge- 14/07/2012). Chief complaint is shown as " Patient who is known case of chronic kidney disease(on maintenance hemodialysis) c/o Umbilical swelling since 5 months.."In the history of present illness, it is strated as " .. known case of HT.." Treatment given is shown as " one unit of B Positive Red blood cells transfusion done on 4/7/2012. Two units of packed cells transfused on 11/07/2012. In the Patient Transfer Out Form dated 3/07/2012 issued by St. Isabel's Hospital, Chennai, under the " Special Notes", it is stated as " Patient is on dialysis (326 cycle).." In Claim Investigation Report dated 06/09/2012 completed by Sri Guru Raghavendra Associates, Chennai, it is stated that the life assured has been under treatment for hypertension for 4 years, chronic kidney disease for 4 years and she is on maintenance dialysis for the past 2 years.

The records submitted by the insurer clearly establish the existence of the diseases/ ailments which have relation to the nature of the claim made prior to the date of proposal. The Insurer's decision to reject daily Hospital Cash Benefit (HCB) claim, Surgical Cash Benefit (SCB) claim and Critical Illness Rider Benefit claim under the above policy and cancellation of the policy is fully justified.

The complaint was DISMISSED.
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SYNOPSIS
AWARD No: IO (CHN) L 078 / 2013-14 dated 18/11/2013
Complaint No. IO (CHN)/21.01.2547/2013-14
Sri.R.Dakshinamurthy Vs. LIC of India, Chennai DO I

The complainant, Sri.R.Dakshinamurthy (Principal Insured), had taken a LIC's Jeevan Arogya policy bearing number 705510568 for Sum assured of Rs.1,00,000/- with date of commencement as 13/08/2011 from Chennai Division I of LIC of India. Smt. D.Chandra, wife of the principal insured is also covered under this policy. The policy-holder has opted for initial daily Hospital Cash Benefit (HCB) of Rs1000/- and Major Surgical Benefit (MSB) of Rs.1,00,000/-. Accident benefit rider and term assurance rider are not covered..The complainant had claimed Rs.2,04,000/- incurred by him in connection with his total hip replacement surgery on 13/12/2011. (date of admission- 12/12/2011, date of discharge-17/12/2011) The Insurer has rejected the entire claim.

The complainant, Sri. R.Dakshinamurthy, the Principal Insured, preferred a claim for Rs2,04,000/- towards the expenses incurred by him in connection with his hospitalization during the period 12/12/2011 to 17/12/2011 and surgery under-gone by him on 22/12/2011. He has made a claim for both HCB and MSB under the above policy. The claim was rejected for the reason "Pre-existing illness irrespective of prior medical treatment or advice. The presence of chronic arthritis was not declared in the proposal form which was filled and signed by the complainant at the time of taking the health policy. The present fracture and hip surgery is directly related to this pre-existing condition."

A personal hearing of both the parties was held on 29/10/2013. During the hearing, both the parties to the dispute presented their versions.

In the In-patient Discharge Summary dated 17/12/2011 issued by Sundaram Medical Foundation Dr. Rangarajan Memorial Hospital, Chennai, Diagnosis arrived at in the hospital is shown as " Chronic Arthritis Left Hip due to Avascular Necrosis." Under the heading " Brief Clinical summary ", it is mentioned as " Mr. Dakshinamurthy, 58 years/M, was apparently normal 16 years back. He had a fracture neck of femur left hip in 1996 and was treated by Orif with cancellous screws which was later revised by screw removal and fibular strut grafting 1 year later.. Now c/o pain in the left hip , difficulty in walking and limp increased since last 8 months , c/o inability to squat , sit cross legged…." Under

the heading "Procedure details", it is stated as " Total Hip Replacement done on 13/12/2011."

In the proposal form dated 20/06/2011, the principal insured has answered in the negative for the question no. 10 (7) (x) which reads as follow as:- "Has the life to be insured ever suffered or is suffering from Musculoskeletal diseases e.g. Osteoporosis…, any physical disability or other disorder of the bones, joints, arthritis, gout etc" However, the life assured was medically examined by an authorized medical examiner of the Insurer at the inception of the policy. In his Confidential Report dated 22/06/2011, the medical examiner has replied as follows for the question no. 11:- Is there any evidence of operation, if so state

- **(a) Date of operation → 1996**
- **(b) Nature & cause → l. hip fracture due to accident……**
- **(c) Location , size& condition of scar → L.hip 7 cm. scar**
- **(d) Degree of impairment → Scar healthy.**

The medical examiner has answered question no. 12 in his confidential report as follows:- Is there any evidence of injury due to accident or otherwise

- **(a) date of injury → 1996**
- **(b) nature of injury →L. hip fracture by accident…..**
- **© degree of impairment →No improvement**
- **(e) Duration of unconsciousness, if any→ .No**

In the Deformity Questionnaire dated 22/07/2011 completed by Dr.P.Fakhruddin, Govt. General Hospital, Chennai, the doctor has mentioned that the insured is having normal movements, normal gait, normal walking, and he is able to squat. He has also noted that the affected limb is of normal length. The doctor has also furnished the details of the deformity which has occurred 15 years back.

Based on the above medical records, Zonal Office Underwriting Section of the Insurer has given the decision as follows:- " Accept at ordinary rates under T 903-24 for both Principal insured and beneficiary ."

The Insurer contended that the insured has not disclosed the following details in the proposal form dated 20/06/2011:- " pain in the left hip, difficulty in walking , increase in limp, inability to squat and sit cross legged since last 8 months which is prior 4 months prior to the date of proposal." It is true that the insured has not disclosed these facts in the proposal dated 22/06/2011. However, this material information stands furnished in the confidential Report of the medical examiner dated 22/06/2011 and in the deformity questionnaire dated 22/07/2011 completed by Dr.P.Fakhruddin, Govt. General Hospital, Chennai. The decision to accept the proposal at ordinary rates without any exclusions, clauses, lien etc. was taken by the Insurer only after scrutinizing the above medical records. The Insured has also put his signature in the above medical records in the presence of medical examiners/ doctors. The Insurer's rejection of the claim on the grounds that the insured has not disclosed this material information in the proposal form is not maintainable.

In view of the fore-going, the insurer's rejection of daily Hospital Cash Benefit (HCB) claim and Major Surgical Benefit (MSB) claim under the above policy is not justified.

The representative of Insurer informed the during the hearing that, if the claim is allowed, eligible HCB shall be paid and eligible MSB amount for total hip replacement is 40% of the sum assured.

The complaint was Allowed for the eligible Hospital Cash Benefit (HCB) and eligible Major Surgical Benefit (MSB) as per Policy contract.

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SYNOPSIS
AWARD No: IO (CHN) L 098 / 2013-14 dated 31/01/2014
Complaint No. IO (CHN)/21.003.2777/2013-14
Sri. S.Sundar Vs. TATA AIA Life Insurance Company Ltd

The complainant, Sri. S.Sundar, had taken a Shubh Life policy with critical illness rider benefit on his own life bearing number C179856130 for Sum assured of Rs.85,000/- (Critical illness rider benefit (lump sum benefit)-Rs.85,000/-) for a policy term of 10 years (premium paying term- 5 years) with date of commencement as 24/03/2011 under Yearly mode with a premium of Rs. 16649/-(which includes critical illness rider premium of Rs.389/-) from TATA AIA Life Insurance Company Ltd. The complainant, Sri.S.Sundar, the life assured under the above policy had taken treatment for cerebral venous sinus thrombosis with seizures, LV failure with large LV clot in September/ October 2012 and claimed critical illness rider benefit.

The complainant, Sri. S.Sundar, the life assured under the above policy claimed critical illness rider benefit of Rs.85,000/- for the treatment taken by him in Kovai Medical Centre and Hospital Ltd, Coimbatore for cerebral venous sinus thrombosis with seizures, LV failure with large LV clot in September/ October 2012. The Insurer informed the complainant vide their letter dated 20/06/2013 that (a) from the medical information available, the condition suffered (cerebral venous sinus thrombosis) is not a qualifying condition.(b) there is no liability under the said supplementary contracts as per the terms and conditions of the Supplementary critical illness rider (lump sum benefit) and hence, the claim is declined. The Insurer has also informed the complainant that this is not a valid claim on the above grounds and they are unable to honour his claim and hence the claim is declined.

A personal hearing of both the parties was held on 24/01/2014. During the hearing, both the parties to the dispute presented their versions.

As per the Discharge Summary dated 18/10/2012 issued by Kovai Medical Center and Hospital Limited, Coimbatore, (date of admission) – 30/09/2012, final diagnosis arrived at is shown as " Cerebral Venous Sinus Thrombosis with Seizures, LV failure with large LV Clot- CAD . Against presenting complaints, it is mentioned as "One episode of

convulsions" In the discharge summary dated 29/09/2012 (date of admission – 28/09/2012 issued by Salem Medical Centre Hospital, Salem, diagnosis arrived at is mentioned as " DM/DCMP/LC CLOT/ Arachnoid Haemorrahage/ICH/with Seizure "In the Questionnaire for interview of MA dated 22/05/2013 completed by Dr.K.Vijayan, Kovai Medical Center and Hospital Limited, Coimbatore, the doctor has mentioned that the life assured was diagnosed to have stroke on 30/09/2012. He has also stated that the life assured had one episode of Seizure and the onset was acute. For the question " Are there any ongoing neurological deficits that are expected to be permanent ", the doctor has given a reply as " At present - NO". The doctor has also noted that the life assured had stroke epilepsy in 1999 and the details were not known to him.

All the conditions relating to the "critical illness" under the subheading " Stroke" have been fulfilled except that of " ongoing neurological signs that are expected to be permanent."(part of condition (i) under the heading "Stroke") for the treatment taken by the above life assured in September/October 2012 for cerebral venous sinus thrombosis.
The Insurer has mentioned in their repudiation letter that " From the medical information available, the condition suffered (cerebral venous sinus thrombosis) is not a qualifying condition…. there is no liability under the said supplementary contracts as per the terms and conditions of the Supplementary critical illness rider (lump sum benefit) and hence the said claim is declined." By this, the Insurer says that the critical illness of "Cerebral venous sinus thrombosis" is not covered under the critical illness rider benefit (lump sum benefit) under the above policy. The condition under which the Insurer has declined the claim is not appropriately substantiated and hence not in order.

The Insurer was directed to pay an EXGRATIA amount of Rs.40,000/- (Rupees Forty Thousand only) is awarded to be paid to the complainant by the Insurer in full and final settlement of the claim made for "Critical illness Rider Benefit" under the above policy.

The complaint was PARTLY ALLOWED on Ex-gratia basis

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SYNOPSIS

AWARD No: IO (CHN) L-103 /2013-14 dated 27/02/2014
Complaint No. IO (CHN) / 25.015.2856 /2013-14
Sri.V.Ravindran Vs. Bharti AXA Life Insurance Company Limited

The complainant, Sri. V.Ravindran, as a proposer, had taken a Bharti AXA Life Aajeevan Sampatti policy bearing no. 500-8838541 on the life of his minor daughter, Shanmati Ravindran, for a sum assured of Rs.2,08,607/- with policy issue date (Policy date) as 17/07/2012 with a yearly premium of Rs.19,999.92 from Bharti AXA Life Insurance Company Limited. The policy-holder has complained that his request for cancellation of policy has not been acceded to by the Insurer. The complainant, Sri.V.Ravindran, had sent an e-mail communication to the Insurer on 15/08/2012

stating that he has received the policy document on 25/07/2012 . He has added that he had gone through the contents of the policy and found that the policy was not satisfactory to him. He had requested the broker of the company, namely Ms. Bajaj Capital Ltd., (through whom the policy was introduced) to cancel the policy and return the money he has paid. The Insurer, vide their e-mail dated 28/09/2012 addressed to the complainant, has stated that they have not received any communication from him regarding cancellation/ alteration of/ in the captioned policy within the said free-look period. The complainant preferred a complaint dated 04/07/2013 with the Insurance Ombudsman, Lucknow centre (since the complainant was then residing within the territorial jurisdiction of office of the Insurance Ombudsman, Lucknow centre). The complaint was transferred to this centre on 12/11/2013, at the request of the complainant (since he got transferred to Chennai).

A personal hearing of both the parties was held on 19/02/2014. During the hearing, both the parties to the dispute presented their versions
The complainant has submitted a proposal bearing no. 6733968 dated 12/07/2012 and a cheque for Rs.20,000/-to the intermediary at the point of sale (Broker). The policy was issued with issue date (Policy date) as 17/07/2012. A copy of the proposal form along with the policy document was despatched on 20/07/2012 by speed post (AWB No.EM201886560IN (Proof for the same not submitted) along with a covering letter dated Nil stating that " .....We request you to carefully go through the contents of your policy document to ensure that the feature and benefits are as per your requirements.....In case, the policy is not to your satisfaction, you can withdraw your policy within the free-look period of 15 days from the date of receipt of the policy.." A copy of the covering letter was made available to this Forum. The Insurer has mentioned that a copy of the proposal form was also sent along with the policy document. The policy document was received by the policy-holder on 25/07/2012 as confirmed in his e-mail dated 15/08/2012 addressed to the Insurer. The complainant has sent an e-mail on 15/08/2012 to the Insurer requesting for cancellation of the policy. The complainant did not have any answer to the question of the Forum as to why stop payment instructions have not been given to the bankers immediately on knowing the policy did not suit him. As per the papers submitted by the Insurer, the first communication requesting for cancellation of policy under "Free-look Period cancellation" was sent to the Insurer on 15/08/2012 which is after 22 days from the date of receipt of policy document by the policy-holder.

The Insurer's decision to reject the "Free-look period Cancellation " request of the complainant is fully justified.

The complaint was DISMISSED.

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SYNOPSIS
AWARD No: IO (CHN) L 107 / 2013-14 dated 13/03/2014
Complaint No. IO (CHN)/21.04.2898/2013-14
Smt.S.Maheswari Vs LIC of India , Madurai Division

The complainant, Smt.S.Maheswari (Principal Insured) had taken a LIC's Jeevan Arogya policy bearing number 747350284 for a sum assured of Rs. 100000 from Madurai Division of LIC of India. . The policy- holder had opted for initial daily Hospital Cash Benefit (HCB) of Rs1000/- . Major Surgical Benefit (MSB) payable is mentioned as a percentage of sum assured depending upon the nature of surgery under-gone as listed in the conditions and privileges of the policy. The complainant had submitted the claim for Rs.1,32,111/-- incurred in connection with her hospitalisation during the period 22/04/2013 to 03/05/2013 (uterus removal and hernia operation on 23/04/2013) .

The Insurer has rejected the entire claim on the grounds that the treatment taken for uterus removal and hernia operation on 23/04/2013 comes under the exclusion of specific waiting period of two years from the date of commencement of the policy.
A personal hearing was conducted on 11/03/2014. Neither the complainant nor her representative was present during the hearing. During the hearing, the representative of the Insurer presented the insurer's versions with regard to the above complaint.

In the Discharge Summary dated 03/05/2013 issued by Women' Centre Hospitals, Coimbatore,(date of admission – 22/04/2013) , under the heading " Admitting Diagnosis", it is stated as " 41 years P1L2 with para umbilical hernia with fibroid uterus with complex right adenexal cyst." Under the heading "Surgical procedure", it is mentioned as "Total abdominal hysterectomy with BSO with hernioplasty with abdominoplasty with adhesiolysis." Date of surgery noted as 23/04/2013.
As per the terms & conditions of the policy, the specific waiting period shall be 2 (two) years from the cover commencement in respect of each insured .

It is evident that the complainant is not eligible for Major Surgical Benefit (MSB) claim and Hospital cash benefit (HCB) claim under the above policy for the above-mentioned surgeries as per the Conditions & privileges applicable to this policy.

The Insurer's decision to reject daily Hospital Cash Benefit (HCB) claim and Major Surgical Benefit (MSB) claim under the above policy is fully justified.

The complaint was DISMISSED.

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SYNOPSIS

AWARD No: IO (CHN) L 112 / 2013-14 dated 24/03/2014

Complaint No. IO (CHN) / 21.003.2899 /2013-14

Ms.Jikaarnesvari Venugopalan Vs TATA AIA Life Insurance Co. Ltd

The complainant, Ms.Jikaarnesvari Venugopalan had taken a Tata AIG Life Health First policy from TATA AIA Life Insurance Co. Ltd., bearing Policy No. C 219502593 with date of Commencement as 04/11/2011 for a term of 05 years with an annual premium of Rs.7833/- . Benefits available under the above policy are daily Hospital Benefit - Rs. 250/ per day, Post hospitalisation benefit - Rs.125/- per day (for maximum period of 3 days) ,Surgical Benefit - Rs. 12500/- , critical illness benefit - Rs.1,25,000 /- and death benefit - Rs.1000/- with lifetime limit of Rs.2,50,000/-.She had under-gone Coronary Angiogram in Dr.K.M.Cherian's Frontier Lifeline Hospital, Chennai on 04/10/2013 and took treatment in the hospital from 02/10/2013 to 07/10/2013.

The complainant, Ms.Jikaarnesvari Venugopalan, the insured under the above policy, submitted an application for critical illness (as per self-contained note of the insurer) in connection with her treatment and surgery in the hospital from 02/10/2013 to 07/10/2013. The Insurer has rejected the claim vide their letter 01/11/2013 on the grounds that the insured was suffering from Diabetes Mellitus since prior to her application for insurance. They have also informed the complainant that they are repudiating their liability under the policy forfeiting the premiums paid there-under and rescinding the above policy from inception accordingly. A personal hearing of both the parties was held on 11/03/2014. During the hearing, both the parties to the dispute presented their versions.

As per discharge summary dated 07/10/2013 issued by Dr.K.M.Cherian's Frontier Lifeline Hospital, Chennai , as per the prescription dated 21/06/2011 issued by Suray's clinic for diabetic and medical care, Chennai, and as per the Test Results of Primex Scans & Labs, Chennai, dated 30/07/2011, , it is clear that the complainant (viz) the life insured under the above policy, was suffering from diabetes mellitus much earlier to the date of proposal submitted for effecting the insurance. As per the policy conditions, the insurer has rejected the claim.

The Insurer has rescinded the above policy from inception and has repudiated their liability under the policy forfeiting the premiums paid there-under. The representative of the Insurer confirmed during the hearing that 2 yearly premiums stand paid under the above policy. Section 64 of the Indian Contract Act (Rescission of a contract) stipulates that when a person at whose option contract is voidable, rescinds it, the other party there to need not perform any promise therein contained in which he is a promisor. The party rescinding a contract shall, if he has received any benefit there under from another party to such contract, restore such benefit, so far as may be, to the person from whom it was received. In view of the above, in the present case, the Insurer is liable to refund the full premiums received under the above policy, as the policy has been rescinded from inception by the Insurer.

The Insurer was directed to pay an amount of Rs.15,600/- (Rupees fifteen thousand six hundred only) on ex-gratia basis in full and final settlement of the claim under the above policy as the policy contract was rescinded from inception.

The complaint was PARTLY ALLOWED on EX-GRATIA basis.

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GUWAHATI

<u>GUWAHATI OMBUDSMAN CENTRE</u>
<u>Complaint No. GUW-L-009-1314-0070</u>
Dr. Pankaj Bharadwaj
- Vs -
Birla Sunlife Insurance Company Limited
<u>Date of Order : 11.02.2014</u>

<u>Complainant</u> : The Complainant stated that he wanted to obtain a single premium policy from the Birla Sun Life Insurance Co. Ltd. and as per discussion with the Agent of the Insurer, the Agent suggested him to take Vision Plan where one could pay a one-time premium and could expect a good return after the completion of five/six years. Accordingly, he gave a cheque for Rs. 1.00 Lac to the Agent. The Agent took his signatures on the proposal form and the Agent did not give him chance to fill in the proposal form. He received the Policy document on 10.01.2013. While going through the policy document, he found that the policy term is shown as To Age 100 years and Pay Term as 10 years. The Insurer had sent some medical test report along with the policy document which were done at Lakhimpur, Assam. But, he had never been to Lakhimpur and he had never gone for any medical test at the time of procuring the policy. He is not satisfied with the activities of the Insurer. Hence, he has lodged a complaint before the Insurer on 22.01.2013 either for cancellation of the policy and refund of premium amount or change it into a single premium policy with five years term i.e. within free look period of 15 days from the date of receipt of the policy document which was received by the Insurer on 24.01.2013. Inspite of repeated requests and reminder, the Insurer has not taken any steps either to refund the premium amount or to change the mode of term. Being aggrieved, he has filed this complaint.

<u>Insurer</u> : The Insurer has stated in their "Self Contained Note" that on the basis of application form submitted by Dr. Pankaj Bharadwaj, they issued Policy No. 005729827 with the date of commencement on 31.08.2012 for a Sum Assured of Rs. 6,94,220.00. The policy bond was handed over to the client on September 12,2012. They have not received any complaint from the Complainant and they have come to know about the allegations of the Complainant from the instant complaint made before the Office of the Insurance Ombudsman, Guwahati. The Insured has made this instant complaint for the first time after lapse of one year from the date of issuance of the policy. Thus he did not avail the freelook option within the stipulated period of 15 days. Since the Complainant had failed to

exercise the option of freelook and had approached them after a long delay the request for cancellation is denied.

<u>Decision</u> : I have carefully gone through entire documents available on record as well as the statements of the parties. It is stated by the Complainant that he has received the policy document on 10.01.2013. In support of his contention, he had shown the policy bond forwarding Envelop before this Authority at the time of hearing wherein it was clearly shown the date of sending the policy document. The copy of letter dated 22.01.2013 written by the Complainant to the Insurer makes it ample clear that the Complainant lodged a claim before the Insurer for cancellation of the policy and refund of premium within free look period of 15 days. The said letter was sent through First Flight Courier dated 23.01.2013 (Annexure – II) which was received by the Insurer on 24.01.2013. Although the Insurer has stated in their "Self Contained Note" as well as in the statement of the representative of the Insurer that the policy bond was handed over to the Policyholder on 12.09.2012, they have failed to prove by submitting any documentary proof that the policy document was handed over on the above date to the Policyholder. Moreover, the Complainant has alleged that the Insurer had sent some medical test report along with the policy document which were done at Lakhimpur, Assam. He firmly stated that he had never been to Lakhimpur and he had never gone for any medical test at the time of procuring the policy. According to him, these medical documents are also false and fabricated.

Considering the entire facts and circumstance, I am of the view that the Insurer is liable to refund the entire premium amount to the Complainant under the above policy canceling the policy as the Complainant applied for cancellation of the policy within the free look period of 15 days from the date of receipt of the policy document. Accordingly, the Insurer was directed to refund the entire premium amount to the Complainant alongwith penal interest @ 8% within 15 days from the date of receipt of this Award. With this observation, the complaint is treated as closed.

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<u>GUWAHATI OMBUDSMAN CENTRE</u>
<u>Complaint No. GUW-L-009-1314-0053</u>

Mr. Saubhagya Mal Jain
- Vs -
The Birla Sun Life Insurance Co. Ltd.
<u>Date of Order : 06.02.2014</u>

<u>Complainant</u> : The Complainant stated that he received telephone calls from Akansha verma and Manish Agarwal who introduced themself employee of the Birla Sun Life Insurance Co. Ltd in the month of December, 2012 and influenced him to buy the policy by saying that the policy is for a term of 5 years.. They had also mentioned that medical facility will be given to both him and his

grandson. They told him that the WOP rider will be there. Accordingly, he gave consent to open a policy for his grandson Mr. Devansh Jain and he paid Rs. 30,000/- as premium. He received the policy document in the month of January, 2013. While going through the policy document, he found that the premium paying term is shown as 15 years and WOP is also not there in the policy.. They have cheated him and have hurt his emotions too. In the month of March, 2013, he prayed either for cancellation of the policy and refund of premium along with penal interest or change it into 5 years term period. But, the Insurer has rejected his prayer. Being aggrieved, he has filed this complaint.

<u>Insurer</u> : The Insurer has stated in their "Self Contained Note" that on the basis of application form submitted by Mr. Saubhagyamal Jain to insure the life of his grandson Mr. Devansh Jain on 19.12.2012 they issued Policy No. 005883179 with the date of commencement on 22.12.2012 for a Sum Assured of Rs.3,89,445.00. The policy bond was delivered to the Complainant on 29.12.2012 through Blue Dart Courier. They received the prayer for cancellation of the policy and refund of premium amount from the Complainant on 14.03.2013. i.e. beyond the free look period of 15 days. As the Complainant did not avail of the freelook option within the stipulated period of 15 days, they have rejected the prayer of the Complainant. However, considering the advanced age of the Complainant, they propose to convert the existing policy to a 5 years pay term as requested by the Complainant.

<u>Decision</u> : I have carefully gone through entire documents available on record as well as the statements of the parties. It is apparent from the copy of the policy document that Mr. Saubhagya Mal Jain procured the above policy on the life of Mr. Devansh Jain with the date of commencement on 22.12.2012 for a Sum Assured of Rs.3,89,445.00. Policy term is shown as To Age 100 years and Pay Term 15 years. According to the Complainant, in the month of March, 2013, he lodged a complaint before the Insurer either for cancellation of the policy and refund of premium along with penal interest or change it into 5 years term period as he was not satisfied with the terms and conditions of the policy.

It appears from the "Self Contained Note" as well as from the statement of the representative of the Insurer that they issued Policy No. 005883179 to Mr. Saubhagyamal Jain on the basis of application form submitted by him. The Complainant applied for cancellation of the above policy beyond free look period of 15 days. Therefore, they rejected the prayer of the Complainant. However, considering the advanced age of the Complainant, they propose to convert the existing policy to a 5 years pay term as requested by the Complainant.

As the Insurer has decided to convert the policy to a 5 years pay term as per choice of the Complainant, I have nothing to discuss further on the case. However, on receipt of required documents from the Complainant, the Insurer should take steps to convert the same within 15 days from the date of receipt of this Award. With this observation, the complaint is treated as closed.

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GUWAHATI OMBUDSMAN CENTRE
Complaint No. GUW-L-009-1314-0002

Mr. Sushil Kr. Agarwala
- Vs -
Birla Sunlife Insurance Company Limited
Date of Order : 02.01.2014

Complainant : The Complainant stated that he had a Policy bearing Policy on the life of his wife with the Birla Sun Life Insurance Co. Ltd. While the said policy was in force, one Mr. Dipak Kapoor and Ms. Akangsha Varma, who introduced themselves as official of Head Office of Birla Sun Life Insurance Co. Ltd., Mumbai told him over phone that the Company has introduced a new plan, if he pays Rs.50,000/-, after three years he will get Rs.1,50,000/- (Approx) and no further premium will be required to pay as it is an one time investment. Accordingly, he gave consent and one employee of the Insurer collected a cheque for Rs.47,000/- from him. The Insurer issued policy No. 005491299 with the date of commencement on 31.03.2012. But, after one year he received a call from the Insurer and requested him to pay the annual premium under the above policy. After the going through the policy document, he was surprised that the Insurer had mis-sold the policy. Then he requested the Insurer to cancel the new policy and refund of premium. But, the Insurer has rejected my prayer. Being aggrieved, he has filed this complaint.

Insurer : The Insurer has stated in their "Self Contained Note" that Mr. Sushil Kr. Agarwala submitted the application form dated 28.03.2012 and on that basis they issued Policy No. 005491299 to the Complainant. The Policy bond was dispatched to the client's address through Blue Dart dated 23.04.2012. But, they received the first complaint / prayer for cancellation of the policy from the Complainant on 27.04.2013 i.e. beyond the free look period of 15 days. As the Complainant did not avail of the freelook option within the stipulated period of 15 days, they have rejected the prayer of the Complainant.

Decision : I have carefully gone through entire documents available on record as well as the statements of the parties. It appears from the copy of Application Form that the Application form was duly signed by the Complainant on 28.03.2012. On the basis of that, the Insurer had issued the policy bearing No. 005491299 to the Complainant. I find no mistake on the part of the Insurer as the Insurer issued the policy as per data available in the Application form. It appears from the copy of "Self Contained Note" as well as from the copy of the policy document that they issued the above policy on 28.03.2012. The copy of letter dated 27.04.2013 written by the Complainant to the Insured discloses that the Complainant made a written complaint before the Insurer for cancellation of the policy and refund of premium amount which was received by the Insurer on 29.04.2013. It is ample clear from the said letter that the Complainant prayed for cancellation of the

policy and refund the premium amount beyond the free-look period of 15 days from the date of receipt of the policy document. The Complainant also failed to produce any document that he requested the Insurer to cancel the policy and refund of premium within the Free Look Period of 15 days from the date of receipt of the policy document.

Considering the entire facts and circumstances as discussed above, I am of the view that the decision of the Insurer for non acceptance of request of the Complainant is just and proper. Finding no ground to interfere with the decision of the Insurer, the complaint is dismissed and is treated as closed.

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GUWAHATI OMBUDSMAN CENTRE
Complaint No. GUW-L-009-1314-0056

Mr. Rabindra Sinha

- Vs -

The Birla Sun Life Insurance Co. Ltd.

Date of Order : 07.03.2014

Complainant : The Complainant stated that he took Policy No. 004191498 from the Birla Sun Life Insurance Co. Ltd. with the date of commencement on 18.06.2010. On payment of first premium, he could not pay the second premium of Rs.25,000/- due to domestic problem and own sickness. Without any prior information, the Insurer sent a Surrender Value of Rs. 5,846.65 out of Rs.25,000/- against his policy. He alleged that the bulk amount was deducted by the Insurer from the principal amount due to wrong calculation. He also stated that if it is fixed in the Bank definitely would not less than the principal amount. Being aggrieved, he has filed this complaint.

Insurer : The Insurer has stated in their "Self Contained Note" that on the basis of application forms submitted by Mr. Rabindra Sinha they issued Policy No. 004191498 with the date of commencement on 18.06.2010. The renewal premium for the said policy was due on 18.06.2011. However, the Complainant failed to submit the renewal premium within the stipulated time. The Complainant had failed to deposit the renewal premiums all these years and finally the policy got terminated on July 18, 2013 due to want of premiums for the said policy. Due to the termination of the policy on 18.07.2013 and as per the terms and conditions of the policy, an amount of Rs.5,846.65 vide cheque No. 897655 dated 19.07.2013 was sent to the Complainant. As the Complainant had only paid the initial premium and failed to pay the renewal premiums within grace period, the policy got terminated and the surrender value was provided to the client after deducting the surrender charge along with the service tax from the fund value. The fund value at the end of the 18.07.2013 stood as Rs.21,296.15. The surrender charge of Rs.13,750.00 deducted from the fund value. Hence, the net fund value arrived at

Rs.7,546.15. Further an amount of Rs.1699.50 as service tax was deducted from the net fund value. Therefore, the net amount payable to the client was Rs.5,846.65 as per terms and provisions of the policy.

Decision : I have carefully gone through entire documents available on record as well as the statements of the parties. The Complainant stated in his complaint petition that after making payment of first premium, he could not pay the second premium of Rs.25,000/- till date due to exigencies of domestic problem and own sickness. It is ample clear that the policy was lapsed since 18.06.2011 as the Complainant failed to pay the renewal premium due on 18.06.2011. It is clearly mentioned in Premium Discontinuance of the Policy Provisions that if the policy is not revived by the end of the two year revival period, the Insurer will terminate the contract and pay the Surrender Value as of the lapse date to the Insured at that time or at the end of the third policy years, whichever is later. As per the above provision the Insured paid Rs. 5,846.65 to the Insured after deducting the surrender charge along with the service tax from the fund value. As the Complainant did not take initiative to revive the policy within 2 years from the lapsed date the policy got terminated and I find no irregularity on part of the Insurer in taking termination action against the above policy. The Complainant alleged that if Rs.25,000/- is fixed in the Bank definitely would not less than the principal amount. It is an admitted fact that the insurance concept is totally different with the Bank. Hence, investment in insurance cannot be compared with the Bank.

Considering the entire facts and circumstances as discussed above, I am of the view that the Insurer has rightly paid the Surrender Value as per terms and conditions of the policy. Finding no ground to interfere with the decision of the Insurer, the complaint is dismissed and is treated as closed.

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HYDERABAD
Hyderabad Ombudsman Centre
Case No. L-004-1314-0115

Mr. Kanakaraju Pilla
Vs
Aviva Life Insurance Co. Ltd
Award dated : 18.11.2013

Mr. Kanakaraju Pilla filed a complaint that his insurance policy was cancelled by Aviva Life Insurance Company Ltd. and forfeited the premium paid, without his knowledge; hence,

he requested for refund of the premiums paid by him, with interest.

On carefully going the written and oral submissions and the documentary evidence submitted by both the parties, it was observed that:

1. **Mr. Kanakaraju Pilla had taken a policy from Aviva Life Insurance Company for sum assured Rs. 7,87,500/- with the date of commencement as 21.03.2011, under non medical scheme and paid two annual premiums. Subsequently, he applied for a term assurance policy and voluntarily disclosed his medical history in his proposal for insurance that he was suffering from 'Diabetes' for 5 years. The proposal was declined by the insurer and the deposit received thereunder was refunded. However, the insurer refused to receive the 3rd premium under existing policy on the pretext that there was non-disclosure of material facts in the proposal for the policy and further, forfeited the total premium paid thereunder.**

2. **The complainant reiterated that he had no intension to hide the facts regarding his health. He himself had voluntarily disclosed his medical history at the time of proposal for the term policy. He was also interested in continuing the existing policy.**

3. **The sole evidence available with the insurer about the complainant's medical problem was the voluntary declaration made by the complainant in the proposal for a new policy.**

From the above observations, it is very clear that the insurer's conclusion 'that the complainant had diabetes as on the date of proposal for the existing policy' was solely based on the complainant's own declaration in the proposal for the new policy that he was having diabetes for five years. The Insurer has not conducted any investigation or inquiry about the medical condition of the complainant. On the other hand, had the complainant not disclosed the period of 5 y ears about his diabetes, the insurer would not have concluded that the complainant had not stated his correct health condition while proposing for the first policy. Had the complainant not approached the insurer for a second policy, the insurer would have continued the existing policy as such.

It is therefore very clear that the complainant cannot be accused of deliberately suppressing material facts while taking the existing policy. His seeking the second policy; his declaration about his having diabetes for 5 years and; his undergoing medical examination clearly establish his bonafides. Considering this position, in my view, the insurer acted hastily and harshly in cancelling the existing policy and in forfeiting the premiums paid.

In view of what has been stated above, the insurer is directed to reinstate the policy of the complainant and to accept the subsequent premiums, treating the premium as received on the date it was originally remitted.

In the result, the complaint is allowed.

Hyderabad Ombudsman Centre
Case No. L-25-006-769/2013-14

Mrs. Sudha Bhat
Vs
LIC of India, Udipi Division
Award dated : 24.12.2013

Mrs. Sudha Bhat filed a complaint that the Major Surgical Benefit under her insurance policy was wrongly denied by the insurer, i.e. LIC of India, Dharwad. Hence, she requested for settlement of the same.

Pursuant to the notices issued by this office, the complainant remained absent and representative of the insurer attended the hearing held at Bengaluru on 22.11.2013.

The complainant through a letter dated 20.11.2013 expressed her inability to attend the hearing in view of her doctor's advice not to undertake journey, because of her severe post-operative problems. However, she requested for settlement of the claim since the surgery undergone by her comes under the Major Surgical Benefit of the policy.

The Insurer's representative stated that they have since reconsidered the claim and would be settling the same as per the terms of the policy, treating that the surgery

comes under 'Major Surgical Benefit'.

The representative of the insurer assured settlement of the claim, treating the complainant's claim allowable under 'Major Surgical Benefit' of the policy.

In the result, the complaint is allowed with a direction to the insurer to settle the claim within 2 weeks.

Hyderabad Ombudsman Centre
Case No. L-008-1314-0152

Mrs. Nirmala Srihari
Vs
Bharti AXA Life Insurance Company
Award dated : 25.03.2014

Mrs Nirmala Srihari, nominee had filed a complaint stating that her request for cancellation within free look period was denied by M/s Bharti AXA Insurance Company; hence, she requested for refund of premium as per the terms and conditions of the policy.

On a careful consideration of the written and oral submissions of both the parties and the documentary evidence adduced, it is observed that the insurer had declined the cancellation of the policy under Free look period as the request was received after the stipulated time. Original policy bond is an important document and was sent by the insurer through courier. The complainant should have returned it through courier/speed post or should have personally handed over the same to the agent, but preferred sending by ordinary post. He has not made any attempt to seek clarification either from the Sales Executive or from the Bangalore office. There is no proof of sending back the policy bond to the insurer. The mails sent for cancellation without returning the original policy bond would only serve the limited purpose of providing contemporaneous evidence to the effect that a request for cancellation of policy was made within the free look period. However, the insurer's actions in securing an indemnity bond and sending a duplicate bond show that the insurer accepted the contention that the original bond was lost in transit. On this backdrop, the complainant's re-exercising of free look option on receipt of duplicate bond, appears only logical.

In view of the above, particularly considering the fact that the complainant has sent mails for cancellation of the policy within the stipulated time period, I am inclined to direct the insurer to refund the premium paid subject to recovery of expenses incurred in issue of duplicate policy bond as an ex-gratia payment.

In result, the complaint is allowed in part as an ex-gratia.

Hyderabad Ombudsman Centre
Case No. L-23-001-284/2013-14

Mrs. Kumuda C.N.
Vs
LIC of India, Bangalore-II DO
Award dated : 03.01.2014

Mrs. Kumuda C.N. wife of late Mr. B. Ravi filed a complaint stating that the death claim under the policy of her deceased husband for the annuity was not settled by the insurer, i.e. LIC of India, Bangalore. Hence, she requested for settlement of the claim.

On careful consideration of the contentions of both the parties and the documentary evidence adduced by them, it was noticed that the deceased life assured had obtained the insurance policy with a specific purpose, i.e. for monitory support to his dependant -handicapped sister, in his absence. As contested by the insurer, the policy "Jeevan Vishwas" itself was designed to meet such a desire of the policyholders. As such, demand of the complainant for settlement of entire amount in lump sum is unreasonable and it would jeopardize the interests of the dependant handicapped.

The insurer had submitted that they were ready to settle the annuity according to the option exercised by the nominee/complainant for the available Capital Sum. As such, settlement of annuity from the due date of first annuity, i.e. on 1.12.2010, should commence as per the option to be exercised by the complainant. However, since there was abnormal delay at the insurer end, the insurer is directed to pay the arrears of annuity installments from 1.12.2010 onwards, alongwith interest @ 9% p.a.

In the result, the complaint is allowed and the insurer is directed to settle the annuity installments in arrears from the first due date, i.e. 1.12.2010, as per the option exercised by the complainant, with a simple interest @ 9% p.a., for each installment until the date of its actual payment.

Hyderabad Ombudsman Centre
Case No. L-24-003-079/2013-14

Mr. V. Selvaraj
Vs
TATA AIA Life Insurance Co.Ltd.
Award dated : 18.11.2013

Mr. V. Selvaraj filed a complaint that he had taken an insurance policy from TATA AIA Life Insurance Company which matured for settlement on 11.2.1013; however, the maturity amount was not settled by the insurer. Hence, he requested for settlement of the same.

On careful consideration of the written and oral submissions made by either party and the documents adduced, it is observed as hereunder:

(1) The complainant had taken a 'Pension Plus' policy with an annual premium of Rs. 11090/- for a term of 10 years commencing on 11.02.2003. Insurer offered him vide their intimation letter dated 14.11.2012, for payment of maturity value of Rs 145963.87. Complainant submitted discharge voucher along with bank details for crediting the maturity proceeds, and the insurance updated the bank account details in their records vide letter dated 22.11.2012.

(2) The complainant had requested the Insurance Company vide letters dated 16.02.13, 27.02.13, 06.03.13, 14.03.13, 24.03.2013 & 26.03.2013 for full settlement of maturity benefit. The Insurer vide their letter dated 13.03.13 has informed the insured that they were unable to refund the full amount and have offered to consider options allowed under the policy on maturity, viz., out of maturity value, a minimum of 67% of the benefit amount could be invested in annuities either from open market or from Tata AIA, and rest 33% could be withdrawn.

(3) The policy conditions envisage that on maturity date if the policyholder was living, the policy value should be applied in one of the two ways that is (i) 100% towards purchase of an annuity issued by Company or other institutions in the market (ii) up to 1/3rd towards cash lump sum and the balance towards purchase of an annuity. It is pertinent to note that the above option was to be exercised by the policyholder and that he could purchase the annuity with the company or any other Indian Life Insurance Company.

(4) In spite of the fact that as per the policy conditions, the policyholder could commute only 33% of the maturity proceeds, the insurer had issued the discharge voucher for the entire amount of Rs 145963.87. Later, the insurer tried to defend their action saying that it was a typographical mistake in their communication. The complainant had reminded the insurer by way of written letters on six (6) occasions, for settlement of the entire amount; but there was no written reply.

In fact, the insurer was expected to enlighten the policyholder about the various types of Annuities and the returns he was likely to get if the Annuity was purchased from their company. The policyholder was to be advised the procedure in case he desired to take the Annuity from Insurance Company. They should also inform that in case policyholder was not desirous of purchasing annuity, what would be the surrender value payable to him on surrendering the policy.

There was a serious lapse on the part of the insurer on procedural matters in intimating the complainant vide their letter dated 14.11.2012, that the maturity amount was Rs. 145963.87, and it gave hope to the complainant that he would get back the entire sum. The insurer did not bother to reply to any of the six letters of the complainant before the maturity date that it was not possible for settlement of full maturity value. There was no record about the claimed telephonic information. It was stated by the complainant that he was already 65 years of age and was suffering from ill-health; as such, had to obtain loan to meet his hospital expenses anticipating receipt of entire maturity proceeds.

The peculiar facts of this case; the failure of the insurer in ensuring proper communication to the complainant as per the terms of the policy; the fact of hope of

return of maturity amount created in the mind of the complainant and the complainant's commitments in expectation of maturity amount, compel me, to conclude that the complainant should not suffer for the mistake and indifference of the insurer. On the other hand, insurer cannot disown a communication, just by claiming it to be a typographical error, particularly, when they had not bothered to send replies to repeated communications from the complainant.

In view of the aforesaid reasons and the facts, the insurer is directed to settle the maturity value of Rs. 145963.87, as mentioned in their letter dated 14.11.2012, along with a simple interest @ 9% from 11.2.2013 till the payment, in full and final settlement under the policy.

In the result, the complaint is allowed.

Hyderabad Ombudsman Centre
Case No. L-019-1314-0009

Dr. Surapaneni Rajagopal
Vs
HDFC Standard Life Insurance Co. Ltd.
Award dated : 31.01.2014

Dr. Surapaneni Rajagopal filed a complaint that the maturity settlement under the policy taken by him from HDFC Standard Life Insurance Company, was wrongly denied; hence, he requested for settlement of the same.

On careful consideration of the written and oral submissions of both the parties and the documentary evidence adduced, it is observed that the policy issued to the complainant was of 'Annuity' type. The insurer had informed the policyholder/complainant on 26.11.2012 that the policy was due for vesting on 12.3.2013 and the details of various options available to him under the policy, including 33% of the maturity proceeds as cash lump sum. Further, he was asked to submit the policy at least two weeks prior to maturity date, for claiming the cash value.

The complainant was literate enough to go through the conditions of the policy. More so, he has agreed that the policy was taken with a specific purpose. As such, the insurer cannot be compelled to act beyond the scope of the policy contract, that too after the expiry of the policy term. During the hearing, on appraising the available options under the policy, the complainant has agreed to receive the annuity as per the policy conditions.

In view of the aforesaid reasons, the insurer is directed to settle the claim of the complainant as per the option that would be availed by him, in accordance with the terms of policy.

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

Hyderabad Ombudsman Centre
Case No. L-24-001-638/2012-13

Mr. Basawaraj B. Totagar
Vs
LIC of India, Dharwad
Award dated : 28.02.2014

Mr. Basavaraj B. Totagar had taken two (2) insurance policies from LIC of India which were due for maturity claim settlement on 02.02.2012. However, the insurer did not settle the maturity claim as per the policy conditions, and intimated the complainant that one policy would be settled without profits and the other policy was in lapsed condition under which, only paid-up value was payable. He made several requests to the insurer for settlement of maturity claim as per policy conditions, i.e., with profits, but in vain. Hence, he requested for settlement of the maturity claim under both the policies, as per the policy conditions.

On perusal of the documents submitted and the submissions made by both the parties it is observed as hereunder:

(1) The complainant had purchased two convertible whole life policies from LIC commencing from 02.02.1997 and the installment premium is Rs.1238- per annum. On the written request of the proposer made at the end of five years from the date of commencement of the policy, the insurer would convert the policy into endowment with profit or without profit and enhance the premium depending on the policy term.

(2) It is observed from the document 630720136, policy is to be converted in an endowment assurance policy WITH PROPITS/WITHOUT PROFITS premium payable from 02.02.2002 TO 02.02.2011 would be 2685/-. Subsequently they found mistake in premium calculation and revised the premium to Rs 3587/-(endowment without profits) for policy term 15 years and the premium was paid. The policy has matured for payment on 02.02.2012.For the policy no 630720137, policy is to be converted into an endowment assurance policy WITH PROFITS/WITHOUT PROFITS premium payable from 02.02.2002 TO 02.02.2011 would be 2685/-.Premium was revised to Rs4815/- for policy term 15 years due from 2/2002, but policy lapsed from 2/2002.

(3) The Insurer has sent a letter dated 05.03.2012 under policy no 630720136 policy issued with definite conversion without profit .Hence sum assured only would be payable as maturity claim. Policy no 630720137 was issued with definite conversion with profit .But Insurer has not received premiums from 2/2002 and onwards. Hence policy became paid-up from 2/2002. He has option to surrender the policy for paid-up value/surrender value. Insurer has requested the policyholder i.e. the complainant to submit the discharge forms for settlement of maturity claim.

(4) On receipt of the said letter the life assured has written to the Insurer vide letter dated nil for policy no 630720136- to please check the premium as he has paid premium for maturity amount with profit. For the policy no 630720137, he requested to let him know as to how much premium was to be paid. It is observed from the letter dated 25.11.2013 of the complainant that he has not agreed to the

clarifications given by the Insurer and was insisting on payment of sum assured with bonus.

(5) With regard to Policy document bearing nos 630720136&630720137 under dispute, the Insurer has mentioned that each policy was to be converted in to endowment assurance policy WITH PROFITS/WITHOUT PROFITS premium payable from 02.02.2002 TO 02.02.2011 would be 2685/-.We observed from the records that Insurer wrongly quoted Rs 2685/- for policy term 15 years (with profit) instead of Rs 4815/-. Evidently, this mistake has crept in due to parallax error, while seeing manual for fixing revised premium. Subsequently, the Insurance Company has regretted the mistake committed by them vide letter dated 12.03.2005.

(6) Policy no 630720136 -Policy was converted to 'without profits' with premium paying term 15 years .Complainant has paid revised premium of Rs.3587/- from the date of conversion. For Policy no. 630720137, premium was revised to Rs 4815/-(with profit) from the date of conversion. But the complainant has not paid the revised premium. Hence, the policy lapsed from the date of conversion.

(7) The complainant who vehemently argues now that Sum Assured and bonus should be paid as maturity benefits under policy no 630720136, has stated that he issued the cheque in 2/2005 for Rs 12426/- and received the cheque dishonor intimation vide letter dated 10.04.2012 i.e. after lapse of 7 years. Being a Bank Officer, this forum firmly believes that the complainant would have had first hand information on his cheque dishonor as the cheque amount wouldn't have been debited to his account. It is wrong for the complainant to expect credit to his premium account, without debiting of the cheque amount to his bank account. The question of crediting premium account would arise only on credit of the cheque proceeds to the Insurer's account. The Insurance Company cannot be penalized for the mistake that has crept in unintentionally. The complainant cannot ask for enforcing the contractual obligations without paying valid consideration.

(8) It has been held by the National Consumer Disputes Redressal Commission in Case No.178 of 1995 that the typographical error would not entail the complainant to receive the amount mentioned by mistake. Parties to the agreement are not entitled to get benefit of apparent mistakes.

In view of the aforesaid reasons and the facts, I do not find any reason to interfere with the decision of the Insurer. Further, Insurer is directed to pay simple interest@ 9% p.a. from 02.02.2012 on the amounts payable till the payment of the maturity proceeds in full and final settlement under the above policies.

THE COMPLAINT IS PARTLY ALLOWED

Hyderabad Ombudsman Centre
Case No. L-24-013-789/2012-13

Mrs. Seema Venkatesh Narvekar
Vs
Aviva Life Insurance Co. Ltd
Award dated : 28.03.2014

Mrs. Seema Venkatesh Narvekar filed a complaint that she had taken an insurance policy from Aviva Life Insurance Company which matured for settlement on 22.02.2012, but the insurer did not settle the claim. Hence, she requested for settlement of the maturity claim.

On perusal of the documents adduced and the oral submissions made during the hearing by both the parties, it is observed that;

(a) The complainant had taken a Unit linked Pension Plus policy bearing no RPG1683261 with an Annual premium of Rs 100000/- for a term of 5 years commencing on 22.02.2007 and paid the premium for 4 years; The complainant requested the Insurer for full refund of maturity amount vide letter dated 11.07.2012 followed by another letter dated 05.09.2012, in view of her old age and to meet hospital expenses.

(b) The Insurer vide their letter dated 16.07.2012 has informed the complainant that they were unable to refund the full amount as per the terms of the policy; as such, but offered to consider options allowed under the policy on its maturity viz-

(i) Up to 1/3 towards cash lump sum and balance towards purchase of an annuity either from AVIVA or any other insurance company as per her wish.

(ii) 100% towards the purchase of annuity either from AVIVA or any other insurance company as per her wish.

Aggrieved by the above offer, the complainant approached this forum requesting for settlement of full maturity amount.

Thus, the issue to be decided as per the complaint was whether the request of the complainant could be acceded to for settlement of the entire maturity amount in a lump sum.

It has been observed from the record that the policy taken by the complainant was a "Pension Plus Regular-Unit Linked" commencing from 22.2.2007, for a term of 5 years. The frequency of premium payment was 'Annually' at the rate of Rs. 100,000/-. At the end of the term of policy, the pension was to be paid in the form of annuities as per the option then exercised by the annuitant. With such terms and conditions, the policy document was sent to the complainant by the insurer through a covering letter dated 11.9.2007. The complainant was further advised through that letter that she was having the right to reconsider her decision, within 15 days of receipt of the policy document. The complainant had received the said policy document and subsequently paid 3 annual premiums there-under. Due to non-payment of last annual premium, the status of the policy was changed to "inforce notice period" on 22.8.2011. Thereafter, the said policy matured on 22.2.2012.

While the facts being so, on 10.4.2012 the complainant had lodged a complaint with the insurer alleging mis-selling and misrepresentation and demanded full refund of the maturity amount.

The complainant is a Graduate and literate enough to go through the terms and conditions of the policy document. As such, I hold that the allegation of the complainant that the policy was mis-sold to her was an after-thought which cannot be accepted. The policy itself was devised by the insurer, which was approved by the IRDA, to meet the

requirement of old age and provides for receiving periodical fixed amount in the form of annuity by the policyholder. As per the terms of the policy, the policy holder was eligible to commute 1/3rd portion of maturity amount by way of cash lump sum also. Another contention of the complainant was that she was in need of money to meet her hospital expenses due to old age. If she was really in need of money in lump sum, she could have surrendered the policy prior to the date of maturity itself and had taken back the surrender value as per the terms of the policy. However, she has not done so.

As such, the demand of the policyholder/complainant for refund of the entire maturity amount in a lump sum after the date of maturity, appears to be unreasonable and against to the policy contract. The insurer cannot be asked to act contrary to the terms and conditions of the policy.

In view of the aforesaid reasons and the facts, the insurer is directed to settle 1/3rd of the maturity amount to the complainant as commutation under the policy, with a simple interest @ 9% p.a. from the date of maturity till the date of settlement, and to pay the annuity installments payable with reference to the 2/3 of maturity amount plus interest accrued @ 9% p.a. from the date of maturity, as per the option that should be exercised by the complainant, as to whether she would opt for receiving annuity from the insurer or any other annuity provider. If the complainant opts to receive annuity from any other annuity provider, the insurer shall transfer the balance 2/3 of the maturity amount alongwith simple interest @ 9% p.a. upto the date of such transfer, to the annuity provider chosen by the insured. If no option is exercised within a month of receipt of this award, the insurer may take it that the complainant has opted to receive annuity from the insurer.

In the result, the complaint is partly allowed.

Hyderabad Ombudsman Centre
Case No. L-24-013/2013-14

Mr. Sugodu B. Muddappa
Vs
Aviva Life Insurance Co. Ltd
Award dated : 28.03.2014

Mr. Sugodu Basappa Muddappa filed a complaint stating that the maturity claim due

on 4.3.2013, under the policy taken from Aviva Life Insurance Company Limited, was not settled by the insurer; hence, he requested for settlement of the same.

On perusal of the documents adduced and the oral submissions made during the hearing by both the parties, it is observed that;

(c) The complainant had taken a Unit linked Pension Plus policy bearing no APG1874914 with an annual premium of Rs. 50,000/-, for a term of 5 years commencing on 4.3.2008 and paid the premium for 5 years; The complainant requested the Insurer for full refund of maturity amount in view of his financial difficulties to meet family medical requirements and other financial commitments.

(d) The Insurer informed the complainant that they were unable to refund the full amount as per the terms of the policy; as such, offered him to consider options allowed under the policy on its maturity viz-

- **(i) Up to 1/3 towards cash lump sum and balance towards purchase of an annuity either from AVIVA or any other insurance company as per her wish.**
- **(ii) 100% towards the purchase of annuity either from AVIVA or any other insurance company as per her wish.**

Aggrieved by the above offer, the complainant approached this forum requesting for settlement of full maturity amount.

Thus, the issue to be decided as per the complaint is, whether the request of the complainant could be acceded to for settlement of the entire maturity amount in a lump sum.

It has been observed from the record that the policy taken by the complainant was a "Pension Plus Regular-Unit Linked" policy, commencing on 4.3.2008, for a term of 5 years. The frequency of premium payment was 'Annually' at the rate of Rs. 50,000/-. At the end of the term of policy, the pension was to be paid in the form of annuities as per the option to be exercised by the annuitant. With such terms and conditions, the policy document was sent to the complainant by the insurer. The complainant was further advised through a letter that he was having the right to reconsider his decision, within 15 days of receipt of the policy document. The complainant had received the said policy document and subsequently paid 4 annual premiums there-under. Thereafter, the said policy matured on 4.3.2013.

While the facts being so, on 25.3.2013 the complainant had lodged a complaint with the insurer alleging mis-selling and misrepresentation. Since he was in financial difficulties, he demanded full refund of the maturity amount.

The complainant is a Graduate and literate enough to go through the terms and conditions of the policy document. As such, I hold that the allegation of the complainant that the policy was mis-sold to him was an after-thought which cannot be accepted. The policy itself was devised by the insurer, with due approval of the IRDA, to meet the requirement of old age and, provides for receiving periodical fixed amount in the form of annuity by the policyholder. As per the terms of the policy, the policy holder was eligible to commute 1/3rd portion of maturity amount by way of cash lump sum also. Another contention of the complainant was that he was in need of money to meet his family medical requirement. If he was really in need of money in lump sum, he could have surrendered the policy prior to the date of maturity itself and could have taken back the surrender value as per the terms of the policy. However, he has not done so.

As such, the demand of the policyholder/complainant for refund of the entire maturity amount in a lump sum after the date of maturity, appears to be unreasonable and against to the policy contract. The insurer cannot be asked to act contrary to the terms and conditions of the policy.

In view of the aforesaid reasons and the facts, the insurer is directed to settle 1/3rd of the maturity amount to the complainant as commutation under the policy, with a simple interest @ 9% p.a. from the date of maturity till the date of settlement, and to pay the annuity installments from its first due date, i.e., 4.3.2013, as per the option that should be exercised by the complainant, as to whether he would opt for receiving annuity from the insurer of any other annuity provider. If no option is exercised within a month of receipt of this award, the insurer may take it that the complainant has opted to receive annuity from the insurer.

In the result, the complaint is partly allowed.

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Hyderabad Ombudsman Centre
Case No. L21-007-348/2012-13

Smt. N. Anantha lakshmi

Vs
Max Life Insurance Co. Ltd.

Award Dated : 4.10.2013

Smt. N. Anantha Lakshmi filed a complaint that her claim for 'critical illness benefit' was wrongly rejected by the insurer, i.e. Max NewYork Life Insurance Co. Ltd.; hence, she requested for settlement of the same.

On a careful consideration of the contentions of both the parties and the documentary evidence on record, it was observed from the policy document that under 'critical illnesses' 5 ailments were covered, i.e. Cancer, Coma, Kidney failure, Multiple sclerosis and Heart Attack. Further, the 'Heart Attack' was defined as hereunder:

"The first recorded occurrence of heart attack or myocardial infarction which means death of heart muscle, due to inadequate blood supply, which results in all of the following condition of acute myocardial infarction:

***typical clinical symptoms (for example, characteristic chest pain);**

***new characteristic electrocardiographic changes;**

***the characteristic rise of cardiac enzymes or Troponins recorded at the following levels**

Or higher;

1. **Troponin T> 1.0 ng/ml**
2. **AccuTnl>0.5 ng/ml or equivalent threshold with other Troponin I methods: and**

***the evidence must show a definite acute myocardial infarction.**

The following conditions are however not covered:

***angina; and**

***other acute coronary syndromes eg. Myocyte necrosis.**

The diagnosis must be confirmed by a Cardiologist acceptable to the Company".

With the above wording, the ailment 'Heart Attack' was very clearly defined. As such, the point to be decided on the complaint was whether the ailment suffered by the complainant was in conformity with the aforesaid definition.

As per the Discharge Summary dated 23.3.2012 of Department of Cardiology, Sir Ganga Ram Hospital, New Delhi, the complainant was admitted in that hospital on 19.3.2012 and was diagnosed as having - Acute LVF, Dilated Cardiomyopathy, Severe LV dysfunction, Diabetes mellitus and Hypothyroidism.

As per the Attending Physicians Statement (for critical illness benefit) dated 19.3.2012 issued by Dr. Arun Mohanty of Sir Ganga Ram Hospital, New Delhi – the complainant suffered with severe LV dysfunction and DCMP (Dilated Cardiomyopathy).

The aforesaid two documents clearly prove the fact that the ailment of the complainant does not come under the definition of 'myocardial infarction'. Though both the ailments, i.e. 'myocardial infarction' and 'dilated cardiomyopathy' are the problems of heart, they are not one and the same. Since the conditions mentioned in the policy document were very specific and purely technical in nature, opinion of a Cardiologist was also sought and as per his opinion – there was no report of either cardiac enzymes (CPK, CPKMB, Trop I or Trop T) and no report of coronary angiography. Thus, it could not be concluded that the complainant had suffered from coronary artery disease or myocardial infarction.

In view of the aforesaid reasons, I hold that the rejection of claim by the insurer was in accordance with the policy conditions and it does not require any interference.

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

Hyderabad Ombudsman Centre
Case No. L-21-001-859/2012-13

Mr. M.B. Hiremath
Vs
LIC of India, Dharwad
Award Dated : 15.10.2013

Mr. Mallikarjunayya Basayya Hiremath had filed a complaint that the 'Hospital Cash Benefit' under his 'Jeevan Aarogya' policy was not settled as per the policy conditions by the insurer, i.e. LIC of India, Dharwad; hence, he requested for settlement of the same.

Upon careful consideration of the documentary evidence adduced by the insurer, it was observed from policy document, 'LIC's Jeevan Arogya (Table 903)', that the complainant was eligible for 'Initial Daily Benefit' of Rs. 1,000/- under the policy. Under the conditions and privileges of the policy, the Benefits payable were - i) Hospital Cash Benefit, ii) Major Surgical Benefit, iii) Day Care Procedure Benefit and iv) Other Surgical Benefit. A list of 140 items under 'Day Care Surgeries' and list of 140 items under 'Major Surgeries' were provided.

As per the discharge summary submitted by the complainant, it was observed that the surgery performed on him was 'Closed Reduction – L wire insertion', which was appearing under the annexure of 'day care surgeries' under item no.71, i.e. 'closed reduction of fracture'. Hence, he was eligible for the benefit under 'day care procedure' only. But, since the complainant was hospitalized for 19 days, he was expecting the 'Hospital Cash Benefit' for 18 days (1st day excluded from 19 days) i.e. an amount of Rs.18,000/- (Rs. 1,000/- x 18 days).

To clarify this point, the insurer replied that since the complainant was eligible for Day Care Procedure Benefit only, as per policy conditions & privileges, booklet page 3 & 4, serial no.3(v) , the Hospital Cash Benefit shall not be payable in the event of insured undergoing any specified Day Care Procedure.

As seen from the contents of the policy document and its conditions & privileges, the insurer had settled the claim strictly in accordance with the conditions mentioned therein. Under condition no.2 Benefits (iii) Day Care Procedure Benefit, an amount equal to 5 (five) times the Applicable Daily Benefit, shall be payable by the insurer regardless of the actual costs incurred. Under condition no.3 Benefit Limits & Conditions: Hospital Cash Benefit Limits and Conditions: (v) the Hospital Cash Benefit shall not be payable in the event of insured undergoing any specified Day Care Procedure.

In view of the aforesaid reasons, in my considered opinion, the settlement made to the complainant was strictly in accordance with the conditions and privileges mentioned in the policy, and he was not eligible for any other benefit under the policy. The rejection of Hospital Cash Benefit was as per the conditions & privileges of the policy and the decision of the insurer was in order. In the result, the complaint is dismissed without any relief.

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Hyderabad Ombudsman Centre
Case No. L-21-001-001/2013-14

Mrs. Nagarathnamma
Vs
LIC of India, Bangalore-I
Award Dated : 17.10.2013

Mrs. Nagarathnamma filed a complaint stating that the accident benefit claim under the policy of her deceased son, was rejected by the insurer, i.e. LIC of India, Bangalore-I; hence, she requested for settlement of the same.

I have considered the documentary evidence submitted and arguments advanced by both the parties. It was the contention of the complainant that her son/life assured died in a road accident and as per the documentary evidence it was clearly established that he died due to accident; hence, she demanded for settlement of 'accident benefit'. However, the argument of the insurer was that since death of the deceased life assured happened in his

intoxicated condition, as per the policy conditions, they did not have the obligation to settle the 'accident benefit'.

Since the dispute was about rejection of 'accident benefit', the point to be decided in the case was what the policy condition relating to the 'Accident Benefit' stated in the policy bond and how the condition was interpreted by the insurer in rejecting the said benefit.

As per the contents of the policy bond, under condition no. 10, Accident Benefit was stated as "If at any time when this policy is in force for the full sum assured, the Life Assured, before the policy anniversary on which the age nearer birthday of the Life Assured is 70, is involved in an accident resulting in either permanent disability as hereinafter defined or death and the same is proved to the satisfaction of the Corporation, the Corporation agrees in the case of (a) Disability to the Life Assured: (i) & (ii)…. (b) Death of the Life Assured: To pay an additional sum equal to the Sum Assured under this policy, if the Life Assured shall sustain any bodily injury resulting solely and directly from the accident caused by outward violent and visible means and such injury shall within 180 days of its occurrence solely, directly and independently of all other causes result in the death of the Life Assured".

"The Corporation shall not be liable to pay the additional sum referred in (a) or (b) above, if the death of Life Assured shall: (i) be caused by intentional self-injury, attempted suicide, insanity or immorality or while the Life Assured is under the influence of intoxicating liquor, drug or narcotic….etc."

In the context of the above wording, it is crucial to examine the documentary evidence adduced by the insurer, i.e. the FIR, Post Mortem Report and other related evidence, to understand as to whether death of the deceased life assured happened under the influence of intoxicating liquor, or not.

In the Post Mortem Report No. 2000/06 dated 15.7.2006/1.9.2006 of Bangalore Medical College, it was reported that the cause of death of the deceased life assured was due to injuries sustained; however, the report also contains an observation that the deceased had consumed alcohol prior to death. Further, as per the enquiry report

endorsement dated 10.7.2009 of the Under Secretary to Government Internal transactions Department (Crimes), the "deceased Umesh along with his friends K.S. Somashekara went for the birthday party of his friend to Narasimhaswamy temple situated at Mandya. While going he had drinks at Cauvery Wine store at Vijayanagar, and then he took the wine from there, went to Thirumala Daba situated near Bidadi, and had drinks there also. As Umesh had taken more alcohol and saying that he was going to act in the Cinema he danced too much and when he all of a sudden went out of the Daba to the Road, some un-known vehicle dashed against him, on account of it, he sustained injuries to his leg. Then he was taken to Bangalore in Auto by Mallikarjun and he left him near his house, from there he was shifted to Marthas hospital, and he died on the way."

All the aforesaid documentary evidence clearly establishes the fact that the deceased had consumed alcohol and the accident occurred because he moved on to the road in the intoxicated state. The accident finally led to his death. Since the policy clearly stipulates that the insurer shall not be liable to pay the additional sum referred, if the accidental death of Life Assured occurs while the Life Assured is under the influence of intoxicating liquor, the denial of accident benefit by the insurer appears to be in order.

In view of the detailed reasons enumerated above, I hold that the insurer has rightly repudiated the Accident Benefit in this case. I do not find any reason to interfere with the decision of the insurer.

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

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Hyderabad Ombudsman Centre
Case No. L-21-001-324/2013-14

Mrs. Jala Manjula
Vs
LIC of India, Secunderabad
Award Dated : 28.11.2013

Smt Jala Manjula filed a complaint stating that the Accident Benefit claim under the policies of her husband Sri Jala Srinivas was mechanically rejected by the insurer, i.e. LIC of

India. As such, she requested for settlement of accident benefit.

On a careful consideration of the written and oral submissions and the documentary evidence submitted by the both the parties, it was observed that (i) there was a power cut daily up to 10 AM and the deceased life assured started work 2 hours before the scheduled ending time of the power cut, with an intention to complete the work very early before the power resumed. But that day power came, much before the usual 10 Am and the work was not over by that time. (ii) repudiation of Accident Benefit by the insurer was for the sole reason that the accidental death of the deceased life assured occurred while doing unauthorized work, (iii) the Post Mortem Report revealed that the deceased might have died of 'cardiac arrest due to ante-mortem electric shock', (iv) as per the Police Final Report, the death of deceased was accidental due to 'electric shock', and no foul play was noticed, and (v) the Electricity dept also opined that no departmental person was responsible for that accident.

However, on perusal of the Reports of the Electricity dept. and Police dept., pertaining to the criminal case, they did not allege anything against the deceased life assured that he committed a breach of law.

Further, the detailed investigation report of Asst Divisional Engineer, Operation, APCPDCL; Huzurnagar, which read as "on 04.07.2010 at about 8.00 hrs Sri Jala Sreenu Alias Srinivas S/o. Veeraiah R/o Kalvapally village in Garidepally and other labours went to erect the Palmyra tree stump in between the electric poles, while erecting palpove stemp the edge is dashed to 11KV line and he got electrocution died on spot. It is concluded no departmental person was responsible for this accident."

As can be seen from the above extracts, both the police and electrical departments clearly stated that it was an accident and neither of the reports had accused the deceased life assured of committing a breach of law.

In view of what has been stated above, I feel that the insurer has grossly erred in concluding that the deceased life assured died while committing breach of law. Consequently, I hold that the complainant is entitled to Accident Benefit Claim. The Insurer is directed to settle the claim in terms of the conditions of all the six policies.

In the result, the complaint is allowed.

Hyderabad Ombudsman Centre
Case No. L-029-1314-0209

Mrs. Y. Bala Siddamma
Vs
LIC of India, Cuddapah
Award Dated : 17.01.2014

Mrs. Y. Bala Siddamma wife of late Mr. Y. Anil Kumar filed a complaint that the Accident Benefit under the policy of her deceased husband was wrongly repudiated by the insurer, i.e., LIC of India, Cuddapah Division. Hence, she requested for settlement of the same.

Pursuant to the notice given by this office, both the parties attended hearing on 17.01.2014 at Hyderabad.

The complainant reiterated the contents of the complaint. The representative of Insurer, on the other hand stated that the insured died due to electric shock while committing breach of law. This was confirmed as per the reports given by the Police and Electricity departments. The complainant stated that the deceased life assured was a labourer and it was an accidental death due to electric shock. They requested for settlement of accident claim benefit. The insurer argued that the insured had no experience in electrical work but tried to repair a live wire and ended up in death. It was a voluntary work undertaken at his own risk and not an accidental one. As such, accident benefit is not payable under the policy.

I have heard the contentions of both the parties and perused the documents/reports submitted.

The Preliminary report given by Asst. Divisional Engineer, Operation APSPDC Ltd., Yerraguntla clearly indicated that work was undertaken by the deceased on the live line without switching off DTR and he got electric shock and died. It further stated that work was taken up un-authorisedly and there was no authorized person to supervise the work. Proceedings of Tahsildar Report dated 02.07.2012 and Proceedings of the Sub Divisional Office police Officer, Kadapa Report dated 26.04.2012 also confirm that the death was due

to electrocution. The insured person did not have any knowledge / experience of electrical work but undertook the job of repairing the live line at his own risk and died of electric shock. The accident occurred while the deceased life assured was committing breach of law. The insurer has rightly repudiated the accident claim as per the terms of the policy.

In view of the above, I do not find any reason to interfere with the decision of the insurer.

In result, the complaint is dismissed.

Hyderabad Ombudsman Centre
Case No. L-029-1314-0262

Mrs Pramilla P.R.
Vs
LIC of India, Shimoga
Award Dated : 25.03.2014

Smt Pramila P R had filed a complaint stating that her hospitalization claim for radiotherapy treatment under Health Insurance policy was not settled as per the terms and conditions of Insurer i.e. LIC of India, Shimoga; hence, she requested for settlement of the same.

On a careful consideration of the written and oral submissions of both the parties and the documentary evidence adduced, it is observed that the insurer had repudiated the claim for violation of clause (xvi), an exclusion, under the policy. The insurer is not disputing the fact of admission in the hospital. Radiotherapy treatment can be taken as an out-patient and there is no need of taking admission in the hospital. The relevant policy clause reads *"xvi) Hospitalisation for the sole purpose of physiotherapy or any ailment for which hospitalisation is not warranted due to advancement in Medical technology."*

Considering the facts and circumstances of the case, I am inclined to agree with the view of the insurer.In view of the above, I do not find any reason to interfere with the decision of the insurer. In result, the complaint is dismissed.

Hyderabad Ombudsman Centre
Case No. L-029-1314-0215

Sri.Manjunath K.G

Vs
LIC of India, Mysore

Award Dated : 25.03.2014

Sri Manjunath K G had filed a complaint stating that major surgical benefit under Health Insurance policy was not settled by the Insurer i.e. LIC of India, Belgaum; hence, he requested for settlement of the same.

On a careful consideration of the written and oral submissions of both the parties and the documentary evidence adduced, it is observed that the insurer repudiated the claim as the surgery underwent by the insured person was not listed in the surgery benefit annexure. It is evident from the discharge summary of CSI Redfern Memorial Hospital, Hassan that the insured person was admitted in the hospital for 10 days from 02.06.2013 to 12.06.2013 and Surgery of Laminectomy & disectomy was done on 03.06.2013. The insured has no dispute as regards the settlement of Hospital Cash. I find that the policy provided for payment of expenses only for certain surgeries and the surgery undergone by the complainant doesn't figure in the list of surgeries for which the policy provides for payment. I find the insurer has acted according to the terms of the policy.

The contract of insurance is one of "utmost good faith" and both parties to the contract shall abide by the terms and conditions of the policy. Since the surgery was not mentioned in the list i.e. Surgical benefit Annexure, the claim was repudiated by the insurer.

In view of the above, I do not find any reason to interfere with the decision of the insurer.

In result, the complaint is dismissed.

Hyderabad Ombudsman Centre
Case No. L-029-1314-0256

Mr. B. Venunarayan
Vs
TATA AIA Life Insurance Co.Ltd.

Award Dated : 28.03.2014

Mr. B. Venunarayan had filed a complaint stating that his claim for critical illness benefit under the Health Protector policy taken from i.e., TATA AIA Life Insurance Company Limited, was not settled by the insurer, as per its terms and conditions. Hence, he requested for settlement of the same.

On a careful consideration of the contentions placed on record by both the parties and the arguments put forth by them during the hearing, I find that the Cordiologist opinion on the ECG done at Vijay diagnostic centre dated 29.5.2013 was "Mild positive for exercise induced ischemia". Further, the coronary angiogram report dated 10.7.2013 diagnosis reflects TMT +ve for exercise induced ischemia. As per those reports, the complainant/life assured did not suffer 'acute myocardial infarction' as there were no typical changes of 'myocardial infarction (MI)' in ECG. The complainant only had abnormal ECG which suggested Ischemia but not an infarction as per (TMT Test Report). This defeats the condition precedent for entitlement of 'critical illness benefit'.

Therefore, I agree with insurer that the complainant had not suffered 'Heart Attack' to claim the benefit of critical illness benefit in accordance with the policy terms and conditions. As such, the decision of insurer in rejecting the claim was in order.

In view of what has been stated above, the complaint is dismissed without any relief.

Hyderabad Ombudsman Centre
Case No. L-029-1314-0213

Sri Ashok Kumar Motilal
Vs
Reliance Life Insurance Co Ltd.

Award Dated : 28.03.2014

Mr. Ashok Kumar Motilal filed a complaint stating that medi-claim reimbursement under the policy taken from Reliance Life Insurance Company was wrongly rejected by the insurer; hence, he requested for settlement of the same.

On a careful consideration of the contentions placed on record by both the parties and the arguments put forth by them during the hearing, I find that under the terms and conditions of the policy, Clause 5.4 clearly stated that 'no claim was payable on treatment of Cataract in the first 2 years from policy issuance as there was a 2 year 'waiting period'. Further, in the claim form submitted to the insurer, the complainant clearly furnished his replies to the column "Ailment/Hospital details" stating that his first consultation was on 24.12.2012, and the illness was first detected "3 months" prior to that date. As such, 3 months prior to his first consultation comes within the 'waiting period' of 2 years from commencement of policy, i.e., 20.12.2010. Therefore, I agree with insurer that the complainant claim for reimbursement of the medical expenses was not covered under the terms of the policy. As such, the decision of insurer in rejecting the claim was in order.

However, the operation underwent by the complainant was after 2 years of commencement of the policy and it could not be determined exactly from which date onwards the said ailment had commenced. Though technically, the claim of the complainant was not payable as per the terms of policy, keeping in view the peculiar circumstances of the case, in my considered opinion, the complainant deserves to be given appropriate consolation benefit, with an ex-gratia settlement of Rs. 20,000/-.

In view of what has been stated above, the insurer is directed to settle an amount of Rs. 20,000/- in favour of the complainant, as an ex-gratia payment.

In the result, the complaint is allowed partly under ex-gratia.

Hyderabad Ombudsman Centre
Case No. L-23-006-336-2013-14

Mrs. Kamala Gopal
Vs
Birla Sun Life Insurance Co. Ltd.
Award Dated : 9.12.2013

Mrs. Kamala Gopal filed a complaint that a wrong policy was issued to her by Birla Sun life Insurance Company and her request for cancellation of the same was denied; hence, she requested for refund of premium paid.

On careful consideration of the contentions of both the parties and the documentary evidence adduced by them, it was noticed that the complainant was 73 years old, childless and having lot of health problems. Her only source of income was pension. In the said background, it was uncommon to expect her to invest money for risk coverage of a third person, i.e. her sister's son. In the proposal form, the relationship of the complainant with the life assured was mentioned as 'Mother', which is incorrect.

Further, it was evident from the complainant letter dated 26.10.2012 addressed to the insurer that the representatives of the insurer tried to convince her that she gets the benefit of medical-expenses reimbursement under the policy. Immediately after receipt of the modified policy document also, she conveyed the above facts to the insurer and requested for refund of the amount paid by her. The series of communications on the issue between the complainant and the insurer amply proves the fact that the policy issued to her was not to her desired benefits.

It was a fact that the complainant had availed the 'free-look' option earlier to the modified policy. But that does not mean that a policy holder cannot seek remedy in case the modified policy issued after the free look period also does not address the concerns pointed out earlier. In my view, as the concerns expressed by her were appearing genuine, denial of cancellation of the policy was not justified on the part of the insurer.

In my considered view, there must be a definite role of the Agent who had actively canvassed and induced the complainant to take the policy on the life of her sister's son. As such, entire blame cannot be attributed to the complainant. Hence, it would be appropriate to compensate the complainant with refund of the premium received under the policy, in the interest of justice.

In view of what has been stated above, the complaint is partly allowed and the insurer is directed to refund the premium received under the policy, under ex-gratia to the complainant.

Hyderabad Ombudsman Centre
Case No. L-041-1314-0169

Mr. M. Laxminarayana
Vs
SBI Life Insurance Company Limited

Award Dated : 07.01.2014

Mr. M Laxminarayana filed a complaint that he took an insurance policy from SBI Life Insurance Company Limited, in the year 2011. The said policy was wrongly cancelled by the insurer and his request for refund of premiums was rejected by the insurer. Hence, he requested for refund of the premium.

Pursuant to the notices issued by this office, complainant was absent and representative of insurer attended the hearing conducted at Hyderabad on 30.12.2013.

The representative of the insurer submitted that the policy of the complainant was cancelled in view of suppression of his actual health condition at the time of taking of the policy. They came to know through his second proposal that he was 'diabetic and hypertensive' even prior to the policy issued to him. As such, on the ground of breach of 'utmost good faith', the policy was cancelled and forfeited the premium under 'forfeiture regulations'. However, though they were entitled to forfeit the entire premium received

under the policy, they reviewed the case afresh and decided to refund the surrender value of the policy as a special case. Accordingly, on 9.12.2013 an amount of Rs. 32,480/- was credited to his Bank Account no. 62082829349. Hence, he requested to close the complaint.

Based on the aforesaid submissions of insurer, it is clear that the matter has since been settled by them amicably. The complainant didn't attend the hearing. This is a clear indication that he is not interested in pursuing the matter any longer.

As the complaint has been amicably settled, no further relief is considered necessary. For statistical purpose, it is deemed to have been partly allowed.

Hyderabad Ombudsman Centre
Case No. L-019-1314- 0136

Mr. B. Prabhakar
Vs
HDFC Standard Life Insurance Co. Ltd.

Award Dated : 20.01.2014

Mr. Bandi Prabhakar filed a complaint that he had taken an insurance policy reluctantly, under the scheme of Credit card of his banker, from HDFC StandardLife Insurance Company Limited. He did not receive the policy document, but the insurer refused to cancel the policy on the pretext that it was a time barred request. Hence, he requested for cancellation of the policy and refund of premium recovered from him.

Pursuant to the notices issued by this office, both the parties attended the hearing held at Rajahmundry on 11.12.2013.

At the hearing the complainant repeated what was stated in the complaint and had produced the evidence of his suffering from the ailments. As such, requested for refund of the premium debited to his bank account.

On the other hand, the representatives of the insurer submitted that they had

reviewed the matter and decided to cancel the policy and refund the premium received there under.

In view of the submissions of the insurer that they had reviewed the matter and decided to refund the premiums, their representatives were asked to furnish the details in a note, within a week, how the issue of the complainant has been addressed.

Subsequently, on 10.1.2014 an email has been received from the insurer, informing that the matter had been settled by refunding the premium received under the policy to the complainant. Accordingly, a cheque bearing no. 377765 dated 2.12.2013 for an amount of Rs. 50,000/- had been sent to the complainant and the same was encashed by him on 30.12.2013.

Since the matter has been resolved by the insurer, apparently there was no issue to be decided.

In the result, the complaint is closed as settled.

Hyderabad Ombudsman Centre
Case No.L-002-1314-0044

Mr. M.V.S. Subrahmanyam,
Vs
SBI Life Insurance Company Limited
Award Dated : 6.9.2013

Mr. M.V.S. Subrahmanyam filed a complaint that he had taken an insurance policy from SBI Life Insurance Co. Ltd.; however, the insurer had debited the installment premium to his bank account without his knowledge. Hence, he requested for refund of the premium.

On careful consideration of the written and oral submissions of both the parties and the documentary evidence adduced by them, it was noticed that the policy was issued to the complainant by collecting the initial premium in cash. The

policyholder/complainant had authorized the Branch Manager, State Bank of India, Annavaam Branch by way of a SIEFT dated 29.2.2012, to debit the periodical renewal premium of the policy, to his bank account no. 11313354342.

During the hearing, after being apprised of the aforesaid fact of authorizing the bank by way of a SIEFT, the complainant realized that the renewal premium was debited to his bank account as per his instructions; as such, he has agreed to continue the policy and not insist for either cancellation or refund of premium.

In view of the above stated reasons, since the matter has been amicably sorted by both the parties, the complaint is dismissed.

KOCHI *

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/LI/21-001-139/2012-13

P D Thambi

Vs

LIC of India

AWARD No. IO/KCH/LI/82/13-14 dated 09.10.2013

Policy bearing No. 776166846 was assigned in favour of the complainant on 24.02.2011. He submitted an application for surrender of the policy on 04.04.2011 in the Branch Office of the insurer. The insurer did not allow the surrender. The complainant is aggrieved and therefore, the complaint.

The complainant submitted that the policy taken by Smt. Rahana was assigned in his favour on 24.02.2011 and that assignment was registered and an endorsement was made to that effect in the policy document. He submitted a request for surrender of the policy on 04.04.2011 The complainant, who is the assignee of the policy, is entitled to surrender the policy and receive surrender value.

The insurer submitted that the complainant, who is the assignee of the policy, had already reassigned the policy in favour of the original policyholder. So, the complainant is not entitled to receive any benefit under the policy. It was further submitted that the complainant is an Agent of the insurer and the very assignment of the policy in his favour is not proper. The insurer would concede that the alleged reassignment in favour of the policyholder is not endorsed in the policy document.

Decision:- The complainant is still in possession of the original policy documents. Assignment of the policy vide registration No. 3416 on 24.02.2011 is endorsed in it. Admittedly, there is no endorsement of the alleged reassignment of the policy done on 20.06.2011. If there was actual reassignment of the policy in favour of Smt. Rahana, that would have been noted in the policy. Further, the original policy document will be with her. The insurer failed to produce any request made by the complainant for reassignment of the policy in favour of Smt. Rahana. So, the only conclusion that can be arrived at is that there is no reassignment of the policy by the complainant in favour of Smt. Rahana. At the same time, there is sufficient evidence to conclude that there is valid assignment of the policy in favour of the complainant. The word 'assignment' means transferring the interest a man has in anything to another. So, by virtue of the assignment, the assignor had transferred her interest in the policy in favour of the assignee – the complainant. The complainant had submitted application to surrender the policy on 04.04.2011. The insurer had not intimated the complainant regarding any deficiency in the surrender request made by him. The policy conditions would reveal that there is provision for surrender of the policy without surrender charge. So, the complainant is entitled to receive surrender value. In the result, the insurer is directed to process the surrender request submitted by the complainant and provide surrender value to him promptly within the prescribed period failing which, the amount payable to the complainant shall carry interest at 9% per annum from the date of filing of the complaint till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/LI/21-015-120/2012-13

M Kumaran

Vs

Bharti AXA Life Insurance Co, Ltd.

AWARD No. IO/KCH/LI/83/13-14 dated 10.10.2013

The complainant had taken Future Confident II plan policy from the Respondent-Insurer in 2008. He had paid three half yearly premiums of Rs.6,000/- each.Due to financial

difficulty, he could not make payment of further premiums. The insurer closed the policy and sent a cheque for Rs.2,855.10 in 2012. Therefore, the complaint.

The complainant submitted that he had returned the cheque to the insurer At the time of taking the policy, he was given assurance that he can surrender the policy and will get refund of the entire premium paid by him. He had been cheated by the insurer. He is entitled to refund of the premium amount paid by him.

The insurer submitted that on account of non-payment of 4th half yearly premium even within the grace period, the policy lapsed as per Section 4.5 of the policy conditions. As there was no revival of the policy within the revival period, it got terminated. Fund value less surrender charge available in the policy was provided to the complainant. The complainant is not entitled to any further amount.

Decision:- An insurance policy is the creation of a contract of insurance between the insured and the insurer. The rights and liabilities of the parties to the contract are governed by the policy conditions. The complainant can claim only the benefits provided under the policy terms and conditions. In this case, the policy lapsed and thereafter, the policy got terminated on account of non-reinstatement of the policy as provided under Section 4.5 of the policy. So, the policy was terminated as provided under Section 8 of the policy conditions. As per Section 7.5 of the policy conditions, the surrender charge leviable is 80% of the Fund Value in the 2nd policy year. As per the terms and conditions of the policy, the complainant is entitled to surrender value of Rs.2,855.10 only. That is his legal entitlement. But he had invested his hard earned money of Rs.18,000/- in the policy. The Account Summary would reveal that Insurer had earned substantially while the complainant had received a meagre amount. It is to meet such pathetic situations Rule 18 of the RPG Rules has been incorporated. Rule 18 empowers the Insurance Ombudsman to award Ex-gratia payment in appropriate cases. On a consideration of the entire facts, evidence and circumstances available in the complaint, I am satisfied that this is a fit case where Rule 18 of RPG Rules can be invoked so as to direct the insurer to pay a further amount of Rs.5,000/- to the complainant on Ex-gratia basis. In the result, an award is passed directing the insurer to pay Rs.7,855.10 (Rs.2,855.10 and Rs.5,000/- Ex-gratia payment) within the prescribed period failing which, the entire amount shall carry interest at 9% per annum from the date of award till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/LI/21-009-219/2012-13

P C Devayani

Vs

Bajaj Allianz Life Insurance Co, Ltd.

AWARD No. IO/KCH/LI/86/13-14 dated 23.10.2013

The complainant had taken a policy from the Respondent-Insurer on the belief that on maturity she could withdraw the entire amount. On attaining maturity, the insurer informed that the amount had been re-invested and she will not be able to withdraw the amount. But she will be getting pension for her entire life. She had not consented for the re-investment of the original policy amount. She is entitled to get refund of the maturity benefit. Therefore, the complaint.

The insurer submitted that though the maturity intimation was given to the complainant well in advance, she neither surrendered the policy nor exercised the options available on maturity. Out of the maturity value of Rs. 66813/- , Rs. 22271/- was paid to her as commutation and the balance was utilized for purchase of Annuity on her life. She had submitted her option for the same on 03.10.2012 . Now she can not seek refund of the entire maturity value.

Decision:- There is no dispute at all regarding the policy issued. The policy was issued under New Unit Gain Easy Pension Plus Plan with single premium of Rs. 50000/- and DOC 03.01.2007. The maturity and vesting date is shown as 03.01.2012. Admittedly, the complainant did not surrender the policy prior to 03.01.2012. There is no reliable evidence that the maturity intimation was sent to the complainant prior to the vesting date. The insurer has informed that, out of the maturity value of Rs. 66813/- , Rs. 22271/- was paid to the complainant as commutation value and the balance was utilized for purchase of Annuity on her life. They have also produced the unit the statement on maturity. The insurer has produced copies of Maturity Discharge Form and Annuity Form for Annuity Product purportedly signed by the complainant. The seal would indicate that those documents were received in their office on 03.12.2012. They have also informed that a new policy was issued to the complainant for Annuity payment. This aspect is not disclosed by the complainant in her complaint. All these circumstances would lead to the conclusion that neither the complainant nor the insurer had approached this Forum with clean hands. The facts now disclosed neither support the averments in the complaint nor the pleadings in the Self Contained Note. In the circumstances, the complainant is not entitled to any relief in the complaint. In the result, the complaint is dismissed. No cost.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/LI/21-009-138/2012-13
M C Mathew

Vs

Bajaj Allianz Life Insurance Co, Ltd.

AWARD No. IO/KCH/LI/84/13-14 dated 22.10.2013

The complainant had taken policy from the Respondent-Insurer in 2005 by investing an amount of Rs. One Lakh. He did not receive any notice from the insurer regarding maturity of the policy. While so, he received another policy document and he sent a letter to the insurer seeking free-look cancellation of the new policy. The request was denied by the Insurer stating that the new policy is a continuation of the earlier policy and therefore, the free-look cancellation facility is not available. Therefore, the complaint.

The complainant submitted that only in January 2010 he knew that the policy issued to him was a Pension plan. Certain forms were got signed from him for disbursement of the maturity amount and an amount of Rs.97,797/- was credited in his account and thereafter he received policy documents under New Pension plan. He is entitled to refund of the premium irrespective of the annuity received by him from the insurer.

The insurer submitted that the complainant had taken a Pension policy and it attained maturity on 28.09.2010. He exercised his Annuity option and accordingly, he was paid 33% of the fund value and the balance 67% plus 2% extra was utilized for purchasing Pension Guarantee policy. The complainant had received annuity for two years. As the new policy issued is a continuation of the earlier policy by investing the fund value of the first policy, the complainant is not entitled to free-look cancellation of the new policy.

Decision:- There is no mention in the 2nd policy schedule that the rights and liabilities of the insured and the insurer will be controlled by the policy conditions of the previous policy, i.e, the First policy. The Second policy issued is under a different plan. The contents of the Second policy schedule would reveal that it is the outcome of a new contract of insurance. So, the Second policy has independent existence and is not dependant on the First policy. The terms and conditions of the Second policy govern the rights and liabilities of the parties to the contract of insurance in that policy. The Insurer had very specifically stated in the welcome letter that the insured is entitled to free-look cancellation of the policy if the same is submitted within 15 days. The right of the insured to have free-look cancellation of the policy is specifically mentioned in Section.10 of the policy conditions. Now, the Insurer cannot turn round and contend that the contents of the welcome letter and Section.10 of the policy conditions are not applicable or available to the complainant. Annuity is being paid from the benefits being derived by the Insurer

by investing the purchase price which is available intact. So, rejection of the request for free-look cancellation of the policy is against the policy conditions and therefore, cannot be sustained. In the result, an award is passed directing the Insurer to allow free-look cancellation of the policy bearing No. 0204381803 and refund the purchase price less stamp duty charges within the prescribed period, failing which, the refund amount shall carry interest at 9% per annum from the date of filing of the complaint(23.05.2012) till payment is effected. No cost

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<u>OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI</u>

Complaint No. IO/KCH/LI/22-009-173/2012-13

Dr. Tom Mathew

Vs

Bajaj Allianz Life Insurance Co, Ltd.

<u>AWARD No. IO/KCH/LI/85/13-14 dated 22.10.2013</u>

The complainant had taken unit linked insurance policy from the Respondent-Insurer in 2005. He had issued a cheque for Rs.25,000/- towards 2nd year premium. Thereafter, he paid 3rd year premium. Now, it is revealed that the cheque issued towards 2nd premium had not been collected by the Insurer due to their negligence. He is entitled to receive refund of premium paid by him with compensation and interest. Therefore, the complaint.

The complainant submitted that he was issued with proper receipts from the insurer for all his premium payments. He is suffering from the negligence on the part of the insurer. He has lost confidence in the Insurer and does not want to continue the policy. The Insurer had already received Rs.50,000/- from him. He is entitled to refund of the premium paid with compensation and cost.

The insurer submitted that the cheque for 2nd premium was sent for collection and later it was revealed that the cheque was lost in transit. In the meanwhile, the cheque issued by the complainant in August 2007 was collected and that amount was credited towards third premium. The complainant can still revive the policy by paying premiums due. The complainant is not entitled to refund of the premiums paid by him.

Decision:- The Insurer has no case that the cheque issued by the complainant was dishonoured for want of amount in his account to honour the cheque. So, by issuing a cheque for Rs.25,000/- on 23.08.2006, the complainant had performed his part of the contract of insurance. No action was initiated by the insurer to trace the cheque or to intimate the loss of the cheque to the complainant. The Insurer did not demand a new cheque from the complainant towards 2nd premium and kept idle. There is no

explanation forthcoming from the side of the Insurer for receipt of 3rd premium in a lapsed policy. The Insurer has no case that after the lapsation of the policy on 30.08.2006, the policy was revived by payment of premium due by the complainant. All these facts and circumstances would reveal that the Insurer had not acted in good faith, which is the most important ingredient of a contract of insurance. No proper service was provided by the Insurer. All these circumstances are sufficient enough to direct the Insurer to cancel the policy and provide refund of premium to the complainant. In the result, an award is passed directing the Insurer to cancel Policy No. 0008301910 (Allianz Bajaj Unit Gain Plus policy) issued to the complainant and provide him refund of premium (Rs.50,000/-) after deducting stamp duty, within the prescribed period , failing which, the refund amount shall carry interest at 9% per annum from the date of filing of the complaint (11.06.2012) till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/LI/21-006-202/2012-13

K A Vargis

Vs

Birla Sun Life Insurance Co, Ltd.

AWARD No. IO/KCH/LI/87/13-14 dated 24.10.2013

The complainant had taken Secure 58 policy from the Respondent-Insurer in favour of his daughter on 26.11.2011 paying Rs. 3 lacs as premium. He submitted a request for free-look period cancellation of the policy. After much delay , he received a cheque for Rs. 299280/- on 14.05.2012. He had not been paid interest for the delayed period and also an amount of Rs. 720/- was deducted towards stamp duty without any reason. Therefore, the complaint.

The insurer submitted that on the basis of the request made by the complainant the policy was cancelled and an amount of Rs. 299720/- was refunded to him. Re. 720/- was deducted towards stamp duty charges paid already. No delay had occurred in providing refund of the premium. The complaint is only to be dismissed.

Decision:- "The free look period" is provided in the policy conditions. Refund of premium is subject to the right of the insurer to reduce the amount of the refund by expenses incurred by them in issuing the policy and as permitted by IRDA. In IRDA(Protection of Policy holder's Interest) Regulations 2002, Reg. No. 6(2) , 15 days free-look cancellation option is provided and here itself it is provided that expenses such as proportionate risk premium for the period of cover , medical exam fee and stamp duty charges are allowed to be deducted from the refund amount. So, the deduction of stamp duty charges is authorized by the above mentioned Regulation. Apart from stamp duty, no other amount

was deducted from the premium paid by the insured. So, it can be seen that the deduction of stamp duty charges is authorized by the Regulation and policy conditions. It is seen that the cancellation request was received by the insurer on 29.02.2012. Therefore , the complainant can not contend that there is inordinate and unreasonable delay in allowing the free-look cancellation. So, the request made by the complainant for interest on account of delay can not be allowed. So, the complainant is not entitled to any relief in the complaint. In the result, the complaint is dismissed, No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/LI/21-006-149/2012-13

K Giridhar

Vs

Birla Sun Life Insurance Co, Ltd.

AWARD No. IO/KCH/LI/89/13-14 dated 28.10.2013

The complainant and his wife had taken 3 Saral Jeevan policies from the Respondent-Insurer. At the time of taking the policies, the understanding was that the complainants need not pay further premiums and that they could get benefits under the policies at the end of the 4th year. Thereafter, it was revealed that the complainants have to pay further premiums. They are not in a position to pay further premiums. They are entitled to get refund of the premiums paid by them. Therefore, the complaint.

The complainant submitted that no further payment was made as they were under the impression that the policies were single premium policies. The Agent of the Insurer had cheated them. The first complainant further submitted that surrender may be allowed and refund may be granted on compassionate ground.

The insurer submitted that the policies issued were regular premium policies with policy term and premium term of 20 years. The complainants had paid the initial premium only. The first complainant issued two cheques towards defaulted premiums in the first and second policies taken by him and those cheques were dishonoured on account of Stop Payment Memos issued by the complainant. As there was no revival of the policies, all the three policies had been terminated. The entire fund value available had been appropriated towards surrender charge.

Decision:- The policies were issued based on contract of insurance. The policy conditions govern the rights and liabilities of the parties to the contract, i.e., the insured and the insurer. Compassion, sympathy, etc have no role while deciding the rights and liabilities pertaining to a contract of insurance. The first complainant had invested more than

Rs.90,000/- in his policies. The second complainant had invested Rs.59,360/- in her policy. A perusal of the policy conditions and the fund value statements reveals that the entire fund value available had been appropriated towards surrender charge. This is legally permitted as per the policy conditions. But the fact remains that the complainants have been put to a miserable position. While they are losing their entire investment, the Insurer had gained substantially. They had realized a substantial portion of the investment by way of various charges.The fund value had been appropriated towards surrender charge. It is to meet such situations Rule 18 had been incorporated in the RPG Rules. Rule 18 empowers the Insurance Ombudsman to grant Ex-gratia payment in appropriate cases. When the entire facts, evidence and circumstances are taken into consideration, I am satisfied that this is a fit case where Rule 18 of RPG Rules can be invoked to award Ex-gratia payments to the complainants. In the result, an award is passed as follows :-The Insurer is ordered to pay Ex-gratia payment of Rs.12,000/- in the 1st Policy and Rs. 24000/- in the 2nd policy to the first complainant and Rs.24,000/- in the 3rd Policy to the 2nd complainant. No cost

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/LI/21-006-197/2012-13

B Soumya

Vs

Birla Sun Life Insurance Co, Ltd.

AWARD No. IO/KCH/LI/90/13-14 dated 28.10.2013

The complainant had taken a policy from the Respondent-Insurer in August 2008 by paying premium of Rs.20,302/-. She paid 3 more yearly premiums. At the time of taking the policy, she was told that she could surrender the policy after three years. In 2011, she approached the Insurer for surrender and they insisted production of original policy documents. She had never received policy documents. Therefore, the complaint.

The complainant submitted that though she had taken policy in 2008, she was never provided with the policy documents. She was unable to produce the same for surrender as she never received the original policy documents. The complainant may be allowed to surrender the policy and receive surrender value.

The insurer submitted that the policy was issued to the complainant in August 2008 and the same was despatched to her in the address provided by her. It never returned undelivered. Production of original policy document is required for surrender of the policy. No proper surrender request was submitted by the complainant prior to the submission of the complaint before this Forum. The complaint is only to be dismissed.

Decision:- The Insurer had failed to produce any evidence to the effect that the policy documents were promptly despatched to the complainant. At the same time, it is to be noted that in spite of non- receipt of policy documents in time, the complainant did not raise even a little finger demanding the policy documents. The only conclusion that can be arrived at is that the complainant is not in possession of the original policy documents. As per the provision for policy surrender, the insured can surrender the policy at any time for its surrender value. If the surrender is after the first three policy years, the surrender value is the policy fund value. So, if the surrender is after the first three policy years, there is no surrender charge. If the complainant still desires to surrender the policy, to receive the policy fund value, she can do so and receive the entire policy fund value without deduction of surrender charge. Production of original policy document is a must for receiving surrender value. The complainant can make a proper surrender request complying with the legal formalities related to inability of the insured to produce the original policy document for surrender. The complainant can tide over the given situation either by submitting an Indemnity Bond or an Affidavit as directed by the insurer. In the result, the complaint is disposed of with a direction to the Respondent-Insurer to allow surrender request of the complainant as and when submitted by her, complying with the legal formalities. The complainant shall be provided the entire policy fund value promptly. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/LI/21-013-167/2012-13

Lovely Shaji

Vs

Aviva Life Insurance Co. Ltd

AWARD No. IO/KCH/LI/92/13-14 dated 30.10.2013

The complainant who is settled in Canada had taken Save Guard Policy from the Respondent-Insurer while she was in India in 2007. She had paid three instalments within the due dates amounting to approximately Rs.2,44,000/-. After five years, she received a cheque for Rs.1,78,000/- much less than the invested amount. Therefore, the complaint.

The complainant submitted that the definite understanding at the time of taking the policy was that she need pay only three annual premiums. So, she did not pay further premiums. She had been cheated by the agent of the Insurer. She is entitled to receive at least the entire premium amount paid by her with interest.

The insurer submitted that the complainant had applied for a policy with term of 15 years. The policy was issued based on the proposal submitted. The complainant did not

pay premium due in 2010 (4th instalment). As there was no revival request from the side of the complainant even after 2 years, the policy was terminated by virtue of Article 13 of the Policy conditions. and was issued a cheque for Rs.1,78,000/- being the surrender value. They had acted strictly in accordance with the policy conditions. Nothing more is payable now.

Decision:-Admittedly, the policy was issued based on the proposal submitted by the complainant. As per the proposal form, the complainant applied for Save Guard Policy wherein the policy term and premium paying term are 15 years. Annual premium payable is Rs.78,000/- and Sum Assured is Rs.5,85,000/-. The complainant had not raised any allegation regarding the contents of the proposal form. It is seen that the policy was issued based on the request made by the complainant in the proposal form submitted by her. There was no request for free look cancellation of the policy. So, the allegation that the agent of the Insurer cheated the complainant in issuing the policy cannot be sustained. A policy document evidences the contract of insurance between the insurer and insured. The policy conditions govern the rights and liabilities of the parties to the contract. So, the complainant can neither contend nor plead that she is ignorant of the policy conditions and therefore, she did not make payment of further premiums. By virtue of Article 13.4, the policy was automatically terminated on the expiry of the reinstatement period. It is seen from the fund statement that the surrender value payment is in order. The policy with life cover cannot be compared with the fixed deposit in Bank. Fixed deposit does not provide life cover. The policy being Unit linked, Fund Value will depend on market fluctuations. So, the complainant is not entitled to any further relief from the Insurer. In the result, the complaint is dismissed. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/LI/21-008-193/2012-13

P R Ramani

Vs

Kotak Mahindra Old Mutual Life Insurance Co. Ltd

AWARD No. IO/KCH/LI/93/13-14 dated 08.11.2013

The complainant had taken Money Back policy from the Respondent-Insurer by paying premium of Rs.30,000/- on 31.03.2011. Due to financial difficulties, she could not pay further premiums. She had demanded for refund of the premium paid by her. The premium had not been refunded by the insurer. Therefore, the complaint.

The complainant submitted that she took policy on the definite understanding that the same was a single premium policy. She received a letter stating that her policy had lapsed. She had been cheated by the Officers of the Insurer. She is entitled to receive back the premium paid by her.

The Insurer submitted that the complainant had applied for a regular premium policy and accordingly, the policy was issued. The premium paying term was 15 years. As there was no payment of subsequent premiums, the policy lapsed. Even now, the policy can be revived by the complainant by paying the premiums due. The complainant is not entitled to refund of premium.

Decision:- Regarding the policy applied for and received by the complainant, there is no allegation in the complaint filed by her before this Forum. The proposal form would reveal that the complainant had applied for regular premium policy with policy term and premium term of 15 years each. From the policy schedule. it is seen that the policy had been issued based on the proposal submitted by the complainant. . The complainant did not make any request for free-look cancellation. In the complaint given to the insurer as well as the complaint filed before this Forum, the reason for non-payment of further premiums is financial stringency. The averment in the complaint regarding this aspect betrays the new contention of cheating raised by the complainant at the time of hearing. Regarding cheating, there is no averment in the complaint. So also, there is no trace of evidence regarding cheating. Hence, the bald averment regarding cheating stands unsubstantiated. There is no evidence before this Forum that prior to 17.05.2012 the complainant had made any request for cancellation of the policy and refund of the premium. . As per Clause 9 of the policy conditions, only on payment of premium atleast for three consecutive years, the policy will acquire guaranteed surrender value. The complainant had not succeeded in establishing that the policy is vitiated on account of mis-selling or cheating. The policy had not acquired any surrender value as provided under Clause 9 of the policy conditions. Therefore, the complainant is not entitled to the relief of refund of premium prayed by her in the complaint as there is no enabling provision in that regard. In the result, the complaint is dismissed. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/LI/21-005-039/2013-14

A I Jacob

Vs

HDFC Std Life Insurance Co. Ltd

AWARD No. IO/KCH/LI/94/13-14 dated 14.11.2013

The complainant had taken a policy from the Respondent-Insurer paying Rs.1 lakh and believing it to be single premium.. When he read the policy documents, it was revealed that the terms and conditions are entirely different from what was told to him. He is not in a position to remit further premiums. Therefore, the present complaint seeking refund of premium.

The complainant submitted that at the time of applying for the policy, he was given assurance that the policy will be a single premium one. He was provided with a regular premium policy. He wrote to the Insurer for return of the premium. He had been cheated by the Officers of the Insurer. Therefore, he is entitled to get refund of premium paid by him.

The Insurer submitted that the complainant had applied for regular premium policy and based on the contents of the proposal form, policy was issued with premium paying term of 10 years. Due to non payment of premiums, the policy had attained the status of 'Discontinued Policy'. The lock-in period is five years. So, refund of premium or payment of fund value is not possible now.

Decision:- The proposal form would reveal that the complainant had applied for ProGrowth Super II Policy with policy term of 10 years. Annual premium is Rs.1 lakh and Sum Assured Rs.10 lakhs. From the policy schedule it is seen that the complainant was issued with policy as requested by him in the proposal form. The complainant did not make any request for free look cancellation. So, it is to be inferred that the complainant was satisfied with the policy received by him. The argument of the complainant that he did not go through the contents of the policy documents is not in tune with the conduct of an ordinary prudent person. The above discussed situation would reveal that no element of cheating is involved in the issuance of the policy to the complainant. Policy conditions form part of the policy. The rights and liabilities of insured and the insurer are controlled and governed by the policy conditions. . The detailed Unit Statement submitted by the Respondent-Insurer would reveal that the policy had attained 'Auto Discontinued' status on 26-03-2013. The Unit Fund Value available as on that date was Rs.85,195.70. Unit Fund Value less Discontinuance Charge will go to Discontinued Policy Fund as provided in the policy conditions. As the lock-in-period is five years, the complainant is entitled to receive Discontinued Policy Fund with accrued interest only on

completion of the lock-in-period. From the above discussions, it can be found that the complainant is not entitled refund of the premium. Therefore, the complainant is not entitled to the relief prayed in the complaint. In the result, the complaint is dismissed. No costs.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/LI/21-007-215/2012-13

Balan Kalathil

Vs

Max Life Insurance Co. Ltd

AWARD No. IO/KCH/LI/95/13-14 dated 14.11.2013

Complainant is the holder of Amsure Family Money Back policy issued by the Respondent-Insurer. When the policy lapsed due to non-payment of premiums, he made an application for revival of the policy. But the insurer declined to reinstate the policy. He is entitled to get the policy revived or else, to get the refund the premium paid by him. Therefore, the complaint.

The complainant submitted that he had paid four annual premiums of Rs.21,125/- each. He is entitled to refund of the entire premium paid by him prior to lapsation of the policy. He is now pressing the relief of refund of premium only.

The insurer submitted that the complainant took policy after understanding all the features and policy conditions. The policy provides life cover and the term is 19 years. The complainant remitted premiums till the year 2009 only. The required medical documents to ascertain his health condition for revival, were not submitted by him. Therefore, they refused to revive the policy. He is not entitled to receive cash value as the policy is not in force.

Decision:- An insurance policy is the creation of a contract of insurance entered into between the insured and the insurer. The rights and liabilities of the parties to the contract are governed by the policy conditions. As per the policy provisions, premiums are payable on the due date specified in the policy schedule. A grace period of 15 days from the due date of payment of premium is provided. It is stated that if the premium is not paid by the end of the grace period, the policy will lapse. It is also stated that if the policy had acquired Cash Value, then there will be non-forfeiture provision as opted by the proposer in the proposal form. In the instant case, as the complainant had paid four annual premiums, the policy had acquired Cash Value as per policy conditions. The right to surrender the policy cannot be denied by the insurer as the policy had acquired Cash

Value. A perusal of the policy conditions would reveal that there is no policy provision which would enable the insured to receive refund of the premium after the policy had run for four policy years and lapsed on account of non-payment of further premiums. If the complainant is desirous of surrendering the policy, he can do so for getting the Surrender value. The complainant is not entitled to the relief of refund of premiums. In the result, the complaint is disposed of directing the Respondent-Insurer to promptly provide surrender value to the complainant, if he opts to surrender the policy. This need not be taken as a direction to the complainant to surrender the policy. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/LI/21-001-220/2012-13

Rajeev R

Vs

LIC of India

AWARD No. IO/KCH/LI/96/13-14 dated 15.11.2013

The complainant and his family members are covered under Health Plus policy issued by the Respondent-Insurer. He was admitted in MCH, Tvm and underwent Coronary Angiography. The claim for MSB was repudiated by the insurer stating that surgery conducted was not a listed surgery entitling Major Surgical Benefit. Therefore, the complaint.

The complainant submitted that he underwent Angioplasty. It is not true to state that he had not undergone any surgery for removal of block in the coronary artery. The surgery was a major one and the risk involved is similar to open heart surgery.Therefore, he is entitled to Major Surgical Benefit provided under the policy.

The insurer submitted that the complainant's hospitalisation at Medical College Hospital, Thiruvananthapuram was for three days and he was provided Hospital Cash Benefit for one day after excluding the first 48 hours. No stent was implanted in the case of the complainant. If only a minimum of two stents are implanted, it will be considered as a major surgery listed in the policy/Appendix. So, they rightly repudiated the claim for Major Surgical Benefit.

Decision:- Health Plus policy does not provide reimbursement of hospital expenses. The policy provides three benefits, Hospital Cash Benefit, Major surgical Benefit and Domiciliary Treatment Benefit. Hospital Cash Benefit and Major Surgical Benefit are as per the rates/percentage of Sum Assured prescribed in the policy. In the Surgical Benefit Annexure, 49 major surgeries are listed. As per the policy, if only the insured undergoes

any one of the surgeries listed, he is entitled to Major Surgical Benefit. Case Summary issued from Medical College Hospital, Thiruvananthapuram, shows the diagnosis as CAD-IWMI. The procedure done is Coronary Angiography. The lesion was dilated twice with balloon. After the procedure, the lesion partially opened up. It is specifically stated that since terminal OM is small vessel, stenting was not done. So, it can be seen that the procedure underwent by the complainant is not a Major Surgical Procedure listed in the Annexure as there was no stenting done.. So, the complainant is not entitled to Major Surgical Benefit provided under the policy. As the procedure underwent by the complainant does not qualify for Major Surgical Benefit provided under the policy, the repudiation decision taken by the Respondent-Insurer is sustainable. In the result, the complaint is dismissed. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/LI/21-011-221/2012-13

P N Raveendran pillai

Vs

ING Vysya Life Insurance Co. Ltd

AWARD No. IO/KCH/LI/98/13-14 dated 18.11.2013

The complainant on the insistence of the Manager of ING Vysya Bank, invested Rs.1 lakh in ING Vysya Life Insurance. He was made to believe that the policy will give better returns than the bank deposit. When he approached the insurer for surrender, he was told that he had been issued with a Pension Policy. These facts were not disclosed to him at the time of applying for the policy. Therefore, the complainant is seeking return of premium with interest.

The complainant submitted that he wanted a single premium policy . When he surrendered the policy, the amount received was much less than the amount invested by him towards premium. He is entitled to receive the balance amount with interest.

The Insurer submitted that the complainant submitted proposal form after understanding the policy features and, terms and conditions . Policy was issued as requested by him in the proposal form. After completion of three policy years, he surrendered the policy and received the surrender value. After receiving the surrender value, he cannot seek refund of the premium paid by him.

Decision:- Admittedly, the complainant is a retired Govt. employee. He is educated. Policy was issued based on the proposal submitted by him. Regarding the contents of the proposal form, the complainant had not raised any allegation. Copy of the proposal form

would reveal that he had applied for the policy with a premium paying term of 5 years and vesting period of 10 years. Copy of the policy schedule would reveal that the policy was issued in accordance with the request made by the complainant in the proposal form. He did not make any request for free look cancellation of the policy. The complainant surrendered the policy on 17-12-2012. The policy conditions form part of the policy. The policy conditions govern the rights and liabilities of the parties to the contract, that is, the insured and the Insurer. As per Clause 9.3.1, the surrender benefit will be fund value minus surrender charge. It is seen that the payment made is in accordance with the policy conditions. The complainant cannot contend that he is not bound by the policy conditions. After having paid the initial premium, having committed default in payment of further premiums and having surrendered the policy as provided under the policy conditions, the complainant cannot now contend that surrender charge is not leviable as provided under the policy conditions. So, the Insurer had acted in accordance with the policy conditions. The claim advanced by the complainant for further amount is not sustainable. In the result, the complaint is dismissed. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/LI/21-001-199/2012-13

Dr. V Gopalakrishna Pai
Vs
LIC of India

AWARD No. IO/KCH/LI/99/13-14 dated 19.11.2013

The complainant had taken two Money Back policies from the Respondent-Insurer. Both policies were taken in July 1987. From October 1987, the Respondent-Insurer increased rebates on Sum Assured and Mode of payment. The complainant made a request for availing that benefit for the policies taken by him. There was no positive response from the side of the insurer. Therefore, the complaint.

The complainant submitted that the conclusion arrived at by the Insurer that the rebates are not applicable to the policies which commenced prior to 03.10.1987, is without any basis. He is also entitled to the rebate irrespective of the date of commencement of the policies.

The insurer submitted that Circular No. 1386/4 dated 01.10.1987 issued by the Insurer is very definite that the Sum Assured rebate and Mode rebate are available only to policies which commenced after 03.10.1987. The policies taken by the complainant and his wife commenced prior to 03.10.1987 and therefore, the complainant is not entitled to claim the benefit of the circular. It was also argued by the Officer that the complainant had been provided with the difference in premium, collected wrongly. The complaint is only to be dismissed.

Decision:- A close reading of the contents of the circular is required for understanding and deciding the dispute. There is no specific mention in the circular that policies commenced prior to 03.10.1987 are excluded from the benefit of rebate. There is no exclusion made in the circular in relation to policies which commenced prior to 03.10.1987. So also, there is no specific mention in the circular that the benefit is available only to policies which commenced on or after 03.10.1987. The circular is concluded by stating "7. The above revision comes into effect from 03.10.1987". Now, we have to gather what was the intention of the Insurer while issuing such a circular. The intention is to be gathered from the contents of the circular as well as the wordings used. Hon'ble SC in one of its latest decisions pronounced on 08.10.2013 in Union of India Vs. National Federation of the Blind, while dealing with interpretation of a provision in 'Persons with Disabilities Act 1995' held that while interpreting any provision of a statute, the plain meaning has to be given effect and when the language therein is simple and unambiguous, there is no need to traverse beyond the same. The principle laid down by the Hon'ble Apex Court in that decision can be borrowed for deciding the instant case also. So, it can be concluded that the benefit of Sum Assured rebate and Mode rebate must be made available in the policies in dispute with effect from 03.10.1987. In the result, an award is passed directing the Insurer to quantify and pay the benefit of Sum Assured rebate and Mode rebate made available vide circular No.1386/4 dated 01.10.1987 to both policies w.e.f. from 03.10.1987, within the prescribed period, failing which, the amount payable shall carry interest at 9% per annum from the date of filing of the complaint till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/LI/21-001-207/2013-14

K A Raghavan

Vs

LIC of India

AWARD No. IO/KCH/LI/100/13-14 dated 21.11.2013

The complainant, a retired Naval Officer, had taken Jeevan Akshay-VI policy from the Respondent-Insurer. He was told that he can surrender the policy at any time after one year. He invested Rs.8 Lakhs in the policy in 2010. After 2 years, he requested for surrender of the policy on medical ground. The insurer rejected his request. Therefore, the complaint.

The complainant submitted that he had invested his pension benefits, in the policy. .He had been receiving monthly pension @Rs.5,793/-. If surrender is not allowed, he may not be able to continue his treatment and the entire investment made by him would become futile. So, surrender of the policy is to be ordered.

The insurer submitted that in the proposal form, the complainant had exercised pension Option 'I' and policy was issued accordingly. The policy taken by the complainant is under Immediate Annuity plan and he had been receiving monthly pension @ Rs.5,793/-. As per the policy conditions, surrender is not possible. Therefore, they rightly rejected the surrender request of the complainant. The complainant is not entitled to any relief.

Decision:- The complainant had been receiving monthly pension @ Rs.5,793/- for the last three years. Regarding the policy received by him, he had not made any challenge before making surrender request. The complainant has no case that he did not go through the policy and the policy conditions. He has no case that the policy issued to him was not in tune with the request made by him in the proposal form. In the policy conditions and privileges, which form part of the policy, there is specific mention that the policy will not acquire any surrender value. L.I.C. of India decided to allow surrender of Immediate and Deferred Annuity policies on certain terms and conditions. Such a decision was taken by the Respondent-Insurer on humanitarian consideration. The complainant had exercised pension Option 'I'. Where pension option exercised is other than Option 'F', surrender of the policy is not allowable even on medical ground as per the contents of the circulars. Advantages and disadvantages are inherent in the policy and they run with the policy and policy conditions. The rights and liabilities of the parties to the contract are governed by the policy conditions. While interpreting a contract of insurance, compassion, sympathy, poverty etc have no role at all. The provisions of a contract of insurance are to be construed strictly. Even a Court of Law or a quasi judicial authority cannot add, amend or incorporate any new provision in the policy conditions so as to help the insured or the insurer. The relief sought by the complainant cannot be allowed. In the result, the complaint is dismissed. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/LI/21-001-230/2012-13

P M George

Vs

LIC of India

AWARD No. IO/KCH/LI/101/13-14 dated 21.11.2013

The complainant had taken Money Back policy from the Respondent-Insurer. Survival Benefit of Rs.10,000/- was due to him on 28.09.2011. But he was issued with a cheque for

Rs.8,228/-. It was revealed that the Insurer had debited premium amounts from the Survival Benefit amount. Therefore, the complaint.

The complainant submitted that two premiums already paid by him had been deducted from the Survival Benefit amount. He had suffered monetary loss on account of part payment of the Survival Benefit. So also, the Insurer had caused mental agony to him. According to him, he is entitled to compensation on account of the financial loss suffered by him and also on account of mental harassment meted out to him by the Insurer.

The insurer submitted that premium due in March and June 2011 were deducted from the SB payable to the complainant. He had paid those premiums on 31.08.2011. Before receipt of those premiums, the payment under the policy was effected on 23.08.2011. The excess premiums were adjusted towards future dues. Thereafter, the complainant was issued with a cheque for Rs.433/- towards interest on account of delayed payment. The compensation claimed cannot be allowed.

Decision:- The Insurer did not take any step to refund the excess premium paid by the complainant. But they adjusted the excess amount towards premiums due in December 2011 and March 2012. That adjustment of premium was without the consent and knowledge of the complainant. The insurer's contention is that the complainant had not suffered any monetary loss and if at all any monetary loss was there, it was taken care of by issuing a cheque for Rs.433/-. The Respondent-Insurer had conveniently forgotten the human element involved in the issue. The complainant is a painter getting a meagre income. He was expecting Rs.10,000/- which is a huge amount as far as he is concerned. The poor insured was harassed mentally by the insurer. The complainant was put to undue mental strain by the insurer. There was no proper response from the side of the insurer to the several representations made by him seeking Redressal of his grievance. An amount of Rs.2,500/- towards compensation would meet the ends of justice. The Insurer is also liable to issue a fresh cheque for Rs.433/- to the complainant. In the result, an award is passed directing the Respondent-Insurer as follows :-

1. **Issue a fresh cheque for Rs.433/- to the complainant**
2. **To pay Rs.2,500/- towards compensation to the complainant within the prescribed period, failing which, that amount shall carry interest at 9% per annum from 29.06.2012 till payment is effected. No cost.**

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/LI/21-003-074/2012-13

Tomy Thomas

Vs

TATA AIA Life Insurance Co. Ltd

AWARD No. IO/KCH/LI/102/13-14 dated 22.11.2013

The complainant had taken a policy from the Respondent-Insurer bearing No. C 330585444. Credit of Half Yearly premium of Rs.12,173/- made through bank was denied by the insurer. The Insurer had taken up a stand that premium due on 04.06.2010 had not been paid. Therefore, the complaint.

The complainant submitted that the Karukachal Branch of South Indian Bank issued DD No. 43411 dt. 04.06.2010 for Rs.12,173/- towards premium payable in June 2010. The Insurer had wrongly credited that amount in another policy, it is stated. The present stand taken by the Insurer cannot be accepted as they had been receiving payments and crediting the same in the proper policy all along except the payment made on 04.06.2010. The complainant is entitled to refund of the premium paid.

The insurer submitted that they had received DD No.43411 towards payment of premium in policy No.330058544. That was credited in a policy with same number. As that policy was in a lapsed condition, they had refunded the premium of Rs.12,173/- to that policyholder. Now, they are not in a position to recover that amount from that policyholder. Everything happened on account of the wrong policy number mentioned in the DD. The relief sought by the complainant is not allowable.

Decision:- While the Insurer is contending that the payment made by the banker of the complainant was adjusted in another policy and that payment was refunded to the other policyholder, they are bound to produce the relevant documents. They have utterly failed to do so. Inspite of the wrong policy number given in the Demand drafts, except the DD dt. 04.06.2010, all the other demand drafts drawn towards premium payment in Policy No.3300585444 were credited in the policy of the complainant. As to how it happened, there is no explanation from the side of the insurer. So, it is evident that there was no application of mind while making credit of the DD. If the payment effected by the complainant through his bank was credited or appropriated towards premium in another policy held by a stranger and the Insurer had effected refund of that amount to that stranger, the insurer is legally bound to initiate legal action against that stranger-policyholder for refund of the amount received by him without any authority. The Insurer had not initiated any legal action for realization of that amount from that wrong policyholder. In the nature of the facts available in the complaint, the Insurer cannot wash

their hands clean and claim impunity. They are bound to compensate the complainant for the loss suffered by him. In the result, an award is passed directing the Insurer either to refund Rs.12,173/- paid by the complainant vide DD dt. 04.06.2010 or to appropriate that amount towards future premium payable by the complainant in the policy with due intimation to the complainant. No cost.

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MUMBAI
CENTRE

LIFE INSURANCE MISC.CASES
Complaint No.LI- 846 (2013-2014)
Complainant: Shri . Gopal Merani
v/s.
Respondent: Kotak Mahindra Old Mutual Life Insurance Ltd

Award dated 14.03.2014

Kotak Mahindra Old Mutual Life Insurance Ltd issued policy no. 00585594 to Shri Gopal Merani on 27.02. 2007. He requested the company to Switch Over the fund from Guaranteed Growth to Guaranteed Bond on 1st February, 2011 and again from Guaranteed Bond to Guaranteed Growth on 16th February,2012. However the company failed to honour his request. Hence he applied for cancellation of the policy and refund of premium amount along with interest on 10.02.2012. However the company did not accede to his request as request for cancellation of the policy was received beyond free look period.

Aggrieved by their decision Shri Gopal Merani approached the Office of the Insurance Ombudsman seeking intervention in the matter for settlement of his grievance.

The parties to dispute were called for hearing on 10.03.2014 at 11.00 p.m .

The complainant Shri Gopal Merani appeared before the Ombudsman. He submitted his written submission which is taken on record.

Kotak Mahindra Old Mutual Life Insurance Ltd was represented by Shri. Anurag Hurkat. Shri Anurag submitted that the company received Fund Switch Over request i.e.from Guaranteed Growth to Guaranteed Bond from the complainant on 1st February, 2011 and further the company received fund switch request i.e. from Guaranteed Bond to Guaranteed Growth on 16th February, 2012. Shri Anurag accepted that the company failed to carry out both the requests and he apologized for the same. He stated that the company is ready to resolve the grievance of the complainant by continuing his policy giving retrospective effect to his fund switch requests and allotting him additional units whatever is applicable to his policy. Ombudsman asked him whether the complainant had applied for cancellation of the policy, to this he accepted that the company received cancellation request from the complainant on 10.02.2012 but since the request was received beyond free look period, the policy cannot be cancelled, it has to be surrendered.

On hearing the deposition of both the parties to dispute, Ombudsman observed that there is deficiency in service provided by the company since the company had not acceded to the Switch Over request of the complainant . However Ombudsman observed that the company should have rectified the fund value and should have paid the surrender value as on 10.02.2012 with 10.5% interest . Shri Gopal Merani stated that since there is breach of contract, the company should not levy any surrender charges.

Ombudsman directed the company to comply with the following requirements under information to the complainant before 14.3.2014:-

1) **Fund value available under policy no. 00585594 as on the date of last premium paid by the complainant in 2009.**
2) **Fund value as on the date of 1st request for Fund Switch Over and Fund Value available after giving necessary effect of Fund Switch Over as per the request of the complainant.**
3) **Fund value as on the date of 2nd request for Fund Switch Over and Fund Value available after giving necessary effect of Fund Switch Over as per the request of the complainant.**
4) **Surrender Value (after making necessary rectification of Fund Switch Over) as on 10.02.2012.**
5) **Amount of interest @ of 10.5% on the surrender value from 10.02.2012 till date.**

On 13th March, 2014, the forum received email from Kotak Mahindra Old Mutual Life Insurance Ltd wherein the following details were given:-

1) **Fund Value under policy no. 585594 as on the date of last premium paid by the customer in 2009 is Rs. 28402.4923**
2) **Fund value after giving necessary effect of Fund Switch Over (date 01.02.2011) as per the request of the complainant is Rs. 37451.42**
3) **Fund value after giving necessary effect of Fund Switch Over (date 16. 02.2012) as per the request of the complainant is Rs. 40753.68**
4) **Fund Value as on 10.02.2012 is Rs.40677.71 and Surrender Value as on 10.02.2012 is Rs. 39763.60**
5) **Amount of Interest @10.5% on the surrender value from 10.02.2012 till 10.3.2014 is Rs. 8682.68**

The forum is of the view that since the complainant had requested for Fund Switch Over twice which was not given necessary effect by the company, it has lead to inappropriate loss to him. It is also observed that the complainant had applied for cancellation of the policy on 10.02.2012, which was not acceded since the request for cancellation was received beyond the free look period. However the company is ready to give necessary retrospective effect to his fund now .Hence the company is directed to provide him with Surrender value as on 10.02.2012 after giving necessary rectification effect to his fund and interest @ of 10.5% till the date of payment.

ORDER

Kotak Mahindra Old Mutual Life Insurance Ltd is directed to pay Surrender Value of Rs. 39763.60 which was available as on 10.02.2012 to Shri Gopal Merani on cancellation of his Policy No .00585594 along with interest @ of 10.5% from 10.02.2012 till the date of payment. The complainant is directed to give his consent within 7 days of receipt of this Order along with surrender form and policy document to the company. The company should release the payment with 3 days of receipt of the above requirement from the complainant. There is no order for any other relief. The case is disposed of accordingly.

If the complainant is not satisfied with this order, he is free to approach any other Forum /Court for redressal of his grievance, he may deem fit.

(A.K.Dasgupta)
INSURANCE OMBUDSMAN

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Complaint No. LI – 564 (12-13)

Complainant: Smt. Sivilia Rodrigues

V/s

Respondent : SBI Life Insurance Company Ltd.

Award dated :29.11.2013

Mrs. Sivilia Rodrigues had taken policy no. 22000092302 from SBI Life Insurance Company Ltd. on 31.03.2012 by paying a single premium of Rs. 9 lakhs. However on receipt of the policy document, she came to know that she has been cheated by the agent. She had informed the agent that she wanted a policy for Tax Benefit. However agent gave her Annuity policy. She never wanted a policy wherein her money would be blocked for life. She had requested the company to cancel the policy and refund her the premium amount but the company did not accede to her request.

Aggrieved by their decision Smt. Sivilia Rodrigues approached the Office of the Insurance Ombudsman in the matter for settlement of her grievance. The parties to dispute were called for hearing.

Ombudsman asked the company representative why the policy was not cancelled during free look period , to this she stated that Date of commencement of the policy was 31.03.2012 and the complainant had sent for cancellation in 08/2012.Since the complainant had not opted for cancellation during the free look period , the policy was not cancelled . Ombudsman asked her when the customer received the policy document to this, the company representative stated that she is not aware of it and will have to confirm the same from her office. Ombudsman asked the company representative when the policy was signed by the company, to this she stated that it was signed on 18.04.2012. Ombudsman informed her that since policy was signed after 18.04.2012, the customer might have received the policy by end of April, to this she agreed. Ombudsman asked her then why the company has not cancelled the policy on the basis of letter dated 02.05.2012 sent by the complainant, to this she stated that the company is not in receipt of this letter. Ombudsman informed her that the company has written to the complainant a letter dated 26.07.2012 wherein they have not refused receipt of letter for cancellation from the complainant. He also pointed out that the same letter also states that "the policy was dispatched at the end of December 04, 2010" whereas the date of commencement of the policy is 31.03.2012. The company representative informed the forum that she is not in receipt of copy the letter dated 26.07.2012 sent to the complainant by the company .

On hearing the deposition of both the parties to dispute, Ombudsman observed that the company representative is herself not aware of complete details of the complaint .He also observed that the company has already acknowledged and responded to the letter for cancellation of policy within the free look period. The information given in letter dated 26.07.2012 is also contradictory. Hence the contention of the complainant that the letter to cancel the policy was given within free look period is justified. As such the

company is directed to cancel the policy treating it as free look cancellation and refund the premium amount after deducting applicable charges. In case the complainant has encashed any annuity cheques received earlier, the company was advised to deduct the same from the amount payable and refund the balance to the complainant, along with the interest at IRDA rate, within 10 working days.

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Complaint No. LI – 604 (12-13)

Complainant: Ms. Sunita Patki & Mr.Sachin Patki

V/s

Respondent : SBI Life Insurance Company Ltd.

Award dated 28.11.2013

Mr. Sachin Sadashivrao Patki had taken health plan, policy no. being 46002848706 from SBI Life Insurance Company Ltd wherein his wife Mrs. Shilpa Patki and son Master Avdut Patki were also covered. Master Avdut had undergone treatment for Pyogenic Meningitis for which Mr. Sachin Patki lodged the claim of Rs. 1,80.000/- and fracture of shaft femer for which he lodged the claim for Rs. 30,000/- . However the company rejected the claim for meningitis due to inconsistencies in medical report and claim for fracture of shaft femer for non receipt of X-ray. Ms. Sunita Sadashivrao Patki had also taken health plan , policy no. being 46002163310 from SBI Life Insurance Company Ltd. wherein she lodged a claim for treatment of snake bite. However the company rejected her claim on the grounds that X-ray was missing along with other reports and there were discrepancies in the line of treatment given to her.

Aggrieved by their decision Ms. Sunita Patki and Mr. Sachin Patki approached the Office of the Insurance Ombudsman seeking intervention in the matter for settlement of their claim.

After perusal of the records, parties to the dispute were called for a hearing .The complainant Mr. Sachin Patki and Ms. Sunita Patki had authorized Mr. Sachin's brother-in-law Mr. Prashant Patil to depose the case. Mr. Prashant submitted that Ms.Sunita Patki was hospitalized in Shatayushi Hospital for treatment of snake bite on 21.10.2011. She was in the state of Coma for few days. FIR and Jabab was done. After she was discharged from the hospital, claim was lodged , and it was rejected on the grounds that X-Ray was missing along with other reports. He stated that since X- ray was not done, there is no question of it been missing from other documents submitted to the company. When they again represented their case, the company had called for certain clarification from Hospital where Ms. Sunita was hospitalized .As the company did not receive those clarification, they again sent a repudiation letter to the complainant stating that as per

clause 10.2.4 of policy terms and conditions ,since all documents were not submitted , the claim has been repudiated.

He further stated that Master Avdut, son of Mr. Sachin Patki had under gone treatment for :-

1)Pyogenic Meningitis for which they lodged the claim of Rs. 180,000/- and

2 Fracture of Shaft of Femer for which they lodged the claim for Rs. 30,000/-

However the claim for Meningnits was rejected due to inconsistencies in medical report and also clarification was called from the doctor which was not received by them . The claim for Fracture of Shaft Femur was repudiated on the grounds of non receipt of Original X-Ray. He stated that they have submitted justification given by Dr Sharad Pawar and have also submitted X-ray to the Aurangabad Branch of SBI Life Insurance Company Ltd. and they have acknowledgment for the same. He also stated that they have received email dated 25.07.2013 wherein they have rejected the claim on the grounds of Section 19 which defines Hospital .However in the same email in the following paragraph , it shows that hospital has all the facilities and hence the letter is self contradictory. He stated that till date company has stood by their decision of repudiation of claim.

The company representative stated that on receipt of claim under policy investigations were conducted and it revealed that there were certain discrepancies in the treatment taken by Ms. Sunita such as:-

1) **Indoor case papers were not serially arranged,**
2) **Anti venom treatment was beyond the limits recommended by National Snake Bite Management Protocol,**
3) **Acute Renal Failure should have developed immediately after sometime of snake bite whereas the report shows that it developed after 7 days of the incident,**
4) **Ms. Sunita was kept in hospital for 54 days out of which 49 days she was in ICU etc.**

The company had called for clarification related to the treatment given to the complainant (Ms. Sunita) from the Medical Superintendent of Shatayushi Hospital on 22.08.2011. The nature of injuries suffered and the duration and nature of treatment offered raised several doubts about the genuineness of the claim. Company had asked for original papers from the hospital but they have not received the same. However Mr. Prashant Patil stated that all papers were submitted to the company investigator and a copy of it was also send through post/courier.

In case of claim lodged under the name of Master Avdut, SBI Life Insurance Company Ltd. representative stated that there were certain inconsistencies noted in documentation such as :-

1) Master Avdut had suffered from Pyogenic Meningitis .However CT scan was not done though in all cases of neurological problems doctor calls for CT scan.

2)All investigations done including CSF (Cerebral Spinal Fluid) examination were found to be within normal limits .

Mr. Prashant Patil stated that the doctor had not advised any CT scan in case of Master Avdut and this requirement was never called for by TPA Emeditek and SBI Life Insurance Company Ltd. Ombudsman asked her why company did not make any effort to take the documents from the Hospital after getting necessary authority letter from the Complainant , to this she stated that they had not taken any authority letter from the complainant but wrote to the hospital authorities to give clarification under both the

cases. Ombudsman informed her that without taking necessary authority letter from the patients, hospital may not part with their information. Ombudsman also asked her whether they have doubt whether the Complainant had manipulated or fabricated the hospital records to which she stated that the company is still ready to relook their decision on all the three cases provided necessary clarification is received from the Hospital authorities.

On hearing the deposition of both the parties to dispute, the forum observed that there is no dispute on the hospitalization of both patients as it was need of the hour. The company has denied the claim on the grounds of non receipt of certain clarification from Hospital Authorities on which the complainant has no control. It is extremely painful to see that instead of asking the hospital authorities to share the documents with them after taking necessary consent from the complainant, the company has decided not to settle the claim on the basis of non receipt of certain documents from the hospital..

Under these circumstances the company was directed to seek documents related to the cases after obtaining necessary consent/authority letter from the complainants within 10 working days. The complainant was also directed to cooperate with the company and give them authority letter to collect necessary documents from the hospital, if asked for by the company. The 2nd Hearing for the case was scheduled

The complainant Mr. Sachin Patki along with his brother- in law Mr. Prashant Patki appeared before the Ombudsman on the scheduled time .

SBI Life Insurance Company Ltd representatives were also present. Ombudsman asked them what documents they have collected pertaining to the complaint , to this the company representative stated that stated that they had taken necessary authority from the complainant to collect records from the hospital and were able to obtain X-ray of Shaft of Femur of Master Avdut. Based on this X-Ray , they are ready to settle the claim pertaining to treatment taken by Master Avdut for Fracture of Shaft of Femur.

He stated that relating to claim for Pyogenic Meningitis of Mr. Avdut and claim for Snake bite of Mrs Sunita Patki, the company had called for explanation from the respective doctors. However the doctors have given certificate about the treatment they have given in each case, but the company representative stated that it did not match with the line of treatment as per the opinion of their Company doctors. The company representatives further stated that the doctors who treated Mrs. Sunita and Master Avdut were not ready to divulge any further details and were not ready to justify their line of treatment.

Ombudsman observed that, from the above facts, it clearly proves that the company has not been able to prove beyond doubt that there was no hospitalization. The company representative has been harping on the point of inconsistencies in the line of treatment, but has not been able to provide any sustainable evidence inspite of giving sufficient time to collect the documents. It is also seen that the complainant has cooperated with the company and has provided necessary authority to the company to enable them to extract documents from the hospital authorities on his behalf. Inspite of this the company was not able to prove their contention. The whole purpose of the second hearing was only to give fair opportunity to the company to support their stand of irregularities in treatment taken by both Mrs. Sunita Patki and Master Avdut Patki. The forum also observed that though the company was not able to produce any evidence to prove their contention, they are not ready to settle the claim.

The forum observes that the claim cannot be denied on mere suspicion. Hence in the absence of any sustainable documentary evidence, the SBI Life Insurance Company Ltd. is directed to settle all the three claims i.e. Mrs. Sunita Patki's claim pertaining to snake bite ,Master Avdut's claim pertaining to Pyogenic Meningitis and Fracture of Shaft of Femur, as per policy terms and conditions

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Complaint No. LI – 825 (10-11)

Complainant: Mrs.Pravina Karia

V/s

Respondent : HDFC Standard Life Insurance Company Ltd.

<u>Award dated 17.02.2014</u>

Mrs. Pravina Karia had taken policy no. 11393465 on 14.11.2007 from HDFC Standard Life Insurance Company Ltd. by paying premium of Rs.25,00,000/-.She received the policy document on 10.01.2008. On going through the policy document, she found that the terms and conditions of the policy were not the same as were promised at the time proposal. She applied for Free Look cancellation of the policy. However the company did not accede to her request as they informed her that they received her request for cancellation of the policy beyond the free look period.

Aggrieved by their response, Mrs. Pravina Karia approached the Office of insurance Ombudsman seeking intervention in the matter of settlement of her grievance.After perusal of the records; parties to dispute were called for hearing

The entire documents submitted to the forum and deposition of both parties to dispute has been taken on record. The scrutiny of the documents reveals the following:-

1) **It is established that Mrs Pravina Karia, a graduate NRI, residing in UK approached HDFC bank in 2007 for investing Rs. 25 lakhs in a growth plan. The plan that was offered to her was Unit Linked Pension Plus Plan for premium paying term of 3 years. The proposal form duly signed by her clearly shows that she has opted for Yearly mode of premium payment . On receipt of policy documents on 10.01.2008, she found that the policy terms and conditions were different than what was assured to her at the time of proposal. During the course of hearing, she informed that she wrote to Mr. Seshadri of HDFC Bank on 19.01.2008 for cancellation of policy and refund of premium. Thus it is clear that the letter was dispatched to HDFC Bank and not to HDFC Standard Life Insurance Company Ltd. The letter was sent through ordinary post as informed by the complainant during the deposition for which she does not have any acknowledgment. Mr. Seshadiri has informed HDFC Standard Life Insurance Company Ltd. that after policy issuance ,Mrs Pravina Karia never contacted her till December, 2009 .Thus the forum observes that the complainant is not able submit any documentary evidence to prove that the letter for cancellation of the policy during free look period was sent to the insurer.**

2) **The letter dated 30.10.2008 written by Mrs. Pravina Karia to High Commission of India, London mentions that she received the policy documents in UK on 10.01.2008 and she has asked to cancel the policy on 11.01.2008 but there was no reply from HDFC Unit Pension Plus policy bank to sort this mess. The forum observes that Mrs. Pravina Karia has neither submitted any proof of this dated 11.01.2008 to the forum nor did she mention about it during the course of hearing.**
3) **Mrs. Pravina Karia has neither mentioned about her complaint letter dated 11.01.2008 nor about letter dated 19.01.2008 to the company in her first email to them on 17.03.2009.**
4) **The complainant has produced a copy of benefits available under the plan which she has informed that it was given to her at the proposal stage by Mr.Seshadri wherein it is mentioned that "complete exit allowed after 3 years with no surrender charge". However on going through the document, the forum observed that no where it is mentioned in the document that the plan is floated by HDFC Standard Life Insurance Company Ltd. The complainant being educated should have questioned about this to Mr. Seshadri. The complainant has not been able to provide any sustainable documentary evidence to prove that the terms and conditions of the policy were not consistent with the promises made at the time of proposal.**
5) **The complainant has informed that after going through the policy, she realized that the benefits under the policy were not the same as was promised at the time of proposal. Hence she applied for cancellation on 19.01.2008. However the forum finds it difficult to accept her contention as the email id of the Grievance Redressal Officer of HDFC Standard Life Insurance Company Ltd. is mentioned in the First page of the policy document just below the paragraph <u>where free look option is mentioned</u>. The forum fails to understand why Mrs. Pravina Karia chose to contact HDFC Bank for cancellation of her policy instead of the contacting the grievance department of HDFC Standard Life Insurance Company Ltd.**

The forum also observes that Mrs. Pravina Karia has paid only one annual premium and policy lapsed due to non payment of premiums. The company has paid Rs. 12, 37,203.88 as per terms and conditions of the policy, being Unitized Fund value of as on date of lapsation. I therefore do not find sufficient grounds to establish that the request for cancellation of policy no. 11393465 by Mrs. Pravina Karia and refund of entire premium of Rs. 25 lakhs is fair and just. Under these circumstances, I hold that the complainant Mrs. Pravina Karia cannot be granted any relief from this forum.

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Complaint No.LI- 1002(2012-2013)

Complainant: Shri Ismail Qazi
v/s.
Respondent: Life Insurance Corporation of India

Award dated 10.10.2013

The Complainant Shri.Ismail Qazi had taken policy no. 01002494 on 06.05.2008 from Kotak Mahindra Old Mutual Life Insurance Ltd. He stated that on 14.09.2012 he had applied for partial surrender in one of the Branch Office of Kotak Mahindra Old Mutual Life Insurance Ltd. .However the amount informed to him was different every time he followed it with the officials and they asked him to comply with same the requirement over and again. He complained it to the Grievance Redressal Cell of the insurer. However he did not get any positive response from them.

Aggrieved by their decision, Shri. Ismail Qazi approached the Office of the Insurance Ombudsman .After perusal of the records, parties to the dispute were called for a hearing .

The complainant Mr. Ismail Qazi appeared and deposed before the Ombudsman. He submitted that he had taken policy no. 01002494 from Kotak Mahindra Old Mutual Life Insurance Ltd. on 06.05.2008. On 14-09-2012, he went to Malad Branch of the Kotak Life for partial surrender as he was in need of money. Some officials from Malad Branch informed him to apply for partial withdrawal of Rs. 25000/- . On 17-09-2012, company informed him that they are unable to process his request because surrender value exceeds the withdrawal limit. However they did not inform him as to how much amount he can withdraw as surrender value. On 29.09.2012 he again went to the Branch Office to enquire about the partial surrender value. There the officials informed him to again apply for partial amount of Rs. 15000/- and accordingly he gave an application for the same. On 3.10.2010, Mr. Nitin Padval, official from Kotak Life informed him that his request has been rejected. 07.10.2012, he sent an email to enquire about the same. On 11.10.2012, he received reply from the company mentioning that withdrawal of Rs.15000/- is possible , however he will have to submit the surrender form. He informed the Kotak life officials that partial surrender form was already submitted on 29.09.2012. After making several followup , the officials again informed him that he is eligible for Partial Withdrawal of Rs. 12,000/- only. As he was tired of the inconsistent replies received from the company and was also fed up of making followup with them , he sent letter on 30.11.2012 stating that he wants to withdraw his premium amount. On 27.12.2012 , he again received letter from the company stating that he is eligible for partial withdrawal of Rs. 20000/- . However till date he has not received any amount from the company.

The company representative submitted that as per the partial withdrawal clause, the minimum required fund value under the policy taken by Mr. Ismail Qazi is Rs.25000/- .He stated that the complainant applied for partial surrender of Rs. 23000/-on 14.09.2012. Company rejected his request since the minimum balance required is Rs.25000/- and his

fund value was Rs. 38000/- . He stated that when the complainant was informed about the partial withdrawal of Rs. 15000/-, the company did not proceed for the same as the written request was not received by the company. When the complainant showed the acknowledgement copy of application form for partial withdrawal of Rs. 15000/- submitted to the company on 29.09.2012, the company representative informed the forum that the company is not in receipt of this application and probably Branch Office might be having the same. On 26.11.2012, the company apologized for giving wrong information and informed him that only Rs. 12000/- could be given as partial surrender value. However he stated that Rs. 12000/- was a wrong figure and he apologized for the same. On 27.12.2012, the company informed that he can withdraw upto Rs. 20,000/ along with the calculation of how they arrived at the amount.

On hearing the deposition of both the parties to dispute, the Ombudsman observed that there has been service deficiency and total callousness on the part of the company in handling this case. Only when the complainant wrote to the company that he wants to cancel his policy and refund of premium amount, then the company arrived at the correct partial withdrawal figure. The company executive also agreed that there was some service deficiency on the part of the company. Ombudsman asked the complainant whether he still wants to go in for partial withdrawal option to which the complainant agreed. Ombudsman directed the company executive to contact his office and get the correct amount.

The company representative informed the forum that the fund value as on the date of hearing was around Rs. 49000/- and the complainant is eligible for partial withdrawal amount of Rs. 24000/- .

Ombudsman directed the company to issue Mr. Ismail Qazi a cheque of Rs. 24000/- as partial withdrawal amount within 7 working days and no further documents to be called from the complainant. Mr. Qazi was also directed to inform the forum on receipt of the cheque . Kotak Mahindra Old Mutual Life Insurance Ltd. was also directed to examine whether Mr. Qazi can be compensated for undue harassment and inform the forum accordingly. Mr. Ismail Qazi was also agreeable to this settlement.

On 04.10.2013, the forum received email from Shri Ismail Qazi that he has received an amount of Rs. 24000/- from Kotak Mahindra Old Mutual Life Insurance Ltd. as partial surrender.

On 9.10.2013, the forum received email from Kotak Mahindra Old Mutual Life Insurance Ltd. stating that a cheque of Rs. 24000/- dated 1.10. 2013 was sent to the complainant and they have waived the part surrender charges of Rs. 539.33.The company has also informed that they will be paying the interest part to the complainant within 2-3 days

As the dispute under the policy no.01002494 has been settled by Kotak Mahindra Old Mutual Life Insurance Ltd. , the complaint is treated as resolved and closed at this forum.

Complaint No. LI – 1156 (2013 – 2014)

Complainant: Mr. Rakesh Bhalla
V/s

Respondent : AVIVA Life Insurance Company Ltd

Award dated 09.12.2013.

Mr. Rakesh Bhalla had taken Aviva Life Saver Advantage plan, policy no. NLS3060513 from AVIVA Life Insurance Company Ltd on 09.08.2011 for sum assured of Rs. 15,75,000/- and annual premium of Rs. 1,00,000/- . The agent had informed him at the time of taking the policy that the annual mortality charges towards his policy would be Rs. 4822/- and an amount of Rs. 88,363/- would be invested out of the premium of Rs. 1 Lakh. However on receipt of the fund statement on 12.06.2012, he was surprised to know that out of the premium of Rs. 1 lakh, around Rs.52000/- was debited as charges. As he felt cheated, he requested the company to cancel the policy and refund the premium amount. However the company informed him that since his request for cancellation was received beyond the free look period, they cannot accede to his request.

Aggrieved by their response, Mr. Rakesh Bhalla approached the Office of Insurance Ombudsman .After perusal of the records, parties to dispute were called for hearing .

The complainant had authorized his wife Mrs. Veena Bhalla to represent his case. Mrs. Veena Bhalla appeared and deposed before the Ombudsman. Mrs Veena submitted that they had an account with Induslnd Bank and the bank executive had given her husband an investment scheme with life coverage wherein the executive had assured returns of more than what a fixed deposit would fetch .Accordingly policy no. NLS3060513 from AVIVA Life Insurance Company Ltd was issued to her husband on 09.08.2011 and policy was received by them on 12.08.2011. She stated that they received a Policy Account Statement wherein Mortality charge was mentioned as Rs. 4822/- and investment amount was mentioned as Rs. 88,363/- . She stated that they believed that the Mortality charges would only be Rs. 4822/- annually. They were continuously following up with the bank and the insurance company for the Fund statement but both the bank and Aviva life did not accede to their request. When they received the notice to pay renewal premium, they informed the company officials that unless they receive fund statement they won't make further premium payments. Thereafter they received the fund statement. On receipt of the fund statement they realized that around Rs.52000/- was debited as mortality charges out of the premium amount of Rs. 1 lakh. When Mr. Bhalla initiated enquiry, they informed him that Rs. 4822/- was monthly mortality charge. Mrs. Veena Bhalla stated that they felt cheated and requested the company to cancel the policy and refund the premium amount. However the company did not accept their request. Ombudsman asked her as to why they did not cancel the policy during the free look period, to this she stated that they had blindly trusted the bank officials with whom they had account for a long period of

time and did not go through the policy document on its receipt. Ombudsman also asked her whether they had given their complaint in writing to Induslnd Bank and any response was received for their complaint, to this she stated that they had personally followed up their complaint with the bank and her husband has written several emails but she is not having the copy of the same.

The company representative stated that the complainant has signed and submitted the proposal form along with benefit illustration which clearly explains the various applicable charges. She stated that the complainant has not cancelled his policy during the free look period. She also stated that from 2nd year onwards the complainant has not paid the premium and hence the policy is in lapsed condition and the fund value is around Rs. 13000/- which would be paid at the end of lock – in-period of 5 years. Ombudsman asked her how the fund statement shows increase in mortality premium, when it is written in policy document that 'Mortality charges shall remain guaranteed thought out the policy term' to this she stated that as age increase the mortality charges are also increased and there was some changes in service tax which had an impact on mortality charges. She stated that the policy document clearly shows that mortality charges are levied monthly. Ombudsman also observed that the Senior Vice President, Operations had written letter to Mr. Bhalla which shows that the mortality charges have increased. However the letter does not have the date when it is written and the company has also not informed the forum about the receipt of the same by the complainant. Ms. Dipti said that she is not aware of that letter and requested the forum to give a copy of that letter to discuss it with her seniors. The forum accepted her request. Ombudsman also observed that though the plan sold to Mr. Bhalla was Aviva Life Saver Advantage, the company has sent a brochure of Life Shield plan along with their written statement. Ombudsman also observed that the benefit illustration shows benefits upto 13 years whereas the policy term is 15 years and though the plan is Unit Linked Endowment plan, at the end of 13th year , the maturity benefit is just Rs. 26,856/- for 10% yield and maturity benefit is zero in case of 6% yield. It is also brought to the notice of the forum that the benefit illustration is not signed on all the pages by the complainant.

On hearing the deposition of both the parties to dispute, Ombudsman directed the company to give their observation on undated Revised Terms letter and the date on which it was sent to the complainant and also the date on which it was received by him. The complainant was directed to submit the copies of his complaint letter sent to the Induslnd Bank/Aviva Life and also the copy of their response received by him. On 22.11.2013, the complainant submitted to the forum the copies of email sent on 11.06.2012 by him to the officials of Induslnd Bank and also AVIVA Life Insurance Company Ltd.

On 4.12.2013, the forum received email from the company wherein letter dated 02.12.2013 was also attached which states that " the undated Revised Terms letter is never sent separately to the policyholders. It is part of the policy documents pack sent to the policyholders in case of rated up policies. The said Revised Terms letter is generated along with other policy documents for rated up cases. The receipt of the policy documents have been confirmed and admitted by the policyholder at the time of Welcome Calling

done on 20.09.2011 on this contact number 9322909040 and during the course of hearing as well".

Having recorded the deposition of both parties to the dispute and a perusal of the various documents presented to the forum, I proceeded to examine the case in depth:-

The policy clause relevant to the case is reproduced below:-

The policy terms and conditions shows Table of charges and the 3rd item listed in this table is the Mortality Charge which states that " This is the cost of life insurance cover under the policy. This is levied at the beginning of each month from the unit account by cancelling units of the equivalent amount. The Mortality Charges will apply on the sum assured plus a Top-up Sum assured, if any. The Mortality Charge shall remain guaranteed throughout the policy term".

Thus from the above it is clear that the Mortality charge is debited every month from the unit account. The Benefit Illustration which is appended at the end of the policy also shows Mortality charge of Rs. 53,412/- p.a. The complainant Mr. Rakesh Bhalla being a literate person and from Finance background should have gone through the terms and conditions of the policy on its receipt and should have cancelled the policy during the free look period if he was not satisfied with it. The allegation of the complainant that he relied on the Policy Account Statement for charges where in it is mentioned that Mortality charge is Rs. 4822/-is not justified as the forum finds that the no where it is mentioned in the statement that this charge would be on yearly basis .In fact I find that at the end of this statement, it is written "for details on charges, please refer to Standard Terms and conditions of the policy document". The complainant has also not been able to produce any sustainable documentary evidence to the forum which would establish that he was assured of deduction of mortality charges Rs. 4822 /- on yearly basis.

A contract has to be interpreted as per terms and conditions guiding the contract. In the instant case, the policy document is the evidence of insurance contract. The complainant should take adequate care while signing for such an insurance cover and should understand all the provisions of the product. A policy is a contract between the insurer and insured and once the offer is accepted it becomes an enforceable one and neither party can go against the provisions of the contract. Therefore the forum does not find fault with the company since they have acted as per the terms and conditions of the policy and I do not find any reason to interfere with the decision of the company in not cancelling the policy.

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Complaint No.LI- 58 (2011-2012)
Complainant: Smt. Shirin Master
v/s.
Respondent: Birla Sunlife Life Insurance Company Ltd.

Award Dated : 18.03.2014

Smt. Shirin Master was persuaded by Development Credit Bank officials to purchase Unit Linked Pension Plan from Birla Sunlife Life Insurance Company Ltd, Policy no. being 02902627 in 2009. At the time of proposal, the bank officials informed her that she had to pay Rs.2, 50,000/- as 1st year premium and thereafter in 2nd and 3rd year, she had to pay Rs.10,000/-only. However when 2nd premium was due, the company insisted that full premium of Rs.2, 50,000/- should be paid. Smt. Shirin Master paid Rs.10, 000/- as second year premium as per the premium notice received by her and this premium was duly accepted by the company. Thereafter she did not pay any premium. Since 3 years premiums were not paid under the policy, the company terminated her policy and paid her Surrender Value of Rs. 1, 76,842.22 on 11.10.2012. She requested that total premiums paid by her should be refunded with 10% interest. However the company did not accede to her request.
Aggrieved by their decision Smt. Shirin Master approached the Office of the Insurance Ombudsman seeking intervention in the matter for settlement of her claim.

The parties to dispute were called for hearing on 18.03.2014 at 10.30 am.
The complainant Smt. Shirin Master along with her husband Shri Gulamali Master appeared and deposed before the Ombudsman. Shri Gulamali Master submitted that they have an account with DC Bank. The Bank Officials insisted her to purchase the policy and informed her that she had to pay premium of Rs. 2,50,000/- in first year and Rs. 10,000/- in the 2nd and 3rd year. When they received the premium notice in the subsequent year, they was shocked to see that they had to pay Rs.2.50 lakhs instead of Rs.10,000/- as promised at the time of proposal. They wrote to the DCB bank about their grievance but did not receive any reply. Then they wrote to Birla Sunlife Life Insurance Company Ltd. The company officials informed her that the facility of paying Rs.10, 000/- premium was available to those clients who signed up before 31st March ,2009 and since Smt. Shirin Master had signed on 19th May,2009, this facility is not available to her. Meanwhile she paid Rs. 10,000/- premium , as at the bottom of the Renewal Notice dated 19.04.2010 received by her , it was mentioned " as per the policy features, you have an option to pay reduced annual premium subject to a minimum of Rs. 10,000/- in the 2nd policy year onwards without any reduction in Sum Assured." The premium was duly accepted by the company. The Complainant pleaded that the company should refund her premium of Rs. 2, 60,000/- with 10% interest.
Ombudsman asked them whether they have any documentary evidence of promises made at the time of proposal to this she stated that they do not have any such evidence.
Birla Sunlife Life Insurance Company Ltd was represented by Shri Preetesh Kubal. Shri Preetesh Kubal submitted that on the basis of proposal form and benefit illustration signed by Smt. Shirin Master, policy was issued to her on 19.05.2009 .The circular issued

by IRDA dated 23rd Feb, 2009 states that "the premium in the second year onwards shall not be less than 75% of the premium for the first year." This circular was applicable to all policies issued after 1st April, 2009. Hence the acceptance of Rs. 10,000/- premium by the company under the policy in dispute could not be construed as a premium amount in full. Shri Preetesh Kubal accepted that the Renewal Notice dated 19.04.2010 was erroneously sent by the company as similar premium reminder notices were sent to other customers who had solicited the policy prior to March, 2009.He admitted that there was a contravention of IRDA guidelines. He further stated that since premiums were not received from second year onwards, the company paid surrender value of Rs. 1, 76,842.22 on 11.10.2012 as per policy terms and conditions.

Ombudsman asked Shri Preetesh Kubal as to what is company's decision on the issues raised by the complainant, to this he stated that the company is ready to pay the difference of total premiums paid by the life assured under policy no. 02902627 and surrender value already paid to her by the company .

The complainant Smt. Shirin Master informed the forum that the offer made by the company is acceptable to her.

As the dispute under the policy no. 002902627 has been settled by Birla Sunlife Life Insurance Company Ltd, the complaint is treated as resolved and closed at this forum.

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Complaint No. LI – 1576 (2012-2013)
Complainant : Shri Nandkishor Pandey
V/s
Respondent : Tata AIA Life Insurance Company

Award dated : 18.11.2013

The complainant Mr. Nandkishor Pandey had taken policy from Tata AIA Life Insurance Company in the name of his son Master Darshil Pandey. Mr. Nandkishor Pandey received the policy document on 7.08.2011. On going through the policy document, he came to know that 3 signatures on page no. 25, 26 and 27 were not signed by him. In addition, the commitment of periodic cash payment made by the agent at the time of proposal was 7.5% whereas in the policy document, it appeared to be only 5%. Hence he gave the policy for free look cancellation on 10.08.2011 to Tata AIA Life Insurance Company , Powai br. The same was delivered to the company on 12.08.2011. The copy of proof of dispatch of the letter for free look cancellation was also submitted to the company. However the company did not accede to his request stating that the request for cancellation was received beyond the free look period.

Aggrieved by their decision Shri Nandkishor Pandey approached the Office of the Insurance Ombudsman seeking intervention in the matter for settlement of his complaint.

After perusal of the records, parties to the dispute were called for a hearing on 29.10.2013 at 5.00 p.m. at Camp – Goa

On hearing the deposition of both the parties to dispute, the forum observed that there is sufficient evidence to prove that the letter for cancellation of the policy was sent to the insurer within the free look period i.e. Letter dated 21.11.2011 from Department of Post stating that consignment no. EM442355955IN was delivered on 12.08.2011 and copy of dispatch of the consignment no. EM442355955IN to TATA AIA Life, Powai Branch. Hence Company was directed to cancel the policy treating it as FREE LOOK CANCELLATION and refund the premium amount within 7 working days. The company representative was given copy of the letter dated 21.11. 2011 received from Department of Post and also copy of dispatch of consignment no. EM442355955IN to TATA AIG Life, Powai Branch.

On 13.11.2013, the forum received email from the company stating that they have cancelled the policy treating it as Free Look Cancellation and issued cheque no. 315165 for an amount of Rs. 13937/- in favour of the complainant Mr. Nandkishor Pandey.

As the dispute under policy has been settled by the Tata AIA Life Insurance Company, the complaint is treated as resolved and it is closed at this Forum.

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