

Group Personal Accident Policy

Bhubneshwar Ombudsman Centre

Case No.11-011-0265

Sri. Natbarlal Barai

Vs

Bajaj Allianz General Insurance Co. Ltd.

Award Dated : 18.03.2008

Complainant's son late Rakesh Barai was covered under Group P.A Policy with Bajaj Allianz General Insurance Co. Ltd. for sum insured of Rs. 100000.00 for a period of one year commencing from 13.09.2004. During currency of the on 14.11.2004 late Rakesh Barai left his house and did not return. On 17.11.2004 his dead body was recovered from the railway track by Capital P.S and UD Case was registered vide 105/04 dated 17.11.2004. Postmortem was conducted by Capital Hospital, Bhubaneswar and concerned doctor opined that cause of death was due to accidental run over by running train. Police authorities have opined that death was accidental in nature and there is no foul play. Complainant lodged a claim for compensation of Rs. 100000.00. Insurer repudiated the claim on the ground that it was a case of suicide.

Being aggrieved the insured complainant approached this forum.

Insurer filed self-contained note stating that inquest report clearly reveals it is a case of suicide and deceased's brother has given a statement u/s 161 CrPC to the police stating that incident is probably a case of suicide.

During hearing Insurer reiterated their stand taken in the self-contained note whereas complainant submitted the post-mortem report and police final investigation report to substantiate his claim.

Hon'ble Ombudsman directed the Insurer to pay Rs. 100000.00 to the complainant as the post-mortem report and police final investigation report clearly stated that the death was due to accidental running over by train and not due to suicide.

Chandigarh Ombudsman Centre

Case No. : GIC/221/OIC/11/08

R.P. Aggarwal

Vs

Oriental Insurance Co. Ltd.

Award Dated : 4.10.07

FACTS : Shri R.P. Aggarwal was insured under Group PA Policy with the insurer. He met with a serious accident on 11.8.06 causing major leg fracture. As per advice of the doctor he was under treatment upto 17.12.06. He lodged a claim for Rs. 1.25 lakhs through his employer under the GPA Policy. However, the claim was settled for Rs. 50,000/- only. No clarification was given for the claim being settled for lesser amount.

FINDINGS : The insurer informed that they had taken medical opinion of Dr. K.D. Sharma who is renowned orthopaedic surgeon who opined that weekly benefit for eight weeks was adequate for the kind of injury sustained. Hence GPA claim was settled for

8 weeks along with other benefits. The payment was released on 29.1.07 after obtaining necessary discharge voucher for full and final settlement of the claim. The insured again represented against the amount of claim which was again referred to Dr. K.D. Sharma who confirmed his earlier opinion. On a query whether Dr. K.D. Sharma had seen the patient at any point of time, the insurer replied in the negative. On a query whether the complainant was attending duties during these 129 days period, the insurer and the complainant replied in the negative.

DECISION : Held that the patient was under treatment for 129 days as given in hospital records. Moreover, the treating doctor had access to the patient and knew his physical condition. He was a better judge to know the physical condition of the patient and give recommendation for the duration of the treatment. In view of the above, the claim of the complainant that he should be given weekly benefit under the policy for 18 weeks appears to be justified. Since 8 weeks benefit had already been paid, additional amount for remaining 10 weeks along with reimbursement of medical expenses as per terms and conditions of the policy should be paid by the insurer to the complainant.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.05.1262/2007 – 08
Mr. T. Velayutham
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 24.12.2007

The Complainant Mr.T. Velayutham was covered under the group personal accident policy obtained by his employer M/s Kumaran Systems from The Oriental Insurance Co. Ltd. Mr. Velayutham met with an accident at the work place during the policy period and had claimed temporary total disablement compensation covered under the policy for a period of 52 weeks amounting to Rs. 1,56,000/- @ Rs.3,000/- per week. The insurer had offered compensation for 8 weeks only. Aggrieved by this the insured approached the forum claiming for 52 weeks compensation.

The insurer based on the opinion of the panel doctor offered compensation for 8 weeks only. As per the insurer, after treatment for the injuries sustained during the accident, the insured was admitted for dislocation of shoulder which might be due to a pre existing condition of Glioma. The independent opinion from doctors also mention that the same could be a pre existing condition. There was no evidence that the entire hospitalization is sequel to the accident on 19.07.2005.

As per the orthopaedic surgeon the insured was incapacitated upto January 2006 and hence the compensation of 8 weeks offered by insurer is not reasonable. No treatment was given for malformation and only symptoms were controlled and the condition medically managed. The insured had been found out to be having the malformation in the left frontal region and hence compensation for 52 weeks in full is also not justified. Further, the insurer have not conclusively established past history of neurological disorder against the insured.

Taking all these into account, disability compensation for absence from work for the period from 20.07.2005 to 31.03.2006 amounting to Rs.1,11,000/- is awarded by allowing the claim partly.

Chennai Ombudsman Centre

Case No. : IO (CHN) 11.03.1370 / 2007-08
S.Purushothaman
Vs
National Insurance Co. Ltd.

Award Dated : 26.03.2008

The complainant, a member of the Road Safety Club Pvt. Ltd was covered under a Group policy with Personal Accident and hospitalisation expenses cover. He met with a road accident and was hospitalized. He made a claim for reimbursement of Rs. 22,000/- but the insurer offered only an amount of Rs 1,600/-. Since this amount was much less than the amount actually spent by him, he did not accept the cheque and approached the forum. He stated that he had submitted the bills as were available with him.

The insurer contended that the insured had submitted bills for an amount of 9494/- towards his treatment expenditure following the accident. But they sent the voucher only for Rs 1627/- for which the papers were in order. The pharmacy bills were not supported with proper prescriptions and he had also claimed post-hospitalization medical expenses which were not payable as per policy conditions. Another bill for Rs.4700/- was towards surgeon's fees for root canal treatment but the same was disallowed as the same was typed in a white sheet about which no reference has been made either in the Discharge Summary or the Discharge Card. They had sent the cheque to the master policy and the cheque was neither returned nor encashed by the Road Safety club. They felt the accident was genuine and they have no objection in settling the claim provided the insured produces supporting prescriptions and proper bills.

After hearing the parties it was found that the insurer had been willing to reimburse the expenses provided the insured was able to submit the supporting papers. Some of the documents submitted had been on white paper although the hospitalisation had been made in a reputed hospital. It seemed therefore that the treatment had been taken as outpatient. The tailor made policy covered expenses incurred during hospitalisation and did not envisage reimbursement of any post hospitalisation or domiciliary expenses. Although some time was allowed to the complainant to submit the missing / authentic documents, he did not do so.

It was therefore decided that the decision of the insurer to offer to reimburse only those expenses that were as per the policy conditions, was in order.

Complaint was dismissed.

Delhi Ombudsman Centre
Case No. GI/156/OIC/06
Smt.Apoorva Kapoor
Vs

Oriental Insurance Company Limited

Award Dated : 14.01.2008

The complaint was heard on 13.07.2007, 21.09.2007, 02.11.2007 and on 02.01.2008. The complainant, Smt. Apoorva Kapoor, was represented by her father Shri B.Lal Kocher. The Insurance Company was represented by Shri S.K.Anand, Assistant Manager.

Smt. Apoorva Kapoor has lodged a complaint with this Forum on 18.09.2006 that her husband late Shri Sudhir Kapoor was covered under Personal Accident policy taken

from the Oriental Insurance Company Limited. She requested the Forum that her claim be paid.

At the time of hearing on 21.09.2007, after examination of the reports submitted by Dr.Vipin Gupta and Dr.Sanjay Kumar Jaiswal wherein both the doctors have discussed the hospitalization in Apollo Hospital on 09.10.2005. This Forum requested the Insurance Company that since the complainant, Smt. Apoorva Kapoor, has mentioned that the death could be due to accident on 07.09.2005 and Shri Kapoor was first admitted in AIIMS, they should get the matter investigated at the AIIMS so that the details of injury could be ascertained. Further, Shri B.L.Kocher was also requested to submit discharge summary of AIIMS.

At the time of hearing on 02.01.2008, Shri Kocher, the representative of Smt. Apoorva Kapoor, informed the Forum that they have submitted the discharge summary of AIIMS. Shri Sudhir Kapoor was removed from AIIMS to Apollo Hospital as they thought that he would be looked after well at a Private Nursing Home and he would get better medical attention. Further, he informed the Forum that Shri Sudhir Kapoor was in constant touch with the hospital after the discharge from Apollo Hospital. He was visiting the hospital as well as sought medical treatment on telephone because of his pain in hand as well as pain in leg. On 09.10.2005, he had a fall in the bathroom, thereafter he was admitted in Apollo Hospital where he expired. Shri Kocher further pleaded that late Shri Kapoor was a young gentleman of 29 years of age and enjoyed good health before meeting with the accident and the Insurance Company's contention that he had a cardiac failure as a result of which he had died and not as a result of accident either on 07.09.2005 or on 09.10.2005 and his claim should be paid. He further mentioned that not only the claim has been paid by LIC of India and ICICI Prudential but even ICICI Lombard has paid the claim against the credit card claim issued by ICICI Bank Limited. The Forum advised Shri Kocher that ICICI had informed the Forum that the claim they have settled against late Shri Sudhir Kapoor was an ex-gratia. Further, the Forum advised the representative of the complainant that the General Insurance policy covers death due to accident which have certain conditions in it. He however, requested that Personal Accident claim of Shri Sudhir Kapoor be settled.

The representative of the Insurance Company informed the Forum that they had consulted two doctors on the basis of the documents submitted by the complainant and both the doctors have mentioned that the fall in the bathroom on 09.10.2005 and as per the indoor records of the Apollo Hospital, the cause of death of Shri Sudhir Kapoor was cardiac failure. They have further mentioned that the insured had a cardiogenic syncope first, leading to fall in bathroom and losing consciousness and then he had cardiac arrest in emergency unit of Apollo with 2-3 episodes of seizures. Further as per the opinion of the doctors, did not have fall due to seizures. The exact cause of seizures is uncertain because further investigations like contrast CT/MRI or MR Venogram were not done to assess for any possible Intercerebellar leisure. So the most probable cause of seizure was Hypoxia to brain due to cardiogenic syncope. As per the advice of the doctors, the insured died due to medical reasons and not due to injury. The present claim of Smt. Apoorva Kapoor does not fall under the provisions of Personal Accident policy. Further as per the instructions of the Forum, they had got the medical reports of AIIMS. They had appointed Dr. Vipin Gupta who got the medical reports of Shri Sudhir Kapoor from All India Medical Institutes of Medical Sciences (AIIMS). Dr.Vipin Gupta has submitted his report dated 10.11.2007 wherein he was of the opinion that the claimant plea that the fall on 09.10.2005 is related to injury sustained on 07.09.2005 is not correct. As per treatment papers of 07.09.2005, insured was not having any sign/symptom suggestive of head injury, nor insured's contention that some nerves were pressed/injured causing death on 09.10.2005 is medically

possible. Accordingly from the opinion submitted by both the doctors the death of Shri Sudhir Kapoor was not accidental but medical as such the claim is not payable.

After hearing both the parties and on examination of the documents submitted, it is observed that Shri Sudhir Kapoor had met with an accident on 07.09.2005. He was admitted in All India Medical Institute of Medical Sciences (AIIMS) and after initial treatment, was moved to Apollo Hospital where surgery for fracture distal end of radius left hand was performed. After getting discharges from Apollo Hospital, he again had a fall in the bathroom on 09.10.2005 and was admitted in Apollo Hospital and died on the same day. The Oriental Insurance Company Limited have repudiated the claim on the grounds that the Personal Accident policy does not cover natural death which as per the opinion of their doctors clearly establishes that Shri Sudhir Kapoor had died because of cardiogenic syncope and not due to accidental death as a result of fall in bathroom. The Personal Accident policy covers any bodily injury resulting solely and directly from accident caused by external violent and visible means, then only the policy responds to claims lodged under the policy. In the case of Shri Sudhir Kapoor, it has not been clearly established that his death on 09.10.2005 was as a result of accident since the earlier accident was on 07.09.2005 and as per the discharge summary of Apollo Hospitals dated 12.09.2005, Shri Kapoor had sustained injury to his left wrist and left knee. Patient had injury on anterior aspect of left wrist and forearm. Patient has not been able to move his left wrist. He was taken to AIIMS where X-ray done and primary treatment was given. He came to Apollo Hospital for further evaluation and management. He was examined: Deformity and tenderness over left wrist. Would over the anterior or aspect of left wrist tendon intact bone exposed. He was operated and discharged on 12.09.2005. The contention of the complainant that there were certain difficulties may have developed in Nerves systems since Shri Kapoor was suffering from the pain and he was consulting the hospital. There is no evidence which the complainant has put forth except that he was advised to take pain killer drugs. They should have taken a second opinion from another orthopedic surgeon whether the operation conducted at Apollo Hospital have been correctly performed and the injury properly attended. He had a fall in the bathroom on 09.10.2005. It is very difficult for a person to know other than the patient himself whether there was a fall first or cardiogenic syncope, that is, he had any heart problem before he fell in the bathroom. Since Shri Sudhir Kapoor has not given statement nor the doctors made any observations to the cause of death in the death summary, as such, the best way for concluding whether the death was accidental or medical was a Post Mortem Report which in this case has not been conducted. The Insurance Company have got the hospital records, examined by the doctors and as per the opinion of the doctors, death was due to medical reasons and not due to injury. Policy Condition II mentions that the Insurance Company may require post mortem report as an evidence to prove that the death was as a result of accident. Since there is no Post Mortem Report done in this case and the complainant having not been able to establish that the cause of death was accident, I have no other option but to be guided by the opinions of the doctors who have mentioned in their report that the death of Shri Sudhir Kapoor was due to medical reasons and not due to injury.

I, therefore, uphold the decision taken by the Oriental Insurance Company Limited repudiating the claim of Smt. Apoorva Kapoor.

There is no further relief to be granted to the complainant.

The complaint is disposed of finally.

Guwahati Ombudsman Centre
Case No: 11-004-0135/06-07

Mrs. Barnali Das Hazarika
Vs
United India Insurance Co. Ltd.

Award Dated :14.11.2007

Facts (Statements and counter statements of the parties)

In brief, the complaint is that the claim lodged by Smt. Barnali Das Hazarika, wife of Late Ashim Kr Hazarika, was repudiated by the opposite party (OP) / insurance company on the basis of the certificate issued by the SBICPSL stating that the card bearing no.4317-5750-2830-1431- held by Ashim Kr Hazarika was "never used never paid".

The facts involved in the complaint is that Shri Ashim Kr Hazarika, was the holder of the SBI credit card bearing no.4317-5750-2830-1431 and the card holder was insured against loss of life due to the accident up to the amount specified in the policy subject to exclusions, provisions and other terms as specified in the master policy no.040900/46 issued by M/s. United India Insurance Co. Ltd./OP. During the validity of the term of the policy, Mr Ashim Kr Hazarika died on 02.02.06 in a road accident. As per the insurance certificate issued by the OP, while the master policy was in force and the card holder dies solely and directly from an accident caused by violent and visible means other than Air travels, a benefit of Rs.2,00,000/- will be payable. The complainant, being assignee under the policy, submitted her claim and the insurer on receipt of the report from SBICPSL declined to settle the claims on the ground that the card that was hold by the deceased was 'never used never paid'.

The contentions of the insurer in reply to the notices issued inter alia, are that on receipt of the claim papers from the complainant, the insurer asked the complainant to submit claim relevant documents and also to the SBICPSL for "no objection" certificate. The SBICPSL declined to issue NOC on the ground that the card was never used never paid and hence the claim is held to be invalid. On the basis of the reports from SBICPSL, the claim was repudiated.

Decisions & Reasons

Holding SBI card no 4317-5750-2830-1431 by Shri Ashim Kr Hazarika has not been disputed. The above SBI card was also covered under policy no.040900/46/05/0000097 and this has also been admitted by the insurer. The death of the card holder Ashim Kr Hazarika due to a road accident on 02.02.06 has also not been disputed.

The certificate of insurance issued by insurer M/s. United India Insurance Co. Ltd. shows that the complainant Barnali Das Hazarika was the assignee under the policy in respect of SBI card no. 4317-5750-2830-1431. The certificate of insurance reads as under :

"Certificate of Insurance

It is hereby certified that the holder of this certificate being on Primary SBI Cardholder is insured against loss of life due to an accident, upto the amount specified overleaf, subject to exclusions, provisions and other terms as specified in the Master Policy No.040900/46."

The copy of insurance policy issued to the insured M/s. SBI CARDS & PAYMENT SERVICES (P) LTD shows that the period of insurance covered under the policy applicable in the instant case was for the period from 01.01.06 to 31.12.06 and the special condition of eligibility criteria was described as follows :

"Insurance benefits are for primary active cardholders only. A primary active credit cardholder for the purpose of a Insurance cover claim is defined as having a credit

card which has been utilized at least once for the purpose of customer initiated purchase/cash advance transaction and / or made a cash payment of at least Rs.100/- within 89 days prior to the day of the occurrence of the event.”

From the above, it appears that Shri Ashim Kr Hazarika, being card holder was a beneficiary under the insurance cover issued to M/s. SBI CARDS & PAYMENT SERVICES (P) LTD and his death on 02.02.06 due to the road accident was also within the period of validity of the Insurance coverage. As per condition of the policy, insurance claim is maintainable only when the card has been utilized at least once for the purpose of customer initiated purchase/cash advance transaction and /or made a cash payment of at least of Rs.100/- within 89 days prior to the day of the occurrence of the event. This condition applicable to the policy was not made known to the card holders and this also has not been specifically mentioned on the certificate of insurance applicable to the card holders . Consequently, it can be inferred that card holder Ashim Kr Hazarika was not directly aware about the conditions applicable to the policy. The validity conditions mentioned in the “certificate of insurance” was that the certificate of insurance will be valid ‘if fee is paid or card used within 45 days of issuance or renewal cover commences from 1st month after use /payment’. The policy was issued covering the period from 01.01.06 to 31.12.06 and the card holder Ashim Kr Hazarika unfortunately met his death due to road accident on 02.02.06 and he even did not get 45 days time to use his card not to speak of using the same within 89 days. His tragic death came before expiry of even 45 days from the date of its issue. Use of the card within 45 days is one of the conditions applicable to the policy.

The conditions applicable to the policy cannot be said to have been violated as the card holder did not get the scope to use it for the period prescribed and it can be inferred that the card holder did not get the scope to use his card within this specified time. Repudiating the claim on the ground of non use of the card within the specified time, at least once appears, to be not a justified one. It requires reconsideration by the Insurance Company in view of the facts and circumstances.

The insurer shall reconsider the matter afresh and admit the claim and settle it within 45 days. With this findings, the complaint is disposed of.

Guwahati Ombudsman Centre

Case No.: 14-003-0032/07-08

Mr. Dhaneswar Pathak

Vs

National Insurance Co. Ltd.

Award Dated : 18.02.2008

FACTS

The grievance of the complainant is that the claim lodged by him as a nominee under the above policy has not been settled by the Insurance Company although a considerable period has elapsed.

The Facts involved leading to registration of the above complaint is that one Pankaj Pathak was an insured who obtained the above policy under Scheme “Group Janata Personal Accident Insurance Policy” covering the period from 01.02.2004 to 31.01.2016. The sum assured was Rs.50,000/-. On 30.09.05, the insured Pankaj Pathak died due to injuries sustained on his body including the head which was caused by few persons. Police was informed who registered Chandmari P.S. Case No.320/05 and Post Mortem Examination on the dead body of Pankaj Pathak was also carried out and the opinion of the Doctor was that death was caused due to Coma as a result of injuries over the head and all the injuries were ante mortem and was caused by blunt

force impact and homicidal in nature. The Post Mortem Examination was done on 01.10.05 at Guwahati Medical College & Hospital on being referred by Chandmari P.S. in connection with case no.320/05. The insurer above named under whom the policy was taken by the Deceased Life Assured (DLA) through the TPA, Golden Trust Financial Services was informed and usual claim was lodged. It is alleged that the claim has not been settled till date and hence this complaint.

The insurer has not responded even in spite of sending repeated notices.

Decisions & Reasons

The complainant, Mr. Dhaneswar Pathak appears to be the nominee under the above policy. Vide letter dated Nil, the complainant lodged his claim on the death of the policyholder Pankaj Pathak through TPA and the TPA/Golden Multi Services Club Limited had received the same. The TPA vide letter dated 13.02.2006 had forwarded the claim forms along with all documents submitted by the complainant to the insurer, National Insurance Co. Ltd for proceeding with the claim. The claim form submitted in this connection contained the medical certificate from the doctor who treated the policyholder before his death. The said report shows that Pankaj Pathak succumbed to his injuries at GNRC Hospital on 30.09.05 wherein he was admitted for treatment on 29.09.05 and the cause of death is stated to be the injuries sustained on the head and other parts. The policyholder/complainant has also produced the copy of the death certificate of Pankaj Pathak which was issued by the Registrar of Births and Deaths which also clearly proves that Pankaj Pathak died on 30.09.05.

The copy of the policy document is also available before us which shows that the policy covered the risk of accidental death/loss of limbs/permanent total disablement and the documents on record clearly establishes the fact, beyond doubt, that Pankaj Pathak died due to injuries on his head and other parts which were ante mortem and homicide in nature. The medical report clearly proves that the injuries were not self-inflicted and it was homicidal and that can be termed to have been sustained in accidental manner. Causing death in accidental circumstances is the pre-requisite condition under the policy in question and that appears to have been proved prima-facie. When the complainant, being the nominee under the policy, has lodged this claim after the death of the policyholder, it is for the insurer to settle the claim without keeping it pending for an indefinite period.

The insurer is therefore directed to settle the claim in terms of the policy after observing all required formalities.

Hyderabad Ombudsman Centre

Case No.G-11-011-0197

Smt. Tota Laxmi

Vs

Bajaj Allianz General Insurance Co. Ltd.

Award Dated : 7.11.2007

Brief facts : Sri Tota Chinna Ramulu was covered under a Group Personal Accident policy issued by Bajaj Allianz General insurance Co. Ltd., covering the members of Golden Multi Services Club Ltd. The period of insurance was from 23.2.2006 to 22.2.2007 and the sum insured was Rs.1,00,000. On 1.5.2006 the insured left his house and did not return. His body was found on 4.5.2006 near a palm tree and then FIR was lodged. The doctor opined in the post mortem report that death was due to head injury. The police concluded that death was due to accidental fall from a tree. The

nominee, Smt. Tota Laxmi lodged a claim with the insurer. The claim was not paid and the complainant's letter to the Regional Office of the insurer evoked no response.

Complainant's contentions: Her husband died due to fall from a tree. The insurer had not settled the claim despite several reminders.

Insurer's contentions: The insurer stated that the claim was being processed by their Kolkatta office. The delay was due to clarifications sought by their Kolkatta office.

Decision : The insurer had not submitted their self contained note. The insurer's representative stated that they require original post-mortem report to process the claim. The insurers were directed not to insist on the original PM report, but accept a copy certified by either the hospital or the police authorities. Since the insurer has not rejected the claim, they were directed to settle the claim within one month from the date of receipt of the order from this office.

Hyderabad Ombudsman Centre
Case No.G-11-003-0172
Smt. Parsha Sobha Rani
Vs
National Insurance Co. Ltd.

Award Dated : 7.11.2007

Brief facts: Sri Parsha Samba Murthy was insured under Group Personal Accident policy issued by National Insurance Co. Ltd., Chennai, covering the members of Road Safety Club. He was insured for Rs.300, 000 for the period 17.7.2004 to 16.7.2005 and for Rs.200, 000 for the period 11.1.2004 to 10.1.2005. On 10.9.2004, he suffered a snake bite and death occurred in a hospital while undergoing treatment. The nominee, Smt. Sobha Rani lodged a claim with the insurer, but the claim was kept pending. Aggrieved, she approached this office seeking intervention.

Complainant's contentions: She submitted all documents to the insurer and went round their office several times, but her claim was not paid. Her representation to the Regional office of the insurer also did not evoke any response.

Insurer's contentions: They appointed an investigator and the processing of the claim is in progress. The post mortem report did not confirm that cause of death was due to snake bite as a question mark was put in the report against the relevant column. The Forensic Science Lab report did not reveal presence of any chemical poison in the sample sent to them. Their investigator raised several doubts about the cause of death, which were not cleared and hence the claim was kept pending.

Decision : The complainant had stated that her husband had a policy of SBI Life Insurance Co and claim was paid by them with accident benefit. M/s United India Assurance Co. Ltd also settled a personal accident claim on her husband's life. The Post Mortem report had noted fang marks on the left foot. The insurer was directed to dispose off the claim within two months from the date of the order.

Hyderabad Ombudsman Centre
Case No.G-11-003-0128
Smt. Ammayamma
Vs
National Insurance Co. Ltd.

Award Dated : 8.11.2007

Brief facts : Sri Chandrasekhar was insured under a group personal accident policy issued by National Insurance Co. Ltd., Divisional Office-V, Chennai covering the members of Road Safety Club. The sum insured for accidental death while riding a two wheeler was Rs. 200, 000 and the period of insurance was from 25.8.2005 to 24.8.2006. The insured met with an accident on 4.1.2006, while riding a two wheeler and died on the spot. A claim was lodged by Smt. Ammayamma, mother of the insured but the settlement was delayed. The complainant approached the Regional Office of the insurer, but her representation did not evoke any response.

Complainant's contentions: She stated that the claim was reported to M/s Shriram Chits. The claim form and other documents were also submitted in 06/2006 but there was no response from the insurance company. She stated that the claim is delayed by the insurer for no valid reasons.

Insurer's contentions: On receipt of claim documents, they appointed an Investigator. As per policy conditions, the claim intimation was required to be submitted within thirty days from the date of accident, but in this particular claim there was a delay of nearly two months. They also contended that the claim was not lodged by the nominee under the policy. In view of the delay in intimation of the claim and in view of the discrepancy about the claimant, the claim was not paid.

Decision : The complainant submitted that the nominee is her deceased-husband. She requested for condonation of delay, if any. The insurer confirmed that their investigator did not suspect any adverse feature in the claim. Hence it was decided to allow the complaint and accordingly the insurer was directed to admit the claim for Rs.200, 000 as per policy.

Hyderabad Ombudsman Centre
Case No.G-11-004-0178
Smt. Rinku Agarwal
Vs
United India Insurance Co. Ltd.

Award Dated : 15.11.2007

Brief facts : Sri Dinesh Agarwal had a SBI credit card which was valid up to 05/2007. As per arrangements SBI had with M/s UII Co. Ltd., he was covered under a Group Personal Accident Insurance for a sum of Rs.2 lakhs. The insurance coverage was valid subject to certain requirements of usage /payments of the card being complied with. Sri Agarwal died due to accidental drowning in a swimming pool on 7.8.2005.

Smt. Rinku intimated the death and sought claim forms on 8.8.06. On 14.8.2006, the insurers pointed out that as per policy conditions the death should have been intimated to them within a month and sought from her reasons for delayed intimation.

Complainant's contentions: She stated that she saw her husband's card and insurance certificate only in 08/2006 and immediately informed the insurance company.

Insurer's contentions: They stated that they have not received the reply given by the complainant to their letter dated 14.8.2006.They also stated that the reasons given by the complainant for delay in intimation of death does not warrant waiver of policy conditions.

Decision : During the hearing session, the insurer argued that benefits would be extended only as long as the card account was maintained in good standing and the card was not suspended or cancelled. Also there should not be any outstanding amount pending for more than 90 days and card should have been paid for or used within 45

days of its issue. The insurer contended that they did not receive any confirmation from SBI regarding eligibility of the cardholder for benefits.

In view of the submissions made by both sides, it was decided to condone the delay in intimation of the claim. The complainant was asked to submit to the insurer necessary proof from SBI regarding eligibility for insurance amount, within two months from the date of order.

Hyderabad Ombudsman Centre

Case No.G-11-009-0170

Sri M. Satyanarayana

Vs

Reliance General Insurance Co. Ltd.

Award Dated : 15.11.2007

Brief facts : Sri M.Satyanarayana, an employee of APSRTC, was covered for Rs.2 lakhs for the period 20.12.2005 to 19.12.06 under a Group Personal Accident Policy given by the insurer to the members of Road Safety Club. The insured was injured on 21.3.06 in an accident that occurred at Warangal. The insured suffered a crush injury on his left foot and all toes of the foot were amputated the next day at NIMS, Hyderabad. The insured took treatment in NIMS as an inpatient till 7.4.2006. The insured's disability was assessed at 43% by the District Medical Board and a claim was made accordingly. The insurer offered to consider payment of Rs.28, 000/- only and the insured was not satisfied with the settlement offered.

Complainant's contentions: All toes of his left foot were amputated as a result of accident and he is eligible for Rs.90,000/- as per policy conditions.

Insurer's contentions: They calculated the admissible amount as per policy conditions. As per policy conditions, the amount payable shall be 10% of Capital Sum Insured for loss of big toe and 1% of CSI for each of the other toes, they contended.

Decision : The insurer represented that benefits are payable as per table of benefits stated in the policy document and not as per percentage of disability assessed by the doctor.

The insurer was found to be justified in interpreting the policy conditions. However, it was observed that the complainant had gone through a lot of trauma and was required to be in a hospital for more than a fortnight. The policy benefits were found to be not easily comprehensible and were also not explained to the complainant leading to the grievance. The complainant was found to be having stiffness of the ankle etc. as certified by the medical board. The policy provides for benefits for other than listed disabilities based on Doctor's certificate. Considering the same, it was decided to order an extra payment of Rs.20,000/- on exgratia basis in addition to the benefit offered by the insurer.

Hyderabad Ombudsman Centre

Case No.G-11-003-0159

Smt. Pappu Laxmi

Vs

National Insurance Co. Ltd.

Award Dated : 15.11.2007

Brief facts : Smt. Laxmi was covered under a Group Personal Accident policy issued by National Insurance Company Ltd., Chennai to members of Road Safety Club for the period 25.5.2005 to 24.5.2006. The policy included coverage for inpatient

hospitalization expenses up to Rs.25,000. On 31.7.05 while traveling in a car, the insured met with an accident involving a lorry near Tanuku, W.Godavari District. She received first aid at Tanuku Area Hospital for her injuries including a head injury and proceeded to her native place Gajapathinagaram in a rented vehicle. She received further treatment at Janani Nursing Home, Gajapathinagaram and lodged a claim for Rs.10,500/-. Her claim was not settled even after several representations and hence she filed the present complaint.

Complainant's contentions: Following her treatment at a hospital in Gajapathinagaram she submitted bills for Rs.10,500/- to the insurer for reimbursement but the insurer did not settle her bills.

Insurer's contentions: They repudiated the claim on 28.3.2007 through a letter addressed to the Road Safety Club on the ground that the claim was intimated 10 months after the accident; no FIR; no medical investigation reports ; no medical record from Area Hospital, Tanuku; Discharge Summary and hospital bills were given on white paper.

Decision : The insurer stated that they are not liable to pay the claim as the insured had not undergone any CT scan after a head injury and necessity for admission into a hospital was not established by the insured. The record produced by the insured did not indicate any active line of treatment given to her for the 12 days. The complainant also conceded during the hearing that she received dressing during the period of hospitalization and said that she does not remember staying at the hospital on all those nights. She had gone to her house which was nearby. In view the arguments placed by the insurer, it was decided to dismiss the complaint.

Hyderabad Ombudsman Centre
Case No.G-11-005-0202
Smt. G. Kasi Annapurna Naga Tulasi
Vs
Oriental Insurance Co. Ltd.

Award Dated : 21.11.2007

Brief facts : Sri G.V.Somaraju was covered under a Group Personal Accident policy issued by Oriental insurance Company Ltd., Eluru covering the members of the District Co-op. Central Bank. The sum insured was Rs. 50,000/- and the period of insurance was from 1.8.2005 to 31.7.2006. Sri Somaraju was critically injured in a road accident on 5.10.2005 and died on the same day while he was being shifted from Tadepalligudem to Rajahmundry. The body of the insured was cremated without post-mortem examination. A claim for Rs.50, 000 was lodged with the insurer and all documents were submitted. The insurance company rejected the claim on the plea that the claim cannot be paid without submission of post mortem report as per policy conditions.

Contentions of the complainant: Her husband was seriously injured and he was in coma when he was taken to Govt. Hospital, Tadepalligudem. When he was being shifted to Rajahmundry for better treatment, he expired on the way. She is the nominee under the policy. Due to ignorance, they did not get a post mortem done on the body of the insured. Later they informed the police about the accident. Her husband died of accidental injuries and not for any other reason.

Insurer's contentions: As per their claims procedures it is mandatory for the claimant to submit PM report and police inquest reports. In the absence of such reports actual cause of death cannot be established. Hence they rejected the claim.

Decision : The complainant claimed that LIC settled death claim under their policy with accident benefit. She also submitted that she filed a case with MACT, Eluru seeking compensation for the death of her husband. She had conveyed that due to ignorance and illiteracy they had not intimated the police immediately about the accident. As per police records, the police have initially registered an FIR and later altered the relevant section of crime from grievous injuries (IPC Sec338) to Death (Sec304 A) and filed the charge sheet accordingly. MACT, Eluru awarded compensation considering it as death due to accident As the record clearly confirms motor vehicle accident and the insurers' investigator confirmed death due to injuries, it was decided to award payment of the sum insured as ex-gratia.

Hyderabad Ombudsman Centre

Case No.G-11-004-0201

Smt. G. Kasi Annapurna

Vs

United India Insurance Company Ltd.

Award Dated : 21.11.2007

Brief facts : Sri G.V.Soma Raju was covered under a group PA policy (Andhra Bank-Abhaya Gold) issued by UII Company Ltd. covering the account holders of Andhra Bank for a sum insured of Rs. 100,000/-. The insured was grievously injured in a road accident on 5.10.2005 and died on the same day while being shifted from Tadepalligudem hospital to Rajahmundry. The body of the insured was cremated without post mortem. When a claim was made, the insurer rejected the claim for not submitting FIR, Post Mortem reports etc. The nominee requested for settlement of claim without such reports, but the insurer refused to do so.

Complainant's contentions: Her husband was seriously injured and he was in coma when he was taken to Govt. Hospital, Tadepalligudem. When he was being shifted to Rajahmundry for better treatment, he expired on the way. Due to ignorance, the matter was not reported to police. Later, the matter was informed to police. She submitted all documents except post mortem & inquest. Hence her claim should be settled.

Insurer's contentions: The cause of death could not be confirmed in the absence of postmortem report. As the policy covers only accidental deaths, they are justified in rejecting the claim.

Decision : The complainant submitted that she received Accident Benefit under a policy issued by LIC. She also submitted that she filed a case in Motor Accident Claims Tribunal, Eluru claiming compensation for death of her husband in the road accident. The insurer reiterated those as per MOU with Andhra Bank, Post Mortem Report and Inquest Reports are necessary for settlement of claims. MACT, Eluru awarded compensation considering it as death due to accident. Therefore, the insurer was directed to settle the claim on ex gratia basis.

Hyderabad Ombudsman Centre

Case No.G-11-010-0108

Sri M. Gangayappa

Vs

IFFCO Tokio General insurance Co. Ltd.

Award Dated : 21.11.2007

Brief facts : IFFCO Tokio General Insurance Company Ltd. had issued a Sankat Haran Kisan Gramin Bima Yojana Group Personal Accident policy. The policy grants

PA cover of Rs.4000/- for one year to the farmer on each and every purchase of IFFCO fertilizer bag subject to a maximum sum insured of Rs.100,000/- to any farmer. Sri M. Shiva Kumar had purchased 18 bags of fertilizer on various dates. He died of electric shock on 10.3.2005. A claim was lodged with the insurer for Rs.72,000/-, the sum insured corresponding to 18 bags. The insurer settled the claim for Rs.44,000/- and rejected settlement of balance amount on the ground that signature on the bill for the remaining 7 bags was not tallying with the membership records of the Co.op. Society. The complainant, who is the father and nominee of the deceased, applied to this office for a review of the matter.

Complainant's contentions: He submitted that his son purchased fertilizer bags from Ethonda Primary agricultural co-op. society. Rejection of claim in respect of seven bags is not in order.

Insurer's contention: Signatures on receipt nos. 1319 & 2622 did not tally. There was overwriting on bill No.2622 and correction of bill date in bill No. 2449. They received claim for Rs.52,000 (13 bags) from Sri M. Gangayappa, the father of the deceased and for Rs.20000 (5 bags) From Smt. Rekha, wife of the deceased. They had paid Rs.24,000 to Sri Gangayappa and Rs.20000 to Smt. Rekha and disallowed Rs.28,000/- for the said reasons.

Decision : As per policy conditions, serially numbered cash receipts containing name, signature of the buyer, date etc. is required as evidence for insurance. The insurer submitted a report of Sri Maneesh Saxena, hand writing and finger print expert, who submitted that signatures did not tally. The insurer had objected to the correction in date of bill No.2449 for 3 bags. The insurer's investigator and Society Secretary confirmed sale of fertilizers on 24.1.2005. As per investigator, this particular bill was issued prior to 24.1.2005. Thus there need not be any doubt on the genuineness of the date of this bill. The investigator had not raised any doubt regarding signature on this bill. Hence, the insurer was directed to pay an amount of Rs.12000/- being the insurance for purchase of three bags vide bill No.2449. The complaint was allowed partly.

Hyderabad Ombudsman Centre
Case No.G-11-003-0213
Smt. Mahankali Lingamma
Vs
National Insurance Company Ltd.

Award Dated : 25.11.2007

Brief facts : Sri M. Venkateswarlu was insured under a group personal accident insurance policy issued by National Insurance Co. Ltd., Chennai covering the members of Road Safety Club. The sum insured was Rs.3,00,000/- and the period was from 3.6.2005 to 2.6.2006. He died due to electrocution on 11.12.2005. The claim preferred by the complainant was rejected due to abnormal delay in intimation of the claim. The complainant appealed to the RO of the insurer, but there was no response from them.

Complainant's contentions: After death of her husband all papers were submitted to the Road Safety Club, but the claim was rejected by the insurer alleging delay in intimation.

Insurer's contentions: There was abnormal delay in intimation and hence claim not payable as per condition No.3 and 4 of the policy. They were denied the opportunity to conduct a proper and timely investigation of the claim.

Decision: The insurer's representative conveyed that their Chennai office decided to settle the claim by condoning the delay in intimation and that they had sent a discharge voucher. The complainant could not submit any proof regarding the actual date of intimation. Hence her claim for awarding interest was not considered. The insurer was directed to release payment within 15 days from the date of receipt of discharge voucher from the complainant.

Hyderabad Ombudsman Centre
Case No.G-11-003-0243
Smt. M. Hemalatha
Vs
National Insurance Company Ltd.

Award Dated : 11.12.2007

Brief facts : Sri Uma Srinivasan was insured under group PA policy issued by National Insurance Co. Ltd., George Town Branch, Chennai covering the members of Road Safety Club. The sum insured for accidental death while riding a two wheeler was Rs.2,00,000 and for accidental death by any other accident was Rs.3,00,000/- and the period was from 23.3.2005 to 22.3.2006. The insured was involved in an accident on 24.5.2005 while riding a motor cycle and died. The nominee and mother of the insured, Smt. Hemalatha lodged a claim with the insurer. Her claim was rejected by the insurer stating that conditions No.3 & 4 of the policy were not complied with.

Complainant's contentions: She stated that the claim was intimated over phone within a week of her son's demise both to Road Safety Club and to the insurance company. She further stated that various papers as required by the insurance company were submitted.

Insurer's contentions: The insured died while driving a two wheeler. The claimant did not produce driving license and there was a delay in intimation of claim. Hence they refused the claim invoking conditions 3 and 4 of the policy.

Decision : The claimant stated that her son was holding a driving license and it was lost at the time of accident and a certificate from the police confirming loss of wallet was submitted by her to the insurer.

The insurer's representative submitted that a valid driving license must be submitted to prove that the insured had not committed any breach of law, which is an exclusion under the policy. From the records it was observed that the complainant submitted all documents to the insurer on 17.7.2005. The complainant stated that obtaining all records such as police reports and death certificates etc. consumed lot of time and requested for condonation of delay. As per policy conditions, PA policies exclude claims arising out of breach of law with a criminal intent. The non production of driving license in this case does not amount to breach of law with criminal intent. The rejection of claim merely for non submission of driving license is devoid of any reason and not supported by any policy exclusion. Accordingly, the insurer was directed to settle the claim for the sum assured of Rs.2,00,000/- as per policy conditions.

Hyderabad Ombudsman Centre
Case No.G-11-003-0229
Smt. Kante Satyavathi
Vs
National Insurance Company. Ltd.

Award Dated : 11.12.2007

Brief facts : The complaint is about non settlement of death claim under a group PA policy. Sri Kante Ramu was covered under a group PA policy issued by National Insurance Company Ltd., insuring members of Golden Trust Financial Services. The sum insured was Rs.1,00,000/- and the period of insurance was from 23.6.2003 to 22.6.2018. The insured died in a road accident on 27.10.2005, when he was returning home after a late night movie. The claim was not settled by the insurer despite repeated letters from the complainant.

Complainant's contentions: She submitted all documents in the office of GTFS, Visakhapatnam on 20.12.2005, who in turn had forwarded the same to the insurer. There was no response from the insurance company till the date of her complaint to the Ombudsman Office.

Insurer's contentions: They appointed an investigator and are awaiting his report.

Decision : The insurer's representative stated that they would take appropriate action on the claim after receiving their investigator's report. Since the complainant stated that she reported the claim on 2.11.2005, the insurer was directed to get their investigator's report and settle the claim within two months from the date of the award. The insurer was also directed that interest as per IRDA guidelines would become payable if the claim is not settled within the two month period.

Hyderabad Ombudsman Centre

Case No.G-11-011-0226

Smt. N. Guramma

Vs

M/s Bajaj Allianz Gen. Insurance Co. Ltd.

Award Dated : 11.12.2007

Brief facts : The complaint is about non settlement of PA claim. Sri Nalli Chinna Papaiah was insured under a group PA policy covering members of Golden Trust Financial Services. The sum insured was Rs.2,00,000/- and period of insurance was from 30.5.2005 to 29.5.2010. Then insured died due to electric shock on 19.8.2005, while working in agricultural fields. The claim was rejected by the insurer stating that the insured had no official power connection in his fields. The claimant submitted to the insurer electricity bill and a certificate from the electricity department to the effect that the fields were having electricity connection. Still the claim was not settled.

Complainant's contentions: She stated that the insurer rejected the claim alleging that there was no official power connection to the fields. She had submitted the bill paid on 11.10.2006 and also a certificate from the department certifying that there was a service connection No.50 in their fields. She submitted that her claim was unreasonably rejected by the insurer.

Insurer's contentions: Their investigator concluded that there was no official power connection to the electric motor. As per their investigator, the electric connection was obtained after the death of the insured. They have sought the electricity bills from 07/05 to 09/2005, but they have not received the same. The insured committed breach of law by illegal tapping of power and hence they are not liable to pay the claim.

Decision: The insurer's representative stated that they kept the claim pending for want of requirements. The complainant brought a certificate from the Asst. Engineer, Kalasapadu dated 24.11.2007 which reads as follows:

"This is certified that the agricultural service connection No.50 of Tellapadu existing in the name of Nali Chinna Papaiah of Tellapadu village in Kalasapadu (M). The service is existing from 30.11.1987."

The insurer has not expressed any doubt about the cause of accident due to electric shock. Hence, the insurer was directed to verify the veracity of the certificate and dispose the claim accordingly within one month from the date of the order.

The complaint was admitted for statistical purposes.

Hyderabad Ombudsman Centre
Case No.G-11-003-0200
Smt. Polanki Anuradha
Vs
National Insurance Co. Ltd.

Award Dated : 11.12.2007

Breif facts : The complaint is about non settlement of death claim. Sri P. Narasimha Reddy was insured under a group PA policy issued by National Insurance Co. Ltd., DO V Chennai covering the members of Road Safety club. The insured amount was Rs. 200,000/-. The insured died on 17.7.2005 allegedly due to snake bite. His wife Smt. Anuradha lodged a claim with the insurer. The insurer appointed an investigator, but had not settled the claim despite several reminders from the complainant.

Complainant's contentions: Her husband died due to snake bite. They submitted all documents sought by the investigator appointed by the insurer. She received information from the Road Safety Club that her claim was not processed because of the delay in intimation of claim.

Insurer's contentions: They appointed an investigator immediately after receiving information about death of the insured. From the Post Mortem report they observed that death was due to snake bite, but the viscera was not sent for chemical analysis.

Decision : From the record, it is evident that the death intimation was given to Road Safety club on 16.8.2005. The insurer appointed an investigator on 31.8.2005 and the investigator submitted a report dated 24.7.2006 in which he stated that death was due to snake bite. The insurer did not act on the report of the investigator and now they are raising a doubt about cause of death. The insurer was found to be not observing IRDA guidelines to settle claims within six months. As a clear delay is observed, the insurer was directed to settle the claim with interest as per IRDA guidelines from 1.4.2006 till the disposal of the claim.

Hyderabad Ombudsman Centre
Case No.G-11-003-0261
Sri Bharat Laxman
Vs
National Insurance Company Ltd.

Award Dated : 26.12.2007

Brief facts : The complaint is about rejection of accident claim. Sri Bharat Laxman was insured under a group PA policy issued to the members of Road Safety club for the period from 18.6.2005 to 17.6.2006. On 5.2.2006, while the insured was going on his motor cycle he was hit by another motor cycle due to which he sustained injuries. He took treatment at Area Hospital, Suryapet in 02/2006 and later at Hyderabad. He lodged a claim for Rs.25,000 but the same was not considered by the insurer.

According to the insured, he met with an accident on 5.2.2006 and police were informed immediately. He further stated that he sustained a fracture in leg, for which he was treated in the Area Hospital at Suryapet and later he was on bed-rest for nine months. He also took treatment in Sai Krishna Super Specialty Neuro Hospital,

Hyderabad in 11/2006 and was again on bed-rest for 4 months. He lodged the claim thereafter.

According to the insurer, claim was lodged with them on 12.6.2007 with a delay of about 15 months from the date of accident. Hence they returned all papers on 21.6.2007.

Decision : The complainant submitted that he was confined to two spells of long bed-rest. The insurer rejected the claim on account of undue delay in intimation of claim. As per hospital records there was a gap of nine months between the two hospitalizations. It was also learnt that the insured claimed grant from Chief Minister's Relief Fund, but the insured could not recall the exact amount of relief given as the same was directly paid to the hospital. Further, the expenses claimed by the insured were not incurred as in-patient expenses. As per policy conditions, only in-patient expenses up to Rs.25000 are allowed. The second hospitalization does not fall within the policy period. In view of the observations noted, the complaint was disallowed.

Hyderabad Ombudsman Centre
Case No.G-11-003-0269
Sri K. Ramachandra Singh
Vs
National Insurance Company Ltd.

Award Dated : 26.12.2007

Brief facts : The complaint is about rejection of PA claim under a group PA policy. K. Ramachandra Singh was a member of a group PA policy issued to the members of Road safety Club. The period of insurance was from 3.7.2005 to 2.7.2006. On 10.4.2006 while the insured was waiting for a bus, he was hit by a motor cycle and sustained injuries. A claim was lodged by the insured for settlement of PA benefit, but the insurer did not respond.

According to the insured/complainant, he sustained a head injury and fractured his leg in the accident. He is taking VRS from Railways as he was having memory lapse. According to the insurer, the claim was lodged with them after a lapse of 11 months from the date of accident. According to the papers received by them, the claim was for temporary disablement arising out of accident and hence not admissible.

Decision : The insured stated that he suffered memory loss as a result of accident and hence had to apply for VRS. He also stated that he had to take six months leave after the accident for recovery and hence he could not submit necessary papers to the insurer. The insurer's side stated that the claim could not be processed due to the inordinate delay in submission of papers. They also stated that the insured is claiming Rs.5 lakhs without any basis and the capital sum insured was only Rs.3 lakhs as per policy conditions. In view of the reasons given by the insured for the delay in intimation, it was decided to condone the delay. The insurer was asked to complete the procedures like investigator's report, obtaining necessary documents from the insured etc. and process the claim within three months from the date of the order. The complaint was admitted for statistical purposes only.

Hyderabad Ombudsman Centre
Case No.G-11-003-0251
Sri N. Janakiram
Vs
National Insurance Company Ltd.

Award Dated : 26.12.2007

Brief facts : The complaint is about delay in settlement of claim under a PA policy issued to the members of Road Safety Club. (Late) Sri N. Gopal Rao was insured under a group PA policy issued by the insurer and the period of coverage was from 25.12.2004 to 24.12.2005. The sum insured was Rs. 2 lakhs. The insured died on 10.3.2005 while boarding a train. The nominee and son of the insured lodged a claim with the insurer, but no reply was given by the insurer.

According to the complainant all documents were submitted on 26.9.2005, but no response was given by the insurer even after a lapse of more than two years.

According to the insurer, the claim intimation was received in 06/2005 with a delay of more than three months and hence they did not settle the claim.

Decision: The complainant submitted that intimation about death was given to M/s Shriram Chits within two months of the death. The complainant requested for condonation of the delay. The insurer's representative stated that they appointed an investigator and the investigator confirmed death due to accident. Since the insurer kept the matter pending without trying to find out the reasons for delay, it was decided to allow the complaint. Accordingly, the insurer was directed to settle the claim. However, the complainant's request for payment of interest was not considered.

Hyderabad Ombudsman Centre

Case No.G-11-003-0255

Smt. Akarapu Nagamani

Vs

National Insurance Company Ltd.

Award Dated : 26.12.2007

Brief facts : Sri A. Nagabrahmachary was insured under a group PA policy covering the members of Road Safety Club (Shriram Chits). The sum insured for accidental death while riding a two wheeler was Rs. 200,000 and the period of insurance was from 24.8.2005 to 23.8.2006. The insured died on 11.6.2006 in a road accident while he was going on a motor cycle. The claim was not settled by the insurer despite several reminders from the complainant.

According to the complainant all documents were submitted to Shriram Chits in 11/2006. She further stated that she received claim under another policy taken from M/s Bajaj Allianz Insurance Co. Ltd., but the present insurer did not even acknowledge her letters.

According to the insurer, the claim was intimated to them on 30.3.2007 i.e. after a lapse of eight months after the death. They further stated that they are awaiting their investigator's report and assured to process the claim after receipt of the report.

Decision: The complainant stated that some delay was there in securing police records and hence she could not file the papers with the insurer as per policy conditions. She requested for condonation of the delay. The circumstances causing the delay as stated by the complainant appear to be valid and reasonable. Therefore, the insurer was directed to complete their investigation and process the claim within two months from the date of the order. Thus the complaint was allowed.

Hyderabad Ombudsman Centre

Case No.G-11-003-0310

Sri P. Nageswar

Vs

National Insurance Co. Ltd.

Award Dated : 10.1.2008

Brief facts : The complaint is about non settlement of medical expenses claim. Sri P. Nageswar was insured under a group PA insurance policy covering the members of Road Safety Club. The period of insurance was from 25.2.2005 to 24.2.2006 and the sum insured for in-patient hospitalisation expenses following an accident was Rs.25000/-. The insured sustained a fracture of his right thigh bone when he fell from an auto rickshaw on 11.3.2005. He was admitted to NIMS, Hyderabad and was discharged on 1.4.2005 after treatment. He lodged a claim with the insurer for reimbursement of medical expenses incurred by him, but the claim was not settled.

According to the complainant, he fell from an auto rickshaw when its front wheel got separated and he sustained a fracture. He also stated that all claim papers were submitted to Shriram Chits about a month after the accident.

According to the insurer, they approved the claim for Rs.24,310/- and a cheque was sent to the Road Safety Club, Chennai. Inadvertently, the cheque was dispatched with only one signature and it was returned to them for second signature. Thereafter the cheque got misplaced in their office and they are now willing to issue a fresh cheque.

Decision : The complainant submitted that he incurred an expenditure of Rs.50,000/- but he did not submit any bills. As per policy conditions, the limit for reimbursement of hospitalisation expenses is only Rs.25,000/-. From the record it is very clear that the insurer did not take any action to issue a fresh cheque in lieu of the returned cheque. Hence, the insurer was directed to pay the claim with interest as per IRDA guidelines from the date of cheque i.e. 20.4.2006 till the date of fresh payment. The complaint was allowed partially.

Hyderabad Ombudsman Centre

Case No.G-11-003-0284

Smt. A. Lalitha Kumari

Vs

National Insurance Company Ltd.

Award Dated : 10.1.2008

Brief facts : The complaint is about non settlement of PA claim. Sri A.Satyanarayana Babu was insured under a group PA policy issued to the members of Road Safety Club. The period of insurance was from 25.4.2005 to 24.4.2006 and the sum insured for accidental death while riding a two wheeler was Rs.2,00,000/-. The insured died in a road accident on 26.8.2005. The complainant lodged a claim with the insurer and the insurer appointed an investigator to verify the details of the accident, but the claim was not settled.

According to the complainant, all relevant documents were submitted to the Road Safety Club in 10/2005, but there is no response from the insurer even after a lapse of two years.

According to the insurer, the claim was intimated to their office in 12/2005 i.e. after a lapse of four months from the date of accident. Their investigator also confirmed that death was due to accident. However they could not settle the claim as they did not receive full Post Mortem report and they would be in a position to know whether the insured was under the influence of alcohol at the time of accident through the PM report only.

Decision : The insurer's side represented that there was delay in intimation of the claim. The complainant gave her explanation for the delay and hence it was decided to condone the delay. As per record, the accident was caused by the driver of auto

rickshaw, whom the police have charged. The investigator of the insurer also did not express any doubt that the insured was under the influence of alcohol at the time of accident. In view of the findings observed from the records and pleadings of both sides, it was decided to order the insurer to settle the claim without insisting for a full post mortem report. However, the complainant's request for compensation was not considered as there was delay on their part. Thus the complaint was allowed partly.

Hyderabad Ombudsman Centre
Case No.G-11-003-0282
Sri K. Sudershan Reddy
Vs
National Insurance Company Ltd.

Award Dated : 16.01.2008

Brief facts : Sri Sudarshan Reddy was insured under a group PA policy covering the members of Road Safety Club of Shriram Chits. The period of insurance was from 31.8.2005 to 30.8.2006 and the sum insured under the head 'weekly compensation' following an accident was Rs.1000 per week for a maximum of 104 weeks. The insured was injured in an accident on 22.10.2005 while riding a motor cycle and sustained a fracture of his right leg. He is employed as a teacher in the ZP High School, Yadlapally. Following the accident, he was hospitalized at the NIMS, Hyderabad and was absent from duty from 23.10.2005 to 17.3.2006. A claim was lodged with the insurer, with all relevant documents. According to the complainant, his claim was not settled by the insurer stating that only Xerox copies were submitted and that there was no proper employer-employee relationship. He contended that the leave certificate and salary certificate were given in original.

According to the insurer, the claim was for weekly compensation. The certificate given by the complainant from his employer was on a white paper.

Decision : The insurer also alleged that claim intimation was delayed beyond 30 days from the date of discharge from hospital. The complainant submitted that he could not attend his school for a period of 19 weeks i.e. up to 17.3.2006 due to the injuries sustained in the accident. He also submitted a medical certificate from NIMS advising him rest from 23.10.2005 to 17.3.2006. As per record the insured was employed in a local authority school and such schools normally do not have elaborate stationery and letter-heads of their own. The insurer could have deputed their investigator, if they had any doubt about the genuineness of the record produced. In view of the reasons given by the insured for the delay in reporting about claim, it was decided to condone the delay and allow the complaint. The insurer was directed to process the claim for weekly compensation.

Hyderabad Ombudsman Centre
Case No.G-11-003-0309
Smt. Rekha
Vs
National Insurance Company Ltd.

Award Dated : 16.01.2008

Brief facts : The complaint is about non settlement of death claim under a group PA policy issued to the members of Road Safety Club of Shriram Chits. Sri Siva Kumar was covered under the group policy. The sum insured was Rs. 200,000/- and the period of insurance was from 3.12.2004 to 2.12.2005. The insured sustained an electric shock

and died on 10.3.2005. A claim was lodged with the insurer and they deputed M/s Golden Eye Detectives to investigate into the claim and circumstances of the death. The complainant contended that there was no communication from the insurer about status of the claim.

According to the insurer, the claim intimation was received in their office on 3.1.2006 i.e. after a lapse of about 10 months from the date of accident. They could not settle the claim since the loss was not reported within 30 days, as required by policy conditions.

Decision : The complainant's representative stated that they had submitted all documents in the office of Shriram Chits after about 45 days from the date of death. He requested for condonation of delay. The insurer's representative stated that the sole reason for keeping the claim pending was the inordinate delay in intimating the accident / death. From the records produced it was observed that the insurer's investigator confirmed the accidental nature of death. The insurer's side was found to be not justified in not corresponding with the complainant. Accepting the reasons given by the complainant regarding delayed submission of claim papers, it was decided to condone the delay and allow the complaint. Accordingly, the insurer was directed to settle the claim.

Hyderabad Ombudsman Centre
Case No.G-11-003-0321
Sri B. Malliah
Vs

National Insurance Company Ltd.

Award Dated : 16.01.2008

Brief facts : The complaint is about non settlement of accident claim under a group PA policy issued to the members of Road Safety Club. The period of insurance was from 25.12.2004 to 24.12.2005 and the sum insured was Rs.200,000/-. The insured was working on a crane on 13.4.2005 when he was involved in an accident causing crush injury to his left hand. He lost his thumb, index and middle fingers of his left hand due to amputation following crush injury. A claim was lodged with the insurer, but the same was not settled.

According to the insurer, the claim was reported after a lapse of six months from the date of accident. They stated that the claim was not settled due to delayed intimation. They further stated that the initial claim was for reimbursement of medical expenses but later the insured submitted a disability certificate of 60% and claimed compensation for permanent partial disability. They stated that as per policy terms, their liability worked out to 41% of the capital sum insured.

Decision : The complainant stated that he was in hospital for one month after accident and that he could inform Shriram Chits after about a month from the date of accident. From the papers on record it was observed that the investigator of the insurer had not raised any doubts about the cause of accident or about the disability. Based on the facts of the case, it was decided to condone the delay and the insurer was directed to settle the claim for 41% of the capital sum insured as assessed by them.

Hyderabad Ombudsman Centre
Case No.G-11-003-0315
Smt. Ch. Usha Rani
Vs
National Insurance Company Ltd.

Award Dated : 16.01.2008

Brief facts : The complaint is about non settlement of PA claim under a group PA policy issued to the members of Road Safety Club. The period of insurance was from 17.7.2005 to 16.7.2006 and the insurance coverage for accidental death was Rs. 300,000/-. The insured Sri Mohan Rao died on 2.9.2005 in a road accident, when the car he was travelling collided with a truck.

According to the complainant, a claim was lodged with the insurer and all the required documents were submitted to Shriram Chits on 15.11.2005. She had also submitted a legal heir certificate and a letter giving details of accident on 7.8.2006, but the insurance company remained silent.

According to the insurer, the claim was intimated to them on 2.12.2005. As per policy conditions, claims are to be intimated within one month from the date of accident and hence the delay in intimation was more than three months. They rejected the claim for the said reason.

Decision : The complainant could not submit any proof of intimation given by her to Shriram Chits. She stated that some delay occurred in procuring documents from various authorities and requested for condonation of delay.

The insurer maintained that the claim is not admissible on account of delayed intimation. They also stated that they appointed an investigator to verify the accident details. It was noted that as per record, the investigator had not expressed any doubts about the cause of death. It was observed that the insurer had not tried to find out the reasons for delay in submission of papers by corresponding with the complainant. Based on complainant's submissions it was decided to allow the complaint and accordingly the insurer was directed to settle the claim.

Hyderabad Ombudsman Centre

Case No.G-11-012-323

Sri Dushyant Gupta

Vs

ICICI Lombard Gen. Insurance Co. Ltd.

Award Dated : 21.01.2008

Brief facts : The complaint is against partial settlement of mediclaim. Sri Gupta and his family were covered under a group health insurance policy covering the employees of M/s Cross-Tab Marketing Services Pvt. Ltd. for the period 7.3.2007 to 6.3.2008. Smt. Abhilasha Gupta was hospitalized from 6.6.2007 to 7.6.2007 with complaints of severe abdominal pain, UTI etc. Cashless facility was not extended by M/s TTK Health Care Services Pvt. Ltd, the insurers' TPA. Sri Gupta lodged a claim for Rs.16,440/- and submitted relevant bills. The claim was not settled despite reminders from the complainant.

As per the contentions of the complainant, his wife was required to stay in the hospital for the second day because of the delayed response from the TPA for his request for cash-less facility.

The insurer's representative stated that they released admissible claim amount of Rs.10,186/- and as per their policy conditions the sub limit for room rent was Rs.1500/- per day.

Decision : Both sides were heard on 4.1.2008. The insurer's representative informed that request for cashless approval was received in the afternoon on 7.6.2007 and their TPA reverted within a few hours on the same day. They contended that the request for cashless facility was received late.

The complainant agreed that some delay took place to complete the paperwork in the hospital, in the morning of 7.6.2007. The complainant also stated that he was yet to submit his bills amounting to Rs. 50,000/- pertaining to a later treatment to the insurer for reimbursement. As the complaint is premature, it was decided to dismiss the complaint.

Hyderabad Ombudsman Centre
Case No.G-11-003-0308
Smt. S.K.Gulzar Sultana
Vs
National Insurance Company Ltd.

Award Dated : 25.01.2008

Brief facts : Shaik Mastan Vali Ahmed was insured under a group PA policy, covering members of Road Safety Club (Shriram Chits). The sum insured was Rs.2,00, 000 and period of insurance was from 12.7.2005 to 11.7.2006.The insured died on 23.11.2005 in a road accident. A claim lodged by the complainant was not settled by the insurer alleging delay in intimation of the claim.

As per the contentions of the complainant all papers were submitted to the insurer on 2.6.2006. As per the insurer, there was a delay of about three months in intimating the claim.

Decision : Both sides were heard on 23.1.2008. The complainant stated that she had sent a written intimation to Road Safety club on 26.12.2005 about death and all claim documents were submitted on 2.6.2006. The insurer's representative stated that death intimation was received by them on 21.2.2006 i.e. after three months from the date of death. On the date of hearing, the insurer was yet to receive the investigator's report. Based on the representations made by both sides, it was decided to condone the delay and the insurer was asked to process the claim within two months from the date of the award. The complaint was allowed.

Hyderabad Ombudsman Centre
Case No.G-11-003-0298
Smt. Sama Karuna
Vs
National Insurance Co. Ltd.

Award Dated : 25.01.2008

Brief facts : The subject matter of complaint is about non settlement of GPA claim. Sri Sama Shankar Reddy, an employee of BSNL was insured under a group PA policy issued by NIC Ltd., covering members of Golden Multi Services Club. The period of insurance was from 23.3.2004 to 22.3.2019 and the sum insured was Rs.400,000. He died on 3.2.2005 allegedly due to run over by a train while crossing railway tracks. Death claim lodged by Smt. Karuna was not settled by the insurer even after several reminders.

According to the complainant all papers relating to the claim were submitted through GTFS office to National Insurance Co. Ltd., Kolkatta on 10.3.2005. She stated that the insurer's investigator visited their house in 11/2006.

The insurer stated that appointed an investigator on 16.8.2006 and are yet to receive investigation report.

Decision : Both sides were heard on 23.1.2008. As per the contentions of the complainant, claim intimation was given within a month to GTFS. She further stated that all required documents were submitted on 10.3.2005.

The insurer's representative stated that they are yet to receive their investigator's report. The insurers' representative could not explain the reasons for delay in processing the claim. It was also observed that LIC of India had settled Double Accident Benefit under a policy held by the deceased. Considering the submissions made by both sides, the insurer was directed to process and dispose the claim within two months from the date of the order. Otherwise the insurer would have to settle the claim with interest as per IRDA guidelines.

Hyderabad Ombudsman Centre
Case No.G-11-003-0348
Sri Mohd. Rehman Sharif
Vs
National Insurance Co. Ltd.

Award Dated : 8.2.2008

Brief facts : Sri Rahman was insured under a group personal accident policy issued by National Insurance Co. Ltd., Chennai covering the members of Road Safety Club Pvt. Ltd. (Shriram Chits Ltd) and the period of insurance was from 28.9.2004 to 27.9.2005. The sum insured was Rs.3, 00,000. The insured met with a road accident on 17.3.2005 and injured his left eye, which resulted in loss of sight in that eye. A claim was lodged with the insurer but the claim was not settled by the insurer and the present complaint is about non settlement of the claim.

Decision : The insurer contended that their investigator could not complete investigation due to non furnishing of relevant details by the insured. Both sides were heard in a hearing session held on 6.2.2008. The complainant stated that he was also covered under another group policy issued by UIL Co. Ltd., under AB Abhaya Gold Group PA policy and that they paid disability claim. As per policy condition, the compensation for loss of sight in one eye is Rs.150,000/-. It was observed from the papers that the insurance company had misplaced the file leading to the delay in settlement of the claim. Further, there was nothing on record to suggest that the insurer had called for any requirement. Hence the insurer was directed to dispose off the claim within two months from the date of the order. The complaint was allowed.

Hyderabad Ombudsman Centre
Case No.G-11-003-0366
Smt. D.P.Suvarna Kumari
Vs
National Insurance Co. Ltd.

Award Dated : 20.2.2008

Brief facts : Sri K.S.Y.Rajanna was insured under a group personal accident policy covering members of Road Safety Club (Shriram Chits). The sum insured was Rs.2,00,000/- and the period of insurance was from 14.2.2005 to 13.2.2006. Sri Rajanna suffered severe head injuries on 6.12.2005 and died. Smt. Suvarna Kumari intimated on 24.2.2006 to Shri Ram Chits Pvt. Ltd., Kurnool about death of her husband, who in turn forwarded the intimation to their Chennai office. The claim was not settled by the insurer even after a representation was made to the RO of the insurer.

Decision : The insurer stated that the claim was not registered in their office and hence question of settlement does not arise.

The complainant produced a letter from Road Safety Club, Chennai stating that documents were submitted to them on 6.3.2006. The complainant stated that some delay in intimation of claim was caused due to time consumed in obtaining documents from various offices. From the papers submitted, it became clear that claim documents were submitted to Shri Ram Chits, Chennai. However, it is not established whether the documents were transmitted to the office of the insurer. As the complainant is an illiterate lady coming from a poor family, it was decided to condone the delay and she was asked to submit a fresh set of documents. The insurer was directed to process the claim papers within three months from the date of receipt of documents from the claimant. The complaint was admitted for statistical purposes.

Hyderabad Ombudsman Centre

Case No.G-11-010-0372

Smt. K. Venkata Laxmi

Vs

Iffco Tokio General insurance Co. Ltd.

Award Dated : 10.3.2008

Brief facts: Sri Konakalla Pulla Rao, a tobacco farmer was insured under a group PA policy issued by the insurer to M/s Tobacco Board for the period 16.11.05 to 15.11.06. Sri Pulla Rao allegedly met with an accident on 18.4.06 when the moped he was riding skidded. He received treatment from one Dr. K. Raja Rao at Chintapalli but died on the same night. A claim was lodged with the insurance company but they did not settle it on the ground that a police FIR and Post Mortem Report were not submitted. Aggrieved by the decision of the insurer, the complainant approached this office.

Decision: The insurers stated that police FIR and PM Report are necessary documents to establish admissibility of claim under the terms of the policy. According to the contentions of the complainant, the insured person suffered a major head injury and Dr. Raja Rao had given first aid. She added that her husband had passed away while being taken to a referral hospital. She also stated that no one was responsible for the accident and he fell by himself from the moped. She stated that the dead body was cremated without FIR and a PM examination.

The basis of complainant's claim is the certificate dated 25.4.06 issued by one Dr. Raja Rao in which the doctor noted (sic) " Sri Pulla Rao had brought to me on 18.4.06 at 10.00 pm with h/o head injury due to skidding of his moped and gasping state; I gave him first-aid and cardio pulmonary resuscitation and to refer the case to a higher centre but he expired at 10.10 pm." Leaving aside the grammatical errors, what can be reasonably concluded from the above was that in addition to head injury Sri Pulla Rao had a heart related problem which was attended by the doctor and that Sri Pulla Rao died in the doctor's presence.

The insurer's representative pointed out that it was a necessary prerequisite for claim consideration that the injury from accident should be the sole and direct cause of death. From the doctor's certificate we are unable to conclude that the death of Sri Pulla Rao was caused solely and directly by accident. A police enquiry report dated 17.5.06 was also submitted in which it was stated that (late) Sri Pulla Rao received multiple grievous injuries whereas the doctors report and photographs of the dead body indicate only one injury on the forehead. It was also observed that while the doctor report says that the insured was taken to him at 10.00pm, the police enquiry report refers to injured being admitted to the hospital at 7.00 pm.

In one of the statements given by the witnesses, it was mentioned that the insured died at 12.15 in the night while undergoing treatment in Adarsh Hospital, Rajahmundry. The doctor had not recorded it as a case of unnatural death or medico-legal case. It was thus not established that the reported accident was the sole and direct cause of the insured' death. The complaint was rejected.

Hyderabad Ombudsman Centre

Case No.G-11-010-0373

Smt. Nandam Laxmi

Vs

Iffco Tokio General Insurance Co. Ltd.

Award Dated : 10.3.2008

Brief facts : Sri Nandam Adishesu was insured under a Group Personal accident policy covering tobacco growers attached to Tobacco Board, Jangareddygudem for a sum insured of Rs.1,00,000/- per person and the period of insurance was from 16.11.05 to 15.11.06. The insured's dead body was found in the river Godavari on 18.1.06. A police FIR was registered and post-mortem examination done. The claim was rejected by the insurer stating that death was not due to accident.

Decision : The complainant stated that the insured person went for treatment to Rajahmundry on 10.1.06 and went missing. His body was found in the river on 18.1.06 and according to her, the insured died due to accidental drowning in the river.

The insurers got the claim investigated. According to them, the dead body was found at a busy place but there were no eye witnesses to the accident. According to them death must have been due to some natural causes like a chronic disease and not due to accident. They contended that there are several inconsistencies in the nature of accident reported and hence they rejected the claim.

In the police report it was mentioned that no foul play was suspected and death was attributed to drowning. In the post mortem report also the cause of death was mentioned as due to cardio respiratory failure due to shock and asphyxia due to drowning. The insurers have not placed any cogent evidence to prove that death was due to some other cause and they based their rejection action on some assumptions. As such the complaint was allowed and the insurers were directed to settle the claim.

Hyderabad Ombudsman Centre

Case No.G-11-003-0405

Smt. T. Prarthana Kumari

Vs

National Insurance Co. Ltd.

Award Dated : 18.3.2008

Brief facts : Sri T.Ravi Kumar was covered under a group PA policy covering members of Golden Multi Services Club of GFTS. The sum insured was Rs.5,00,000/- and the period of insurance was from 15.3.2003 to 14.3.2018. The insured was employed as a Field Officer in The AP Co-op. Oil Seeds Growers Federation Ltd. The insured was injured in a road accident on 31.10.2004 and died on 9.11.2004 while undergoing treatment. A claim was lodged by Smt. Prarthana but she did not receive any response from the insurer despite follow up. Aggrieved, she filed a complaint in this office.

Decision : The complainant stated that she submitted all documents to Golden Multi Services Club, Hyderabad only on 21.6.2006, after the original insurance bond was traced. The insurer's representative submitted that the claim was under process and that they had sought certain information on 14.2.2008.

The complainant stated that death was informed to the Hyderabad office of Golden Multi Services Club on 6.1.2005 itself but submission of claim forms was delayed as the original insurance certificate was not traceable. The representative of the complainant submitted that they were not aware of the existence of the policy until the deceased's colleagues informed them of it. They requested for condonation of the delay. The delay in intimation of the claim was condoned and the insurer was asked to complete their investigation process and dispose of the claim within three months. The complaint was allowed.

Hyderabad Ombudsman Centre
Case No.G-11-003-0362
Smt. Putta Swathi
Vs
National Insurance Co. Ltd.

Award Dated : 18.3.2008

Brief facts: Sri Ravi was insured under a group PA policy, covering members of the Road Safety club. The period of insurance was from 25.5.2004 to 24.5.2005 and the sum insured was Rs.2,00,000/-. Sri Ravi died in a road accident on 19.3.2005. Smt. Swathi, the nominee lodged a claim with the insurer, but the insurer did not settle the claim. Aggrieved, she approached this office.

Decision: The complainant stated that all papers were sent in October/November, 2005. She also represented to the Chennai RO of the insurer. The insurer's representative stated that they received claim intimation on 5.1.2006 and they could not settle the claim owing to the delayed intimation.

During the hearing, the complainant admitted that some delay was there in reporting the claim, but stated that the delay was due to non receipt of insurance certificate from the insurer through M/s Shriram Chits. A letter from Shri Ram Chits, Nizamabad also establishes that there was a delay in receipt of policies from the insurance company, which was not refuted by the insurer. The insurers remained silent even after receiving their investigator's report. The delay was condoned and the insurer was directed to settle the claim.

Hyderabad Ombudsman Centre
Case No. G 11.012.0409
Shri V Srinivas Reddy
Vs
ICICI Lombard General Insurance Co.Ltd.

Award Dated : 25.03.2008

Brief Facts : Sri V Srinivas Reddy was insured under a Group Personal accident insurance policy issued by ICICI Lombard General Insurance Co.Ltd., covering the members of Malhotra Shaving Products (P) Ltd., He was injured in a road accident and lodged a claim for temporary total disablement through E-med Life who were the insurance brokers. The claim was not settled despite constant follow-up.

Decision : The insurer stated that as per the policy the claim should be intimated to them within 90 days but this particular claim was received by them after 6 months. It is

observed that all the claim documents were routed through the broker. The claim form was acknowledged on 14.09.2007 (within 90 days) and the insurer submitted that the endorsement might be that of the broker. The complainant submitted that all the required papers were submitted by him immediately on resumption of duty and there was no delay on his part. In view of timely submission to the broker the insurers were directed to condone the delay in intimation, process and dispose the claim.

Hyderabad Ombudsman Centre
Case No. G 11.003.0389
Sri Balanagu Jayalakshmi
Vs
National Insurance Co.Ltd.,

Award Dated : 25.03.2008

Brief Facts : Sri B Ravichandra was insured under a Group Personal Accident Policy issued by National Insurance Co.Ltd., Kolkotta covering the members of Golden Trust Financial Services for the period 01.09.2004 to 30.09.2014. He was a money lender and was lured by his clients to a rental house on pretext of returning the money, but murdered him there. A claim was lodged with the insurers but there was no response.

Decision : The insurers contended that the policy covered accidents only and murder was not an accident as held by Supreme Court in Rita Devi Vs. New India Assurance Co.Ltd., It is observed that as per the Police Charge Sheet the wives of the two accused were in the Gulf earning money and these two were addicted to vices and indulged in violent activities for money. The FIR recorded that gold and other articles worth Rs. 40,000/- were stolen from the deceased by the accused. From the record it is observed that the primary motive of the accused may not be termed as murder, but that they were in need of money and also did not want to repay the earlier loan taken. Thus the primary motive of the accused being theft, it was held that for the purposes of this insurance claim the death of Sri Ravichandra needs to be viewed as accidental and within the purview of the policy. The LIC and United India have also settled the claim under accidental benefits. The insurers are directed to settle the claim.

Hyderabad Ombudsman Centre
Case No.G-11-003-0459
Sri P. Laxminarayana
Vs
The National Insurance Company Ltd.

Award Dated : 31.3.2008

Brief facts : Sri Laxminarayana was covered under a group PA policy issued by the insurer to the members of Road Safety Club (Shriram Chits) for the period 10.8.2005 to 9.8.2006. Sri Laxminarayana met with a road traffic accident on 26.11.2005 and suffered fracture of his right scapula and also received head injuries. The claim papers seeking compensation under the policy were sent through Road Safety Club and intermediary Ski Insurance, Mangalore to the insurers. There was no response from the insurers and hence the insured approached this office seeking settlement of his claim.

Decision : The complainant submitted that all claim papers were given to the insurer in 01/2006 and sought early settlement of claim. The insurers contended that the claimant ought to have submitted claim intimation within thirty days from the date of accident and because of the delay of about twelve months they could not arrange proper and timely investigation. They stated that claim could not be entertained in view of inordinate delay. An examination of the papers on record revealed that the

complainant had intimated the accident to the Road Safety Club and obtained the claim form. The delay occurred due to lack of clarity in procedure for filing of claim on the part of the Road Safety Club. Hence, it was held that the complainant cannot be penalised for a lapse on the part of the intermediary and the insurers were directed to dispose of the claim within two months from the date of the award.

Hyderabad Ombudsman Centre
Case No.G-11-003-0322
Smt. B.Dhanamma
Vs
National insurance Co. Ltd.

Award Dated : 31.3.2008

Brief facts : Sri Komariah was insured under a group PA policy covering members of Golden Multi Services Club (GTFS). The period of insurance was from 8.12.04 to 7.12.2014 and the sum insured was Rs.1,00,000 only. The insured died on 4.12.2005 in a road accident. The intimation to GTFS was given on 5.12.2005, which in turn was forwarded to the insurer. The completed claim forms were sent to the insurance company on 25.2.2006 and thereafter there was no response from the insurer. The complainant represented to this office about her pending claim.

Decision : The insurer stated that the claim was under process. They observed that the name of the deceased is differing with the name stated in the insurance certificate. They had written for clarification on 21.11.2007 and 3.1.2008 but did not receive any reply from the complainant. The insurers stated that they are ready to settle the claim if they receive an authentic document that the insured and deceased are one and the same.

The complainant submitted that her husband's name was Bandlagorla Komaraiah and she was not aware how the name was mis spelt as Bharalla Garda Kamariah in the certificate of insurance. She produced a Kisan Credit Card and Voter ID Card of her husband wherein the name was spelt as Bandlagorla Komaraiah. The insurer's representative could not produce original proposal papers or any other paper evidencing issue of policy to some person other than the complainant's husband. The insurers have not arranged for any inquiry also in this case till the date of hearing. As such the insurers were directed to investigate the claim and dispose the claim within two months from the date of this order. The complainant was directed to co-operate with the insurer in the investigation process. The complaint was admitted for statistical purposes.

Hyderabad Ombudsman Centre
Case No. G 11.003.0413
Shri K.Easwara Rao
Vs
National Insurance Co. Ltd.

Award Dated : 31.03.2008

Brief Facts : M/s. Quantum International insured all their distributors and their nominees under a Group Personal Accident Policy issued by National Insurance Co.Ltd., New Delhi. Sri K Easwara Rao a distributor and Smt. K Chinnammalu as nominee were insured for a sum of Rs. 1,00,000/- each. Smt. Chinnammalu met with a road accident on 03.08.2005 and died. The claim was intimated to M/s. Quantum

international and all the claim papers were submitted who in turn forwarded them to the insurance company. The claim was not settled despite many reminders.

Decision : The insurers stated that the policy No. 8201460 was not issued by their Jhandewalan Branch; with whom entire correspondence was made. It was mentioned in all the correspondence that the claim was under policy No. 8201460 but a copy of policy No. 8201461 was enclosed. This discrepancy was observed by this office and the complainant's representative confirmed that they had pursued with M/s. Quantum International for correct certificate after they had received a letter from this office. It is observed that the complainant had approached the insurers Head office. A mere acknowledgement by the Head office cannot be said to be sufficient to dispose a grievance. The insurers Head office ought to have identified the policy issuing office or at least could have written to the complainant. The policy No.8201460 was issued by insurer's DO 22 New Delhi. The claim intimation was given in time and documents were also submitted and because of lapses the claim was not settled. The complainant is directed to immediately submit all documents to the insurers' DO 22 New Delhi. The insurers are directed to condone the delay in registration of the claim and process it and dispose within 2 months from the date of the order. Otherwise, they have to pay the sum insured of Rs. 1,00,000/- with interest as per IRDA guidelines from date of the order till date of payment , complaint is allowed.

Hyderabad Ombudsman Centre
Case No. G 11.003.0395
Shri A K Lekhraj
Vs
National Insurance Co. Ltd.

Award Dated : 31.03.2008

Brief Facts : Sri A.K. Lekhraj was insured under a group personal accident policy issued by National Insurance Co.Ltd, Kolkotta covering the members of Golden Multi Services Club for a sum insured of Rs. 5,00,000/- He was grievously injured in a road accident and his right leg was amputated above the knee . The intimation was given within 15 days and the documents sought by the insurance company were submitted but the claim was not settled.

Decision : The insurers submitted that they had sought from the insured proof of income and driving license. The complainant placed on record a copy of letter wherein the Kolkotta office advised their Hyderabad Regional office to appoint an investigator. The intimation was given immediately and papers submitted. The insurer is not justified in seeking the information on a piece meal basis. They ought to have arranged investigation much earlier. i.e, before this office was approached. There is no relevance in seeking income proof at the time of claim which ought to have been done at the time of granting cover. The insurers were directed to complete the process of investigation and dispose the claim within two months from the date of the order. In case of default the insurers will have to settle the claim with interest as per IRDA guidelines form the date of order till date of payment.

Hyderabad Ombudsman Centre
Case No. G 11.003.0427
Smt. Munawar Sultana
Vs
National Insurance Co. Ltd.

Award Dated : 31.03.2008

Brief facts : Sri Syed Hussain was insured under a group Personal Accident Policy issued by National Insurance Co.Ltd., Kolkotta covering the members of Golden Multi Services Club for a sum insured of Rs. 3,00,000/-. He met with an accident on 2.3.2006 and died. His wife Smt. Munawar Sultana submitted all the documents and despite her pursuing, the claim was not settled.

Decision : The insurers stated that they had sought the attested copy of Ration card/Voter ID card, income proof and driving license to ascertain the admissibility of the claim. It is observed that the claim intimation was given in time and the required documents submitted. The insurer could not produce copies of letters seeking the documents and the complainant stated that no letter was received by her. The insurers ought to verify the income aspect at the time of granting cover. The insurers were directed not to insist on income proof and driving licence as they are not relevant to determine the admissibility of the claim. The IRDA guidelines stipulate that the process of investigation should be completed within 6 months from intimation of claim and insurance company has to dispose the claim within one month after receipt of investigation report. It is observed that the insurers seek to appoint an investigator now. They are directed to complete the processing and pay the claim within 2 months from the date of the award together with interest as per IRDA Protection of policy holders interest's guideline from 01.01.2007 till date of payment.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-003-121/07-08
Sri.K.V.Nandakumar
Vs
National Insurance Co. Ltd.

Award Dated : 29.10.2007

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant an employee of M/s.He-Man Engineers had taken a group personal accident policy. He met with an accident on 14.3.05 and he was on continuous treatment and joined duty only on 29.1.07. His claim for reimbursement of expenses and compensation as per policy condition were not settled inspite of his repeated reminders and complaint to higher authorities of insurance co. Aggrieved by this he approached this Forum for justice. It was submitted on behalf of insurer that the settlement was delayed on account of non-receipt of treatment records. They arranged an investigation and as the investigation report was incomplete they have appointed another investigator and they are waiting for his report.

On verification of records it can be seen that as per medical records he was disabled upto 29.1.07 and he joined duty only on 29.1.07. Total period of disablement comes to 686 days i.e. 98 weeks. As per policy condition he is eligible to get a compensation of Rs.1000/- per week for the period of disablement, subject to a maximum of Rs.100000/- and also hospital expenses at the maximum of Rs.10000/-. From the bills produced it can be seen that he has spent more than 10000/- towards medicine itself. As the disablement period is 98 weeks he is eligible to get compensation of Rs.98000/- for disablement and Rs.10000/- towards hospital expenses. Thus the complainant is eligible to get an amount of Rs.108000/-. The complainant submitted that he is agreeable for Rs.108000/- as compensation and hospital expenses. The fact that he was disabled for 98 weeks was not disputed by the insurer. The medical certificate also shows that he joined duty only on 29.1.07 i.e., after 98 weeks. For the protracted treatment he incurred an expense of morethan Rs.10000/-. This fact also was not

disputed by the insurer. Hence an award is passed to pay a sum of Rs.108000/- to the complainant with interest at 8% since 29.1.07 till the date of payment.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-005-240/2007-08
Sri.N.K.Babu
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 19.12.2007

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. As a worker of M/s.Apollo Tyres the complainant is covered by a GPA policy issued to M/s.Apollo Tyres. On 1.7.06 while he was working in the company he sustained some injury on his right thumb. The claim for Rs.2042/- was repudiated by the insurer on the ground that the injury was of the nature of sprain and is not visible externally. The repudiation is only on the ground that the injury sustained was not visible externally or through X-ray. In the self-contained note submitted by the insurer it was submitted that the injury was sprain/contusion right thumb. The only question is to be considered is that whether the injury is visible or not. The certificate issued by the doctor who treated the patient says that the patient was suffering from sprain/contusion of right thumb. In the claim form against the question relating to accident the attending doctor has certified that injury was externally visible. Also it is specifically stated that there was contusion of right thumb. This fact was not disputed by the insurer in self contained note also. It can be seen that the injury is visible externally and hence there is no point in the contention of the insurer that the injury is not visible externally. The complainant is eligible to get the benefit and insurer is therefore directed to settle the claim of Rs.2042/- with 8% interest.