Vs.

Sh. Shivnath Chaturvedi (Deceased)

Smt. Seema Chaturvedi and Anr.

STATE CONSUMER DISPUTES REDRESSAL COMMISSION UTTARAKHAND, DEHRADUN

Date of Admission : 10.09.2013
Date of Final Hearing : 08.05.2025
Date of Pronouncement : 26.05.2025

SC/5/A/13/246

1. The Oriental Insurance Company Ltd.
Registered Office and Head Office at A-25/27
Asaf Ali Road, New Delhi – 110002

2. The Oriental Insurance Company Ltd.
Railway Road, Opposite Jwalapur Post Office,
Jwalapur, Haridwar
Through The Oriental Insurance Company Ltd.
Divisional Office, 1st Floor, 4-B, Sachdeva Colony,
Opposite Nainital Bank Limited
Haridwar Road, Dehradun

(Through: Sh. S.P. Singh, Advocate)
…..Appellants

VERSUS

1. Sh. Shivnath Chaturvedi (Deceased)

1/1. Smt. Seema Chaturvedi W/o Late Sh. Shivnath Chaturvedi
1/2. Miss. Praneeta Chaturvedi D/o Late Sh. Shivnath Chaturvedi
R/o 76/2 Sharda Nagar, Jwalapur, Haridwar, Uttarakhand

(Through: Sh. Shivam Sharma, Advocate)
….Respondent Nos. 1/1 & 1/2

2. Raksah T.P.A. Pvt. Ltd.
15/5Mathura Road, Faridabad

…..None for Respondent No. 2

Coram:
Ms. Kumkum Rani, President
Mr. C.M. Singh, Member

ORDER

(Per: Ms. Kumkum Rani, President):

This appeal under Section 15 of the Consumer Protection Act, 1986 has been directed against judgment and order dated 11.07.2013 passed by the learned District Consumer Disputes Redressal Forum, Haridwar (hereinafter to be referred as the District Commission) in consumer complaint No. 265 of 2011 styled as Sh. Shivnath Chaturvedi vs. Branch Manager The Oriental Insurance Company Ltd. and Others, wherein and whereby the complaint was allowed directing the Insurance Company to pay Rs. 60,000/- to the complainant within a month from the date of judgment and order.

2. The facts giving rise to the present appeal, in brief, are as such that the complainant had purchased a 'Happy Family Floater Policy' from The Oriental Insurance Company Ltd., which was a Mediclaim Insurance Policy No. 252900/48/2011/1369 for a sum of Rs. One Lakh for himself, his parent and his daughter through the agent of the Insurance Company. First policy was purchased on dated 16.10.2009 and it was valid till 15.10.2010. The said policy was again renewed for a further period of one year on dated 16.10.2010 till 15.10.2011 with same sum insured amount. Suddenly his mother's health deteriorated for which the complainant demanded an amount of Rs. 54,096/- from the Insurance Company, but despite of completing all the formalities, the amount was not paid to the complainant by the Insurance Company. Thereafter, the complainant issued a notice through his lawyer to the Insurance Company and in the absence of any remedial measure, the complainant lodged a complaint before the District Commission alleging deficiency in service on the part of the opposite parties.

3. In the written statement filed by the opposite parties, it was stated that no cause of action has arisen against them and the answering opposite party immediately forwarded the complainant's claim to the opposite party No. 3 wherein it was found that the claim of the complainant's mother comes under the exclusion clause and hence, the claim was repudiated.

4. After hearing both the parties and after taking into consideration the facts and evidence on record, the District Commission has passed the impugned judgment and order on dated 11.07.2013 whereby the District Commission has allowed the complaint in the above terms.

5. On having been aggrieved by the aforesaid judgment and order of the District Commission, the opposite party Nos. 1 & 2 have preferred the present appeal as appellants.

6. In the appeal, the learned counsel for the appellants has contended that the order of the Commission below is against law, facts and merits of the case and the Commission below has not considered the written statement and evidence filed by the appellants. The District Commission has not considered the terms and conditions of the policy. The policy in question is a contract between both the contracting parties and both the parties are bound by the terms and conditions of the policy. As per the terms and conditions of the policy, the claim was not payable. The Commission below has not considered the fact that the mother of respondent No. 1 – complainant was suffering from Acute Chronic Renal Failure and hence the claim was not payable. There was no deficiency in service by repudiating the claim of respondent No. 1. The Commission below has not considered the fact that the disease with which the mother of respondent No. 1 suffered, was covered under the policy after a period of two years. The District Commission has not considered the exclusion clause of the policy and has

wrongly awarded a sum of Rs. 54,096/- towards medical expenses incurred in the treatment and toward damages without any evidence. There was no deficiency in service of the appellant, the impugned judgment and order is non-est in the eyes of law. Hence, the appeal be allowed and the impugned judgment and order is liable to be set aside.

7. Learned counsel Sh. S.P. Singh for the appellants as well as learned counsel Sh. Shivam Sharma for respondent Nos. 1/1 and 1/2 has appeared. None has appeared on behalf of respondent No. 2, hence vide order dated 25.07.2024 the appeal was proceeded ex-parte against the respondent No. 2

8. We have heard and perused the pleadings, evidence & documentary evidence available on record.

9. During the arguments, learned counsel for the appellants stated that the complainant's mother was suffering from Diabetes and other related complications. As Diabetes is covered under exclusion clause 4.3of the terms and conditions of the policy, hence the claim was rightly repudiated by the Insurance Company.

10. Learned counsel for the respondent No. 1/ complainant has stated that the claim made by the respondent No. 1 / complainant was as per the terms and conditions of the insurance policy. Learned counsel for respondent No. 1 has cited following case law, which is as under:-

First Appeal No. 176 of 2015, M/s Jindal & Co.
Vs. Universal Sompo General Insurance Co. Ltd.
and Others, NCDRC, decided on 14.10.2024

The facts and circumstances of the case are different as the insurance policy in the above case pertains to insurance of goods and stocks and has no application to the case in hand.

11. On perusal of the record, it is evident that the respondent No. 1 purchased a 'Happy Family Floater Policy' No. 252900/48/2011/1369 (first policy) from the appellants, which was valid from 16.10.2009 to 15.10.2010 for Rs. One Lakh after payment of Rs. 3,570/- (paper Nos. 22 & 23). The said policy was further renewed for second year on dated 16.10.2010 to 15.10.2011 (policy No. 252900/48/2011/2335) with same sum insured of Rs. One Lakh after a payment of Rs. 3,830/- (paper Nos. 24 &25). The policy covers the respondent No. 1, his both dependent parent and dependent child for a sum of Rs. One Lakh each. On dated 30.12.2010 (when the policy was in its second year) the mother of respondent No. 1 was admitted in Mahant Indresh Hospital, Dehradun with a complaint of Anxiety, Nausea, breathlessness, fever etc. She was diagnosed of Type-2 DM/DN/UTI (Acute onchronic renal failure) and was given medical treatment accordingly. She was discharged from the said Hospital on dated 09.01.2011. Total expenses of Rs. 54,096/- (paper No. 5/10 of the District Commission's record) was incurred in the treatment of respondent No. 1's mother. As cash facility was not provided to the respondent No. 1 by the appellants at the Hospital, the entire expenses were borne by the respondent No. 1 himself, which he later claimed from the appellants. The Insurance Company forwarded the respondent No. 1's medical bills to the Third Party Administrator (TPA) for processing. The TPA on scrutiny of the medical bills of the respondent No. 1, declared that the respondent No. 1's mother was suffering from and diagnosed of Type-2 DM/DN/UTI (Acute chronic renal failure) and as per terms and conditions of the policy in question. They further stated that if the disease comes under first two years general exclusion clause, then the expenses incurred on treatment of such disease

are payable only after awaiting period of 2 years (subject to continuity being mentioned). As diabetes is mentioned under the exclusion clause and the treatment of diabetes began during the second year of policy, hence the Insurance Company repudiated the claim of the respondent No. 1.

12. We have perused the terms and conditions of the policy in question 'Happy Family Floater Policy' of the Insurance Company (paper Nos. 105 to 135). In para No. 4 General Exclusion clause (paper No. 121) is provided as under:-

> 4. **GENERAL EXCLUSIONS**: The Company shall not be liable to make any payment under this Policy in respect of any expense whatsoever incurred by any Insured Person in connection with or in respect of:
>
> 4.1 All Pre-existing Disease (whether treated / untreated, declared or not declared in the proposal form), which are excluded upto 48 months of the Policy being in force. Pre-existing diseases shall be covered only after the Policy has been continuously in force for 48 months.
>
> For the purpose of applying this condition, the date of inception of the first indemnity based health Policy taken shall be considered, provided the renewals have been continuous and without any break in period, subject to portability condition.
>
> This exclusion shall also apply to any complication(s) arising from pre existing diseases.

Such complications will be considered as part of the Pre existing health condition or Disease.

4.2 Any disease other than those stated in clause 4.3, contracted by the Insured Person during the first 30 days from the inception date of fresh Policy. This shall, however, not apply in case the Insured Person is Hospitalized for injuries suffered in an accident, which occurred after inception of the Policy.

4.3 The expenses on treatment of following ailments / diseases / surgeries, if contracted and / or manifested after inception of first Policy (subject to continuity being maintained), are not payable during the waiting period specified below.

	Ailment / Disease / Surgery	Waiting Period
i	Benign ENT disorders and surgeries i.e. Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty etc.	1 year
ii	Polycystic ovarian diseases. 1 year	2 Years
iii	Surgery of hernia. 2 years	2 Years
iv	Surgery of hydrocele. 2 years	2 Years
v	Non infective Arthritis. 2 years	2 Years
vi	Undescendent Testes. 2 Years	2 Years
vii	Cataract. 2 Years	2 Years
viii	Surgery of benign prostatic hypertrophy. 2 Years	2 Years
ix	Hysterectomy for menorrhagia or fibromyoma or myomectomy or prolapse of uterus.	2 Years
x	Fissure / Fistula in anus. 2 Years	2 Years
xi	Piles. 2 Years	2 Years
xii	Sinusitis and related disorders. 2 Years	2 Years
xiii	Surgery of gallbladder and bile duct excluding malignancy. 2 Years	2 Years
xv	Pilonidal Sinus.	2 Years
xvi	Gout and Rheumatism.	2 Years
xvii	Hypertension.	2 Years
xviii	**Diabetes.**	**2 Years**

xix	Calculus diseases.	2 Years
xx	Surgery for prolapsed inter vertebral disk unless arising from	2 Years
xxi	Surgery of varicose veins and varicose ulcers.	2 Years
xxii	Congenital internal diseases.	2 Years
xxiii	Joint Replacement due to Degenerative condition.	4 Years
xxiv	Age related osteoarthritis and Osteoporosis.	4 Years

If the above diseases are pre-existing at the time of inception, Exclusion no.4.1 for pre-existing disease shall be applicable.

13. As evident from Para No. 4.3 Item No. xviii the expenses incurred on treatment of diabetes after inception of first policy are not payable during the waiting period of two years. The respondent No. 1's mother has undergone the treatment of diabetes during the second year of insurance policy in question and as the ailment of diabetes was excluded from the coverage of policy, the Insurance Company has rightly repudiated the claim of the respondent No. 1, as the claims under any policy are judged in four corner of the policy and as per the terms and conditions of the policy. Diabetes and other related complications are excluded any claim arising out of it are payable only after 2 years of policy (subject to continuity being mentioned). In view of the above, we are of the opinion that the respondent No. 1 – complainant is not entitled for any insurance claim as per the terms and conditions of the policy and appeal is liable to be allowed.

14. We hold that the learned District Commission has wrongly awarded the amount to the respondent No. 1 – complainant without appreciating the material facts and evidence available on record. Thus, the District Commission has exceeded its jurisdiction vested in it and has acted upon with the illegality and infirmity, hence, the impugned judgment and order is perverse. Therefore, we are inclined to interfere with the impugned

judgment and order. We are, therefore, of the considered view that the appeal is liable to be allowed and the impugned judgment and order is liable to be set aside.

15. Accordingly, the appeal is allowed. Impugned judgment and order dated 11.07.2013 is hereby set aside and the complaint stands as dismissed. No order as to costs of the appeal.

16. Statutory amount, if any, deposited by the appellants, be released in favour of the appellants.

17. A copy of this Order be provided to all the parties free of cost as mandated by the Consumer Protection Act, 1986 /2019. The Order be uploaded forthwith on the website of the Commission for the perusal of the parties. A copy of this judgment alongwith original record of the District Commission, Haridwar be sent to the District Commission concerned for record and necessary information.

(Ms. Kumkum Rani)
President

(Mr. C.M. Singh)
Member

Pronounced on: 26.05.2025