

District Consumer Disputes Redressal Commission- VIII (Central)

(Govt. of NCT of Delhi)

5th Floor, Maharana Pratap Inter State Bus Terminal Building

ISBT Kashmere Gate, Delhi- 110006

Consumer Complaint No.: DC/77/CC/429/2024

In the matter of

Madhu Sawhney

W/o Late. Sh. Harbans Lal Sawhney

R/o A-3/305, Printer's Apartments,

Sector-13, Rohini, Delhi-110085

... Complainant

Versus

Niva Bupa Health Insurance Co. Ltd.

39, 3rd Floor, Pusa Road,

WEA Karol Bagh,

New Delhi-110005

... Opposite Party No.1

Max Super Speciality Hospital,

Shalimar Bagh Max Hospital,

FC 50, Max Wali Rd, C and D Block,

Shalimar Bagh Site, Shalimar Bagh,

Delhi-110088

... Opposite Party No.2

ORDER

24.09.2026

(Dr. Rashmi Bansal, Member)

By way of the present order, the Commission shall dispose of the present consumer complaint filed by the complainant alleging deficiency in service on the part of the Opposite Party in processing and ultimately repudiating her legitimate health insurance claim, which, according to the complainant, resulted in financial loss, harassment and mental agony.

Case of the Complainant

1. The case of the complainant, in brief, is that she purchased a health insurance policy from the Opposite Party on 10.06.2023, valid for the period from 10.06.2023 to 09.06.2024, for a sum insured of ₹10,00,000/-, vide Policy No. 33245268202300, against payment of premium of ₹96,673/- and another policy dated 13.06.2023, bearing Policy No. 33252413202300, for a sum insured of ₹25,00,000/-, upon payment of an additional premium of ₹54,499/- for the period 13.06.2023 to 12.06.2024. Both the policies were under the “Platinum” variant. It is the case of the complainant that, while obtaining both policies, she duly disclosed her existing medical conditions, namely diabetes mellitus, disorders of lipoprotein metabolism and other lipidaemias, hypertensive disease and its complications. According to her, these disclosures were duly incorporated in the policy documents issued by the Opposite Party. The complainant further submits that the Opposite Party conducted a pre-medical examination before issuance of the policy. The medical examination report was communicated to the complainant by email dated 11.06.2023. According to the complainant, the said report did not disclose or record any pre-existing disease relating to her heart or kidneys. On 22.12.2023, the complainant consulted her family doctor through telecommunication and was advised on 23.12.2023 to consult another doctor for iron therapy. On the same day, she was admitted to the Emergency Department of Max Hospital. During the initial emergency assessment, the Emergency Resident Doctor inadvertently recorded CKD (Chronic Kidney Disease) in the medical record. The complainant asserts that the said entry was erroneous and was subsequently corrected by an addendum dated 30.12.2023, during the very same hospital admission. During the said hospitalisation, a cashless claim request bearing ID 793111 was submitted to the Opposite Party. The Opposite Party, by email dated 26.12.2023, sought additional information and requested treatment records, consultation papers, investigation reports and details of treatment

undertaken for the present ailment prior to hospitalisation. The complainant states that the requisite information was provided through the service provider/TPA to the Opposite Party. On 27.12.2023, the Opposite Party again sought additional information, including a treating doctor's certificate mentioning the duration and etiology of the ailment and treatment records, including past treatment records relating to heart disease. The complainant, by email dated 29.12.2023, furnished the additional information sought by the Opposite Party, including a certificate from the treating doctor stating that the complainant had no history of CKD (Chronic Kidney Disease) or CAD (Coronary Artery Disease). The complainant submits that receipt of the said information was duly acknowledged by the Opposite Party by email dated 29.12.2023. Despite the aforesaid communications and submission of documents, the cashless claim was not approved by the Opposite Party, the reason communicated being insufficiency/non-submission of the requisite documents. The complainant has alleged that the refusal of cashless authorisation was unjustified and amounted to deficiency in service. She submits that she was a senior citizen and was undergoing hospitalisation and treatment and that, because cashless authorisation was not granted, she was compelled to arrange funds herself. The complainant was discharged from the hospital on 30.12.2023. The total hospital bill, according to the complainant, amounted to ₹3,87,391/-, which she paid herself.

2. The complainant thereafter submitted a claim for reimbursement through the online portal of the Opposite Party, as advised by the Opposite Party duly acknowledged by the Opposite Party by email dated 04.01.2024. on 06.01.2024, the Opposite Party informed her that the documents submitted through the portal had been reviewed, but that certain information and documents were still required and called for hard copies of the original claim documents which were duly submitted. However, the Opposite Party again sent an email dated 09.01.2024, reiterating the request for hard copies of the original claim

documents. The complainant alleges that from 09.01.2024 to 15.02.2024, the Opposite Party continued to communicate that the claim was under verification and thereby delayed its processing. On 16.02.2024, the Opposite Party again sought additional information, including documents which, according to the complainant, had already been submitted. The complainant states that all the requisite information, including the original payment receipt, had already been furnished. By email dated 23.02.2024, the Opposite Party informed the complainant that the claim was under evaluation. Thereafter, by communication dated 28.02.2024, the Opposite Party confirmed receipt of the physical documents and informed the complainant that the case was under verification at the hospital level. Despite the aforesaid communications, the Opposite Party again sought additional information on 30.03.2024, including an affidavit from the treating doctor stating that there was no history of CKD. The complainant contends that the requirement of such further affidavit was unnecessary because the treating hospital had already issued a certificate on its letterhead clarifying that the recording of CKD in the emergency notes was erroneous and that the same had been corrected by an addendum dated 30.12.2023, during the same admission. The complainant further submits that, despite repeated requests for an affidavit from the Emergency Doctor, the treating doctor informed her that the Emergency Doctor would not furnish a separate affidavit because the error in the medical record had already been corrected by her by way of an addendum before the complainant's discharge. According to the complainant, the treating doctor also clarified that the complainant's kidney function tests were normal during the admission and that the reference to CKD in the emergency notes had been made inadvertently because the patient had been admitted under the Nephrology Department. The complainant states that she furnished a detailed communication/medical clarification on the hospital letterhead under the signature of the treating doctor, explaining the circumstances in which CKD had been inadvertently recorded and subsequently corrected. The complainant

further submits that a WhatsApp communication was also shared with the Opposite Party, wherein the treating doctor clarified that the Emergency Doctor would not execute a separate affidavit because she had already corrected the medical record by issuing an addendum during the same admission. Despite the aforesaid material, the Opposite Party ultimately rejected the complainant's claim by email dated 25.04.2024, allegedly on the ground of non-submission of mandatory documents and non-compliance with repeated requirements. The complainant has alleged that the documents sought by the Opposite Party had already been supplied and that the repeated demand for the same documents, including an affidavit which the treating doctor had explained could not be obtained from the Emergency Doctor, amounted to an unjustified delay in processing the claim and ultimately resulted in wrongful repudiation.

3. The complainant submits that she had paid substantial premiums for the policies and had complied with the requirements of the Opposite Party. According to her, she was subjected to considerable financial hardship and mental and emotional distress because the claim was first not approved on a cashless basis and was thereafter rejected even on reimbursement. The complainant has further pleaded that, being a senior citizen and aged about 76 years, she has suffered additional hardship and apprehension regarding her future insurance coverage. The complainant has prayed for reimbursement of ₹3,87,391/-, being the hospital expenses incurred by her, along with appropriate interest, compensation for mental agony and harassment and litigation expenses of ₹1,00,000/-. The complainant has also referred to the provisions relating to product liability under the Consumer Protection Act, 2019 and has alleged that the conduct of the Opposite Party amounts to deficiency in service and unfair trade practice and has caused financial, physical and mental harm to her.

Version of the Opposite Party

4. Notice of the complaint was duly issued to the Opposite Party. The Opposite Party failed to file its written version within the statutory period.

Consequently, by order dated 29.05.2025, the right of the Opposite Party to file its written version and evidence was closed.

5. The Opposite Party, however, subsequently filed written arguments. Since the right to file the written version and evidence had already been closed, the said written arguments are being considered only to the limited extent that they advance submissions on questions of law and do not seek to introduce disputed factual material which ought to have been placed on record by way of a written version and evidence.

Evidence

6. In support of her case, the complainant filed her evidence and relied upon, inter alia, the following documents:

- i. the insurance policy documents;
- ii. pre-medical examination reports;
- iii. consultation card of Dr. Ashok Jhingan;
- iv. initial assessment of the Emergency Department dated 23.12.2023 and the addendum dated 30.12.2023;
- v. email dated 26.12.2023;
- vi. emails/communications dated 27.12.2023, 28.12.2023, 29.12.2023 and 30.12.2023;
- vii. discharge summary and final hospital bill;
- viii. WhatsApp communications dated 30.12.2023 and 03.01.2024;
- ix. screenshots showing uploading of documents on the Opposite Party's portal;
- x. acknowledgment email dated 04.01.2024 regarding receipt of the claim;
- xi. email dated 06.01.2024;
- xii. WhatsApp communication dated 07.01.2024 and 08.01.2024;
- xiii. email dated 09.01.2024;
- xiv. correspondence between the parties from 09.01.2024 to 16.02.2024;
- xv. email dated 20.02.2024;
- xvi. communications dated 23.02.2024 to 29.02.2024;
- xvii. email dated 30.03.2024;
- xviii. communication dated 14.04.2024;
- xix. communication dated 19.04.2024;
- xx. email dated 25.04.2024 rejecting the claim.

7. The complainant thereafter filed her written arguments. The written arguments filed by the Opposite Party have also been considered, subject to the limitation as per law.

Findings

8. We have carefully considered the pleadings, evidence and documents placed on record. The policy documents themselves are not in dispute. It is also not disputed on the material before us that the complainant was hospitalised at Max Hospital in December 2023 and incurred medical expenditure of ₹3,87,391/-. The central controversy relates to the manner in which the Opposite Party dealt with the claim, particularly its repeated demands for additional medical documentation and its ultimate rejection of the claim on the ground of non-submission of documents. The documentary record reveals a prolonged series of communications between the complainant and the Opposite Party. The correspondence demonstrates that the Opposite Party repeatedly sought medical records and clarifications from the complainant.

9. It is important to examine the material concerning the alleged CKD carefully. The initial emergency assessment contained a reference to CKD. However, the record also contains an addendum dated 30.12.2023, issued during the same hospital admission, whereby the said entry was clarified/corrected before the discharge of the complainant from the hospital. The medical record further contains a certificate/clarification from the treating doctor specifically stating that there was no past history of renal dysfunction given by the patient. The record also contains material explaining that the reference to CKD in the emergency notes was made inadvertently by the Emergency Doctor and was subsequently corrected during the same admission. The significance of the correction is that the alleged discrepancy was not discovered for the first time after the claim had been raised. The medical record itself contained the contemporaneous correction before the complainant was discharged from the hospital. The complainant thereafter furnished the said

material to the Opposite Party. The communications exchanged between the parties show that the Opposite Party was made aware of the correction and was also provided with the treating doctor's clarification regarding the absence of any history of CKD. The Opposite Party nevertheless continued to seek a further affidavit from the treating doctor concerning the same discrepancy. The complainant has placed on record the communication with the treating doctor wherein it was explained that the Emergency Doctor will not furnish a separate affidavit because the error had already been corrected by her by issuing an addendum during the same hospital admission. The material further indicates that the treating doctor had explained that the patient's kidney function tests during the admission were normal and that the erroneous reference to CKD in the emergency record had already been corrected.

10. Thus, the Commission is confronted with a situation where the medical record itself contained an explanation of the apparent discrepancy, a contemporaneous correction by way of an addendum, and a further clarification from the treating doctor. In these circumstances, the requirement of repeatedly obtaining substantially the same clarification, particularly when the Emergency Doctor had already corrected the record during the same admission, cannot be regarded as a reasonable basis for keeping the claim indefinitely pending.

11. The Opposite Party was required to assess the claim on the basis of the material available to it and to take a reasoned decision in accordance with the terms of the policy. An insurer is undoubtedly entitled to seek reasonable and relevant documents for verification of a claim. However, such right cannot be exercised in a manner whereby the insured is repeatedly called upon to furnish documents which have already been supplied or documents which, in the circumstances, are not reasonably capable of being obtained.

12. In Civil Appeal No.8386/2015 Manmohan Nanda Vs. United India Assurance Co. Ltd. & Anr, the Hon'ble Supreme Court has also recognised, in the context of health insurance, that where the insurer undertakes medical

assessment before issuing a policy and thereafter issues the policy, the insurer must assess the medical risk on the basis of the medical information available to it; it cannot subsequently rely upon an alleged pre-existing medical condition in circumstances inconsistent with its own pre-policy assessment.

13. In the present case, the complainant had disclosed the medical conditions recorded in the policy documents. The pre-medical examination was also conducted by the Opposite Party before issuance of the policy. The complainant's case that no CKD or CAD was recorded in the pre-policy medical examination is supported by the documents placed on record and has not been rebutted by any evidence from the Opposite Party, its right to file evidence having already been closed. More importantly, the present complaint does not rest merely upon the assertion that CKD was absent. The documentary record contains a contemporaneous correction of the emergency record, a treating doctor's clarification and repeated communication of the relevant documents to the Opposite Party. The final repudiation/rejection dated 25.04.2024 proceeds on the ground that mandatory documents had not been received despite repeated reminders. However, the correspondence placed on record demonstrates that substantial medical documentation and clarification had already been furnished by the complainant and had been received by the Opposite Party.

14. The Opposite Party has not produced any evidence before this Commission to demonstrate what particular material, essential for adjudication of the claim, remained unavailable after the complainant had furnished the documents and medical clarification referred to above. It is also significant that the Opposite Party, after receiving the physical documents, informed the complainant on 28.02.2024 that the case was under verification at the hospital level. This itself demonstrates that the claim was being processed on the basis of the documents supplied by the complainant. In these circumstances, the subsequent rejection of the claim merely on the ground of non-submission of

further documents, without satisfactorily establishing why the documents already supplied were insufficient for adjudication, amounts to an unreasonable handling of the insurance claim.

15. The Commission is therefore of the considered view that the Opposite Party failed to process and decide the complainant's claim in a fair, reasonable and diligent manner and thereby committed deficiency in service. We also find that the denial of cashless authorisation had a direct financial consequence for the complainant. The very purpose of availing health insurance with a cashless facility is to enable the insured, subject to the terms of the policy and admissibility of the claim, to obtain hospital treatment without having to arrange the entire hospital expenditure immediately from personal resources. In the present case, the cashless request was not approved and the complainant was consequently required to pay the hospital bill of ₹3,87,391/- herself. The subsequent reimbursement claim was also ultimately rejected. Since we have found the handling and rejection of the claim to constitute deficiency in service and the Opposite Party has not produced any cogent evidence establishing a valid contractual exclusion or other lawful ground for denying the claim, the complainant is entitled to reimbursement of the admissible hospital expenditure proved on record. The amount of ₹3,87,391/-, supported by the final hospital bill and the payment documents relied upon by the complainant, is therefore liable to be reimbursed by the Opposite Party.

16. The complainant has also invoked the provisions relating to product liability under Sections 83 to 85 of the Consumer Protection Act, 2019, alleging that the conduct of the Opposite Party attracts product-liability consequences. However, in view of the findings recorded above, the complaint can be completely and effectively adjudicated on the question of deficiency in service in processing and repudiating the health insurance claim. It is, therefore, neither necessary nor appropriate, for purposes of disposal of the present complaint, to examine or pronounce upon the applicability, otherwise, of the provisions

relating to product liability under Sections 83 to 85 of the Consumer Protection Act, 2019.

17. The complainant was required to undergo prolonged correspondence with the Opposite Party and repeatedly furnish documents and clarifications in respect of her medical claim. Despite the documents and medical clarification being placed before the Opposite Party, her claim was ultimately rejected. The complainant was consequently required to bear medical expenditure of ₹3,87,391/- from her own resources despite having taken health insurance coverage and having paid the stipulated premiums. The complainant has also pleaded that she is a senior citizen aged about 76 years. The Commission has taken this circumstance into consideration while assessing the nature of the hardship and inconvenience suffered by her. At the same time, compensation must remain reasonable and proportionate to the facts established on record. In the circumstances of the present case, an amount of ₹50,000/- towards compensation for mental agony, harassment and inconvenience caused by the deficient handling of the claim would meet the ends of justice.

The complainant was also compelled to approach this Commission for obtaining redressal of her grievance and has incurred litigation expenses. Accordingly, an amount of ₹35,000/- towards litigation costs is considered reasonable.

The complainant has been deprived of the use of the amount of ₹3,87,391/- from the date on which the cashless request was denied and she was required to bear the hospital expenditure herself. Having regard to the facts and circumstances of the case, interest at the rate of 6% per annum on the amount of ₹3,87,391/- from 25.04.24, the date on which the complainant's claim was rejected until actual realisation would meet the ends of justice. The aforesaid interest is being awarded as reasonable compensation for deprivation of the use of the money and not by way of penalty.

Order

18. In view of the foregoing discussion and findings, the complaint is partly allowed and the Opposite Party is directed as follows:

- A. To reimburse to the complainant a sum of ₹3,87,391/- towards the admissible hospital expenditure incurred by her;
- B. To pay interest at the rate of 6% per annum on the aforesaid amount of ₹3,87,391/- from 25.4.24 till the date of actual realisation;
- C. To pay ₹50,000/- to the complainant towards compensation for mental agony, harassment and inconvenience caused on account of deficiency in service;
- D. To pay ₹35,000/- towards litigation expenses;

The amounts directed above shall be paid by the Opposite Party within 45 days from the date of receipt of a copy of this order.

In case the Opposite Party fails to comply with the monetary directions contained herein within the stipulated period of 45 days, the amount of ₹3,87,391/- shall thereafter carry interest at the rate of 9% per annum, instead of 6% per annum, from 25.04.24 until actual realisation. The compensation and litigation costs shall also be paid within the said period.

The complaint stands disposed of in the above terms. A copy of this order be supplied to the parties free of cost as per rules. Thereafter, the file be consigned to the record room.

Divya Jyoti Jaipurkar, President

Dr. Rashmi Bansal, Member