Decision Ref:	2018-0033
Sector:	Insurance
Product / Service:	Travel
Conduct(s) complained of:	Rejection of claim - pre-existing condition
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint concerns the Complainants' travel insurance policy with the Provider.

The complaint is that the Provider has incorrectly or unreasonably declined the Complainants' claim under the policy.

The Complainant's Case

The Complainants booked a holiday and took out a travel insurance policy with the Provider on 17 September 2015.

The first Complainant submits that on or about 27 August 2015 the second Complainant consulted with their local GP due to acute pain in her upper right leg and groin. The first Complainant submits that in order to make a determination as to a firm diagnosis, the second Complainant was referred to the local health centre for an x-ray. The first Complainant submits that the result of the x-ray indicated normal wear and tear due to the ageing process, and anti-inflammatory/pain medication was prescribed.

The first Complainant submits that after two weeks on medication and no improvement the second Complainant again visited her GP suffering acute pain, and was referred to a Hospital's Emergency Department. The first Complainant submits that, while there, further investigations and x-rays were taken, the results of which were again non-specific, indicating normal age related wear and tear only. The first Complainant submits that the medical staff at the Hospital indicated muscular pain (myofascial pain) and suggested that the second

Complainant talk to the on-duty Physiotherapist before leaving the hospital. The first Complainant submits that a letter setting out the Emergency Department's findings was handed to the second Complainant for onward transmission to their GP. The first Complainant submits that at this point physiotherapy was recommended together with medication, and on no occasion was there any indication or mention of osteoarthritis.

The Complainants submit that they were looking forward to a week's winter break abroad commencing on 27 October 2015, however they had to cancel this due to the second Complainant's inability to walk without severe pain. The Complainants made a claim on their travel insurance policy, which was subsequently rejected by the underwriters of the policy on the basis of a pre-existing medical condition, that is, osteoarthritis. The first Complainant states that "*since my retirement in 2002, my wife and I have on average walked with our two dogs, four to five kilometres everyday for the past thirteen years, except for holidays, sick days and inclement weather. This hardly gives credence to the idea of Osteo-arthritis as a pre-existing medical condition*".

The first Complainant states that he purchased the policy in good faith and "*my claim for compensation was made in expectation of the same*". The Complainants submit that they are seeking reimbursement of the cost of their cancelled holiday less the policy excess, amounting to €1,118.00.

The Provider's Case

The Provider submits that the first Complainant purchased the travel insurance policy on 17 September 2015. The Provider submits that prior to this, on 4 September 2015, the second Complainant had an x-ray on her hip to establish the cause for the pain and discomfort that she was suffering. The Provider submits that although a diagnosis was not given, the symptoms were undiagnosed, and "*Therefore the policy was purchased knowing that your wife was suffering with symptoms for which a diagnosis had not been given. It was reasonable to expect on the 17th Sept 2015 when the policy was purchased, that the symptoms could give [rise] to a claim*".

The Provider submits that the following exclusion is set out in the policy terms and conditions:

> *"This insurance will not cover you if you:*
> *3. have any undiagnosed symptoms that require attention or investigation in the future (that is symptoms for which you are awaiting investigations/consultations, or awaiting results of investigations, where the underlying cause has not been established)"*

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainants were given the opportunity to see the Provider's

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response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on 27 February 2018, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

In the absence of additional submissions from the parties, the final determination of this office is set out below.

The issue to be determined is whether the Provider incorrectly or unreasonably declined the Complainants' claim under the policy.

The Provider submits that "*Section A – Cancellation or Curtailment Charges*" of the policy wording states the following:

> *"What Is NOT Covered*
> *2. Any claim arising directly or indirectly from any pre-existing medical condition affecting you unless you have declared ALL pre-existing medical conditions to us and we have written to you accepting them for insurance".*

I note that "***Pre-existing medical condition(s)***" is defined in the policy document on page 8 as:

> *"1. Any past or current **medical condition** that has given rise to symptoms or for which any form of treatment or prescribed medication, medical consultation, investigation or follow-up/check-up has been required or received during the 2 years prior to the commencement of cover under this policy and/or prior to any **trip**: **and***
> *2. any cardiovascular or circulatory condition (e.g. heart condition, hypertension, blood clots, raised cholesterol, stroke, aneurysm) that has occurred at any time prior to the commencement of cover under this policy and/or prior to any **trip**."*

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The Provider submits that the condition, which later resulted in cancellation, occurred prior to the booking of the Complainants' trip and taking out the policy. The Provider, in its letter to the first Complainant dated 20 November 2015, states that the second Complainant's doctor "*has stated that hip arthritis is the cause of the cancellation and also states that you have an existing condition of osteoarthritis*". The Provider submits that this exclusion is outlined in the policy.

I note that page 10 and 11 of the policy document highlights the following:

> ***"Important Health Requirements –***
> ***For All Insured Persons***
>
> ***You** must comply with the following conditions in order to have full protection under this policy. If **you** do not comply **we** may refuse to deal with **your** claim or reduce the amount of any claim payment.*
> *This insurance will not cover **you** if **you**:*
> 1. *are travelling against the advice of a **Medical Practitioner** (or would be traveling against the advice of a **Medical Practitioner** had **you** sought his/her advice);*
> 2. *are traveling with the intention of obtaining medical treatment or consultation abroad;*
> 3. *have any undiagnosed symptoms that require attention or investigation in the future (that is symptoms for which **you** are awaiting investigation/consultations, or awaiting results of investigations, where the underlying cause has not been established);*
> 4. *are not a permanent resident of, and registered with a General Practitioner in, the Republic of Ireland.*
>
> <u>*No claim arising directly or indirectly from a **pre-existing medical condition** affecting **you** will be covered unless*</u>*:*
>
> - ***You** have declared ALL **pre-existing medical conditions** to **us**; and*
> - ***You** have declared any changes in **your** health or prescribed medication; and*
> - ***we** have accepted the condition(s) for insurance in writing.*
>
> *Each **insured person** who has a **pre-existing medical condition** must make a **Medical Health Declaration.***
> *...*
> <u>*Failure to declare **pre-existing medical conditions** that are relevant to this insurance may invalidate **your** claim.*</u>
> *…"*

I note that underneath the heading "*Important Limitations under Section A – Cancellation or Curtailment Charges*" on page 14 of the policy document, it states:

*"Claims under Section A – Cancellation or Curtailment Charges are not covered for incidents arising directly or indirectly from any **pre-existing medical condition** known to you prior to booking any **trip** affecting any **close relative, close business associate, travelling companion** who is not insured under this policy, or any person with whom **you** have arranged to reside temporarily whilst on **your trip** if:*

1. *a terminal diagnosis had been received prior to booking any trip; or*
2. *they were on a waiting list for or had knowledge of the need for, surgery, in-patient treatment or investigation at any hospital or clinic at the time of booking any **trip**; or*
3. *during the 90 days immediately prior to booking any **trip** they had required surgery, in-patient treatment or hospital consultations."*

I note that page 17, 18 and 19 of the policy document sets out, among other things, the following:

"Section A – Cancellation or Curtailment Charges

What IS Covered

***We** will pay **you** up to the amount shown in the **Schedule of Benefits** for any irrecoverable unused travel and accommodation costs (including excursions up to €250) and other pre-paid charges which **you** have paid or are contracted to pay together with any reasonable additional travel expenses incurred if:*

*a) cancellation of the **trip** is necessary and unavoidable; or*
*b) the **trip** is **curtailed** before completion*

as a result of any of the following events occurring:

1. *Unforeseen illness, injury or death of **you,** a **close relative,** a **close business associate** or any person with whom **you** are travelling or staying during **your trip.***

…

Important Limitations

*Claims under Section A – Cancellation or Curtailment Charges are not covered for incidents arising directly or indirectly from any **pre-existing medical condition** known to **you** prior to booking any **trip** affecting any **close relative, close business associate, travelling companion** who is not insured under this policy, or any person with whom **you** have arranged to reside temporarily whilst on **your trip** it:*

1. *a terminal diagnosis had been received prior to booking any **trip;** or*
2. *they were on a waiting list for or had knowledge of the need for, surgery, in-patient treatment or investigation at any hospital clinic at the time of booking any **trip;** or*
3. *during the 90 days immediately prior to booking any **trip** they had required surgery, in-patient treatment or hospital consultations.*

…

What Is NOT Covered

1. *The **excess** as shown in the **Schedule of Benefits, Limits and Excesses.***

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2. *Any claim arising directly or indirectly from a **pre-existing medical condition** affecting **you** unless **you** have declared ALL **pre-existing medical conditions** to **us** and **we** have written to **you** accepting them for insurance.*
3. *…*
4. *Any claims arising directly or indirectly from circumstances known to **you** prior to the date this insurance is purchased by **you** or the time of booking any **trip** (whichever is the earlier) which could reasonably have been expected to give rise to cancellation or **curtailment** of the **trip**.*
5. *…"*

I note that page 51 of the policy documents sets out the "*General Conditions (applicable to the whole policy)*" as follows:

> ***"You** must comply with the following conditions to have the full protection of **your** policy. If **you** do not comply **we** may at **our** option cancel the policy or refuse to deal with **your** claim or reduce the amount of any claim payment.*
>
> 1. ***You** must comply with **our** Important Health Requirements. No cover will come into force, or continue in force, for Emergency Medical and Other Expenses, Cancellation of **Curtailment,** unless each **insured person** who must make a **medical health declaration** in respect of the period for which insurance is required, had declared ALL **pre-existing medical conditions** to **us** and they have been formally accepted by **us** in writing…*
> 2. ***You** must tell **us** before booking any **trip** or departing on any **trip** if there is any change in **your** health, medication or treatment. If **you** do not tell **us** about changes, claims may not be accepted and **your** policy may be invalid. All changes must be declared to Medical Screening on… and accepted before cover can continue."*

The Provider has submitted a copy of the Heath Service Executive's "*Diagnostic Imaging Report*". This Report sets out the following:

Accession	*Exam date*	*Procedure*
…	*Sep 4 2015*	*X-Ray – XR Hip Rt*

> *Report*
>
> *Clinical indication. Stiffness.*
>
> *The hip joint space is relatively well preserved with a little surrounding degenerative change."*

I note that the Medical Certificate completed by the second Complainant's referring physician on 30 October 2015 states, among other things, the following:

/Cont'd…

"4. State precise nature of:-
Medical condition/illness/injury cause of death, that gives rise to the claim | Hip Arthritis

…

5. Has the patient suffered from same or similar condition in the past? | No

6. (a) State exact date of onset as in 4. | 9/10/15 | *(b)Date first consulted* | 9/10/15
(c) Date of any serious deterioration | *Subsequent 2 weeks*

7. What ongoing medical conditions (or any medical complication directly attributable to that condition) investigated by a registered medical practitioner did the person above suffer at the date the holiday insurance was purchased? Please give consultation dates. | *Osteoarthritis*

8. For what medical conditions of the person above was there prescribed medication or treatment for other than a minor ailment by a registered medical practitioner during 30 days (or 90 days for a person 70 years of age or over) immediately preceding the date the holiday insurance was purchased? Please give consultation dates. | *Nil*

…

11. Was the person above receiving or on a waiting list for, or recovering from in-patient treatment in a hospital or nursing home at the date the Insurance was purchased? Please give consultation dates | *No*

…

13. Please provide details of patients state of health at the time the Insurance was purchased | *Well no complaints*

…"

The Complainants submit that the second Complainant has never been diagnosed with osteoarthritis and "*whilst the GP indicated the presence of this condition in the medical report, this was the first time we were made aware of its presence*". The Complainants submit that the reason behind their cancellation was severe pain in the second Complainant's upper leg and groin area, and not the hip. The first Complainant wrote to the Provider on 1 December 2015 enclosing "*a further communication from GP clarifying his comment re Osteo-Arthritis in elderly people*".

I note that the second Complainant's Doctor's letter dated 26 November 2015 states, among other things, the following:

> *"The above named has claimed for inability to travel due to hip pain groin pain. She has been assessed by a physiotherapist & it is felt she has a myofascial syndrome*

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causing her pain. She had an X/R on Sept 4 2015 that showed minimal degenerative change in… & osteoarthritis but it is not possible to say whether this is of a degree sufficient to ascribe for the cause of her pain"

The Provider submits that the policy was purchased by the first Complainant knowing that the second Complainant was under investigation with symptoms. The Provider states that "*This was clearly highlighted throughout the sales process and policy terms and therefore I feel we have acted in terms of the policy terms and fairly*".

The Provider has submitted a screenshot from the sales system with the answers to the medical screening questions. I note that this states:

"1 : Is anyone on a waiting list or have the knowledge of need for surgery, inpatient treatment or investigation at a hospital, clinic or nursing home?(*) – No,
2 : Do you accept that we will be providing you with the main Terms and conditions now and will send you the full Term and Conditions if you wish to proceed with cover? – Yes,
…
5 : No person to be insured has symptoms for which they are awaiting investigaton/consultation, or are awaiting results of ivestigations, where the underlying cause has not been established? – No,
…
*7 : Do you (*or any other insured person to be covered under this policy) have any past or current medical condtion that during the last 2 years:has resulted in symtoms or for which:any form of treatment, medical consultation, or investigation has been required? – No"*

The first Complainant states that "*one cannot reasonably expect that we should anticipate a future health problem with purchasing the policy. For the provider to suggest that I knowingly purchased the policy in light of this information is both unfair and defamatory. Perhaps, if I had purchased the policy on 3rd September my claim may have resulted in a more favourable outcome*".

Having carefully considered all of the evidence before me, while I note the Complainants' submission that they were unaware of the existence of osteoarthritis at the time of taking out the policy, I am of the view that the investigations carried out on the second Complainant on 4 September 2015 should have been disclosed to the Provider for its consideration when medical information was sought during the application process.

The Complainants and the Provider are bound by the terms and conditions of the policy. I am of the view that the policy document clearly sets out that the insurance policy does not cover the following:

*"This insurance will not cover **you** if **you**:*
5. …
6. …

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7. *have any undiagnosed symptoms that require attention or investigation in the future (that is symptoms for which* ***you*** *are awaiting investigation/consultations, or awaiting results of investigations, where the underlying cause has not been established);*

No claim arising directly or indirectly from a ***pre-existing medical condition*** *affecting* ***you*** *will be covered unless:*

- ***You*** *have declared ALL* ***pre-existing medical conditions*** *to* ***us****; and*
- ***You*** *have declared any changes in* ***your*** *health or prescribed medication; and*
- ***we*** *have accepted the condition(s) for insurance in writing."*

I note that the second Complainant's Doctor confirmed in his letter dated 26 November 2015 that the x-ray on 4 September 2015 showed osteoarthritis. I must therefore accept that the Provider was entitled to decline the claim in accordance with the terms and conditions of the policy.

Consequently, it is my Legally Binding Decision that this complaint is not upheld.

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is rejected.

The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

23 March 2018

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that—

(a) ensures that—

(i) a complainant shall not be identified by name, address or otherwise,

(ii) a provider shall not be identified by name or address,

and

(b) in accordance with the Data Protection Acts 1988 and 2003.