Decision Ref:	2018-0070
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - pre-existing condition
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint concerns the Provider's refusal to meet the First Complainant's medical expenses claimed under a health insurance policy in relation to a bilateral hip impingement. The Provider alleges that the First Complainant's hip condition is a pre-existing condition for which she did not have insurance cover under the terms and conditions of the policy at the time that she received treatment. The First Complainant alleges that although she had had some hip pain approximately 10 years earlier, this had long since resolved and the current condition had only become apparent a year or so before she was diagnosed with a bilateral hip impingement. On that basis, the First Complainant asserts that the hip condition was not pre-existing and that the Provider should be obliged to cover her relevant medical expenses under the terms and conditions of the policy.

The Complainants' Case

In a complaint to this Office dated 28 July 2017, the First Complainant says that the Provider refused to pay a claim she had submitted in **January 2016**, in relation to a hip condition that required medical input, physiotherapy and surgery as the Provider claimed that it was a pre-existing condition but this was not the case. She asserts that she gave a medical history to a physician and physiotherapist that she had experienced hip pain approximately 10 years previously, which had resolved at that time.

She asserts that the more recent pain had an approximate two year history and was diagnosed by her orthopaedic surgeon as bilateral hip impingement which she did not know that she had before. She claims that the orthopaedic surgeon did not think it was a pre-

existing condition and that her physiotherapist's letter adds to this assertion. She explains that she and her husband, the Second Complainant, are living in Australia with international cover from the Provider and that all of her treatment and surgery took place in Australia. She asserts that they have been left significantly out of pocket for all of the medical expenses in approximate sum of AU$20,000. She asks that the Provider be directed to pay her legitimate claim and notes that she has included all of the claim forms and receipts which set out the amount of money that has been spent on the required medical treatment.

In an email dated 4 February 2018, the First Complainant explains that any confusion which has resulted from the letters of Dr B and Dr G are explained on the basis that, when she was asked had she ever experienced hip pain before, she answered that she had done so when she was in college when rowing. She asserts that nothing came of this hip pain 10 years previously and it had gone away so she did not follow up on it for further investigation and, importantly, did not experience it again. It was only in 2014 that she began to have hip pain and had it investigated in Australia which led to her diagnosis and surgery.

She accepts that the sports physician, Dr B, indicated that the symptoms were a gradual onset over 10 years but she explains this confusion on the basis that she had experienced pain 10 years previously which had stopped for a long period of time until 2014. She further states that the reference on behalf of the Provider to an onset or exacerbation of hip pain seven years ago was an error on the part of the Provider alone, as the First Complainant had written one (1) year ago and not seven (7) on the claim form. She explains that she provided a follow-up report in relation to her history of hip pain following the decline of her claim.

She asserts that her orthopaedic surgeon, Dr H, agreed that the condition was only diagnosed by him when he met the First Complainant and this was supported by his letter. She further indicates that she would like for someone to contact Dr H as he supported the fact that the condition (i.e. bilateral hip impingement) could only have been diagnosed by an orthopaedic surgeon and this did not happen 10 years ago when she was rowing in college. She explains that she did not have a pre-existing medical condition and did not have hip pain for the 10 years prior to 2014. She claims that the hip pain symptoms that she experienced at that time could have been anything. She asserts that she has been honest and truthful throughout the entire process and had given a full medical history when asked about any hip pain she experienced. She further indicates that the surgery, physiotherapy and rehab that she required were privately funded and at huge expense to her and her husband, the Second Complainant. She notes that it was difficult to follow up on these issues as they are living in Australia and dealing with the Provider in Ireland.

<u>The Provider's Case</u>

In a letter to the First Complainant on 3 March 2016, the Provider stated as follows:-

> *"We note from our records that your policy commenced on 22 May 2012 and that the waiting period applies as below;*
>
> - *5 year waiting period for pre-existing medical conditions expires on 01 July 2018.*

/Cont'd…

> *Unfortunately, we are unable to cover these costs until your waiting period has expired. …"*

In a letter to the Second Complainant dated 30 March 2016, the Provider asserted that it had fully reviewed the claim and remained unable to consider the expenses claimed by the First Complainant in relation to treatment for her hip pain. It sets out the relevant waiting periods for pre-existing medical conditions which (in its view) mean that pre-existing conditions would not be covered for the First Complainant for a five-year period.

In its letter to the second Complainant, the Provider says that it "*reviewed the call in which you requested that* [the first Complainant] *be included on your policy which was made on the 24 June 2013. We can confirm that the advisor fully explained the waiting periods applicable to the policy and advised that* [the first Complainant] *would have no cover for pre-existing medical conditions for 5 years.*"

It asserts that its adviser fully explained the waiting period applicable to the policy and advised that the First Complainant would have no cover for pre-existing medical conditions for 5 years.

The Provider suggests that the medical information received confirms that the First Complainant First suffered from bilateral anterior hip pain 10 to 12 years earlier and underwent investigations. It notes that a doctor confirmed that the symptoms returned over the last year and a course of treatment was recommended. The Provider stated that in view of those facts and as the First Complainant suffered from this condition "*prior to the inception of this policy*", the five-year waiting period was applicable and that it was therefore unable to consider the claim.

In a letter to the First Complainant dated 17 October 2016, the Provider noted that all of the medical information received by it had been reviewed by its chief medical officer in line with the policy wording regarding pre-existing medical conditions. The Provider noted that Dr B had stated on Section C of the claim form dated 16 December 2015 that the medical condition requiring treatment was bilateral hip infringement, which first started 10 years previously. It noted that the physiotherapist, Dr G, also stated that the medical condition started 10 to 12 years earlier while the first Complainant was rowing, and the symptoms had returned over the last year. The Provider notes that Dr G advised in a letter of 14 September 2016 that the earlier episode of hip pain had not been investigated so it was therefore unclear what the source of the pain was at that time.

The Provider contends that as the First Complainant experienced symptoms of hip pain prior to the start of the waiting period (on 1 July 2013) it was therefore within the definition of a pre-existing condition. As the claim in question was due to hip pain, the Provider asserted that it remained unable to consider the expense incurred.

In response to queries raised by this Office, by letter dated 19 January 2018 the Provider states that the First Complainant has been an international member since 22 May 2012 and her cover included a five-year waiting period for any pre-existing conditions until 1 July

/Cont'd…

2018. The letter states that the First Complainant contacted its claims department to submit a claim for enthesopathy of hip region. The Provider also says that the information provided

> *"as part of the original claim in February 2016 included the medical declaration from* [the First Complainant's] *Doctor's starting* (sic) *that* [the First Complainant] *reported that she had an incident of hip pain 10 years and a further Doctors letter in September 2016 stated that the hip pain was present for 10 years and was caused by rowing."*

The Provider refers to a further Doctor's letter in February 2017 which "*stated that the pain dated back 2 years*". The Provider states that from a review of the claim and the medical information provided by the first Complainant's treating doctor, the information provided in the original letter and the newer letter after the decline of the claim, appeared to the Provider to be contradictory. The Provider notes that based on this, it is unable to proceed with the claim or uphold the complaint in relation to the decline.

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 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 17 July 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 key to the present complaint is the interpretation of and operation of General Exclusion 1 to the policy (located on page 25 of the policy document) which makes it clear that the Provider "*will not pay for*

/Cont'd…

1. *A Pre-Existing Medical Condition known to an Insured Person (or of which an Insured Person ought to reasonably have been aware of) and/or from which he/she has suffered from prior to first applying for insurance cover except as provided for under Section 7. General Policy Conditions* – Expiry of Waiting Periods for Pre-Existing Medical Conditions".

I note that the said Section 7 is contained at page 28 of the policy document, and **Pre-Existing Medical Condition** is defined on page 9 of the terms and conditions as:

> *"A medical or psychological condition from which an Insured Person has suffered, or from which an Insured Person has received treatment (including Prescription Drugs) or of which symptoms have manifested themselves prior to the Insured Person being first included for insurance under this Policy."*

Despite an earlier date (22 May 2012) being provided by the Provider in a letter to this Office, the date of inception of the First Complainant's cover with the Provider seems to have been 1 July 2013. It is common case that the relevant waiting period in the present situation was 5 years, a period which recently expired on 1 July 2018. It is therefore accepted that if the relevant waiting period was to apply, and if the First Complainant's condition was a pre-existing one, she would not be eligible to claim benefit for her treatment in late 2015/early 2016, under the terms and conditions of her cover.

In my consideration of the evidence before me, I note the Complainant's contention that the views of Dr H should be taken into account as he supported the fact that the condition (i.e. bilateral hip impingement) could only have been diagnosed by an orthopaedic surgeon and this did not happen in 2004, when the Complainant was rowing in college. It is important to bear in mind however that the existence of a "*pre-existing condition*" is not dependent upon a specific diagnosis or a name being attached to particular symptoms being experienced. It is possible that symptoms can be ongoing either intermittently or continuously for some time such that a pre-existing condition will exist, albeit that no specific diagnosis has been given. It is the symptoms themselves which are relevant, not the name or specific diagnosis of a condition. Consequently, the pertinent question is whether symptoms experienced by an insured person at a particular time, can be subsequently linked to a particular condition in respect of which policy benefits are sought.

I have noted the Provider's contention in the letter dated 19 January 2018 that the Doctor's letter in September 2016 "*stated that the hip pain was present for 10 years and was caused by rowing*". I have examined the Doctor's letter dated 14 September 2016, in detail and I am not satisfied that the letter confirms that the hip pain "was present for 10 years".

In fact, Dr G, in that letter indicated that

> "[the first Complainant] *had reported that she had had an incident of hip pain 10 years previously when rowing… did not have her hip pain investigated in her earlier episode so it is unclear what the source of this pain was. It may have been a muscular or tendinous issue that resolved and has no bearing on her more recent situation. The time of onset of her current pathology cannot be known with any certainty."*

/Cont'd…

In my opinion there is a marked difference between the contents of this letter from Dr G dated 14 September 2016, and the interpretation which the Provider has sought to put on it. The variance, in my opinion, is notable in circumstances where the letter from Dr B, in February 2017 advised, *inter alia*, as follows:-

> *"She required surgery to her hip. This was due to long-term pain from rowing dating back two years. Prior to 2014 she had no pain. I attributed it as being due to cumulative wear on the hip over the two year period prior to seeing me."*

I note that the Provider has also sought to rely on "*the original claim in February 2016* [which] *included the medical declaration from* [the First Complainant's] *Doctors*".
I have considered the medical declarations contained in the Medical Expenses Claim Forms. I note that the details confirmed by Dr G on 1 December 2015 are as follows:-

> *"10-12 years ago [illegible] problems when rowing. Settled.*
> *1/12/15 return of symptoms over last year.*
> *…*
> *Had investigations 10-12 yrs ago in Ireland – results unavailable apparently and nothing recent".*

The use of the phrase "*return of symptoms*" by Dr G is certainly suggestive of the fact that the symptoms experienced by the Complainant in 2004 were similar in nature to the symptoms in 2014, which ultimately gave rise to the treatment which the Complainant underwent. In addition, I note that the Medical Declaration completed by Dr G on 16 December 2015 confirmed a condition of "*Bilateral hip impingement*" and in response to the question as to when the patient had started to experience or notice the signs and symptoms of this condition, the entry confirmed by the Doctor was as follows:-

> *"10 years ago. Gradual onset."*

I note that the Provider seeks to make much of the fact that the information which was provided in "*the original letter*" which was submitted before the claim to the Provider was declined, was different, by way of comparison with "*the newer letter from February 2017*". This has led to the Provider's suggestion that these pieces of correspondence "*would appear to* [be] *contradictory*".

In my opinion however, both of the medical declarations completed by the Doctors are also somewhat contradictory, although in that instance both such declarations were submitted, <u>prior to</u> the decision of the Provider to decline the Complainant's claim.

Bearing in mind such lack of clarity, I considered it appropriate to write to the Provider on **1 May 2018** seeking additional details. In particular, I noted the definition of a "*pre-existing medical condition*" and bearing in mind the 3 alternatives, I asked the Provider to confirm on which basis it had formed the opinion that the Complainant's condition was a "*pre-existing medical condition*", i.e. whether it was:-

/Cont'd…

"

- *A medical condition from which the Complainant had suffered.*
- *A medical condition from which the Complainant had received treatment (including prescription drugs) or*
- *A medical condition of which symptoms had manifested themselves prior to the Complainant being first included for insurance under the policy."*

I also requested the Provider to clarify whether the Complainant's historical medical records had been examined and, in that event, I requested a copy of the said medical records. If the Complainant's medical records had not been examined by the Provider for the purpose of forming an opinion as to whether or not the treatment undergone in respect of which the claim was made, was in respect of a "*pre-existing medical condition*", I asked the Provider to clarify how it was possible for the Provider to come to an opinion in the absence of such historical medical records.
I also asked the Provider to furnish a copy of the audio file for the telephone call dated 24 June 2013, which the Provider's letter of 30 March 2016 confirmed had been reviewed in its content, prior to the issue of a Final Response Letter on that date.

Regrettably, the Provider failed to respond to the queries which this office raised. In those circumstances, I wrote to the Provider again on **8 June 2018** expressing my disappointment that this office had received no response. I furnished a further copy of my letter of 11 May 2018 raising those queries and I again requested a response within a further period of 10 working days. The Provider was advised at that point, that in the absence of hearing from the Provider by way of reply to the queries raised, within that additional period, the adjudication of the complaint would proceed on the basis that the Provider had failed, refused and/or neglected to respond to the information sought by the FSPO in relation to the complaint.

The definition of pre-existing medical condition is a wide one. General Exclusion 1 is also broadly drafted to include all pre-existing conditions "*known to the insured person*" or from which that person "*has suffered prior to first applying for insurance cover*". Neither clause makes it clear which of the parties bears the burden of proof in relation to a pre-existing medical condition. It is also unclear when interpreting General Exclusion 1 as to whether the pre-existing medical condition must be a continuing one or not at the time that the insured applied for insurance cover. The expression "*has suffered from prior to*" is capable of more than one interpretation – a condition that has been and is present at the time that insurance is applied for, or simply a condition that the insured person suffered from at any point in their lives before to applying for insurance.

As noted above, in the medical claim forms submitted by the First Complainant to the Provider, and received on 19 February 2016, the First Complainant describes the condition as "*recent hip pain exacerbation*". As to when the symptoms were first experienced, the First Complainant answers "*last 1 year*" and states that she first saw a doctor for the condition on 16 December 2015. In section C completed by Dr B, the condition is described as "*bilateral hip impingement*" and when asked when the patient first started to experience

/Cont'd…

symptoms, the answer provided was "*10 years ago*" "*gradual onset*". Dr B (a sports physician) indicated that he was unable to confirm a diagnosis.

A further form received the same date refers to the nature of the condition as "*hip pain – recent onset/exacerbation*" and confirms that the First Complainant started to experience the symptoms one year ago. In section C completed by Dr G (a physiotherapist), the condition is described as "bilateral anterior hip pain" and as to when the patient first began to experience symptoms, Dr G notes "*10 to 12 years ago*" "*initial problems when rowing settled*" and then further notes "*return of symptoms over last year*". Dr G further notes "*had investigations 10 to 12 years ago in Ireland/results unavailable. …. Nothing recent*."

A further medical claim form was submitted by the First Complainant to the Provider and received on 16 of May 2016 in relation to the hip impingement condition. In section C, Dr H suggests that the First Complainant experienced the symptoms for approximately two years and consulted him on 21 March 2016.

Dr G wrote a follow-up letter in respect of the First Complainant's symptoms dated 14 September 2016 in which she explained the investigations undertaken and her diagnosis of femoroacetabular impingement (FAI). The letter states that the First Complainant had reported that she had had an incident of hip pain 10 years previously when rowing. Dr G asserts that while FAI morphology is known to develop during adolescence, simply having this morphology does not mean the individual must develop symptomatic joint pathology. She further notes that a large percentage of the population of people with FAI do not develop hip pain. Dr G states that as the First Complainant did not have hip pain investigated in the earlier episode, it is unclear what the source of the pain was. Dr G notes that it may have been a muscular or tendinous issue that resolved and which may therefore have no bearing on the First Complainant's more recent hip pain. She concluded that the time of onset of the First Complainant's then current pathology could not be known with any certainty.

Dr H (an orthopaedic surgeon) wrote a follow-up letter dated 14 February 2017 in respect of the First Complainant's symptoms noting that she was a patient under his care between 21 March 2016 and 16 August 2016 and she required hip surgery. The letter notes that this was due to long-term pain from rowing dating back two years. The letter states that prior to 2014, the First Complainant had no pain. Dr H states that he attributed it as being due to cumulative wear on the hip over the two-year period prior to seeing him.

The Provider has not submitted any medical evidence in support of its contention that the First Complainant's condition was a pre-existing one, other than to point to the fact that the First Complainant by her own admission experienced some hip pain when rowing 10 years before the onset of the condition at issue and that her doctors have occasionally referred to the pain dating back to this time.

I accept that there is some inconsistency in the medical evidence supplied by the First Complainant in support of the claim as regards the onset of symptoms. The Provider is correct in noting that Dr B, for example, stated that the symptoms first occurred 10 years previously while Dr H states a period of two years. In the absence of any explanation for

/Cont'd…

these inconsistencies, the Provider may well have had cause for concern. The confusion has to some extent, been explained by the First Complainant and further explained by letter of September 2016 from Dr G. The First Complainant has explained that she experienced hip pain some 10 years before the onset of her present hip complaint but that those symptoms resolved themselves, and did not impact her for a period of approximately 10 years. It was towards the end of this 10 year pain-free period, in July 2013, that the First Complainant was added to the relevant policy. When the First Complainant experienced hip pain from she says approximately 2014 onwards and attended for medical treatment from 2015 onwards, she properly informed her medical advisers that she had previously experienced some hip pain 10 years previously which had resolved. In my opinion, this somewhat explains the apparent inconsistency in some of the medical evidence put forward, especially when the relevant forms are filled out in a shorthand manner by medical professionals. There is also further inconsistency insofar as some of the records suggest that when the First Complainant had hip pain 10 – 12 years earlier, there were no investigations and the issue simply settled, whilst there is also an alternative suggestion that there were medical investigations, but that the results are unavailable.

In my view, there are two important pieces of medical evidence before me in relation to the First Complainant's diagnosis. Firstly, the letter of Dr G of 14 September 2016 stated that it was unclear what the source of the pain was, that was experienced by the First Complainant over 10 years previously as it was not investigated at the time. Dr G stated that it may have been a muscular or tendinous issue that resolved, and i.e. one that had no bearing on her recent symptoms. She concluded that the time of onset, the then current pathology could not be known with any certainty. Secondly, in the letter of the First Complainant's orthopaedic surgeon who conducted the relevant surgery on her hip, Dr H, diagnoses the First Complainant's present condition as due to cumulative wear on the hip over a 2 year period prior to seeing him in March 2016.

The Provider in seeking to rely upon the exclusionary clause in the policy, bears the burden of proving on the balance of probability that:

(i) the hip pain that was first experienced by the First Complainant in college, was a symptom of the condition that she was diagnosed with over 10 years later, in circumstances where she says she had no pain in the intervening years; and

(ii) the First Complainant was suffering from the symptoms of bilateral hip impingement in the period before she was joined on her husband's policy with the Provider from 1 July 2013.

The medical evidence from the Complainant's orthopaedic surgeon, suggests that the bilateral hip impingement developed over a 2 year period between 2014 – 2015. In addition, in the absence of the First Complainant's historical medical records, the source of pain experienced by the First Complainant 10 years earlier, remains unclear. I take the view that the Provider has not demonstrated that it is more likely than not that (i) the hip pain that was first experienced by the First Complainant in college was a symptom of the hip condition that she was diagnosed with over 10 years later, when she says she had no pain in the

/Cont'd…

intervening years; or (ii) the First Complainant was suffering from the relevant hip condition in the period leading up to 1 July 2013.

I don't believe that the Provider's approach in the present case has been entirely reasonable. There is no available medical evidence from circa 2004 as to what the hip pain experienced by the First Complainant at that time related to. There is certainly no evidence from that time suggesting that the condition experienced by the First Complainant in 2014 i.e. bilateral hip impingement was present from approximately 2004 onwards. Even accepting that there is some uncertainty as to when the present condition manifested itself and what exactly caused the pain in circa 2004, it is entirely unclear that the First Complainant was suffering from the symptoms of bilateral hip impingement in July 2004. The Provider has provided no medical evidence in support of its contention that the condition was pre-existing. It further does not appear to have taken any steps towards seeking to clarify whether the perceived inconsistencies as to the date of onset could be explained by the First Complainant or whether a further explanation could be sought from the medical profession concerned. Instead, it simply rejected the First Complainant's claim with little evidence of investigation or thorough assessment. Indeed, I am very disappointed that the additional queries raised by the FSPO in May 2018, in the context of the investigation of the complaint, were not responded to by the Provider, notwithstanding a reminder to the Provider a month ago, that the information sought was required for the purpose of the adjudication.

The claim in question is quite a large one with the medical expenses incurred by the First Complainant in the region of AU$20,000. In the circumstances, I find that it was unreasonable for the Provider to refuse to cover the First Complainant's treatment in relation to this condition in the absence of any medical evidence to confirm a pre-existing condition. I also consider it unreasonable for the Provider to have adopted the negative and unhelpful attitude that it did, as regards perceived inconsistencies and its failure to address the queries specifically raised by this office in the context of the adjudication of the complaint.

In all of the circumstances, I am satisfied that it is appropriate to uphold the complaint. In the context of somewhat inconsistent information from the Complainant's Doctors in Australia, I am disappointed to note the Provider's failure to seek any further information or evidence of the Complainant's medical records in 2004, before it proceeded to decline the Complainant's claim on the basis that the treatment undergone in late 2015/early 2016 related to a pre-existing condition.

I don't believe that this was appropriate and in those circumstances, I find that the Provider's decision to decline the claim was wrongful, in circumstances where adequate enquiries had not been pursued in relation to the Complainant's medical history.

Accordingly, in order to do justice between the parties, I direct the Provider to reverse its decision to decline to provide benefits for the First Complainant's claim in relation to treatment for bilateral hip impingement and I direct the Provider to provide benefits to the First Complainant pursuant to her contractual entitlements for the relevant treatment, on the basis that the condition was not pre-existing. As the First Complainant has already fully vouched her claim, I intend to direct that the Provider review the relevant expenses claimed

/Cont'd…

and pay benefit for the First Complainant's expenses incurred falling with the terms and conditions of her cover within a period of 35 days.

Whilst the Complainants have been considerably out of pocket, owing to the decision of the Provider to decline the Complainants' claim, without adequate investigations of the First Complainant's medical history, nevertheless, I do not consider it appropriate to direct any further compensation. In this instance, there were certainly inconsistencies in the claim documentation that might reasonably have raised concerns with the Provider of whether or not the Complainant's treatment was in respect of a pre-existing condition. The Provider's error in this instance, was not the consideration of whether or not the Complainant suffered from a pre-existing condition, but rather its decision to form the opinion that in fact the treatment undergone was for a condition which had pre-existed the First Complainant's cover, without adequate investigations or evidence being gathered by the Provider upon which to base such a determination.

On a final note, the level of engagement demonstrated by the Provider with this Office has not been satisfactory. A full request for information and documentation was made to the Provider in August 2017 and the response when it was received, was unclear and not in duplicate as requested. It was therefore returned to the Provider in October 2017 and thereafter, requests were made by this Office for a response from the Provider on 28 November and 5 December 2017, and an escalation letter sent on 18 December 2017 noting that the matter would proceed to adjudication in the absence of a reply within 10 days.

The response that eventually arrived on 19 January 2018 was incomplete. The Provider made little effort to address the complaint put to it by this Office and simply provided a generalised statement as to its attitude to the complaint. In addition, this Office is surprised by the lack of records and documentation furnished by the Provider pursuant to the said request. The file provided consists almost entirely of documentation forwarded to it by the First Complainant in relation to her claim. Despite the fact that a letter dated 30 March 2016 from the Provider to the Second Complainant, refers to an available recording of a phone call between the Second Complainant and the Provider from 24 June 2013 at the time that the First Complainant was added to the policy, no record of this conversation was furnished to this Office as one would have expected, indeed, notwithstanding reminder. This is unacceptable.

/Cont'd…

As with any other regulated entity, the Provider is obliged to comply with the directions of this Office in relation to the provision of information. ***Section 47*** of the ***Financial Services and Pensions Ombudsman Act 2017*** provides as follows:

> *"(3) In conducting an investigation, the Ombudsman may—*
>
> *(a) require any person, who in the opinion of the Ombudsman, is in possession of information, or has a document or thing in his or her power or control, that is relevant to the investigation, to—*
>
> *(i) provide to him or her that information, either orally or in writing,*
>
> *(ii) produce to him or her that document or a copy of the document,*
> *…"*

It is incumbent upon all regulated entities to comply in full with requests made by this Office in the context of a complaint, both by furnishing items of evidence and by answering questions raised by this Office. The Provider in the present matter fell short of the expectations of this Office in this regard. Although certain information was submitted, it was provided well outside the timeline set out by this Office and necessitated several reminders. In addition, a full set of documents and records was not submitted as requested, and again more recently the additional queries put to the Provider by this office were essentially ignored, notwithstanding the reminder issued. It is to be hoped that such an approach will not be repeated, and that investigations by the FSPO will be given a more professional attention by the Provider.

It is my Decision that this Complaint is upheld.

/Cont'd…

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is upheld, on the grounds prescribed in ***Section 60(2)(f)*** and ***(g).***

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to rectify the conduct complained of by reversing its decision to decline to provide cover for the First Complainant's claim in relation to treatment for bilateral hip impingement on the basis that the condition was "*pre-existing*" her cover, and instead to provide benefit to the First Complainant pursuant to the policy, within a period of 35 days of the date of this Decision

- The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

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.

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION
AND LEGAL SERVICES

8 August 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) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.