An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0096
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 arises out of a travel insurance policy and relates to the Provider's refusal to indemnify the Complainant under the policy.

The Complainant's Case

The Complainant took out an annual multi-trip travel insurance policy which was underwritten by the Provider. The policy was taken out on 9 March 2016 and the Complainant, who was 16 at the time, was due to accompany her aunt, uncle and their daughter on a holiday to the United States on 18 March 2016. This holiday had been booked on 28 September 2015.

On 11 March 2016, the Complainant's aunt was admitted to hospital where she was diagnosed with a deep vein thrombosis in her left upper limb and was advised against travelling during the period in which she had been due to travel to the United States. As a result of having to cancel her planned trip due to her aunt's diagnosis, the Complainant made a claim under the policy which was declined by the Provider.

The Complainant claimed the cost of her trip which she states is €1,500. The Provider has refused to indemnify the Complainant on the basis that the symptoms that prevented her aunt from travelling pre-existed the purchase of the policy.

The Complainant is unhappy with the Provider's decision and has submitted that the policy in question should cover the loss suffered. The complaint is that the Provider has wrongfully,

unreasonably and through a mistake of law or fact refused to fully indemnify the Complainant for the loss in question and the Complainant is seeking to be compensated by the Provider for the loss suffered.

The Provider's Case

The Provider has refused to indemnify the Complainant on the basis that the contract of insurance and the policy was sold subject to certain terms and conditions which formed the basis of the contract. In particular, the Provider relies on the assertion that the Complainant's aunt was diagnosed on 11 March 2016 but the symptoms giving rise to a diagnosis were in existence prior to the purchase of the Complainant's policy. The Provider states that the Complainant's aunt first received treatment for the particular symptoms on 8 March 2016 and that following this she was referred to hospital and subsequent diagnosis was given. The Provider states that as the symptoms pre-existed the Complainant taking out a policy on 9 March 2016, the Complainant's claim is excluded pursuant to that part of the policy entitled "Exclusions that apply if a Close Relative or Travelling Companion has Medical Conditions" contained on page 4 of the terms and conditions of the policy. In addition, the Provider relies on that part of the policy entitled "Cancellation or Curtailment Charges" on page 7 of the policy terms and conditions which provides that payment for irrecoverable unused travel and accommodation costs together with any reasonable additional travel expenses will only be paid if the cancellation of the trip is necessary and unavoidable as a result of certain events occurring after payment of policy premium and incurring within the period of insurance.

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 Complainant was 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 16 August 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

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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, my final determination is set out below.

At the outset, although the claim submitted by the Complainant is in the amount of €1,500, an email from the travel agent dated 22 March 2017 sets out that the actual costs incurred by the Complainant amount to €1,222.21. This can be broken down as follows:

i. €596.78 – Cost of flight
ii. €615.43 – cost of hotel accommodation
iii. €10 - Booking fee.

Audio recordings have been provided in evidence of the telephone calls between Provider and the Complainant's mother and aunt after the claim had been submitted to the Provider. I do not consider that the contents of the calls are material to or determinative of my decision.

The Provider has submitted a copy of the relevant Policy Schedule/Validation Certificate pertaining to the Complainant's policy. It shows that the person insured under the policy is the Complainant and it shows that the policy commenced on 9 March 2016 for a period of 365 days. In addition, the said document indicates that the time of issue on 9 March 2016 was 11:41 am. Therefore, it appears that the policy was taken out on the morning of 9 March 2016.

The Provider has provided a copy of the relevant terms and conditions of the policy and a copy of any relevant promotional literature, brochures and product information which it says was provided to the Complainant in and around the time of the commencement of the policy. Amongst other things, the Provider has provided a copy of one of the pages that prospective purchasers of the policy would be presented with prior to taking out the insurance. This provides:

> *"Important conditions relating to health*
>
> *This insurance contains important conditions relating to the health of anyone named above and also exclusions relating to the health of anyone named above, a close relative or travelling companion, which you must read before purchasing this insurance. For details on medical screening requirements, conditions and exclusions relating to health click Here.*
>
> *Please tick to confirm you are satisfied with the important conditions relating to health and the exclusions"*

On Page 4 of the policy terms and conditions, there is a section that provides, amongst other things, as follows:

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> *"Exclusions that apply if a Close Relative or Travelling Companion has Medical Conditions*
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> *If any of the below exclusions apply to Your Close Relative(s) or Travel Companion(s) at the time of taking out this policy or at the time of booking the trip. You will not be covered under Section A - Cancellation or Curtailment Charges….for any claims arising directly or indirectly from:*
>
> > *iii) any Medical Condition for which a Close Relative or Travelling Companion are aware of but for which they have not had a diagnosis."*

In essence therefore, the Provider has declined to indemnify the Complainant on the basis that at the time of inception of the policy i.e. 11:41 am on 9 March 2016, the Complainant's aunt had a Medical Condition (within the meaning of the policy) which she was aware of but had not yet had a diagnosis.

The Provider makes this decision having assessed the relevant medical records leading up to the Complainant's aunt being diagnosed with a deep vein thrombosis on 11 March 2016.

Medical Condition is defined on Page 2 of the policy as meaning "*any disease, illness or injury*".

In a letter dated 2 December 2016 from the Provider to the Complainant, the Provider refers to an admission report from a Dublin Hospital in relation to the Complainant's aunt which refers to a "flare up on Tuesday". The Tuesday in question was 8 March 2016. The Provider also relies on clinical notes from the hospital admission on 11 March 2016 which it states records what symptoms the Complainant's aunt stated she was experiencing on Tuesday, 8 March 2016, a day prior to the inception of the policy. The Provider states that these symptoms were in existence at the time the Complainant took out the insurance policy on 9 March 2016.

I have reviewed the medical records provided and they can be relevantly summarised as follows:

A letter from the Complainant's aunt's physiotherapist dated 3 May 2017 which confirms that the Complainant's aunt attended with her physiotherapist on 9 March 2016 presenting with left-sided scapular pain. It was noted that she was treated with soft tissue mobilisation techniques and responded well to local therapy.

On 11 March 2016, the Complainant's aunt attended at her GP and is referred to a Dublin Hospital. The letter of referral records, amongst other things, that the Complainant's aunt has a swollen left upper limb which has worsened "over the last few days". It notes that the Complainant's aunt had physiotherapy for scapular and shoulder pain which has happened to her before.

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On 11 March 2016, the Complainant's aunt attended at a Dublin Hospital and the admission notes record that when she attended she complained of a swollen left upper limb which had been getting worse over the last few days. There is reference to a "flare up on Tuesday" and that she "attended physio on Wednesday".

The clinical notes taken by the hospital on 11 March 2016 record that the aunt reported that she felt certain symptoms on Tuesday, 8 March 2016. The symptoms included tightness of the left scapula, paraesthesia down the left arm, discomfort and pain, swelling of the left arm, discolouration, size difference and warm to touch.

The objective evidence therefore is that the Complainant's aunt was experiencing certain symptoms the day before the Complainant took out her policy on 9 March 2016. The symptoms are outlined in the paragraph above.

The Complainant's aunt's GP has confirmed in writing that she had never suffered from deep vein thrombosis prior to her diagnosis on 11 March 2016. One could not therefore reasonably expect the aunt to be aware that she had a deep vein thrombosis prior to an actual diagnosis. However, in my view that may be too narrow a construction and the exclusion provision in question provides for the close relative or travelling companion being aware of *any Medical Condition* within the meaning of the policy which therefore means "*any disease, illness or injury*".

The Provider's letter to the Complainant on 5 January 2017 states that "*as the symptoms which gave rise to the claim predate the purchase of the policy, the claim regrettably falls outside the remit of cover"*. I accept that the above reasoning is reasonable and consistent with the terms and conditions of the policy.

The Complainant's aunt appears to have been suffering from some pain and swelling in her left upper limb and other symptoms the day before the Complainant took out the policy. She attended her physiotherapist the following day on 9 March 2016 (it is not known whether this attendance was after the inception of the Complainant's policy at approximately 11:41 am on the same day). The physiotherapist confirmed that the aunt presented with complaints of pain in her scapula and some restriction of cervical mobility.

It appears therefore that following on from some symptoms experienced on 8 March 2016, the first thing that the aunt did was to attend her physiotherapist complaining of scapular and shoulder pain. We are advised by the Complainant's aunt's GP that the Complainant's aunt had a previous history of scapular pain which explains the use of the term "flare up" in the hospital admission notes.

I have no evidence presented to this Office that requires me to look behind the evidence presented by the physiotherapist or the GP and accordingly it appears that the Complainant's aunt experienced some symptoms on 8 March 2016 which she associated with some prior history of scapular and shoulder pain. That in my view, indicates an awareness by Complainant's aunt that she was suffering from *a disease, illness or injury.*

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Therefore, on the basis of the foregoing and the evidence presented to this Office it appears to me that the Complainant's aunt *was aware* that she was suffering from a *disease, illness or injury* such that would entitle the Provider to invoke the exclusion clause upon which it seeks to rely on in this complaint.

For the reasons set out above, I do not uphold this complaint.

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

19 September 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.