An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0145
Sector:	Insurance
Product / Service:	Travel
Conduct(s) complained of:	Rejection of claim Dissatisfaction with customer service Lapse/cancellation of policy Maladministration Mis-selling Disagreement regarding Settlement amount offered
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant incepted a policy of travel insurance with the Provider, on 01st October 2015, which provided cover in respect of the period 01st October 2015 to 10th October 2015. The Complainant was the Policyholder and his wife an insured person under the Policy.

The Complainant and his wife travelled to Lanzarote on 01st October 2015, and they were on holiday when, on 03rd October 2015, the Complainant slipped on a broken footpath and suffered an injury to his hand/arm as a result.

The Complainant submitted a claim form to the Provider, dated 28th October 2015. The Provider initially wrote to the Complainant, advising that on the basis of the terms and conditions of the Policy no benefit was payable to the Complainant. Following correspondence between the parties, the Provider subsequently agreed to waive the applicable policy excess of €150.00 and agreed to pay benefit in respect of receipted costs in the sum of €89.90.

The Complainant's complaint is that this amount is an "insult" to his injuries and that the Provider has wrongfully and/or unfairly refused to compensate him for the severe injuries which he sustained whilst abroad.

The Complainant's Case

The Complainant, who will soon be 60 years old, has submitted that he was on holidays in Lanzarote with his wife when, three days in to the holiday, he suffered a fall on a footpath, which resulted in serious injury to his left hand. The Complainant submits that he is left handed and has been severely debilitated by his injury, which three years on from the incident has had lasting effects particularly on his ability to play music which he submits was his main pastime.

The Complainant submits that as a result of the fall, he suffered significant injuries, namely, a dislocated wrist and elbow, a chipped elbow, and a number of broken bones.

The Complainant submits that he was informed by the Hospital in Spain where he received treatment that his wrist would never function at 100% again and that the best he can expect, into the future, is 60-80% function, plus the onset of arthritis. The Complainant submits that he may also require further surgery in the future.

The Complainant submits that the Provider has informed him that there must be "*total disablement*" before he would be entitled to any benefit under the policy of insurance and he submits that, to him, his injuries constitute total disablement as he is left handed and is never going to have the same level of hand function as previously. The Complainant submits that the Policy is therefore misleading in this regard.

The Complainant submits that the Provider has been unsympathetic toward his situation and queries what the point was, of taking out a "*completely useless policy of insurance*". The Complainant submits that he is seeking to have the Provider compensate him for the injuries which he has suffered.

The Provider's Case

The Provider submits that on **22nd September 2015** the Complainant booked flights to travel to Lanzarote on Thursday **01st October 2015**. The Provider submits that no return flight was booked by the Complainant, at that point. The Provider submits that on **09th October 2015**, the Complainant booked flights home from Lanzarote, to travel on Sunday, **11th October 2015**.

The Provider submits that on **01st October 2015** the Complainant took out a Bronze, Single Trip Policy of travel insurance, on which policy the Complainant is noted as the main insured person, with his partner noted as an additional insured person. The Provider submits that the Policy covered the period of **01st October** to **10th October**, inclusive.

The Provider submits that on **05th October 2015** the Complainant was in contact to advise that on the **03rd October 2015** he had tripped on a broken footpath and injured his arm. The Provider submits that the Complainant advised that he had received medical treatment in a public hospital in Spain following the fall. The Provider submits that the Complainant said that he had availed of his European Health Insurance Card and accordingly there was no cost incurred for the treatment.

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The Provider submits that the Complainant confirmed to it that his treatment at the hospital was completed within a few hours and that he was not required to remain in hospital overnight. The Provider notes that the "*Medical Expenses*" section of his Claim Form states that he was admitted to hospital on the **03rd October** and discharged on the **07th October** but submits that as the Complainant had confirmed to it that he did not stay overnight, and that it is taking the "*discharge date*" referred to by the Complainant as the date that he returned to hospital for further attention.

The Provider submits that it contacted the Complainant on the **10th October 2015** and at that time, the Complainant advised that he had booked flights home for the following day, the **11th October 2015**. The Provider submits that he informed it that he had obtained a "*Fit to Fly*" Certificate from the hospital and that his cast, from thumb to shoulder, had been in place for over a week and that he was therefore safe to fly. The Provider submits that it informed him that he should contact its Claims Department upon his return home.

The Provider submits that it forwarded a Claim Form to the Complainant on **22nd October 2015**. It says that it received back the completed Claim Form on the **02nd November 2015,** and that it responded to the Complainant on the **12th November 2015**. It submits that it advised him that it could not consider taxi expenses as per the policy wording regarding general expenses. It submits that it also advised him that the Irish hotel expenses and the pharmacy receipts in Ireland were not covered under the policy either. The Provider submits that the remaining value of expenses claimed for by the Complainant fell within the excess set out within the Policy and that the Complainant's claim was therefore declined.

The Provider submits that the Complainant subsequently wrote to it, on the **17th October 2015**, and advised that he was not accepting the Provider's decision regarding his claim.

The Provider submits that it acknowledged his complaint on the **17th November 2015** and wrote to the Complainant on the **09th December 2015** and explained that all claims are handled in accordance with the Policy Terms and Conditions, which form the basis of the contract of insurance. It submits that it also explained to him that the flight which had been purchased by the Complainant was not deemed to be an additional travel cost as this would have been payable by him even if the injury had not been sustained, as he had no original return flight booked when he made the trip. The Provider further submits that any expenses incurred by the Complainant upon his return to Ireland or after the expiry of the Policy could not be considered for cover, under the policy terms and conditions.

The Provider submits that, notwithstanding the applicable exclusions in the Policy, it decided to waive the applicable Policy excess and offered to pay the pharmacy costs which the Complainant had incurred abroad, together with the receipted taxi expenses on the 03rd, 07th and 11th October 2015, the days of the Complainant's attendance at the hospital in Spain, totalling €63.62.

The Provider submits that the Complainant responded the following day, declining its offer.

The Provider submits that it wrote to the Complainant on the **05th February 2016** and asked him to itemise the items in respect of which he was seeking reimbursement.

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The Provider submits that the Complainant responded on the **26th February 2016** and advised that his Policy stated "*up to €5000 for a broken bone. I ended up with nine of them*".

The Provider submits that the Complainant advised that he was looking for the following:

- Refund of his submitted holiday expenses;
- Compensation in respect of his injury;
- Compensation in respect of pain and suffering "endured and to come".

The Provider submits that the Complainant advised it that his left wrist was never going to fully function again and that the most he could hope for was for 60-80% function over a lengthy period of time, coupled with the onset of arthritis. The Provider submits that the Complainant also advised that he had not been able to partake in his hobby of music since the accident and that he probably never would again.

The Provider submits that it wrote to the Complainant on the **08th March 2016** and responded to his claim as follows: in respect of his claim for compensation for his injury, it says that it explained that the Policy offers a benefit of €5,000, *if*, during the course of the trip an injury was sustained which resulted in permanent total disablement. Disablement is defined as:

> "*disablement which entirely prevents the Insured person from attending to business or occupation of any and every kind for at least 12months and at the end of that time being beyond the hope of improvement.*"

The Provider submits that based on the information which it had received to date from the Complainant, the Complainant's injuries did not constitute total disablement, as defined in the Policy, as he had confirmed that he was likely to have 60-80% function, following treatment.

The Provider submits that in respect of the Complainant's claim *for "refund of submitted holiday expenses"* it made an upward amendment of its original settlement offer to the Complainant, as follows:

Taxis relating to the Complainant's	
Hospital Admission/discharge/airport costs	€42.80
Pharmacy Costs Abroad	€21.12
Accommodation 10/10/2015	€25.00

The Provider submits that it had agreed, as before, to waive the applicable excess and enclosed a cheque in the amount of €88.92 under separate cover, on the same date, which, the Provider notes, has since been returned to it by the Complainant.

The Provider acknowledges that the injury sustained by the Complainant will require ongoing treatment for some time but submits that the Complainant may be under the misapprehension that the Policy provides for a personal injury claim, when it does not. The Provider submits that while the Complainant may well have a valid claim against the Local

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Authority/ Private Management Company responsible for the footpath in question, but this is not a matter for the Provider.

The Provider submits that, notwithstanding this, it advised the Complainant that if after a period of 12 months he was unable to perform any kind of business or occupation of any kind, that it would re-consider payment under that section of the Policy, upon receipt of a medical report from his treating physician, detailing the extent of his injury and disability.

The Provider refutes the Complainant's suggestion that the policy is a scam and submits that it was sold to the Complainant in good faith, with the terms and conditions set out clearly both prior to and following its purchase.

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 on **15 October 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 Complainant purchased the policy of travel insurance, the subject matter of the within complaint, online on **01 October 2015**.

The Complainant's position is that the claim which was submitted in respect of his injury falls to be covered under the Policy. The Provider's position is that it does not and, whilst it

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has offered to pay benefit in respect of *"submitted holiday expenses",* it has declined to pay the benefit claimed by the Complainant in respect of his injuries.

The Provider's decision to decline the claim was set out in correspondence which issued to the Complainant, dated 23rd October 2015. I have reproduced this letter, by way of background, below:

> *08 March 2016*
>
> *Claim Reference -8820*
>
> *Dear [Complainant]*
> *Thank you for your recent correspondence clarifying the costs and compensation sought for reimbursement.*
>
> *Firstly, may we draw your attention to the 'Introduction' Section of the policy wording which states: 'We agree to pay for damages, liabilities, losses or costs as set out in this Policy occurring during the Period of Insurance within the Geographical Limits.'*
>
> *Section 2 'Medical and Other expenses incurred abroad' states:*
> *We will cover You under this Policy up to the amount shown on Your Schedule of Cover per Insured Person who suffers a sudden and unforeseen Bodily Injury or Illness or dies during a Trip.* ***We will cover the following costs necessarily and reasonably incurred abroad*** *as a result of You becoming ill, sustaining injury or dying outside Ireland during the trip'*
>
> - *Reasonable medical expenses for the immediate needs of a medical emergency*
> - ***Additional*** *traveling costs to repatriate You Home where recommended by Our Senior medical officer*
> - *Reasonable additional accommodation costs up to the amount shown on Your Schedule of Cover in total necessitated by the medical emergency per Trip….*
>
> *As you had no return flight pre-booked, the flight taken on the 11th October 2015 is not deemed an additional expense as this would have been payable in any case.*
> *The accommodation claimed for your overnight stay in Xxxxxxxx on the 11th October 2015 does not fall within the remit of the cover as outlined above (…We will cover the following costs necessarily and reasonably* ***incurred abroad****….)*
>
> *We appreciate the injury sustained will require ongoing treatment for some time; however a travel policy is to cover the emergency expenses associated with travel only. Any treatment on your return to Ireland would have to be referred to your private health insurer if applicable or through the normal healthcare channels. This exclusion is outlined under 'Section 2 Medical & Other Expenses Incurred Abroad': 'Any treatment after the insured person has returned to Ireland.'*
>
> *We understand that your injury resulted in a ruined holiday and we sympathise most sincerely with the circumstances of your claim, however it is with regret that we must*

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advise you once again that there is no cover for loss of enjoyment or compensation for pain and suffering. The General Exclusions section of your policy state that we will not cover: [emphasis added]

't. Loss of Enjoyment'

May we draw your attention to the Personal Accident Section of your policy which you referred to in your correspondence of the 26th February 2016, the policy offers a benefit of €5000 if during the course of the trip, you sustain an injury and this results in Permanent Total Disablement. Permanent Total Disablement is defined as:

'Disablement which entirely prevents the Insured Person from attending to business or occupation of any and every kind for at least 12 months, and at the end of that time being beyond the hope of improvement.'

From reviewing the information you have provided to date, it does not appear that you will be left permanently disabled as a result of the injury sustained during your trip as it is hoped you will regain 60-80% functionality. If after a period of 12 months, you are unable to perform any business or occupation of any kind, payment under this section of your policy will be considered on receipt of a full medical report from your treating physician detailing the extent of your injury and disability.

We will cover the additional accommodation abroad from your initial return date of the 10th Oct until your actual return date of the 11th October (€25.00) together with the pharmacy charges incurred abroad (€21.12) and the receipted taxi expense on the 3rd, 7th and 11th October (€42.80); waiving the applicable policy excess.

This would be our final decision to the complaint and can be used as such should you wish to refer your case to the Financial Services Ombudsman Bureau.

The issue to be decided, therefore, is whether the Provider has acted wrongfully or unreasonably in miscalculating the claim for payment in respect of the injuries which the Complainant sustained.

I would note, at the outset, that a Policy of Insurance is not all encompassing as regards cover provided and does not provide cover for every eventuality - rather the cover provided under a policy of insurance is specifically set out within the policy document. This sets out the details of the agreement entered into between the parties. Events which are covered under the policy are known as "insured perils" and these are subject to the terms, conditions, endorsements and exclusions set out in the policy documentation.

In determining whether the Provider has acted unreasonably and/or unfairly in refusing to pay benefit pursuant to the Complainant's claim, it is necessary to examine the Policy Terms and Conditions, which forms the basis of the contract of insurance between the Complainant and the Provider.

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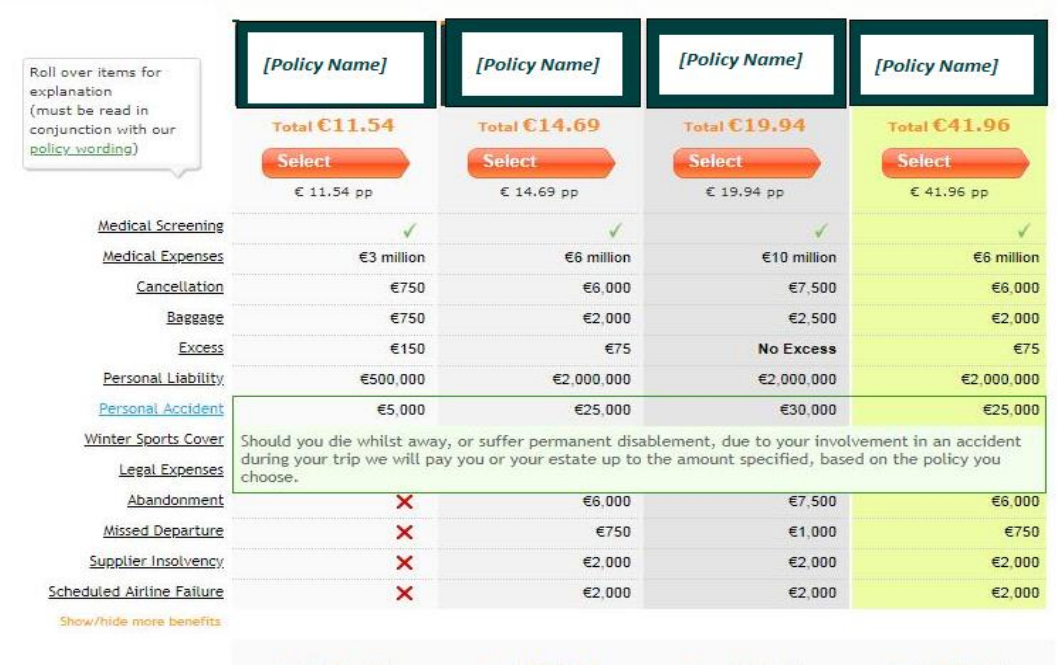
The Purchase of the Policy

The Complainant purchased the Policy, online with the Provider.

I note that when purchasing the policy and choosing a level of cover, the following information was made available to the Complainant before he purchased the Policy:



Roll over items for explanation (must be read in conjunction with our policy wording)	[Policy Name]	[Policy Name]	[Policy Name]	[Policy Name]
	Total €11.54 Select € 11.54 pp	Total €14.69 Select € 14.69 pp	Total €19.94 Select € 19.94 pp	Total €41.96 Select € 41.96 pp
Medical Screening	✓	✓	✓	✓
Medical Expenses	€3 million	€6 million	€10 million	€6 million
Cancellation	€750	€6,000	€7,500	€6,000
Baggage	€750	€2,000	€2,500	€2,000
Excess	€150	€75	**No Excess**	€75
Personal Liability	€500,000	€2,000,000	€2,000,000	€2,000,000
Personal Accident	€5,000	€25,000	€30,000	€25,000
Winter Sports Cover	Should you die whilst away, or suffer permanent disablement, due to your involvement in an accident during your trip we will pay you or your estate up to the amount specified, based on the policy you choose.			
Legal Expenses				
Abandonment	✗	€6,000	€7,500	€6,000
Missed Departure	✗	€750	€1,000	€750
Supplier Insolvency	✗	€2,000	€2,000	€2,000
Scheduled Airline Failure	✗	€2,000	€2,000	€2,000
Show/hide more benefits				

The Provider has submitted that the pre-purchase email, which issued to the Complainant on 01 October 2016, contained the Terms of Business and the Key Facts document.

In respect of a "Personal Accident", the Key Facts section states that the policy:

> "*Provides cover if you sustain bodily injury which results in your death, loss of limb, loss of sight or permanent total disablement*".

It also refers the policyholder to "*section 5 (page 13) Schedule of Cover (Page 1 and 2) General Conditions (page 7 and 8) General Exclusions (Page 8 and 9) Claims Procedure (page 21)"* of the Policy, in this regard.

The said Section 5 and the Schedule of Cover are particularly instructive in assessing the within complaint.

The Policy Terms and Conditions

Section 5

I have had regard to Section 5 of the Policy, which is headed "**Personal Accident**" and it provides as follows:

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If you suffer accidental Bodily Injury during the Trip, which within 12 months is the sole and direct cause of death or disablement, We will pay You or Your legal personal representatives the amount shown on Your Schedule of Cover due to:

1. *Death*
   OR
2. *Loss of One or More Limbs, or total and irrecoverable Loss of sight in one or both eyes*
   OR
3. *Permanent Total Disablement.*

Schedule of Cover

The Schedule of Cover appears on page 1 and 2 of the Policy, which indicates "*there are four types of insurance cover. These are [B], [S], [G] and [P]"*. It sets out the cover available in respect of a "*Personal Accident*" under each type of policy. In the column applicable to the Complainant's type of insurance cover, it states that a limit of €5,000 is payable in the event of "*permanent total disablement",* €3,000 in the event of death and €5,000 in respect of "*loss of limbs/sight*".

The Complainant's Injuries

The Policy provides for the payment of benefit in the event of "*Permanent Total Disablement*" which is defined within the Policy as:

"Disablement which entirely prevents the Insured person from attending to business or occupation of any and every kind for at least 12 months, and at that time beyond the hope of improvement".

The Complainant has submitted medical notes from the Hospital in Spain, where he received treatment. He has not submitted any further medical reports. However, he has advised, by email dated 18 August 2017, that

"*almost 2 years on from the incident I have only "60 – 80% usage of my left hand and wrist. That implies to me that I have total and permanent disablement as well as arthritis onset on up to 40% on my left hand leading me to having to give up my hobby of music."*

By email dated **19 July 2018** the Complainant has submitted that:

"movement restrictions and strength can be noted as not being what they were before injury took place. 20% movement loss."

Whilst I appreciate that the Complainant has suffered significant injuries to his arm, I do not agree with him that the reduction in usage which he has submitted equates with *"total disablement"* as per the meaning set out in the Policy. The definition of total disablement is quite a far reaching one and involves injuries of such a nature as to cause permanent disability, such as precludes the policyholder from undertaking work of any and every kind for at least 12 months and beyond the hope of improvement. The Complainant has not submitted that this is his situation.

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In any event, and importantly, whilst the Complainant is seeking "*compensation*" in respect of his injuries, there is no provision for general compensation in respect of personal injuries under the policy and the maximum amount of benefit payable to him if his injuries fell within the definition of permanent total disablement, would be €5,000. I note in this regard that the Provider has said that it would consider payment under the relevant section of the policy if, after a period of 12 months following the accident he was unable to perform any business or occupation of any kind and upon receipt of a full medical report from his treating physician, detailing the extent of his injury and disability. In my opinion, this was a reasonable position for the Provider to adopt.

Whilst I appreciate that the Complainant has suffered, and continues to suffer from the debilitating injuries incurred from the incident, a policy of insurance is not designed to provide for general compensation arising from loss or damage which occurs during the existence of the policy. Rather, as identified above, whether or not particular damage/loss falls to be covered under the Policy of Insurance which is in place, can be determined only by reference to the terms and conditions relating to cover, as set out within the Policy and Schedule of Insurance.

Having examined all of the evidence before me, and on the basis of the foregoing considerations, I am satisfied that the information relating to the cover available to a Policyholder in the event of a personal accident and the criteria applicable to this was made available to the Complainant prior to purchasing the Policy and was also adequately set out within the Policy documentation itself. I am of the view that the Provider did not act wrongfully or unreasonably, in forming the opinion that the Complainant's injuries did not meet the criteria for any further payment pursuant to the Policy agreement.

As a result, I accept that the Provider did not act unreasonably in originally declining the claim at issue and in subsequently offering to pay benefit only for the limited expenses set out above. Accordingly, whilst I am conscious that this Decision will be very disappointing to the Complainant, nevertheless, on the basis of the evidence before me, I do not find that this complaint can be upheld.

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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.

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION,
ADJUDICATION AND LEGAL SERVICES

09 November 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.