An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0042
Sector:	Insurance
Product / Service:	Travel
Conduct(s) complained of:	Rejection of claim - pre-existing condition Complaint handling (Consumer Protection Code) Dissatisfaction with customer service Maladministration
Outcome:	Upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant purchased a policy of travel insurance, online, with the Provider on **16 June 2016**, prior to a proposed trip to Spain. Insurance cover was provided under the policy for a single trip, for the period **02 July 2016** to **16 July 2016**, in respect of the Complainant, his wife, two daughters and his niece.

On **27 June 2016,** the Complainant contacted the Provider by telephone to advise that it had become necessary to cancel the trip in question, due to the serious illness of his sister in law. The Complainant submits that he was advised by the telephone agent that, in the circumstances it was unlikely that his ensuing claim would be successful, with regard to the Policy wording. He submits that this position was repeated by other telephone agents on subsequent calls.

The Complainant submits that as a result of the representations made to him, he did not initially proceed to submit a claim form to the Provider as he felt, on the basis of the representations made to him by the Provider, that there was little point in so doing.

The Complainant ultimately submitted a claim form on 23 November 2017. The Provider declined the claim by letter dated 18 December 2017.

The Complainant's Case

The Complainant booked a holiday to Spain in April 2016 and purchased a policy of travel insurance, online, with the Provider on 16 June 2016, to travel between 02 July to 16 July 2016.

The Complainant submits it became necessary to cancel the holiday after receiving news that the prognosis for his wife's sister, who had been suffering from cancer, had dis-improved suddenly and severely. The Complainant submits that her "*rapid decline was a shock for all of us"* and that at the time of booking the holiday there had been "*no sense of what was imminent."*

The Complainant submits that on or about 26 or 27 June 2016 he telephoned the Provider to notify it that the holiday would have to be cancelled.

The Complaint submits that during the phone call the agent interrupted him to tell him that they it was unlikely that he would be successful with the claim because of a clause in the contract which excludes cover in situations where the health of a close relative has resulted in the cancellation, where he/she has a pre-existing medical condition.

The Complainant submits that he found the Provider "*to be obstructive in taking on the claim*", and was told over the phone that the claim not likely to be successful. The Complainant submits that he found this to be unhelpful and that it appeared to him that the Provider had already formed an opinion on the claim, before it ever received any claim form or documentation from him in this regard.

The Complainant submits that he was "*dismayed*" by the conversation and that as a result, he parked the matter of submitting a claim and instead set about trying to obtain refunds for the various parts of the holiday which had been booked.

The Complainant submits that the trip had cost €3,500.00. The Complainant submits that he managed to successfully obtain refunds in respect of the cost of car hire, in the amount of €498.00, the cost of hotel accommodation for the first night of the holiday, in the amount of €200.00, and following a series of "*stressful*" phone calls and emails, a full refund of the cost of the flights, in the amount of €900. The Complainant submits that he was unable to get a refund for the full cost of the accommodation, due the short notice involved. The Complainant submits that financial loss arising from the cancellation of the holiday was therefore approximately €1,900.00. This amount was subsequently amended by the Complainant to €1,683.73, due to partial refund which was received in respect of the accommodation expenses.

The Complainant submits that he found it difficult to understand the attitude of the Provider which he contacted it regarding the holiday cancellation and he submits that:

> *nowhere in the online form was there mention of pre-existing medical conditions for anyone other than the four family members who were travelling.*

/Cont'd…

The Complainant submits that he received advice from a third party body, that he should enquire of the Provider as to where on the form he had been asked to outline his sister in law's pre-existing condition.

The Complainant submits that "*the way [the Provider] get the customer, me in this case, to fill a form on medical conditions of travelling party (with offers of discounts if they had their own medical insurance) created an assumption that the focus of the contract implications were on the travelling party and not on relatives…Also if such exemptions "blind side" reasonable expectations why aren't they brought to the attention of the consumer before purchase in the form of standard warnings that exist in other areas of insurance such as motor insurance e.g. penalty points, eyesight prescribed medications etc."*

The Complainant submits he subsequently rang the Provider, to enquire about this and spoke with an agent named O. The Complainant submits that whilst he initially "*found her to be reasonable in tone she continued to remind me that [his sister in law] had a pre-existing condition and it stated was in the contract."*

The Complainant submits that later that day he telephoned the Provider again and asked to speak with a manager. The Complainant submits that this time he spoke with an agent named H., who was, in his view, "*more helpful in manner and tone than her colleague*", but that she also reminded him that his sister in law was suffering from a pre-existing medical condition.

The Complainant submits that "*it is important to state that I estimate that at this stage I had been told five or six times by [the Provider] that the claim was going to be futile.*"

The Complainant submits that he asked H. if there was a specific part of the form which directed him to give details of his sister in law's condition, "*over and above the request for information on the travelling members*" and that he was told, "*No*", which the agent confirmed by way of email.

The Complainant submits that on 19 September 2016 he received a response from the Provider which advised that his complaint was under consideration (the matter had been logged as a complaint by the Provider on 25 August 2016). The Complainant submits that since he had not filled in a claim form and had not submitted evidence of the costs he was submitting a claim in respect of, he decided to ring the Provider on 21 September 2016.

The Complainant submits that he spoke with an agent named S., in order to see whether the Provider wanted him to send on supporting documents. The Complainant submits that "*she felt I should but since she was not dealing with the case I asked her if one of those dealing with case could confirm this by phonecall or email. I didn't hear anything from [the Provider] and I did not send supporting documents as they were not officially requested*."

The Complainant submits that he and his family have been offended and hurt by the *"callous and in one instance rude manner in which we dealt with*." He submits that the Provider showed "*little or no concern for our tragic predicament which flies in the face of the manner*

/Cont'd…

in which the insurance is sold." The Complainant submits that this added more stress to what was already a difficult time for him and his family.

The Complainant submits that the actions of the Provider were "*designed to leave me in no doubt that I was not going to succeed."*

The Complainant subsequently submitted a claim form, together with supporting documentation to the Provider on 23 November 2017. The Provider issued a letter of declinature dated 18 December 2017.

The Complainant submits that the Provider has acted wrongfully and/or unreasonably in declining the claim as he and his family were not asked to disclose information regarding his sister in law's condition at the time of taking out the insurance but rather, that *"only the medical condition of those travelling was specifically mentioned."*

The Provider's Case

The Provider submits that the Complainant purchased a single trip policy of insurance online on 16 June 2016, in respect of a proposed trip Spain from 02 July 2016 to 16 July 2016.

The Provider submits that on 27 June 2016 the Complainant contacted it to advise that he wished to claim for cancellation of the trip due to the illness of his sister in law. The Provider submits that he confirmed that his sister in law was receiving treatment for cancer at the time the policy was purchased. The Provider submits that the Complainant was asked by its telephone agent if he had read the policy terms and conditions and he confirmed to her that he had not, and that it was at this point its agent advised of the strict medical health requirements outlined in the policy. The Provider submits that it contacted the Complainant again shortly after his call to advise that it was sending a Cancellation Claim Form and again advised him of the above Strict Medical Health Requirements.

The Provider submits that on 19 August 2017 the Complainant telephoned and advised that he had been talking with third party bodies about the matter and that he wanted the Provider to outline where, when taking out the Policy, reference is made to medical conditions of close relatives. The Provider submits that the Complainant was advised that these were outlined in the Strict Medical Health Conditions within the Policy and that he was also advised that he needed to send in a Claim Form in order for it to assess the claim.

The Provider submits that the Complainant called back later the same day and asked to speak with a Manager and that he specifically wanted to know if, when purchasing such a policy online, he was required to make a disclosure about pre-existing conditions relating to close relatives. The Provider submits that it advised him that no, it does not ask that question, but that a customer is required to confirm by ticking a box that he has read and accepted the policy terms and conditions, which the Provider submits are also available for review before a purchase is complete.

/Cont'd…

The Provider submits that the Complainant requested email confirmation of the fact that there are no questions relating to close relatives on the proposal form. It submits that later that same day, it issued an e-mail as requested, confirming as follows:

> *during the purchase of your policy online you are not requested to disclose pre-existing medical conditions for your close relatives. It would be impractical to take note of all pre-existing conditions for close relatives, given the scope of the definition of close relatives within the policy. Instead there are a number of outright exclusions which are applied to the ill health of close relatives:*
>
> ***strict medical health requirements**: (See these outlined above)"*

The Provider submits that the Complainant was further advised that:

> *By purchasing your policy you enter into a contract and the policy terms and conditions form the basis of this contract. There is a 14 day cooling off period during which time you can review the policy wording to ensure it is suitable to your needs and obtain a full refund if you find within this timeframe the policy does not contain the cover you require. Please note the policy wording is also available for review on the website prior to purchase. If you require any further information please do not hesitate to contact us.*

The Provider submits that on the 25 August 2016, this matter was logged as a complaint, and a Final Response Letter was sent to the Complainant on the 07 October 2016. The Provider submits this letter conceded that the telephone conversation that took place between its agent and the Complainant on 19 August 2016 was not handled as well as it would expect, in that there was little empathy shown by its agent for the Complainant's circumstances. The Provider submits that an apology was given for this and an assurance provided that upskilling would be provided for the operator involved, to prevent any recurrence in the future.

The Provider submits that it was further explained to the Complainant that notwithstanding the fact that he felt that he was dealt with in a callous manner, this was not the intention of any of its operators but rather that they had wished to make him aware of the exclusion on his policy, in order to manage his expectations regarding the claim.

The Provider has submitted that:

> *the purpose of highlighting any exclusions or conditions at notification stage is not only to manage expectations on the policy cover but so that the claimant is not inconvenienced by spending time collating claim documentation including completion of a medical certificate if there is a possibility that information provided during the notification of the claim indicates that the claim is likely to fall within a contained exclusion.*

The Provider submits that the when purchasing the Policy online, the Complainant was asked to tick a box to indicate his agreement to the terms and conditions of the policy. The Provider submits that furthermore, the confirmation email which it sent to the Complainant on the 16 June 2016 had an attachment with the Policy wording.

/Cont'd…

The Provider submits that the Policy was sold to the Complainant in good faith, and that the terms and conditions were set out clearly both prior to and following the purchase. The Provider submits that there is a 14 day cooling off period during which time the Complainant could have reviewed the policy wording to ensure that it was suitable to his needs and could have obtained a full refund if he found that within this timeframe the Policy did not contain the cover he required. The Provider submits that its records show that the Complainant did not request to cancel the policy.

The Provider submits that the Complainant was advised on 27 June 2016, at the outset, that his claim would be assessed upon receipt of his Claim Form and Medical Certificate. On 19 August 2016 he was again advised that if he sent in his Claim Form, it could assess same.

The Provider submits that it received a Claim Form and supporting documentation from the Complainant on the 23 November 2017 and that it wrote to him on the 18 December 2018, declining the claim. In the letter of declinature, it advised him that having based its assessment on the information it had at its disposal, it concluded that his claim fell outside the scope of his policy cover.

The Complaint for Adjudication

The Complainant's complaint is that the Provider acted wrongfully and/or unreasonably in declining the claim which he submitted pursuant to his policy of travel 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 on **05 February 2019**, outlining the preliminary determination of this office in relation to the complaint. The parties were

/Cont'd…

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.

Correspondence was received from the Provider dated 25 February 2019, confirming its acceptance of the Preliminary Decision. In the absence of additional submissions falling under the categories of an additional point of fact, an error of fact or an error of law, from either party, the final determination of this office is set out below.

The Complainant booked a holiday to Spain in **April 2016** and purchased a single trip policy of travel insurance with the Provider on the **16 June 2016**, in respect of a proposed trip to Spain from the **02 July 2016** to **16 July 2016**, which provided cover in respect of the Complainant, his wife, two daughters and his niece.

The Complainant submits that he and his family were informed on **22/23 June 2016** informed that his sister in law's prognosis had changed.

On **27 June 2016**, the Complainant contacted the Provider to advise that it had become necessary to cancel the trip. He confirmed to the Provider that his sister in law had been diagnosed with cancer a number of years earlier but that the prognosis had very recently and unexpectedly changed. The Complainant has submitted that the response which he received from the Provider made him believe that the Provider had made up its mind that his claim would not be successful, from the outset.

I have listened to the initial telephone conversation which occurred between the Complainant and the Provider, on **27 June 2016**, which I have reproduced, in part, below:

C: *We have booked a holiday, and there's myself and my wife and my two children and my niece, to Spain and we have just been given very bad news about my wife's sister, at the end of last week and ..*

P: I'll just stop you there, can I get a policy number there first of all, if you don't mind [Complainant gives policy number, name and confirms home address]

P: You are due to travel on the 02nd, is it?

C: Yeah. Due to travel on the 02nd, yeah.

P: And are you are cancelling now because it's your sister in law's ill health, is it?

C: Unfortunately we believe, she has been given an number of weeks to live, now we can't obviously fly, in that it is my sister in law, my wife's sister, so we can't fly really in the circumstances, you know it's imminent and like with these things they can't give a definitive time but we have a letter from, that's been, there are a number of us within the family that have booked holidays and we are all in the same boat and

/Cont'd…

we have a letter saying that its imminent and we have to pursue it obviously, this is you know…

P: *Has she been ill for long?*

C: *She has had cancer a number of years but the prognosis has changed drastically in the last week, this is when we got the final treatment, or the treatment that she was undergoing, it was regarded at that point that it was not working and that she was going to, it had progressed significantly and that this is when we got the news then, that it was weeks. And so... Actually she was given a prognosis of years. She's a 45 year old woman, so this was not...*

P: *[Interrupts]... I am going to register your claim for cancellation but I have to be perfectly and frankly honest with you. The Policy was taken out on the 16th June, now do you know, did you read the terms and conditions around the ill health of close relatives, when you took out the Policy?*

C: *Em, I didn't really no, em, eh, but…*

P: *I just, I have to make you aware that if your sister in law was receiving treatment for this condition when you took out the Policy then your claim is not going to be covered.*

C: *But the prognosis at that point was not, it has only become, she was actually in treatment with an expectation that this was going to be...*

P: *[Interrupts]...I know but, I'm afraid the terms and conditions are a little bit black and white when it comes to that. So I am just making you aware at that point that that exclusion is there. Because I don't want to be leading you on and saying I am registering a claim and sending out a claim form and you know everything is going to be fine. There are terms and conditions and when I saw the purchase date of the Policy, I have to make you aware of it. If she was receiving treatment for cancer or for the condition that has caused the terminal prognosis or if she had received a terminal prognosis when you took out the policy, then this claim is more than likely going to be declined. Ok. So I will get the claim form issued out to you, we can just wait until we get the medical certificate competed by her GP back in and we can take it from there, but I just have to make you aware of that. Ok.*

C: *I am absolutely in shock. I mean, the prognosis at the time was not imminent. This prognosis we only got…*

P: *I appreciate that but, em, it's just the wording out of policy, is just really anyone... if the person's condition gives rise to a claim, is receiving or waiting to receive investigation tests or treatment. Okay. If they're receiving treatment, for the condition that gives rise to the claim at the time you took out the insurance, it's not covered. Okay.*

/Cont'd…

C: Can you send me out a copy of that part of the ...I don't know …I'm at a loss now. I don't understand why we were taking out insurance at all really… to be honest we hadn't really expected we were going using it for this purpose…

P: I do appreciate…

C: …I assumed that it did cover the cancellation because I did have a look at cancellation and it said sickness of a close relative...

P: ...The really important conditions there, the strict medical health, they are on the front page of the Policy. Because I know it's just we have to make you aware. So I'm getting the claim form issued out to you anyway [Complainant] we can a look at it when it comes in. I am just making you aware of that exclusion that's there. I'm not saying it won't be covered, I am just saying that they are the terms and conditions it will be assessed against. Right, okay.

C: Right.

P: Okay. So we'll get the claim form issued out to you there, okay.

Further in the conversation, the following exchange occurred:

C: I'm really struggling with this one now. Does anybody get a successful claim..?

P: Yes. Of course they do. Yes, They do. It's just, anyone, when it comes to close relatives we can't screen for close relatives' medical conditions. Okay, for example, if you yourself were suffering from an illness…

C: …I can understand that. I can understand the five people that were there. In terms of us. As far as I know, when I was filling out the form it asked me about my medical conditions and none of the five of us have but in terms of….

P: So, We can screen for your medical condition but what I was going to follow that up by saying was that we cannot screen for your close relatives' medical conditions, it's just you know, you wouldn't have intimate knowledge of your sister in law's medical history or, for example, father in law, or anyone else in your family, so that exclusion is built into it.

[emphasis added]

C: So anyone that has cancer basically is excluded from your cover then, really is that what you were saying?

P: If they are receiving treatment at the time of you purchased the policy or at the time of booking the trip then yes. If you had taken out the policy six months ago or a year ago and your sister in law wasn't receiving treatment at the time, then it wouldn't be an issue. Because the policy was taken out…

C: But she has been receiving treatment for the last, well on and off, is it the fact, it is at the actual time, I mean, or...

/Cont'd…

P: It's at the point ...There's only two dates we look for, at the time you purchase insurance or at the time you book the trip.

….

C: I would have been aware that she had cancer but the prognosis at that point was not terminal, it was, she was in treatment, and the prognosis, because she was a young woman was determined to be optimistic. It's, the last course of treatment was not successful, it was believed to...

P: Ok.

C: …solve it but…like, can you work with me on... like, what… I'm trying to get my head around this bit of it, em...

P: *When I am emailing you the claim form, I'll email you through the strict medical health conditions and you can see the wording there yourself then as well, okay.*

C: And would this be standard policy across the board in most travel insurance?

P: Yes.

C: So, yours isn't particularly…

P: No.

C: Right.

P: You'll have that email in a couple of minutes [complainant] Okay.

C: Alright, thank you.

P: Thanks.

Having listened to the audio recordings, I can understand both why the Complainant was shocked, as the tone and approach of the agent was not pleasant, and why he believed that the Provider had made a pre-determination regarding his claim.

The Provider has submitted that it acted in accordance with the terms and conditions of the policy which set out the relevant exclusions, in declining the Complainant's claim.

Declinature of the Claim

In declining the Complainant's claim, the Provider set out its rationale within its final response letter to the Complainant, dated **18 December 2017**, which stated that:

> *We have now completed our assessment of your claim taking into consideration the terms and conditions which apply to your travel insurance policy.*

/Cont'd…

*We wish to draw your attention to the **Strict Medical Health Requirements** on pages 4 and 5 of your policy wording. Here you will see:*

"No claim shall be paid where at the time of taking out this insurance (and in the case of Annual Multi-trip at the time of booking each Trip), the person whose condition gives rise to a claim:

*- **is receiving, or is on a waiting list for treatment in a hospital** or nursing home; or*
- has received a terminal prognosis; or [sic]

We note from the medical certificate provided that your late sister was undergoing chemotherapy between 2014 — 2016. Your trip was booked in April 2016 and your insurance policy was purchased in May [sic] 2016. As your sister [sic] was receiving and awaiting treatment for cancer when your trip was booked and policy was purchased your claim regrettably falls within the exclusion highlighted above and has unfortunately been declined.

The Provider has at all relevant times, therefore, relied on the "***Strict Medical Health Requirements***" section of the policy, both at the time of advising him by telephone that his claim was not likely to be successful and ultimately in communicating its decision to decline the claim.

I have reproduced the relevant section, which appears at pages 4-5 of the Policy, below:

***Strict Medical Health Requirements**:*

This insurance operates on the following basis:

- *To be covered under this Policy, You must be healthy, fit to travel and fit to undertake Your planned Trip.*
- *The insurance will NOT cover You when You are travelling against medical advice of a qualified Medical Practitioner or with the intention of obtaining medical treatment abroad.*
- *No claim arising directly or indirectly from any Pre-Existing Condition affecting You will be covered unless that condition has been declared to us and accepted by Us in writing. **Please note the definition of Insured Person(s) under Definitions.***

  [my emphasis]

- *Medical Declarations are valid only during the Period of Insurance in which they are made. On renewal of the Schedule of Cover/Policy, Pre-Existing Medical Conditions must be re-declared to Us. Any Pre-Existing Medical Condition not declared to us during the current Period of Insurance will not be covered under Your Schedule of Cover/Policy.*

- *No claim shall be paid where at the time of taking out this insurance (and in the case of Annual Multi-trip at the time of boking each trip), **the person** whose condition gives rise to a claim:* ***[my emphasis]***

/Cont'd…

- *is receiving, or is on a waiting list for treatment in a hospital or nursing home; or*
- *has received a terminal prognosis; or*
- *is travelling against the medical advice of a qualified practitioner or for the purpose of obtaining treatment abroad; or* ***[my emphasis]***
- *Any medical condition in respect of which You or Your Close Relative or Travelling Companion have not received a diagnosis.*
- *Any circumstances You are aware of that could reasonably give rise to a claim on this Policy*

The underlined portion is that part of the clause which was relied upon by the Provider in declining the Complainant's claim, in December 2017.

Reliance by the Provider on this exclusionary clause causes me some concern. I firstly note that it is not clear from the wording used as to which category of person, "***the person*** *whose condition gives rise to a claim*" in question, refers. I see that there is reference made within the third bullet pointed paragraph, to "**insured persons**" (as highlighted above.) The next reference then, to "**the person**" in the absence of any clarification to the contrary, and in the absence of a definition of such a "person" within the definition section, could reasonably be understood to refer to an insured person. However, this is not the way in which it has been interpreted and applied by the Provider.

The Provider's application of the term "person" appears to refer in a vague and general sense to any person. It appears therefore to serve as a very wide and far reaching clause, within a section which refers for the most part to the insured person.

Secondly, the construction of the clause itself does not read coherently as a whole. Whilst the first three tabbed points make sense in the context of the opening statement, it becomes somewhat incoherent at the junction of the third and fourth tabs:

- *No claim shall be paid where at the time of taking out this insurance (and in the case of Annual Multi-trip at the time of boking each trip), the person whose condition gives rise to a claim:*

-is receiving, or is on a waiting list for treatment in a hospital or nursing home; or
-has received a terminal prognosis; or
-is travelling against the medical advice of a qualified practitioner or for the purpose of obtaining treatment abroad; or
-Any medical condition in respect of which You or Your Close Relative or Travelling Companion have not received a diagnosis.
-Any circumstances You are aware of that could reasonably give rise to a claim on this Policy.

[my emphasis]

As set out within the Policy, it therefore reads that:

No claim shall be paid where at the time of taking out this insurance...the person whose condition gives rise to a claim:

/Cont'd…

- Any medical condition in respect of which You or Your Close relative or Travelling Companion have not received a diagnosis.
- Any circumstances You are aware of that could reasonably give rise to a claim on this Policy.

This simply does not make sense. A lack of clarity in any area of a policy is unsatisfactory but particularly so when it occurs within a clause purporting to make clear a policy exclusion.

On balance, I do not consider that the manner in which it is the clause is worded constituted sufficient notice to explain to the Complainant that a claim of the nature which he ultimately made, would fall outside of the policy cover.

I also do not believe that sufficient attention is drawn to the medical exclusions, generally. The Complainant has submitted that because he was asked specific questions about the health of persons travelling and because attention was drawn by the Provider to the fact that any pre-existing conditions of those to be insured, needed to be declared, he understood that these were the only persons whose medical conditions were considered relevant to the cover provided under the policy.

The Provider has acknowledged that it does not ask, as part of the online application for insurance cover, about medical conditions affecting anyone other than those to be insured.

I note in this regard, that at the quotation stage of the online purchase process, under the heading "Important declarations" it states as follows:

***By ticking this box you confirm on your behalf and on behalf of all insured persons that you have read and accepted the policy Terms and Conditions as per Policy Wording all medical conditions have been disclosed in line with the policy Terms and Conditions**, [my emphasis] ….*

Underneath there is a heading entitled:

Medical Screening – Do any travellers have any medical conditions?
Unsure if you or others on the policy have any pre-existing conditions that need to be declared? Click here

The stated rationale of the Provider in this regard is that it is not feasible to ask about the medical conditions of other persons, because the proposer may not be privy to such information and that it is dealt with instead, by way of a general exclusion instead within the Policy.

The Provider confirmed this in a letter to the Complainant dated 07 October 2016 that

Whilst you are correct in saying that we do not ask you about pre-existing medical conditions for close relations when taking out a policy, we do ask you to agree to the Terms and Conditions of the policy, which list a number of outright exclusions.

/Cont'd…

The Provider' s position is that the customer is required to confirm, by ticking a box, that s/he has read and accepts the policy terms and conditions. However, given the far reaching intention of the exclusion clause referred to above, I consider that it would have been only fair and reasonable of the Provider to draw attention to this clause or a more clearly worded clause, in a clear way within the terms and conditions, however this was not done.

I also find it somewhat unusual, by the Provider's own rationale, that it does not ask questions regarding relatives' medical conditions, on the basis that the insured person may not be privy to such sensitive information - yet when it comes to submitting a claim, the Provider requires a medical form to be completed by the GP or treating doctor of this "*person whose condition gives rise to a claim*". If it is the case that a claimant is understood by the Provider as not being privy to the medical details of other persons whose condition may give rise to the claim, it seems somewhat counterintuitive and unduly onerous, then, to then require a claimant to acquire and submit supporting medical documentation from that person's doctor.

Pre-Determination of the Claim

The Complainant has complained that the Provider had made up its mind that his claim would not be successful from the outset and before he ever submitted a claim form. As noted above, the Provider has submitted in this regard that:

> *the purpose of highlighting any exclusions or conditions at notification stage is not only to manage expectations on the policy cover but so that the claimant is not inconvenienced by spending time collating claim documentation including completion of a medical certificate if there is a possibility that information provided during the notification of the claim indicates that the claim is likely to fall within a contained exclusion.*

I find this to constitute an inappropriate system of dealing with claims. A system of claims handling which is purportedly designed to save people the "inconvenience" of submitting a claim form and supporting documentation is predicated upon making a snap assessment of the merits of a claim, without having had due regard to details contained within a claim form or the supporting documentation. This is an exercise more usually carried out by the underwriting function. I do not consider therefore that the mechanism which Provider has employed to filter claims by initial telephone contact is a fair or appropriate manner of claims handling.

Overall, I do not consider that the clause relied upon by the Provider in declining the Complainant's claim was sufficiently clear or that he could have been on adequate notice of its intended consequence. Further, I am not satisfied that that sufficient attention is drawn by the Provider to the medical exclusions, generally. I also consider that its system of making an assessment as to the likelihood of success of the claim at the claim notification stage is not appropriate. Overall, I therefore consider it appropriate to uphold this complaint.
In so doing, I would recommend that if the Provider has not already reviewed and amended the terms and conditions of this type of policy, that it might proceed to do so, having considered the decision in this matter and taking it into account in any future review of the relevant documentation.

/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)(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 make a compensatory payment to the Complainant in the sum of €2,000.00 to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

- 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

28 February 2019

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.