An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0071
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

The Complainants made a claim on their travel insurance policy in respect of a cancelled Caribbean cruise. The Provider declined the claim relying on specific provisions of the policy.

The Complainants' Case

The Complainants booked a cruise in **July 2016**. The scheduled departure date of the cruise was **16 April 2017**. The Complainants purchased a travel insurance policy underwritten by the Provider on **5 April 2017**.

The First-named Complainant states that she visited her local General Practitioner on 28 March 2017 for a urinary tract infection and was prescribed antibiotics. She states that she underwent an MRI scan on 7April 2017 which identified an ovarian cyst and that, on 18 April 2017, she attended her consultant oncologist and was diagnosed with an ovarian malignancy. The Complainants cancelled their travel plans and sought to make a claim under the policy, but this was declined by the Provider.

The First-named Complainant maintains that when she attended with her GP on 28 March 2017, she had no knowledge of any other pending diagnosis.

The Provider's Case

The Provider declined the Complainants' claim for cancellation of their trip on the basis that the First-named Complainant was aware of a pending medical diagnosis when she purchased the policy on 5 April 2017, having visited her General Practitioner on 28 March 2017.

The Provider advised the Complainants that cover is excluded under the policy, for any claim arising from;

> *"Any medical condition for which you are aware but have not had a diagnosis, any medical condition for which you have received a terminal diagnosis, any medical condition for which you are receiving or are on a waiting list for or have knowledge of the need for surgery, treatment or investigation at the hospital, clinic or nursing home."*

The Complaint for Adjudication

The complaint is that the Complainants' claim on their travel insurance policy was improperly declined by the Provider. The Complainants seek reimbursement for the financial loss suffered as a result of having to cancel the trip.

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 26 February 2019, 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, the final determination of this office is set out below.

Prior to considering the substance of the complaint, it is useful to set out the chronology of events (quoting certain correspondence) as well as the relevant terms and conditions of the policy.

Chronology

July 2016	Holiday booked
28 March 2017	Attendance of First-named Complainant with her GP for UTI
05 April 2017	Travel Insurance purchased
06 April 2017	Appointment with Consultant Gynaecologist
07 April 2017	MRI scan which revealed ovarian cyst
10 April 2017	Holiday cancelled. First-named Complainant referred to Consultant Oncologist.
11 April 2017	Claim made on policy
16 April 2017	Scheduled holiday departure date
18 April 2017	Diagnosis of ovarian malignancy
28 April 2017	Medical Certificate completed by the First-named Complainant's GP on behalf of the Complainants as part of claim on the policy. This document includes confirmation from the GP of the condition for which the First-named Complainant was referred, which is described as: "*Recent referral for lower abdominal pain 28/03/17*".
27 June 2017	Letter from Provider declining claim
29 June 2017	Letter from First-named Complainant's GP stating that referral was due to recurrent UTI and that the discovery of the cyst was "*not related to the issue for which she was being originally investigated and referred*."
17 July 2017	Complainants' letter of appeal

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17 August 2017	Provider's First letter responding to appeal indicating that its rejection decision would be affirmed.
20 September 2017	Provider's second letter responding to appeal requesting computerised GP records "*detailing all consultations for 2017 including referral letters to and reports from hospital appointments/consultants*". This material was sought in circumstances where the medical certificate furnished to the Provider had recorded that the First-named Complainant was referred "*due to abdominal pain*" as opposed to for the purposes of investigating a UTI.
27 September 2017	Letter from First-named Complainant's GP enclosing referral letter to First-named Complainant's Consultant Gynaecologist and indicating his view that the request for records was "*entirely inappropriate*".
09 October 2017	Further letter from Provider requesting full medical reports from consultations with Consultant Gynaecologist noting that standard treatment of a UTI would have resulted in a referral to a urologist, rather than to a gynaecologist
12 October 2017	Letter from First-named Complainant's GP providing explanation for referral to a gynaecologist rather than to a urologist
08 November 2017	Letter from Provider reiterating the requirement to furnish full medical reports from consultations with gynaecologist

Policy Terms and Conditions

The Provider has identified the following provisions from the '***Important Conditions Relating to Health***' section of the policy on Page 4 of the Policy Document, in support of its decision to decline the Complainants' claim:

> ***Exclusions that apply to all Insured Persons***
> *(These exclusions apply to all Insured Persons irrespective of whether they are Private Health Insurance or Non Private Health Insurance holder)*
>
> *The following exclusions apply to all* ***Insured Persons*** *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, Section B – Emergency Medical and Other Expenses, Section C – Hospital Benefit,*

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Section D - Personal Accident and Section X3 – Green Fees for any claims arising directly or indirectly from:

*i) Any **Medical Condition** for which **You** are aware of but have not had a diagnosis.*

*ii) Any **Medical Condition** for which **You** have received a terminal prognosis.*

*iii) Any **Medical Condition** for which **You** are receiving or are on a waiting list for or have the knowledge of the need for surgery, treatment or investigation at a hospital, clinic or nursing home.*

The following provision from the '**Claims Conditions'** section of the policy on Page 5 of the Policy Document is also relevant:

*"**You** or **Your** legal representatives must supply at **Your** own expense all information, evidence, details of household insurance and medical certificates as required by **Us**."*

Analysis

In this case, the Provider declined a claim on a policy, initially by reference to the terms of the policy. The matter was subsequently appealed internally however, by virtue of a failure on the part of the Complainants to furnish certain medical records which had been requested, the consideration of the appeal appears to have ultimately been suspended by the Provider.

I note that in its initial rejection of the Complainants' claim (on 27/06/2017), the Provider, having cited the policy terms reproduced above, reasoned as follows:

As quoted above the policy excludes cover for any condition for which you are aware of but have not had a diagnosis. We note from the information provided that you had attended your GP with symptoms of lower abdominal pain on 28/3/2017 however there was no diagnosis. Furthermore we note that you were undergoing investigations into the abdominal pain when your policy was purchased on 5/4/2017 therefore your claim unfortunately falls within the exclusion outlined above and has regrettably been declined.

Subsequent to the Complainants' appeal, the Provider wrote again (on 17/08/2017) reciting the policy terms and stating that cover was not provided for any medical conditions if, at the time of the purchase of the policy, the policy holder was awaiting investigations at a hospital or clinic in respect of symptoms relating thereto. The Provider went on to state:

In this case, you were referred to [the Consultant Gynaecologist] *for abdominal pain on 28th March 2017 this was prior to the purchase date of your policy on 5th April 2017. Your appointment was subsequently with* [the Consultant Gynaecologist] *on the 6th April 2017. Whilst we sympathise with your situation and we do understand that you were not aware of the outcome of your investigations at the time you purchased your travel insurance policy, this does not alter the fact that the results of any investigation for which you were referred prior to purchasing your travel*

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> *insurance policy, are excluded from cover of regardless of the unfortunate outcome of the investigations.*

Thereafter, in the course of considering the Complainants' appeal (including a submission from the First-named Complainant's GP), the Provider requested (on 20/09/2017) "*computerised medical records*" from the GP in circumstances where the medical certificate previously supplied to the Provider (which had been completed by the First-named Complainant's GP) had recorded that the First-named Complainant had been referred to the Consultant Gynaecologist "*due to abdominal pain*", as opposed to for the purposes of investigating a UTI. In my opinion, this was an entirely reasonable line of enquiry which nonetheless prompted the First-named Complainant's GP to express his view (on 27/09/2017) that the request was "*entirely inappropriate*". I disagree with the First-named Complainant's GP in that regard.

In response to the GP's letter, which also clarified that the referral was to a gynaecologist, the Provider wrote again indicating that it now required the full medical reports from consultations with the Consultant Gynaecologist, noting that standard treatment of a UTI would have resulted in a referral to a urologist rather than to a gynaecologist. The Provider continued to state as follows:

> *In light of the above we would require further medical information to determine that the symptoms you were under investigation for at the time you purchased your policy had no link either directly or indirectly to the diagnosis which resulted in the cancellation of your trip.*

The rationale relied upon by the Provider in this case to decline the claim in the first instance was that the First-named Complainant was already under investigations for abdominal pains at the time of the purchase of the policy and that it was these investigations which led to the diagnosis of the condition which resulted in the cancellation of the holiday. In other words, the Provider was of the view that the cancellation arose directly from a medical condition for which the First-named Complainant had not yet had a diagnosis but in respect of which, she was receiving investigations at a hospital (as per the precise terms of the policy).

In my opinion, this was a reasonable decision to make on the basis of the facts made available to the Provider as of 27 June 2017.

The Provider had been furnished with a document completed by the First-named Complainant's GP stating that the referral on 28 March 2017 was due to "*lower abdominal pain*" (a UTI is referenced later in the document as the reason for two earlier consultations but it is not cited as the reason for the referral on 28 March 2017). The First-named Complainant's GP did not furnish a letter arguing otherwise until after 27 June 2017. Accordingly, I am satisfied that the Provider was entitled to come to the conclusion which it came to on 27 June 2017.

After 27 June 2017, it was of course open to the Complainants to seek to put further medical information before the Provider as part of the appeals process and indeed, they did.

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However, I am entirely satisfied that, in response to those further submissions, the Provider was entitled to request further medical records (including the records of the Consultant Gynaecologist) to further investigate matters as per the 'Claims Conditions' section of the policy reproduced above, and indeed, it was reasonable to make that request. The Provider insisted on the provision of the Consultant Gynaecologist's records on 8 November 2017, as per its earlier letter of 9 October 2017. No such records were however, made available.

In circumstances where the Complainants declined to provide the medical records sought (records which I am satisfied were directly relevant to the Provider's investigations on appeal) I have no difficulty in concluding that the Provider was entitled to effectively suspend its consideration of the appeal. In the event that the Complainants decide to furnish the requested records, I would expect the Provider to consider those records and to then conclude its assessment of the appeal.

Lastly, I should note that in the context of the exchange of documentation via this office in relation to this complaint, the Complainants, on 22 August 2018, supplied a 1-page printout of the First-named Complainant's GP records from 2017. The Complainants did not however furnish the medical reports from the consultations with the Consultant Gynaecologist as had twice been requested by the Provider.

In light of the entirety of the foregoing, and in the absence of evidence of wrongdoing by the Provider or conduct within the terms of ***Section 60(2***) of the ***Financial Services and Pensions Ombudsman Act 2017*** that could ground a finding in favour of the Complainants, I am not in a position to uphold the 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.

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION AND LEGAL SERVICES

21 March 2019

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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.