An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0137
Sector:	Insurance
Product / Service:	Travel
Conduct(s) complained of:	Rejection of claim - pre-existing condition Delayed or inadequate communication Dissatisfaction with customer service
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint is that the Provider incorrectly or unreasonably declined the Complainants' claim under their travel insurance policy, for the cost of a holiday which was cancelled due to the illness of the Second Named Complainant.

The First Named Complainant purchased the policy on **17 January 2017** at a cost of €116.65.

The Complainants' Case

The First Named Complainant booked a short holiday on **5 January 2017** for herself and the Second Named Complainant. The planned travel dates were from **20 January – 23 January 2017** inclusive.

The Second Named Complainant began complaining of flu like symptoms and on Thursday **19 January 2017** he attended his GP and he complained of feeling weak and feverish. The GP gave the Second Named Complainant a referral letter to attend the Emergency Department.

The First Named Complainant telephoned the Provider on **19 January 2017**. She explained to the Provider that the Second Named Complainant woke up the morning before,

complaining of flu-like symptoms. The First Named Complainant told the Provider that they were due to fly to Iceland on Friday **20 January**, but the Second Named Complainant was unsure whether he wanted to take the risk of flying.

The First Named Complainant was advised by the Provider that the Second Named Complainant would need to be medically certified as unfit to travel. The Provider further advised the First Named Complainant that the claim would have to be investigated due to the proximity between the policy purchase date and the date the Second Named Complainant became ill.

The Second Named Complainant attended the Emergency Department on Saturday **21 January 2017** and was diagnosed with "*likely viral pneumonia*"

On **7 February 2017**, the First Named Complainant submitted a claim to recover travel expenses of €1056.15 from the Provider in respect of their flights (€65.57 had been refunded by the airline in respect of airport taxes) and their accommodation.

On **20 March 2017**, the First Named Complainant received a letter from the Provider advising that the Complainants' claim to recover travel expenses had been declined.

> *"We note from the medical information provided that your husband attended his GP on 19/01/2017 with a 4 day history of flu like symptoms. As your policy was not purchased until 17/01/2017 no event already in existence prior to this date is covered. The symptoms which eventually led to the cancellation of your trip were already in existence when you purchased your policy; as a result your claim falls outside the scope of cover quoted above and has regrettably been declined"*

The Complainants state that the claim was rejected on spurious grounds after a lengthy evaluation period. The Complainants state that during the telephone conversation with the Provider on **19 January 2017**, the Provider suggested the possibility of a fraudulent claim on the basis that the Complainants were unable to travel.

The Complainants state that they had no way of knowing that they would be unable to travel due to the Second Named Complainant's flu-like symptoms. They say that travel was made impossible by the viral pneumonia which was ultimately diagnosed by a doctor after the insurance was in place.

The Complainants request that the Provider admit their claim to cover the cancelled flights and accommodation costs of €1056.15.

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

The Provider states that the Complainants purchased the travel insurance policy on Tuesday **17 January 2017** and cancelled their holiday on Thursday **19 January 2017**.

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The Provider states that on Thursday **19 January 2017**, the First Named Complainant contacted the Provider requesting a claim form as it had become necessary to cancel their trip to Iceland on Friday **20 January 2017** as the Second Named Complainant had woken the previous day (Wednesday) with a sore throat and had taken leave from work. The Provider enquired whether the Second Named Complainant had seen a doctor and advised that the cancellation had to be medically justified. The Provider further queried when the policy was purchased, and advised that due to the proximity of the purchase of the policy and the Complainant's illness, that the claim would have to be investigated.

The Provider issued a Claim Form on **20 January 2017** and received a completed claim form on **9 February 2017**. The Provider emailed the Complainants on **10 February 2017** seeking additional information in order for the Provider to complete its assessment of the claim. The Provider did not receive this additional information and wrote to the Complainants on **20 February 2017**. The Provider received the additional documentation on **2 March 2017**.

On **20 March 2017**, the Provider wrote to the Complainants and advised them that, having completed its assessment of the claim and taking into consideration the terms and conditions of the travel insurance policy, it was declining their claim.

The Provider states that the letter furnished by the Emergency Department to the Second Named Complainant's GP Practice, dated **21 January 2017**, indicates that the Second Named Complainant had been feeling unwell for five days. The Provider states that this dates back to before the date of purchase of the policy on **17 January 2017**.

The Provider was also furnished with the Second Named Complainant's medical records from his GP and these records indicate that when the Second Named Complainant attended his GP on **19 January 2017** he had been suffering flu like symptoms for 4 days, which pre-dates the purchase of the insurance policy. The Provider further states that this contradicts what the First Named Complainant told the Provider on the telephone on **19 January 2017**, which was that the Second Named Complainant had woken the day before, **18 January 2017**, with a sore throat.

The Provider states that as the policy was not purchased until **17 January 2017**, the flu-like symptoms which eventually led to the cancellation of the trip were already in existence when the policy was purchased. The Provider asserts that the illness of "*likely viral pneumonia*" was only diagnosed after the travel date and therefore, the diagnosis was not the reason that the travel was impossible, it was the flu-like symptoms which were already in existence at the time that the policy was purchased.

The Provider appreciates that when the policy was purchased the Complainants may not have known that the Second Named Complainant's symptoms would result in cancellation. However, the Provider states that this does not alter the terms of the policy which does not cover an illness already occurring at the time when the policy is purchased.

The Provider states that in its letter dated **13 April 2017** to the First Named Complainant, it assured the Complainants:

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"…there was no suggestion by the Provider upon initial notification that you purchased insurance for the purposes of a fraudulent claim. Our records show that during the telecommunication on 19/01/2017 it was unearthed that the insurance policy was bought two days previously. We are sure you appreciate that once the claim date and the policy purchase date are in such close proximity the circumstances must be investigated thoroughly as it must be established that the claim was not in existence prior to the policy purchase. It was not suggested that it was your intent to commit fraud and we are sorry if you were left with that impression"

The Complaint for Adjudication

The complaint is that the Provider incorrectly declined the Complainants' claim for travel expenses arising out of the cancellation of their holiday due to the Second Named Complainant's ill health.

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 on 11 April 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 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.

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The First Named Complainant purchased a travel insurance policy, underwritten by the Provider on **17 January 2017**. The Complainants planned to travel on **20 January 2017**, a holiday that the First Named Complainant had booked on **5 January 2017**.

The First Named Complainant cancelled the holiday on 19 January 2017 due to the Second Named Complainant's ill-health and on the advice of his GP that day.

I note from the documentary evidence before me, that the policy terms and conditions state under *'Cancellation and Curtailment Charges'* that:

> *"You are covered for:*
> *Cancellation – the death, Bodily Injury, or Illness of You, Your Travelling Companion, any person with whom You have arranged to reside temporarily during your Trip, Your Close Relative, or Your Close Business Associate…*
>
> *Conditions applicable to cancellation charges:*
> *All claims relating to cancellation due to a medical reason must be supported by relevant documentation confirming that medical advice was sought and that advice was given by a Medical Practitioner to cancel a Trip prior to the cancellation of that Trip…"*

General exclusions apply to the policy state:

> *"No Section of this Policy shall apply in respect of:*
> *a. Claims arising from circumstances known to You at the latter of:*
> - *applying for this insurance or*
> - *at any time prior to the commencement of the Period of Insurance or*
> - *booking Your trip or*
> - *the commencement of any Trip,*
>
> *or claims arising as a result of a material fact or facts, which have not been disclosed to Us prior to the latter of*
> - *the commencement of the Period of Insurance or*
> - *booking Your Trip or*
> - *the commencement of any Trip"*

I note from the medical certificate on the claim form submitted by the Complainants to the Provider, that the Second Named Complainant's GP recommended cancellation of the holiday on **19 January 2017**.

I accept that the Complainants furnished relevant supporting documentation confirming that medical advice was sought and the Second Named Complainant was advised by a GP to cancel the trip, prior to the cancellation of the trip. Furthermore, I accept that the Complainants did not have knowledge of the extent of the Second Named Complainant's illness at the time of purchasing the policy; indeed the Provider states that it accepts that they did not know that the symptoms would result in them cancelling the holiday. However, the Provider points out that the Second Named Complainant was not diagnosed with likely

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viral pneumonia until **21 January**, after the holiday was already cancelled and therefore it is the Provider's submission that it was due to the symptoms being suffered by the Second Named Complainant on **19 January 2017**, that they cancelled the holiday, i.e. those symptoms which were already in existence, on the date of the inception of the policy.

I accept that the symptoms being suffered by the Second Named Complainant were the reason for the cancellation of the holiday, and the evidence confirms that these were present before the inception of the policy of insurance. As a result, the policy general exclusions apply and the Provider was therefore entitled to refuse the Complainants' claim under the policy.

I note that the Complainants are aggrieved that, during a telephone conversation with the Provider on **19 January 2017**, they felt that there was a suggestion of the possibility of a fraudulent claim. Having listened to audio evidence of this telephone conversation, I accept that the Provider was not suggesting that the Complainants purchased insurance for the purpose of making a fraudulent claim, and rather, it was simply advising that due to the proximity of the purchase of the policy, to the date of the illness, that it was the procedure of the Provider to investigate the claim.

For the reasons set out above, I do not consider it reasonable to 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.

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION AND LEGAL SERVICES

9 May 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.