An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0142
Sector:	Insurance
Product / Service:	Travel
Conduct(s) complained of:	Rejection of claim - pre-existing condition
Outcome:	Substantially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint is in respect of a travel insurance policy which was incepted by the Complainants with the Provider on **26 November 2017** in respect of a trip they planned to take on **13 February 2018**.

The Complainants' Case

The Complainants incepted a travel insurance policy with the Provider online on **26 November, 2017**, to cover a trip they had planned to take on **13 February, 2018** (the "Policy").

On **9 February, 2018**, the Complainants called the Provider's claims line to make a claim under the policy which the Complainants submit was to a premium rate number and the call lasted 45 minutes. The Complainants subsequently received a blank claim form to be completed by them by email on the same date.

The claim was based on the Second Complainant's medical advisor's recommendation to cancel the trip as she had contracted a non-resolving respiratory tract infection for which she was hospitalised for 2 days.

The Complainants say that their claim was improperly declined by the Provider. The Provider refused to honour the policy on the basis that the Complainants had failed in their duty of utmost good faith in that they failed to disclose that the Second Complainant had suffered from asthma for a number of years.

The Complainants make a number of points. Firstly, they say that the respiratory tract infection was not a direct or indirect result of the Second Complainant having asthma and the claim should, therefore, not have been declined.

Secondly, they say that the Second Complainant has never been prevented from travelling due to her asthma previously.

Thirdly, they say that they purchased the best available policy so they should have been treated properly by the Provider, rather than receiving a boilerplate refusal letter. They state that the receipt of such a letter within a short period of time shows a policy on the part of the Provider to refuse claims as a matter of routine.

Fourthly, the Complainants state that the First Complainant was required to make a premium rate telephone call to the Provider's claim line which lasted for 45 minutes and cost over £10 GBP. The Complainants state that this was for the sole purpose of increasing revenue for the Provider. The First Complainant thought this call was for the purposes of making the claim and was surprised when he subsequently received a blank claim form by email which he then had to complete with all the information that he had given the Provider over the telephone on the call.

The Complainants accept that, under the terms of the policy, they should have disclosed that the Second Complainant had asthma. On that basis, they suggest that rather than the Provider refusing their claim in its entirety, it ought admit their claim, assess it and reduce the assessed sum by the premium that would have been payable had the Provider been aware of the Second Complainant having asthma.

The Complainants seek compensation in the sum of £2,684.40 GBP, the cost of the trip less the cost of the travel insurance.

The Provider's Case

The Provider argues that it correctly rejected the Complainants' claim under the terms of the policy. Under the '*Important conditions relating to health*' section of the policy, the following is stated:

> '*This insurance is designed to cover **You** for unforeseen events, accidents and **Serious Illness** occurring during the **Period of Insurance**.*
>
> ***You** must comply with the following conditions to have the full protection of **Your** policy.*

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*If **You** do not comply **We** may at **Our** option cancel the policy or refuse to deal with **Your** claim or reduce the amount of any claim payment.*

*It is a condition of this policy that **You** will not be covered under section A – Cancellation or curtailment charges… for any claims arising directly or indirectly from:*

a) At the time of taking out this policy:

i. *Any **Existing Medical Condition** falling into one, two or all three of the following categories unless **You** have contacted **Us** … and **We** have agreed to provide cover.'*

'*Existing Medical Condition*' is defined in the policy as, among other things, a '*respiratory condition (relating to the lungs or breathing)*.'

The Provider notes that the medical documentation provided by the Complainants in support of their claim indicates that the Second Complainant has an existing medical condition of asthma. The Provider submits that the risk of insuring an asthma sufferer is greater than that of a person who does not have asthma. Due to the non-disclosure of this existing medical condition, the Provider was not afforded the opportunity to properly assess the risk and consider increasing the premium.

The Complainants ticked a box in completing the claim form online, confirming they had read the terms and conditions. Those terms and conditions specifically refer to customers understanding the provisions relating to existing medical conditions. There is a link entitled '*further information on existing medical conditions*', which delves into that aspect of the policy in some depth.

On 26 November, 2017, the Complainants signed an insurance declaration in the following terms:

'*I have read and understood the Important Information, in particular relating to Existing Medical Conditions, as set out in the policy document provided to me. I am aware that the policy is a contract of insurance and by purchasing the insurance I am entering into a contract which has terms, conditions, exclusions and limits which I must accept for all persons to be covered by the policy. If the circumstances of anyone insured by this policy changes* [sic.]*, I undertake to contact the location at which I purchased the insurance without delay.*

I will make all other persons insured by this policy immediately aware of this declaration, which applies to each of them, including the parents or guardians of insured persons less than 18 years of age. Where persons less than 18 years of age are insured on this policy I agree to act as an agent for them in relation to any dispute or complaint.'

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Essentially, the Provider argues that the Complainants were fully aware of the terms relating to existing medical conditions and the effect non-disclosure would have on their policy. As a result, the Provider states that it was entitled to cancel the contract.

The Provider submits that the call made by the First Named Complainant to its claim line was longer than usual as a new employee of the Provider took the call who was not as familiar with the system as an experienced member of staff. The Provider submits that the call was not charged at a premium rate but at a local rate, however, the Provider has offered to refund the cost of the call to the Complainants as a gesture of good will.

The Complaint for Adjudication

The complaint is that the Provider wrongly declined the Complainants' claim under the policy of insurance and the cost of the premium rate telephone call which the Complainants were required to make in respect of notifying the Provider of the claim.

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 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.

No additional submissions were received by this Office from the parties.

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Having considered all of the evidence submitted, I set out below my final determination.

Both parties agree that the Second Complainant suffered from an existing medical condition within the meaning of the policy. The Provider submits that the Complainants ticked a box in completing the claim form online, confirming that they had read the terms and conditions which specifically refer to customers understanding the provisions relating to existing medical conditions. These terms and conditions are contained behind a link on the online proposal from beside where the Complainants ticked the box indicating that they had read and understood the terms and conditions. However, there is no indication that the Complainants were required to access the *"terms and conditions"* text through the link before confirming that they had read and understood them and then proceeding to purchase the policy.

In my view, this is not an ideal scenario, however the Complainants do not argue that they were unaware they should have disclosed the fact of the pre-existing condition at the inception of the policy. The parties differ in respect of the effect that this non-disclosure has on the contract of insurance. The Complainants submit that that the respiratory tract infection suffered by the Second Named Complainant was not a direct or indirect result of her diagnosis of asthma and the claim should, therefore, not have been declined.

The policy provides that an insured will not be covered for the cancellation of an insured holiday for '*any claims arising directly or indirectly from …. [a]t the time of taking out this policy …. Any Existing Medical Condition falling into one, two or all three of the following categories unless You have contacted Us … and We have agreed to provide cover.'* (emphasis added). There is no medical evidence made available by either the Provider or the Complainants to suggest that the non-resolving respiratory tract infection arose, whether directly or indirectly, from the Second Complainant having asthma. On this basis, I believe that the Provider should not have declined the claim.

In respect of the premium call, I note that the Provider accepts that this call took longer than it should have due to the fact of a new staff member taking the call. I note that the Provider has offered to reimburse the Complainants for the cost incurred in making this call. On the basis that the Provider is still willing to refund the cost of the telephone call to the Complainants, I intend to make no finding on that issue.

For the reasons outlined above, I substantially uphold this complaint and direct that the Provider admit and pay the claim in the normal manner.

In this regard, I note that the Provider advised this Office by e-mail dated 1 May 2019 that it had written to the Complainants by letter dated 1 May 2019, confirming that it had proceed to implement the proposed direction set out in my Preliminary Decision dated 26 April 2019.

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This is not usual practice. Ideally the provider should await receipt of my Legally Binding Decision before it proceeds to implement any proposed direction.

Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is substantially upheld, on the grounds prescribed in ***Section 60(2) (b) and (f).***

Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to rectify the conduct complained of by admitting and paying the claim in the normal manner to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants 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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

27 May 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.**