An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0180
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant, who resides outside Ireland, holds an International Health Insurance policy with the Provider since **April 2012**.

The Complainant's Case

The Complainant sets out his complaint, as follows:

> *"I am currently insured with* [the Provider] *under* [its] *Global International Health policy – Level 1. I have been insured under this policy since April 2012 when I moved abroad. Prior to this I held a domestic health insurance* [policy] *with* [the Provider] *since I was* [a] *child. I have never had a break in my health insurance policies. I have had a kidney disease since childhood called IGA Nephropathy.* [The Provider] *are aware of this and have settled health claims in the past based on my illness and associated acute episodes of pain …*
>
> *My complaint is regarding* [the Provider]*'s refusal to settle my claim as they do not believe my medical expenses were in relation to an acute episode of pain associated with my medical condition …*

In early January 2017, I suffered an acute episode of joint pain in relation to my kidney disease. On 19th January 2017, I saw a doctor in relation to my acute episode of joint pain and my condition. The doctor examined me, prescribed further medication and requested blood tests and an ultrasound be performed.
The doctor stated that he would not be able to provide routine management of my condition and I would need to see a Nephrologist in this regard. Please note that my Nephrologist is located in Ireland and there is no one in the [Complainant's country of residence] *that can provide me with ongoing care in relation to my kidney disease. Instead, the doctors on* [location] *can only treat any acute episodes I may have in relation to my kidney disease. My* [Provider] *policy covers me for Acute Episode for Chronic Medical Condition coverage up to EUR 10,000.* [The Provider] *have settled my previous claim based on my acute episode of joint pain …*

On 6th February 2017, I submitted a claim form to [the Provider]*, along with receipts and a medical report completed by my doctor, in respect of all the medical expenses I had incurred in relation to this episode. The invoices gave breakdowns of all tests required and the medical report completed by the doctor stated that the medical condition requiring treatment was IGA Nephropathy and acute joint pain. The total claim amounted to* [amount].

On 20th February 2017, [the Provider] *sent an email stating they would need a medical report from my doctor in order to assess the claim.* [The Provider] *and I went back and forth on this request. Based on my policy and terms and conditions I had provided all information necessary for* [the Provider] *to process my claim and I highlighted the following to* [the Provider]*: - Nowhere in my policy does it state that a separate medical report is required for every claim I made in relation to any Acute Episode for Chronic Medical Condition I may suffer; Section C of the claim form is essentially a medical report which my doctor completed; Section F of the claim form allows* [the Provider] *to contact my doctor directly for further information.*

It took [the Provider] *until 5th April 2017 to confirm what it is they require a medical report to state (which essentially replicates some questions in the current claim form) …It was evident that* [the Provider] *would refuse the claim at this stage as they usually make the claims process extremely difficult …*

On 10th May 2017, [the Provider] *provided a letter in which they refused to settle my claim as they determined that it was not in relation to an acute episode of joint pain and was in fact a routine visit based on the doctor's report they requested. Please also note…where* [the Provider] *refuse me under the acute episode cover,* [the Provider] *will not even cover me under outpatient GP expenses of EUR 500 …*

I'm extremely frustrated with [the Provider] *over this whole process for the following reasons:*

- *Based on the policy, I'm entitled to be refunded for the medical expenses up to EUR 10,000 incurred in respect to acute episodes associated with my medical condition. My claim was based on medical expenses associated with*

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my acute joint pain I suffered in January 2017. However, [the Provider] *have determined that I did not suffer acute joint pain. My visit to the doctor was due to an acute episode which was discussed with the doctor.*
In addition, the doctor refuses to provide me with ongoing care/treatment as he is not a Nephrologist. Therefore, it's impossible for [the Provider] *to determine that this was a routine visit. My Nephrologist is located in Ireland from whom I receive ongoing care which* [the Provider] *do not cover.*

- [The Provider] *stipulate that a claim form must be completed and submitted along with receipts for all claims. This claim form includes a medical report section that was completed, signed and stamped by doctor. Yet* [the Provider] *would not accept this claim form and proceeded to seek a separate medical report which they mentioned should be sent along with my claim form. The terms and conditions of my policy don't stipulate that I need to submit a medical report along with the claim form.*

- *It took* [the Provider] *until 5th April 2017 to confirm what* [it] *is they require a medical report to state. In fact some of what they require is stated in the claim form and is general information/knowledge that the* [Provider's] *medical assessors should possess.* [The Provider] *should update their claim form for acute episode claims in order to ask all relevant questions at the time of the appointment. It's not acceptable to delay a claim and then approach a doctor 3 months later to ask questions in relation to a doctor's appointment.*

- [The Provider] *consistently drag out the claims process for every claim I submit.*

- *In addition,* [the Provider] *refuse to reimburse anything associated with my kidney disease under the outpatient GP expenses of EUR 500 where they refuse to settle expenses under the acute episode claim"*.

As a result, the Complainant seeks for the Provider *"to settle and reimburse us for all medical expenses in relation to this acute episode given that we are entitled to this under the terms of the policy. The total amount to be refunded is* [amount]*"* (approximately €971).

The Provider's Case

The Complainant, who resides outside Ireland, holds an International Health Insurance policy with the Provider. Provider records indicate that the Complainant completed a Medical Expenses Claim Form on 6 February 2017 in respect of the following medical expenses:

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Date of Treatment	Details of Expense	Currency	Amount
19-Jan-17	Consultant Visit	**	200
31-Jan-17	Medication	**	143.25
03-Feb-17	Lab Tests & Ultrasound	**	564.38

The treating doctor, Dr J. advised in Section C of this Medical Expenses Claim Form that the Complainant attended on 19 January 2017 in relation to his *"20yr hx IgA Nephropathy – Symptomatic presently joints"*. As a result, the Provider accepts that these medical expenses relate to the Complainant's chronic medical condition, that is, IgA nephropathy.

In this regard, the Complainant's policy does not provide cover for the routine management of a chronic medical condition, rather it only provides cover for acute episodes of a chronic medical condition, which at pg. 7 of the applicable International Health Insurance Policy Booklet is defined as,

> *"An event or incident of rapid onset resulting in severe pain or symptoms which is of brief duration that it likely to respond quickly to Medical Treatment to stabilise a Chronic Medical Condition"*.

In order to determine if the medical expenses being claimed for by the Complainant related to an acute episode of his chronic medical condition, the Provider required a detailed medical report from the treating doctor.

The Provider notes that in many cases the completion of Section C of the Medical Expenses Claim Form by the treating doctor in question, along with the medical receipts, will provide sufficient information to assess the claim at hand, however there are times where it needs to obtain or request further medical information in order to fully assess claims. The Provider submits that this is reasonable and in line with general insurance procedures, and that it is for the insured to demonstrate that he or she has a valid claim under the terms of the policy. In this instance, it is for the Complainant to demonstrate that his medical expenses claim falls under the cover provided by his policy, for acute episodes of chronic conditions.

In addition, the Provider is satisfied that it previously advised the Complainant in 2015 that future claims relating to his chronic medical condition would need to be accompanied by a separate medical report. In this regard, in its email to the Complainant dated **24 July 2015**, the Provider advised, *inter alia*, as follows:

> *"We received claim…from you dated 2 April 2015, this claim was assessed and as all treatment received was on an out patient basis the maximum out patient benefit of €500 was allowed. It was noted that* [Dr H.] *listed 3 ICD9 codes and stated that the treatment was as a result of "likely exacerbation IgA nephropathy triggered by UTI/prostatitis"*.
>
> *This Section C was reviewed by our medical team and a letter was sent to you advising that IgA nephropathy was considered a "chronic" medical condition within the terms*

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of your contract of insurance. Whilst it is noted that you have previously submitted a claim for treatment, no medical information was submitted in support of that claim to allow such a review and we had not previously deemed this condition to be "chronic" and therefore to be assessed within this benefit limit.

As the treatment was received prior to the submission of medical information and the application of the Chronic benefit limit, the claim was settled from the out patient benefit. This was appealed and in order to allow a further review and ascertain if this treatment was as a result of an acute episode of the IgA nephropathy as opposed to the UTI or prostatitis, we were directed by our Chief Medical Officer to obtain a medical report.

However, we note that you are unhappy with the request to submit this report and in an effort to resolve the matter, we wish to consider the remaining submitted costs as set out in your claim dated 2 April 2015 from the Chronic benefit limit. Please note however, that any future claim must be accompanied by a detailed medical report".

In addition, in its correspondence to the Complainant dated **6 November 2015**, the Provider advised, *inter alia*, as follows:

"Please be advised that as your medical condition IgA nephropathy is deemed as a chronic medical condition under your policy, all future claims can only be considered for treatment resulting from an acute episode only. We wish to advise that we are unable to fully assess future claims until we have received sufficient medical information from your treating doctor which supports that the treatment is as a result of an acute episode. We would advise that you provide a medical report from your treating doctor to enable us to fully assess against the benefits provided under your policy".

The Provider notes that the Complainant has continued to renew his policy in the knowledge that a detailed medical report would be required when making any future claims relating to his chronic medical condition.

The Complainant did not however, include a detailed medical report with his Medical Expenses Claim Form on **6 February 2017**. As a result, the Provider emailed the Complainant on 20 February 2017 asking him to provide a full medical report from his treating doctor. The Complainant emailed on 21 February 2017 seeking further clarification and the Provider responded by way of email on 24 February 2017, as follows:

"We have reviewed your file and confirm that on the 6th of November 2015 a letter was issued to you which stated that we would be unable to fully assess future claims in relation to this medical condition without sufficient medical information from your treating doctor to support that the expenses being claimed were incurred as a result of an Acute Episode of this Chronic Medical Condition. We advised that you provide a medical report from the treating doctor to enable us to fully assess the claim against the benefits provided by the policy. I attach a copy of this letter.

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Our chief medical officer has reviewed the information provided on section C of the claim form and has advised that it was insufficient to assess whether this was an Acute Episode and requested that we obtain a full medical report confirming what the cause of the joint pain is thought to be.

We do not request medical reports for every claim submitted. Reports are only requested when required to fully assess whether a claim falls within the terms and conditions of the policy held. It is stated in the terms and conditions of the policy that you must provide us with a written statement substantiating your claim together with (at your own expense) any documentary evidence, information, certificates, receipts and such like that we require".

The Provider is satisfied that this email was clear as to what information needed to be provided, and the reasons why. The Provider notes that the Complainant sent a further email on 27 February 2017 (and a reminder email on 24 March 2017) that the Provider failed to respond to until 5 April 2017, as follows:

"Please accept my apologies for the delay in the assessment of your claim.

Your claim was referred again to our chief medical officer who has advised that the information provided on section C of the claim form is not sufficient to determine cover under the terms and conditions of the policy.

Your medical condition was deemed to be a chronic medical condition in 2015. As you hold a level 1 policy you have cover for Acute Episodes of this medical condition only. Routine management of the condition would not be covered. In order to validate the claim we require a full medical report regarding the precise nature of the symptoms experienced including the date of onset and duration, the underlying cause of the symptoms, all investigations and treatment carried out to alleviate those symptoms and the future prognosis.

We have requested this information directly from your treating doctor and will await a response from him".

Regardless of the delay in responding, the Provider is satisfied that it advised the Complainant three days after his email of 21 February 2017, that is, on 24 February 2017, of what information was required, and the reasons why.

The Provider notes that the Complainant was dissatisfied that he himself was being asked by the Provider to provide a medical report from his treating doctor as Section F of the Medical Expenses Claim Form gave the Provider the authority to contact the treating doctor itself, if needed. Be that as it may, the Provider does not consider its request for the Complainant to obtain a medical report from his treating doctor, to have been unreasonable, particularly as it had previously advised the Complainant in writing in 2015 that he would need to provide a full medical report in the event of any future claims relating to his chronic medical condition.

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In any event, in order to progress matters and as advised in its email to the Complainant dated 5 April 2017, the Provider did itself then request a full medical report directly from the Complainant's treating doctor.

The Provider received this Medical Report from the Complainant's treating doctor, Dr J. on 18 April 2017. The Provider notes that there is nothing in this Report of his attendance with Dr J. on 19 January 2017, to suggest that any of the medical expenses incurred by the Complainant were to resolve severe pain or symptoms of a brief duration. In this regard, the Complainant's policy only provides cover for acute episodes of a chronic medical condition, which at pg. 7 of the applicable International Health Insurance Policy Booklet is defined as:-

> *"An event or incident of rapid onset resulting in severe pain or symptoms which is of brief duration that it likely to respond quickly to Medical Treatment to stabilise a Chronic Medical Condition"*.

Whilst Dr J. did write *"20yr hx IgA Nephropathy – Symptomatic presently joints"* in Section C of the Medical Claims Expenses Form, the Provider notes that his Medical Report makes no mention of any joint pains and states, *"Basically* [the Complainant] *is here to get new labs and check on his kidneys".* Regardless of whether these were recommended by Dr J. or requested by the Complainant, the Provider notes that an ultrasound and blood tests (Lipid Profile and complete blood count) would not stabilise an acute episode of a chronic condition. In addition, the medication prescribed by Dr J. on 19 January 2017 was not purchased by the Complainant until nearly two weeks later, on 31 January 2017, which the Provider submits is not consistent with an acute episode. Furthermore, Dr J. advised by email dated 21 April 2017 that he prescribed this medication, as the Complainant had been put on it previously by a different doctor, which the Provider therefore considers to have been a renewal of a prescription of medication that the Complainant was already on.

For these reasons, the Provider concluded that the Complainant's medical expenses were not in respect of a contemporaneous acute episode of pain of his chronic medical condition but rather was for the general or routine management of his condition. The Provider notified the Complainant by email on 24 April 2017, of its decision to decline his medical expenses claim, however it sent this email to a second email address that it held on file for the Complainant and which was no longer valid and has since been removed from his record. As a result, the Provider notified the Complainant in writing on 10 May 2017, as follows:

> *"Please note that your claim and documentation has now been fully reviewed, we apologise for the delay in getting back to you and appreciate your patience.*
>
> *Unfortunately we are unable to pay your claim in this instance. As you have been aware, we needed to confirm if this was an Acute episode which resulted in you visiting your doctor.*
> *We have reviewed the full medical report which your treating doctor provided us with and this report indicates that the visit was not related to joint pains and was a routine review.*

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> *As you* [are] *aware, we can only cover Acute episodes of this particular condition. Therefore, we are unable to make any payment on this occasion. We understand this will come as a disappointment to you, however we can only cover expenses which fall under the scope of your policy"*.

The Complainant considers that his medical expenses claim should then have been assessed as out-patient expenses. The Provider notes, however, that the terms of the Complainant's policy, clearly provide that all and any treatment and services for an eligible chronic medical condition will be assessed under Section K, **'Chronic Medical Conditions'**, and that this benefit overrides all other sections and financial limits within this policy, including out-patient cover. In addition, the policy also excludes cover for preventative treatments, medicines and routine check-ups, including preventative examinations and diagnostics.

The Provider is satisfied that it has fairly and correctly assessed the Complainant's medical expenses claim and that the medical information and reports made available from his treating doctor indicate that the costs incurred were in respect of the management of the Complainant's chronic medical condition, rather than to treat an acute episode of that condition and consequently, the costs incurred do not fall within the cover provided by his policy. In addition, with regard to its request for the Complainant to obtain a medical report from his treating doctor, the Provider previously advised the Complainant in writing after his last such medical expenses claim in 2015 that he would need to provide a full medical report in the event of any future claims relating to his chronic medical condition.

Accordingly, the Provider is satisfied that it declined the Complainant's medical expenses claim in accordance with the terms and conditions of his International Health Insurance policy.

The Complaint for Adjudication

The Complainant's complaint is that the Provider wrongly and unfairly declined the Complainant's health insurance 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 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.

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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 28 May 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.

Following the consideration of additional submissions from the parties, the final determination of this office is set out below.

The complaint at hand is that the Provider wrongly and unfairly declined the Complainant's health insurance claim.

The Complainant, who resides outside Ireland, holds an International Health Insurance policy with the Provider and submits, *inter alia*, as follows:

> *"I have had a kidney disease since childhood called IGA Nephropathy.* [The Provider] *are aware of this and have settled health claims in the past based on my illness and associated acute episodes of pain …*
>
> *My complaint is regarding* [the Provider]*'s refusal to settle my claim as they do not believe my medical expenses were in relation to an acute episode of pain associated with my medical condition"*.

The Complainant has had IgA nephropathy for over 20 years and states that he is very familiar with the acute episodes and flare-ups of pain associated with his condition. He states that he had three acute episodes of pain associated with his medical condition in **December 2016** but that due to a shortage of doctors in the [location] at that time, he did not get to see a doctor until **19 January 2017**. The Complainant therefore submits that the medical costs he then incurred on 19 January, 31 January and 3 February 2017 were a direct result of the acute episodes of pain associated with his medical condition that he suffered in December 2016 and should be covered by his policy.

In this regard, the Complainant completed a Medical Expenses Claim Form on **6 February 2017** in respect of the following medical expenses:

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Date of Treatment	Details of Expense	Currency	Amount
19-Jan-17	Consultant Visit	**	200
31-Jan-17	Medication	**	143.25
03-Feb-17	Lab Tests & Ultrasound	**	564.38

The treating doctor, Dr J. wrote in Section C of this Medical Expenses Claim Form that the Complainant had attended on 19 January 2017 in relation to his *"20yr hx IgA Nephropathy – Symptomatic presently joints"*.

I note from the documentary evidence before me that the Provider had previously advised the Complainant in 2015 that his diagnosis of IgA nephropathy was considered a chronic medical condition within the terms of his health insurance policy. In this regard, Part 4, 'Words and phrases used in this Policy', of the applicable International Health Insurance Policy Booklet provides, *inter alia*, at pgs. 6-9, as follows:

> *"**Chronic Medical Condition***
> *A Medical Condition which has two or more of the following characteristics:*
> - *It has no known recognised cure*
> - *It continues indefinitely*
> - *It has come back*
> - *It is permanent*
> - *Requires Palliative Treatment*
> - *Requires long-term monitoring, consultations, check-ups, examinations or tests*
> - *You need to be rehabilitated or specially trained to cope with it.*
>
> ***Chronic Medical Condition – Acute Episode***
> *An event or incident of rapid onset resulting in severe pain or symptoms which is of brief duration that it likely to respond quickly to Medical Treatment to stabilise a Chronic Medical Condition …*
>
> ***Medical Treatment***
> *The provision of recognised medical and surgical procedures and healthcare services which are administered on the order of and under the direction of a Physician for the purposes of curing a Medical Condition, Bodily Injury or Illness or to provide relief of a Chronic Medical Condition"*.

In addition, Part 5, 'What is covered and what is not covered', of this Policy Booklet provides, *inter alia*, at pg. 13, as follows

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*"**Section 2 – Medical and Hospital Benefits***

What is covered …

k) Chronic Medical Conditions – Where a Medical Condition is deemed to be Chronic, the maximum benefit We will pay for all and any Medical Treatment covered by this Policy for each Chronic Medical Condition is limited to:

- *The Acute Episodes of a Chronic Medical Condition on Level 1*
- *The Acute Episodes of a Chronic Medical Condition including routine management and Palliative Treatment on Levels 2 and 3"*

***Please Note:** All and any treatment and services for an eligible Chronic Medical Condition will be assessed under this benefit and as such this benefit overrides all other Sections and financial limits within this Policy"*.

As the Complainant's health insurance policy with the Provider is the International Health Insurance - Level 1, I am satisfied that the scope of cover in respect of his chronic medical condition extends only to acute episodes of that chronic medical condition, in accordance with the policy terms and conditions.

In order for the Provider to then determine whether the medical expenses being claimed for related to an acute episode of the Complainant's chronic medical condition, it obtained a medical report from his treating doctor, Dr J. on 18 April 2017, which advised, *inter alia*, as follows:

"This patient is a generally healthy gentleman who some 20 years ago was diagnosed with IGA nephropathy. He has done well and is presently on allopurinol 300 mg a day, RA MIP RIL 10 mg daily. And says he takes a.m. LO DIP I and the when necessary for blood pressure area. Blood pressure today is 127/88. His urine shows 100 of protein small blood specific gravity of 1.020 he denies any symptoms whatsoever. Physical exam abdomen soft nontender without masses …

Basically is here to get new labs and check on his kidneys. I indicated to him and his wife not a nephrologist would be happy over the basic labs and also an ultrasound of his kidneys. He is previously been biopsied in Ireland to make the diagnosis. Assessment 23 and bilateral ultrasounds CBC have been ordered this any abnormalities then we would probably refer him to University of [X] *nephrology. Apparently his last laboratory exams were approximately a year ago but there were done in Ireland the R of the labs from prior to that which shows some mild renal dysfunction … Depression is history of IgA nephropathy.*

He has not been placed on steroids in the past and was told by his physician in Ireland that he is stable from a renal standpoint. He is going to have the ultrasounds and labs done and will call me next Friday for reports and we would give him a copy of all".

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I am satisfied that it was reasonable for the Provider to conclude that there was nothing in the contents of this report to suggest that the Complainant's attendance with Dr J. on 19 January 2017 was due to a contemporaneous acute episode of his chronic medical condition, as defined in the policy terms and conditions.
I note that in his email to this Office dated 30 October 2018, the Complainant submits, *inter alia*, as follows:

> *"*[The Provider] *seem to be disregarding the fact that on the original medical report my doctor clearly states that I had been experiencing joint pain. I have always stated that I was not experiencing joint pain at the time but had several episodes prior"*.

In this regard, while Dr J. did write *"20yr hx IgA Nephropathy – Symptomatic presently joints"* in Section C of the Medical Claims Expenses Form, I note that in his subsequent detailed report he makes no mention of any joint pains but instead states, *"Basically* [the Complainant] *is here to get new labs and check on his kidneys"*.

Furthermore, the Complainant himself confirms in his email to this Office dated 30 October 2018 that he was not at the time of his consultation with Dr J. on 19 January 2017 suffering from an acute episode of his chronic medical condition.

Whilst the Complainant submits *"I was not experiencing joint pain at the time but had several episodes prior"*, his policy only provides cover for "*an event or incident of rapid onset resulting in severe pain or symptoms which is of brief duration that it likely to respond quickly to Medical Treatment to stabilise a Chronic Medical Condition*".

I am satisfied that there is no evidence before me to indicate that the Complainant had attended Dr J. on 19 January 2017 to stabilise an acute episode of a chronic condition, as required by the policy terms and conditions, nor it seems, would an ultrasound and blood tests stabilise any such acute episode of a chronic condition. As a result, I am satisfied that it was reasonable for the Provider to conclude that the medical expenses being claimed for by the Complainant did not arise from a contemporaneous acute episode of his chronic medical condition, as defined in the policy terms and conditions.

I note the Complainant submits that the Provider should then have considered his medical expenses under the out-patient cover provided by his policy. In this regard, Part 5, 'What is covered and what is not covered', of the applicable Policy Booklet provides, *inter alia*, at pg. 13, as follows:

> *"**Section 2 – Medical and Hospital Benefits***
>
> ***What is covered …***
>
> *k) Chronic Medical Conditions – Where a Medical Condition is deemed to be Chronic, the maximum benefit We will pay for all and any Medical Treatment covered by this policy for each Chronic Medical Condition is limited to:*

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- *The Acute episodes of a Chronic Medical Condition on Level 1*
- *The Acute episodes of a Chronic Medical Condition including routine management and Palliative Treatment on Levels 2 and 3*

> ***Please Note:*** *All and any treatment and services for an eligible Chronic Medical Condition will be assessed under this benefit and as such* ***this benefit overrides all other Sections and financial limits within this Policy".***

[my emphasis]

The Complainant attended Dr J. on 19 January 2017 regarding his chronic medical condition, IgA Nephropathy. In accordance with the terms and conditions of his policy, I am satisfied that any medical expenses related to his chronic medical condition can only be assessed under the section of his policy that provides cover for chronic medical conditions and thus cannot be assessed under any other heading of cover, including out-patient cover.

I note that the Complainant also complains that he was asked by the Provider to obtain a medical report from his treating doctor, yet Section F of the Medical Expenses Claim Form gave the Provider the authority to contact the treating doctor itself, if needed. In this regard, the Complainant submits, *inter alia*, as follows:

> *"*[The Provider] *stipulate that a claim form must be completed and submitted along with receipts for all claims. This claim form includes a medical report section that was completed, signed and stamped by doctor. Yet* [the Provider] *would not accept this claim form and proceeded to seek a separate medical report which they mentioned should be sent along with my claim form. The terms and conditions of my policy don't stipulate that I need to submit a medical report along with the claim form.*
>
> *It took* [the Provider] *until 5th April 2017 to confirm what* [it] *is they require a medical report to state…*[The Provider] *should update their claim form for acute episode claims in order to ask all relevant questions at the time of the appointment"*.

Similarly, in her email to this Office dated 10 October 2018, the Complainant's Representative submits, *inter alia*, as follows:

> *"*[The Provider] *was unable previously to clarify what exactly they needed stated in a medical report. Our understanding is the claim form asked the relevant questions that* [the Provider] *needed to assess the claim.*
> *If their claim form doesn't ask the appropriate questions then it is up to* [the Provider] *to amend this document or provide proper guidance to customers as to what is required"*.

I note, however, from the documentary evidence before me that in its email dated **24 July 2015**, the Provider previously advised the Complainant, as follows:

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> *"Please note however, that any future claim must be accompanied by a detailed medical report"*.

In addition, in its correspondence to the Complainant dated **6 November 2015**, I note that the Provider advised, as follows:

> *"Please be advised that as your medical condition IgA nephropathy is deemed as a chronic medical condition under your policy, all future claims can only be considered for treatment resulting from an acute episode only. We wish to advise that we are unable to fully assess future claims until we have received sufficient medical information from your treating doctor which supports that the treatment is as a result of an acute episode. We would advise that you provide a medical report from your treating doctor to enable us to fully assess against the benefits provided under your policy".*

I am thus satisfied from the documentary evidence before me that in 2015 the Provider had clearly advised the Complainant in writing that future claims relating to his chronic medical condition would need to be accompanied by a medical report.

I note that the Complainant did not include a medical report with his Medical Expenses Claim Form on 6 February 2017. As a result, the Provider emailed the Complainant on 20 February 2017 asking him to provide a full medical report from his treating doctor. The Complainant emailed on 21 February 2017 seeking further clarification and the Provider responded by way of email on 24 February 2017, as follows:

> *"Our chief medical officer has reviewed the information provided on section C of the claim form and has advised that it was insufficient to assess whether this was an Acute Episode and requested that we obtain a full medical report confirming what the cause of the joint pain is thought to be.*
>
> *We do not request medical reports for every claim submitted. Reports are only requested when required to fully assess whether a claim falls within the terms and conditions of the policy held."*.

Whilst the Complainant submits that the Provider took *"until 5th April 2017 to confirm what* [it] *is they require a medical report to state"*, I am satisfied from the documentary evidence before me that the Provider advised the Complainant in its email on 24 February 2017 that it required *"a full medical report confirming what the cause of the joint pain is thought to be"*.

In addition, the Complainant complains that he was asked by the Provider to obtain a medical report from his treating doctor, yet Section F of the Medical Expenses Claim Form gave the Provider the authority to contact the treating doctor itself, if needed. In this regard, given that in 2015 the Provider had clearly advised the Complainant in writing, that future claims relating to his chronic medical condition would need to be accompanied by a separate medical report, I do not consider the Provider's request for the Complainant to obtain a medical report from his treating doctor, to have been unreasonable.

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As with all insurance claims, it is a matter for the policyholder to demonstrate that he or she has a valid claim and it is an insurance industry standard that an insurer may request additional information relating to and clarifying the claim circumstances, in order to fairly and fully assess a claim. Given the wide variety of medical expenses claims that can occur, it is neither practical nor possible for any insurer to tailor a claim form for every eventuality; there will always be circumstances where additional information may need to be sought.

As the evidence before me discloses no wrongdoing on the part of the Provider, it is my Decision therefore that the complaint cannot be upheld.

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

28 June 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.