An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0242
Sector:	Insurance
Product / Service:	Travel
Conduct(s) complained of:	Rejection of claim - pre-existing condition
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint arises out of a travel insurance policy and relates to the Provider's refusal to indemnify the Complainant under the policy.

The Complainant's Case

The Complainant took out a travel insurance policy with the Provider. While he was on holiday in 2016, he began experiencing a sudden onset of pain in his leg. He explains that the pain had become so unbearable that he was reduced to tears and his wife telephoned the Provider's claims line which advised that the Complainant attend at the Heart of Florida Medical Centre. The Complainant states that the Medical Centre's report states that he presented with acute left leg pain and was diagnosed with sciatica. The Complainant explains that the pain and symptoms were unlike anything he had experienced before and it was documented in the report. The Complainant states that it was an acute episode.

The Complainant explained that when he returned from his holiday, he completed the claim documentation in a timely manner. He states that he had wrongly assumed that the claim had been settled but it was very distressing for him to receive an invoice in November 2017 from Global Recovery Alliance in the amount of $5,381.06. The Complainant states that the

Provider has refused to indemnify the Complainant for his claim on the basis that he did not disclose an existing medical condition at the time of incepting the policy.

The Complainant is unhappy with the Company's decision and has submitted that the policy in question should cover the loss suffered. The complaint is that the Company refused to fully indemnify the Complainant for the loss in question. He is seeking that the claim be paid.

The Provider's Case

The Provider submits that the Complainant failed to disclose a pre-existing medical condition of long-standing and recurring hip/low back pain and osteoarthritis of the hip. It states that common complaints of patients with these conditions are pain in the groin or outside the hip, pain in the buttock and or pain in the lower back. The Provider submits that had the Complainant disclosed the pre-existing medical condition correctly, the insurance product that he availed of would not have been offered to him as this product does not cover any pre-existing medical conditions.

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 23 July 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 issue of my Preliminary Decision, the Complainant made a further submission by e-mail to this Office dated 27 July 2019, in which he points out that an incorrect date was

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quoted in the Preliminary Decision relating to the Complainant's wife's telephone call to the Provider prior to the Complainant going to the medical centre in Florida. I note that the correct date should have read ***16 June 2016***. A copy of that submission was transmitted to the Provider for its consideration. The Provider has not made a further submission.

Having considered the Complainant's further submission, I set our below my final determination.

I have been provided with a copy of the terms and conditions of the applicable travel insurance policy which includes the following:

Conditions

- *It is essential that you read and understand the important conditions relating to health section within this wording, as we do not cover pre-existing medical conditions.*

In that regard, the section of the policy entitled "*Important conditions Relating to health*" which provides, among other things, as follows:

This insurance is designed to cover you for unforeseen events, accidents and serious illnesses occurring during the period of insurance.

You must comply with the following conditions to have the full protection of your policy.

It is essential that you read and understand the important conditions relating to health section of your policy.

If after reading the important conditions relating to health section, you decide that this policy does not meet your requirements, please refer to the general conditions applicable to the whole policy section and your entitlement to obtain a refund of the premium.

It is a condition of this policy that you will not be covered under Section A - Cancellation or Curtailment, Section B – Emergency medical and other expenses or Section C – Personal accident for any claims arising directly or indirectly from:

1. Any medical condition(s) which in the past two years:

1.1 you have suffered from; or
1.2 you have received a consultation(s) or investigation(s) on; or
1.3 you have had or are receiving treatment for; or
1.4 you have been prescribed medication.

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Following the claim having been submitted, the Provider sought the Complainant's medical records and received a completed medical history form from the Complainant's general practitioner, Dr A.T. Those records indicate that the Complainant has been receiving anti-inflammatory medication since 2014 and from 2014 to 2016, had a history of bilateral hip pain and low back pain.

Dr A.T. also confirmed that her records contain a past or present history of musculoskeletal disease in the form of low back pain and bilateral hip pain with osteoarthritis in both hips.

I note that the Complainant asserts and that he did not consider that he was suffering from a pre-existing medical condition and therefore did not declare it. However, Dr A.T. was asked whether the Complainant was aware of the above conditions. She replied that he was.

I have examined carefully the screenshots provided from the website which was utilised to take out this policy. The website provided express links for people with pre-existing medical conditions. In addition, the website asks the customer to:

> *"please confirm you have read this **important information** which includes information relating to pre-existing medical conditions and agreed to proceed. You must tell your insurer about pre-existing medical conditions relating to everyone named in the policy, by not declaring these conditions this could lead to your policy being invalid."*

There is a link to the "*important information*" which expressly states, among other things, that:

> *"It is a condition of this policy that you will not be covered for any claims arising directly or indirectly from:*
>
> *1. Any medical condition which in the past two years:*
>
> *1.1 you have suffered from; or*
> *1.2 you have received a consultation(s) or investigation(s) on; or*
> *1.3 you have had or are receiving treatment for; or*
> *1.4 you have been prescribed medication."*

This is not a case where examination of the terms and conditions of the policy suggests that indemnity would otherwise have been provided but for the non-disclosure of a material fact. In this case terms and conditions of the policy are clear in stating that pre-existing medical conditions are not covered.

I note from the material submitted to this Office that the Complainant, "*did not feel that my visits to the GP were relevant*." I further note his observation that, "*it was never my understanding that I had a 'condition' as no diagnosis had ever been given*."

The medical records submitted to this Office detail visits to his GP on seven separate occasions for a 'history of bilateral hip pain and low back pain from 2014 – 2016'. He had

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been diagnosed with 'Osteoarthritis in both hips' according to the medical history provided by his GP, a condition which is specifically referred to in three of the seven visits. The GP also mentions that the Complainant had experienced symptoms for 'last few 12+ years'. This is hard to reconcile with his belief that he did not have a pre-existing medical condition.

I note the medical reports from the Heart of Florida medical centre which diagnosed sciatica. However, the submission for CEGA Assistance states his, "Back pain was muscular in nature, whereas the issue he suffered in America was a neurological / spinal problem.

Therefore the incidents cannot be directly related, but there is an indirect link with the prior muscular problems making the neurological issues more likely to occur." This supports the Provider's view that there is at least an indirect link between his previous medical issues and what occurred while on holiday.

It is well established that the test of materiality for the purpose of non-disclosure in insurance law is that *every circumstance is material which would influence the judgment of a prudent insurer in fixing the premium or determining whether he would take the risk.* Therefore, the test of materiality is generally objective, and a fact is material if it would have reasonably affected the mind of a prudent insurer in determining whether he will accept the insurance and if so, at what premium and on what conditions.

It is clear from the terms and conditions of this policy, and the submissions made by the Provider, that if a pre-existing condition had been disclosed, cover would not have been offered by this underwriter.

I accept that the Provider was entitled to reject the claim on the basis of non-disclosure of the pre-existing medical condition.

I do however have a concern, with the information provided to the Complainant's wife when she telephoned the Provider's agent (on **16 June 2016**) prior to the Complainant going to the medical centre in Florida. A recording of the telephone call was provided in evidence.

I have listened to the telephone conversation between the Provider's agent and the Complainant's wife on 16 June 2016. The conversation begins with the Complainant's wife saying, "*He has done something to his leg. He describes it like sciatica pain….. a lot of pain…..hasn't had a fall, just come on, really*." The agent replies, "*If he is in pain, needs to go a medical facility. I will take some details and open a claim."*

The agent does not raise the possibility that the claim may not be paid by the Provider during the course of the telephone call, nor does he give a guarantee that the Provider will meet any or all costs. He does say, "*We use a third party called [name of company] ….I am going to send you a form: it's called a HIPAA consent form. That allows them to give us information from today's visit. I will send you an e-mail with the consent form. If you can sign it and give to the hospital where you go? On the e-mail I will include our US billing agent because they won't accept any insurance payments unless they go through a local agent. [Name of company] are actually based in Florida. If you give them their address, that will be fine. I*

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will drop them a quick e-mail as well. If you can give us a call back after he has been seen and treated that would be much appreciated."

The agent does discuss the issue of the policy excess of GBP 190 and informs the caller that she, "*will need to pay the first GBP 190 , in the US it's called a deductible. They will ask you at some point what it is and if you know it: it's GBP190."*

There is no doubt that the Provider's agent was very helpful, courteous and pleasant throughout the phone call. However, at no stage did he raise the possibility that the claim might not be paid. Therefore, I think it could have led the Complainant and his wife to believe it would be paid. I believe it would have been prudent and helpful if the Provider's agent had told the Complainant's wife on that call that the claim would be processed in accordance with the Terms and Conditions and that, therefore, there was a risk that they may have to pay the expenditure they were about to commit to, themselves. I believe at the very least, the Provider's agent should have informed the Complainant that the fact that he was 'opening up a claim,' did not mean the claim would in fact be paid. Because this information was not provided, I partially uphold this complaint and direct the Provider to pay a sum of GBP 500 to the Complainant.

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Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially 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 GBP 500, 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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

12 August 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.