An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0297
Sector:	Insurance
Product / Service:	Travel
Conduct(s) complained of:	Rejection of claim - cancellation
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint concerns the Complainants' travel insurance policy with the Provider, incepted on **27 February 2016**. The second Complainant is the policyholder, and both Complainants were insured under the policy.

The Complainants' Case

The first Complainant submits that in or about **November 2015** he was prescribed medication by his General Practitioner (GP) for pain and soreness of his right wrist. On **22 February 2016** he attended his GP with a sudden bout of illness, involving *'severe vomiting'* whilst on a sporting holiday. The first Complainant indicated to his GP that he had also been experiencing indigestion type discomfort and enquired as to whether this might be a possible side-effect of the medication he was taking in respect of his wrist.

The first Complainant submits that, at this time, his GP carried out an ECG and advised him that while there did not appear to be any *'major heart issues'*, he was going to refer him for a '*routine standard ECG with a treadmill test'*, in order to rule out the possibility of angina. The first Complainant submits that he was assured by his GP that there was nothing to be concerned about.

The first Complainant submits that he and his wife booked a holiday *'a few days later'* with intended travel dates **28 May 2016** to **04 June 2016** and they were unaware of any potential

medical issues. The first Complainant submits that he also incepted the travel insurance policy at this time.

The first Complainant submits that after undergoing the ECG treadmill test, on **18 April 2016**, he was advised that an angiogram would be required. The first Complainant submits that he and his wife specifically asked the specialist whether their upcoming holiday would be placed in jeopardy and were advised by the specialist *"absolutely not"*.

The first Complainant submits that an angiogram was carried out on **21 April 2016**, the results disclosed the need for a *'severe medical procedure and the need to cancel the holiday'.* On foot of the cancelation of the holiday on **29 April 2016**, the Complainants submitted a claim to the Provider.

The first Complainant submits that at no time prior to **18 April 2016** was he aware of any underlying medical condition and that it is not the case, therefore, that he failed to report this, as contended by the Provider.

The Provider's Case

The Provider submits that, after evaluating all of the evidence to hand arising from the claim for the cancelation of their holiday, it declined the claim on the basis that the first Complainant had failed to disclose that he had been referred for an ECG with a treadmill test, at the time the Policy was incepted.

The Provider submits that when incepting the policy on **27 February 2016**, one of the questions asked by the sales agent was:

> *"At the time of taking out a policy, has anyone a medical condition for which you are on a waiting list for or have knowledge of the need for surgery, in patient treatment or investigation at a hospital, clinic or nursing home?"*

The Provider states that *'[w]hen incepting the insurance policy on **27 February 2016**, the Complainant declared his High Blood Pressure and High Cholesterol, however, he did not advise that he was on a waiting list for a cardiac referral*'.

The Provider submits that medical information provided in support of this claim confirms that on **22 February 2016**, 5 days prior to incepting this insurance, the first Complainant was referred for investigations.

The Provider submits that all customers are provided with a 14 day cooling off period following receipt of the policy terms and conditions. The Provider states that "*It is incumbent on any individual purchasing a policy to examine same, to ensure that it is appropriate and to ensure that all information is correct and that all conditions are met*." The Provider submits that if, having reviewed the policy terms and conditions, the first Complainant found that they were not suitable for his needs he could have cancelled the policy within 14 days

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and he would have received a full policy refund. The Provider submits that as the policy was not cancelled, a legally binding contract came into force.

The Provider states that *"[s]ince an insurance contract is based upon the duty of utmost good faith, it is important that those seeking insurance should provide full disclosure of all facts to insurers'.* The Provider submits that the policy wording is explicit in that it requires that *'[e]xisting medical Condition(s) as defined by the policy Terms and Conditions be disclosed."*

The Provider submits that the medical certificate provided with the first Complainant's claim form, completed and signed by the first Complainant's GP, states that the reason for the cancellation of his trip was his Coronary Artery Disease and the need for Coronary Artery Bypass Grafts. The Provider submits that the first Complainant failed to disclose this information and as a result it was not given the opportunity to assess the risk and calculate any additional premium payable, to cover the risk in question.

The Complaint for Adjudication

The complaint is that the Provider incorrectly or unreasonably declined the Complainants' claim under the policy.

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 13 August 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, within the period permitted, the final determination of this office is set out below.

The issue to be determined is whether the Provider incorrectly or unreasonably declined the first Complainant's claim under the policy.

The Provider has obligations pursuant to the Consumer Protection Code 2012 (CPC 2012) with regard to the sale of the policy.

Provision 4.1 of the CPC 2012 sets out that:

> *"4.1 A regulated entity must ensure that all information it provides to a consumer is clear, accurate, up to date, and written in plain English. Key information must be brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information."*

Provision 4.21 of the CPC 2012 provides that:

> *"4.21 Prior to offering, recommending, arranging or providing a product, a regulated entity must provide information, on paper or on another durable medium, to the consumer about the main features and restrictions of the product to assist the consumer in understanding the product. To the extent that the contract for the provision of the product is a distance contract for the supply of a financial service under the European Communities (Distance Marketing of Consumer Financial Services) Regulations 2004, the Regulations apply in place of the requirement set out in the first sentence of this provision."*

Provision 4.22 of the CPC 2012 sets out that:

> *"4.22 A regulated entity must provide each consumer with the terms and conditions attaching to a product or service, on paper or on another durable medium, before the consumer enters into a contract for that product or service. To the extent that the contract for the provision of the product is a distance contract for the supply of a financial service under the European Communities (Distance Marketing of Consumer Financial Services) Regulations 2004, the Regulations apply in place of the requirement set out in the first sentence of this provision."*

Provision 4.35 of the CPC 2012 states the following:

> *"4.35 A regulated entity must explain to a consumer, at the proposal stage, the consequences for the consumer of failure to make full disclosure of relevant facts, including:*
> *a) the consumer's medical details or history; and*

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b) previous insurance claims made by the consumer for the type of insurance sought.
The explanation must include, where relevant,
i) that a policy may be cancelled;
ii) that claims may not be paid;
iii) the difficulty the consumer may encounter in trying to purchase insurance elsewhere..."

The Provider submits that during the sales process, the customer is made aware of the benefits of cover and is also made aware of the policy terms and conditions, and agrees with these prior to purchasing the policy. The Provider submits that all sales agents have a laminate which provides important information regarding the selling of insurance, which is visible on every desk and the customer is asked to read through this. The Provider submits that this document explains to all customers that any inaccuracies regarding medical history of persons to be insured, could invalidate the policy.

The Provider has submitted a copy of the laminate. I note that it states, among other things, the following:

"IMPORTANT CUSTOMER INFORMATION
...

Our [travel agent] Sales Consultant will:

- *Offer you information on the [travel agent] Travel Insurance products we have available. You will be able to choose the cover to match your needs but you will need to make your own choice about how to proceed.*
- *Ask you questions, including some about the medical history of all persons to be insured. It is important that you provide correct information as any inaccuracies could invalidate the policy.*
- *Provide you with limited details about your chosen policy. Full details will be provided in writing if you go ahead with the purchase of the policy.*
- *Guide you to read the key facts in the policy summary that explains the significant or unusual exclusions or limitations.*
- *Provide, upon purchase, the policy document which contains the full terms and conditions.*

...
Your cancellation rights
If you find the cover is not suitable, you can cancel the policy within 14 days of receipt of the policy documents and receive a full refund provided you have not travelled and no claim has been or will be made.
...".

The Provider submits that the selling agent was fully qualified to sell insurance products at the time the policy was incepted and the agent asked the Complainants a series of medical questions as per the sales process/script when selling the insurance cover.

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The Provider submits that the Complainants were asked questions to determine if there was a requirement to complete a medical screening, and to see if any existing medical conditions could be covered. The Provider submits that the Complainants were asked, in particular;

> *"At the time of taking out a policy has anyone an existing medical condition relating to:*
>
> *a) a respiratory condition (relating to the lungs or breathing,*
> *b) a cardiovascular condition (including any condition relating to the heart, arteries, veins, cholesterol or blood pressure)*
> *c) a stroke including cerebrovascular accident (CVA) or transient ischaemic attack (TIA),*
> *d) diabetes, or*
> *e) cancer*
>
> *For which you have ever received treatment (including surgery, tests or investigations by a doctor or a consultant/specialist, or prescribed drugs or medication)?*
>
> *At the time of taking out this policy does anyone have medical conditions to declare which relate only to:*
>
> *a) diabetes,*
> *b) high cholesterol*
> *c) blood pressure*
> *d) asthma*
>
> *At the time of taking out the policy, has anyone a medical condition for which you have received surgery, treatment or investigations in a hospital or clinic in the last 6 months?*
>
> *At the time of taking out a policy, has anyone a medical condition for which you are on a waiting list for or have knowledge of the need for surgery, in patient treatment or investigation at a hospital, clinic or nursing home? (if yes, no cover will be provided under Section A – Cancellation or curtailment charges)."*

I note that when incepting the policy on **27 February 2016**, the first Complainant declared his high blood pressure and high Cholesterol, however, he did not advise the Provider that he was on a waiting list for a cardiac referral.

The Provider submits that all customers are provided with a 14 day cooling off period following receipt of the policy terms and conditions. The Provider has submitted a copy of the Customer Declaration signed by the Complainants on **27 February 2016**. I note that the Customer Declaration on page 2, askes the Customer to confirm that:

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"I have read and understand 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, I undertake to contact the location at which I purchased the insurance without delay."*

Within the policy documents which were furnished to the Complainants during the inception of the policy at the office of the travel agent, on **27 February 2016**, I note that under the ***'Important conditions relating to health'*** section of the policy Terms and Conditions on page 14, it states:

"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.*

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, section B – Emergency medical and other expenses, section C – Hospital benefit, section D – Personal accident Section U – Business Travel for any claims arising directly or indirectly from:*

a) ***At the time of taking out this policy****:*

i) *Any* ***Existing Medical Conditions*** *falling into one, two or all three of the following categories unless* ***You*** *have contacted* ***Us*** *on [redacted] and* ***We*** *have agreed to provide cover*

[my emphasis]

Any Existing Medical Condition means

1. Any:

a) *Respiratory condition (relating to the lungs or breathing),*
b) *Cardiovascular condition (including any condition relating to the heart, arteries, veins, cholesterol or blood pressure),*
c) *Stroke including a cerebrovascular accident (CVA) or a transient ischaemic attack (TIA),*
d) *Diabetes, or*
e) *Cancer*

for which ***You*** *have ever received treatment (including surgery, tests or investigations by* ***Your*** *doctor or a consultant / specialist, or prescribed drugs or medication).*

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2. *Any Medical Condition for which You have received surgery, treatment or investigations in a hospital or clinic within the last six months.*
3. *Any **Medical Condition** for which **You** are on a waiting list for or have knowledge of or need for surgery, in patient treatment or investigation at a hospital, clinic or nursing home. (in the case of 3. no cover will be provided under section A – Cancellation or curtailment charges)'*

[my emphasis]

ii) *Any **Medical Condition You** are aware of but for which you have not had a diagnosis. [my emphasis]*

iii) *Any **Medical Condition** which has been diagnosed as a terminal condition.*

b) At any time:

i) *Any **Medical Condition** for which **You** are travelling against the advice of a **Medical Practitioner** or would be travelling against the advice of a **Medical Practitioner** had **You** sought his/her advice.*

ii) *Any **Medical Condition** for which **You** are travelling with the intention of obtaining medical treatment (including surgery or investigation) or advice outside of **Your Home Area.***

iii) *Any **Medical Condition** for which **You** are not taking the recommended treatment or prescribed medication as directed by a **Medical Practitioner.***

iv) *Your travel against any health requirements stipulated by the carrier, their handling agents or any other **Public transport** provider.*

**** You** should only contact **Us** for **Existing Medical Conditions** defined above. **You** do not need to contact **Us** for any other reason.*

Please note:

*If this insurance is extended to include any **Existing Medical Conditions** an endorsement will be issued confirming the terms under which cover has been provided.*

*The endorsement must be kept with **Your** policy documents and products in the event of a claim or incident that may give rise to a claim. We reserve the right not to extend this insurance to cover any **Existing Medical Condition(s).***

***You** should also refer to the general conditions."*

The Provider states that *"the [first] Complainant declared his High Blood Pressure and High Cholesterol, however, he did not advise that he was on a waiting list for a cardiac referral".* The Provider further states that *"[t]he policy wording is clear and explicitly requires that any Existing Medical Condition(s) as defined by the policy Terms and Conditions be disclosed".*

The Provider submits that the Complainants cancelled the trip as a result of the first Complainant's Coronary Artery Disease and the need for Coronary Artery Bypass Grafts. The Provider submits that the first Complainant's General Practitioner confirmed on the medical

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certificate provided with the first Complainant's Claim form, that he first consulted him regarding his condition on **22 February 2016**.

The first Complainant submits that the Provider rejected his claim on the basis that he failed to disclose any cardiovascular condition for which he was on a waiting list for the need for surgery or investigation at a hospital.

The first Complainant states that:

> *"From the records supplied to [the Provider], I now know why and where [the Provider], have reached these supposed facts, but which are incorrect.*
> *1) My medical practice for some reason state Dr. [name redacted], is my GP. I'm not sure why, but I have never even consulted or met him. The Senior Doctor of the practice, Dr. [name redacted] is the doctor whom I have consulted in recent years, and prior to, specifically 22/2/2016.*
>
> *2) The supposed fast-tracked/ rapid access pain clinic, was not such.*
> *a. In fact, on querying my first (5th April) offered date, for the 31st May 2016 (because it clashed with the proposed holiday), the Hospital Cardiology Dept, mentioned in passing, as the next date to be offered was 16th June, the original date would have been sooner, but the request from the medical practice had been marked low risk/priority.*
> *b. Even 22/Feb to 31/May confirms that it was NOT "fast-track/rapid access"*
>
> *3) It was unfortunate, that my GP, Dr. [name redacted], was absent due to ill health (for approx... 3 months), at a similar time, and when the records etc, were requested by [the Provider].*
>
> *4) Having subsequently queried with Dr. [name redacted], what… was advised to [the Provider], and what he knew on my case, and our consultation mtg 22nd Feb.2016, he as sought by his subsequent letter (9/2/2018){copy attached} to make clear, what I was aware*
> *a. I had only relatively recently been prescribed Naproxen, for a rheumatic/arthritic wrist pain (sporting injury), which also has a known side-affect, similar to the symptoms I had.*
> *b. Having just had the all clear from an ECG examination (22/2/2016)*
> *c. A further test to confirm the ruling out of any angina, before considering how to deal with not being able to take Naproxen*
> *d. And there was no immediate impacts to both my exercise & sporting activities, and forthcoming holiday*
>
> *Therefore at the time of taking out the insurance, I fully disclosed all I knew. I was unaware any investigation for any cardiovascular condition (and that there was never any mention of fast-track/rapid access/urgency)."*

I note that the first Complainant's GP's letter dated **9 February 2018** states as follows:

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"This is to confirm that [the first Complainant] has been a patient of our practice since 1987 and I have known him since then.

He consulted me on Monday 22 February 2016 with a 2 month history of a cough and a feeling of 'gas' going up his sternum when walking but he was able to use the gym, run, and play squash with no exertional chest symptoms. Clinically his heart was normal. As his history was not clear cut of angina in that he was still able to play physical sport without chest symptoms, I referred him to cardiology for further evaluation. Whilst he was waiting to see Professor [name redacted] he continued with his normal life including playing sport. At this stage in my opinion he was fit to travel.

He saw a professor of cardiology Professor [name redacted], on 16 April 2016 when an exercise ECG was not clear cut and he had further investigation of angiogram which confirmed coronary artery disease requiring coronary artery bypass graft.

I can confirm that I have been [the first Complainant's] GP for several years and know his medical history well. In my opinion he was fit to travel between 22 February 2016 and 16 April 2016 when his diagnosis was confirmed by tests."

- **Medical Records**

I note that the Medical Records provided by the first Complainant's Medical Practice contains the following entries:

22.02.2016
History: cough 2/12 'feeling of gas' up his sternum on walking, can use gym, run and play squash with no exertional chest symptoms
***Plan:** ECG now*
Outbound Referral: Hospital Referral to rapid access chest pain clinic
[emphasis added]

13.04.2016
History: Not had chest pain clinic apt yet (16 June 2016); worsening chest pain on walking but OK on vigorous exercise.
Plan: Insured privately – see Prof [name redacted] at [place redacted]
Private referral to Cardiologist

21.04.2016
See in cardiac clinic
Major: Triple vessel disease of the heart – Triple vessel coronary artery disease – referred to Prof [name redacted] for CABG"
[emphasis added]

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The Provider submits that when incepting the insurance policy on **27 February 2016** the agent asked a series of questions regarding the health of those to be insured. The Provider submits that the first Complainant's High Blood Pressure and High Cholesterol were disclosed at this point and thus a '*lite screening*' was completed in store.

The Provider submits that one of the questions asked by the sales agent was;

> *"At the time of taking out a policy, has anyone a medical condition for which you are on a waiting list for or have knowledge of the need for surgery, in patient treatment or investigation at a hospital, clinic or nursing home?"*

The Provider submits that the medical information provided in support of this claim confirms that on **22 February 2016** (5 days prior to incepting this insurance) the first Complainant was referred for investigations.

- **Policy Documentation**

I note that the policy summary states, among other things, the following:

"Your Policy Summary

…

Conditions

- *It is essential that you refer to the important conditions relating to health section in the policy wording as failure to comply with these conditions may jeopardise your claims or cover.*

These *"important conditions relating to health"* are partially quoted above at pages 6 - 8.

Analysis

It should be noted that all contracts of insurance are subject to the duty of "*uberrimae fides*" (utmost good faith) and in that regard, I am mindful of the decision in *Chariot Inns Ltd v Assicurazioni Generali spa [1981] IR 199.* The Supreme Court stated that the test for materiality at the time of a proposal for insurance cover, is:

> *"...a matter or circumstance which would reasonably influence the judgment of a prudent insurer in deciding whether he would take the risk, and if so, in determining the premium which he would demand. The standard by which materiality is to be determined is objective and not subjective."*[1]

I have also had regard to the High Court decisions, of *Earls -v- The Financial Services Ombudsman & Anor [2015] IEHC 536*, in July 2015 and *Richardson v FSO & Anor [2015 MCA 112]*, in July 2016, where the Court in each instance carried out a detailed analysis of

[1] Kenny J, Chariot Inns Ltd v Assicurazioni Generali spa [1981] IR 199

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previous case law on non-disclosure and the principles to be applied. From these decisions it is clear that this Office should not proceed on the basis that if a material fact was not disclosed then, *ipso facto* (by that very fact) there has been a breach of the duty of disclosure. Rather, in the Court's opinion, this may not always be the case, as the duty arising for an insured in this regard, is to exercise a genuine effort to achieve accuracy using all reasonably available sources, so that, e.g. if the form of questions asked in a proposal form might limit the duty of disclosure arising, such an issue would require consideration.

Furthermore, the *Earls* decision points to the fact that materiality falls to be gauged by reference to the hypothetical prudent proposer for insurance. The Court held that the arbiter must also give consideration to what a reasonable insured would think relevant and relevance in this particular context is not determined by reference to an insurer alone.

Having carefully considered all of the evidence before me, while I note the first Complainant submits that at no time prior to **18 April 2016** was he aware of any underlying medical condition, I am of view that the first Complainant's referral for medical investigation, was a material fact of relevance to the proposal for the policy in question, and should have been disclosed to the Provider at the time of requesting the inception of the policy. I note that page 13 of the policy document states the following:

> "***Duty of care***
> ***You*** *must take care to answer all questions honestly and to the best of* ***Your*** *knowledge.* ***You*** *must not make any misrepresentation of a fact that could influence* ***Us*** *in accepting* ***Your*** *insurance, this includes* ***Your*** *destination, duration, age and state of health of all travellers on this policy. If* ***You*** *are in any doubt,* ***You*** *should tell* ***Us*** *– calling the number shown on* ***Your*** *policy schedule."*

I consider that the referral for a medical investigation is something that the Complainant, as a prudent proposer for insurance, should have disclosed. I note that the first Complainant, in a submission dated **13 January 2017**, states that *"I can see how some of the absolute facts, may have been incorrectly missed e.g. which GP that was seen by myself, and, what I was advised. Hindsight! – maybe my GP knew or suspected more than patient (i.e. me advised)."*

I am satisfied that there was an obligation on the first Complainant to ensure that he told the Provider about the pending tests he was due to undergo. In addition, the first Complainant should have read the policy terms and conditions and if he had any queries it was open to him to clarify them with the Provider. I note that the first Complainant signed a declaration confirming that he had *"read and understood the Important Information, in particular relating to Existing Medical Conditions, as set out in the policy document".*

I must accept that by the first Complainant not disclosing that, on **22 February 2016**, he had been sent for medical investigations, this amounted to a breach of his duty to make full disclosure. I also accept that in these circumstances the policy cover came into being on the basis of a non-disclosure, and that the Provider did not have the opportunity to correctly assess the risk which it had agreed to cover, at the time of the inception of the policy.

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In circumstances where there was a failure to disclose material information, I am satisfied the Provider was entitled to decline the first Complainant's claim under the policy.

Consequently, it is my Decision that this complaint is not 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

4 September 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.