An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0359
Sector:	Insurance
Product / Service:	Travel
Conduct(s) complained of:	Rejection of claim Complaint handling (Consumer Protection Code)
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The First Complainant purchased a single trip travel insurance policy with the Provider on **12 January 2018**, which provided the Complainants with cover in respect of their honeymoon from **29 March** to **5 April 2018**.

The Complainants' Case

In her email to this Office dated 31 October 2018, the First Complainant advised, as follows:

> *"My condition at time policy was taken out: I went to my GP* [on 28 December 2017] *as I had been having really bad panic attacks since my mother passed away. I was not given medication and I was offered advice for counselling and to see psychiatrist if needed when I went back to Dublin. I was completely honest when I took out my policy. I was advised over the phone my condition was accepted.* [The Provider] *did not look for a written declaration from my GP at the time, they accepted it over the phone"*.

In this regard, her GP, Dr K. advised in correspondence dated 19 April 2018 that the First Complainant *"presented with panic attacks as a result of her mother's death on 28/12/2017. No medication was administered. She was given information regarding counselling and a psychiatrist if she required such services in the future"*.

The First Complainant attended Dr J., Psychiatrist on 3 February, 10 February and 13 March 2018 and he provided her with a medical certificate dated 5 February 2018 advising that *"in my opinion, due to her medical condition she is not fit for work until the symptoms clearly improve"*.

In addition, in his medical certificate dated 10 February 2018, Dr J. confirmed that he recommended cancellation of her holiday on 10 February 2018. As a result, the Complainants cancelled their holiday on 12 February 2018 and submitted a travel insurance claim to the Provider. As part of its claim assessment, the Provider requested *"the computerised medical records for 28/12/2017, 03/02/2018, 10/02/2018 and 13/03/2018"*.

In this regard, the First Complainant sets out her complaint, as follows:

> *"I feel that I am not being treated fairly. I am being asked for excessive private information regarding my claim such as private medical notes from my consultations. I have provided all of the relevant information regarding my condition that is necessary to see…I honestly declared my recent episodes of panic attacks over the phone which was noted as a pre-existing medical condition. I was suffering from panic attacks and not on medication or a waiting list for treatment as declared by GP prior to taking out my policy. My GP has provided a medical certificate for this. I was reassured over the phone which I have a record of when taking out my policy that I would be covered for this condition. It does not outline in the policy that I should provide these medical notes, only that a medical certificate of a consultant relating to mental health is provided if I need to cancel.*
>
> *Also from the policy, my pre-existing medical condition should have been accepted in writing which wasn't and was done over the phone, asking two questions and no explanation about the access to private consultations. Therefore the medical certificates provided are sufficient. All of the relevant information has been provided relating to my mental health and this claim. My psychiatrist advised me not to work or to travel, he has provided a medical certificate for this and outlined my treatment plan. My psychiatrist has also highlighted that I booked my consultations myself so therefore I was not on a waiting list as* [the Provider] *are stating. There is no need to want to access the private notes of consultations"*.

The First Complainant states that she advised the Provider by telephone on 12 January 2018 when purchasing the Complainants' travel insurance policy that she had recently attended her GP for panic attacks and that the Agent had advised her that *"I would be covered for this condition"*. The First Complainant's Psychiatrist, Dr J. confirmed that he recommended cancellation of the holiday on 10 February 2018 due to the First Complainant's condition of *"panic disorder"* and the Complainants cancelled their trip on 12 February 2018 and full cancellation costs applied. As a result, the First Complainant seeks *"to be refunded my full amount of money that I paid for my holiday"*

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The Complaint for Adjudication

The Complainants' complaint is that the Provider wrongly or unfairly declined the Complainants' travel insurance claim, and has wrongfully insisted on gaining access to the First complainant's private medical records.

The Provider's Case

Provider records indicate that the First Complainant purchased a single trip travel insurance policy with the Provider by telephone on **12 January 2018**, which provided the Complainants with cover in respect of their honeymoon from 29 March to 5 April 2018. The Provider notes that the trip for which this insurance policy was purchased had been booked in **May 2017**, however the Complainants had declined the insurance offered at the time of the booking and were willing to accept the financial risk of cancellation, for over 8 months.

The Provider acknowledges that the medical condition declared by the First Complainant during the point of purchase telephone call on 12 January 2018, that is, panic attack, was accepted on the basis that this condition was stable and that no further treatment, consultations or investigations were required at that time. In this regard, it was not made know to the Agent that the First Complainant had attended her GP with a panic attack 16 days previously, on 28 December 2017 or that she had been referred to a psychiatrist at that time.

The Provider is satisfied that its Agent clearly advised the First Complainant during this telephone call that once she was not receiving any further treatment, consultation or investigation in relation to panic attacks, then it could include this medical condition as a pre-existing medical condition and that based on her answers to the questions posed confirming that the condition was stable at the time of purchase, the Provider could consider claims in relation to panic attacks. The Agent did however caution that before the Provider could accept any claim, a claim form would need to be completed and medical documentation provided.

The First Complainant telephoned the Provider on 6 February 2018 advising that she was at that time out of work as she was not well and wanted *"information regarding cancelling a trip and maybe putting in a claim"* and she asked if she had to cancel her trip, *"how does it work – how do you cancel and get money back?"* The Agent informed the First Complainant that if she was cancelling the trip, she would need to cancel with the tour company she had booked with and that the Provider would send her a claim form. The First Complainant again asked *"if I cancel, will I get the money back?"* to which the Agent advised that she could not at that time confirm this.

In his medical certificate dated 10 February 2018, Dr J., Psychiatrist confirmed that he recommended cancellation of the holiday on 10 February 2018. The cancellation invoice indicates that the holiday was cancelled on 12 February 2018 and that full cancellation costs applied. The Provider received the completed claim form on 15 February 2019. The Complainants had been scheduled to travel on 29 March 2018 and return on 5 April 2018.

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As part of its claim assessment, the Provider requested from the First Complainant her *"computerised medical records for 28/12/2017, 03/02/2018, 10/02/2018 and 13/03/2018"*. In cases where the policy is incepted close to the date of loss, in order for the Provider to validate that there was a change in an existing condition to the extent that it gave rise to the unavoidable cancellation of the trip, in this case 6 weeks in advance of the travel date, the Provider must request the contemporaneous notes of the treating physicians. This particular form of substantiation is standard in these cases, and it is not the intention of the Provider to be intrusive, and all submissions are treated in the utmost confidence. Whilst it understands that medical consultations are confidential, the Provider needs to obtain this information in order to assess the claim in line with the policy terms and conditions. In this regard, the Provider has limited its request for detailed information to the dates specifically related to the condition which has given rise to this claim.

The medical condition declared by the First Complainant at point of purchase by telephone on 12 January 2018 was accepted by the Provider on the basis that this condition was stable. It had not been made known to the Agent that the First Complainant had attended her GP with a panic attack 16 days previously, on 28 December 2017 or that she had been referred to a psychiatrist at that time. In this regard, the Provider notes that there are inconsistencies in the initial medical certificate completed by the First Complainant's Psychiatrist, Dr J. on 10 February 2018, where he advises *"Her GP referred the patient to me"*, yet in his letter of 17 April 2018 states *"Not formally referred to me by GP"*. Similarly, her GP, Dr K. confirmed on 27 March 2018 that the First Complainant was referred to a psychiatrist on 28 December 2017, but instead later advised on 19 April 2018 that *"she was given information regarding counselling and a psychiatrist if she required such services in the future"*. This may or may not be material to the claim, however the Provider must investigate this by reference to the computerised medical records.

In addition, whilst the First Complainant's Psychiatrist, Dr J. advises in his letter of 5 February 2018 that *"with a combination of psychotherapy/counselling and medication, improvements in her condition over the coming weeks are likely"*, the Provider notes that the Complainants' trip was cancelled on 12 February 2019, over 6 weeks in advance of the intended travel date, despite this positive outlook. In this regard, the Provider submits that a review of all the relevant medical records will enable it to verity the precise change in circumstances that ultimately necessitated cancellation of the Complainants' trip.

In conclusion, the Provider notes that the Complainants booked a trip to the value of €6,600 on 5 May 2017 and that the booking invoice confirms that they chose at that time not to purchase insurance for the trip. Instead, it was some 8 months later on 12 January 2016 that the First Complainant purchased the single trip travel insurance policy with the Provider, which was 2 weeks after the GP visit during which she was or may have been, referred to a psychiatrist. This referral, or the intention to seek further investigation or treatment, was not declared to the Provider at the point of purchase, and the condition was accepted for cover on the basis that the First Complainant had confirmed that it was stable, and not requiring further treatment, consultation or investigation.

The Provider requires computerised medical records to fully assess this claim, which is a standard form of substantiation in cancellation claims arising from medical conditions, to

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validate that the condition was stable, as declared, when the policy was purchased and to ascertain what changed from the date of purchase, that is, what insured event occurred following the payment of the premium that led to the cancellation of the trip on 12 February 2018.

In the absence of the First Complainant's GP and Psychiatrist notes for this period, the Provider is unable to establish the full facts and verify that an insured event occurred within the period of cover. The Provider has never formally declined the Complainants' claim and it remains open to consideration of the claim, subject the provision of the computerised medical records as requested, showing the notes recorded at the time of the consultations.

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 28 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 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 or unfairly declined the Complainants' travel insurance claim. In this regard, the First Complainant purchased a single trip travel insurance policy with the Provider on 12 January 2018, which provided the Complainants with cover in respect of their honeymoon from 29 March to 5 April 2018, which had been booked in May 2017.

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The First Complainant states that she advised the Provider by telephone on 12 January 2018 when purchasing the Complainants' travel insurance that she had recently attended her GP for panic attacks and that the Agent had advised her that *"I would be covered for this condition"*.

Her Psychiatrist, Dr J. confirmed in his medical certificate dated 10 February 2018 that on that day, he recommended cancellation of the holiday due to the First Complainant's condition of *"panic disorder"*. The Complainants then cancelled their holiday on 12 February 2018 and full cancellation costs applied. As a result, the First Complainant seeks *"to be refunded my full amount of money that I paid for my holiday"* from the Provider.

I have listened to a recording of the telephone call that the First Complainant made to the Provider on 12 January 2018 during which she purchased the Complainants' travel insurance, and I note the following exchange:

First Complainant:	*I, I had to go to the doctor recently, and I, em, I suffered a panic attack …*
Agent:	*- suffered from panic attack only, ok …*
	I have just selected panic attack … and is that condition currently stable?
First Complainant:	*Yeah, I, I mean it's fine, I'm not on any medication, I just, I, it just happened, you know –*
Agent:	*So it's more like a once off incident and you don't have any treatment at the moment?*
First Complainant:	*No, and as of now I feel fine, I don't –*
Agent:	*Sure –*
First Complainant:	*You know what I mean, I'm not* [indecipherable], *I'm not, I'm working and I'm -*
Agent:	*Sure –*
First Complainant:	*Ok*
Agent:	*Should be three questions. First question. Are you on any medication for this problem at the moment?*
First Complainant:	*No*
Agent:	*And second question is, have you been treated for depression in the last three years?*

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First Complainant: *No*

Agent: *Perfect. No more questions in relation to that condition. You said it's currently stable and there is no charge to cover panic attacks, eh, so we can cover it free of charge. Is there anything else in all the medical condition for yourself or* [the Second Complainant]*?*

First Complainant: *No, there isn't, but I do know that when I, when I suffered from the panic attack, like, I wasn't, like, you know, I was not ok for, for, for a while, you know what I mean?*

Agent: *Yeah, that's ok. But as long as its sorted, I mean, its, eh, you don't receive any treatment or consultation or further investigation, eh, we can include that as a pre-existing condition, you just have to answer those two questions and based on the answers, eh, we can see that we can cover also claims in relation to panic attack, eh, I mean at least consider for cover because before we can accept a claim, each claim will have to submit a claim, get claim form completed and some documents from the doctor, eh, then we can make a decision that we can accept that claim, but in general I can say that we can consider for cover that condition as well because you declared that condition, you answered all the questions and at the moment when you purchased the travel insurance policy that condition was stable, there was no –*

First Complainant: *Yeah, it just happened, and I went to the doctor because I didn't know if it was, if I was sick or was it just because of the trauma that I, you know, em, 'cause my mother passed away so it must have been just as a result of that, do you know what I mean?*

Agent: *Yeah. I understand. Exactly…so that would be the same, for example, if, eh, let's say customer recently would suffer, let's say, some, eh, stomach* [indecipherable] *but it is no longer a problem, we have to include that, eh, so just answer a few questions and again we can, we would be able to include that condition. So that same with your condition, it happened in the past within the last two years so that is why it has to be declared to us, then you just need to answer all the questions and if at the moment you don't suffer any problems, or there is no any treatment, eh, we can include that condition as well.*

Having listened to the recording of this telephone call, I am satisfied that the First Complainant did declare that she had recently attended her GP due to a panic attack and

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that she confirmed to the Agent that this condition was stable and that she was not at that time receiving or awaiting any treatment, consultation or further investigation.

It is clear from this recording that it was on this basis that the Agent confirmed that the First Complainant's condition of panic attack would be covered by the travel insurance that she was then in the process of purchasing. This does not, however, mean that any claim pertaining to the declared medical condition would automatically be admitted. Instead, I am satisfied that the Agent advised the First Complainant that any claim she might have cause to submit, relating to a panic attack would be considered by the Provider, rather than any such claims being automatically exempt from consideration.

In this regard, notwithstanding that it was a pre-existing medical condition, the Agent was confirming that the Provider would assess any future claim arising from a panic attack, because the First Complainant had confirmed to the Agent that this condition was stable and that she was not at that time receiving or awaiting any treatment, consultation or further investigation. It is clear that any such claims would have to be assessed in the normal manner, in line with the terms and conditions of the Complainants' travel insurance policy.

As part of any such assessment, I am satisfied that it is appropriate for the Provider to seek medical confirmation that the information that the First Complainant provided, when purchasing the travel insurance policy, was correct, i.e. that her condition was stable and that she was not at that time receiving or awaiting any treatment, consultation or further investigation.

In this regard, I have considered the medical correspondence before me. In his letter dated **5 February 2018**, the First Complainant's Psychiatrist, Dr J. advised, as follows:

> *"*[The Complainant] *has been seeing me for panic attacks (ICD-10 F41.0) since last week, after her symptoms had exacerbated over the last couple of weeks.*
>
> *In my opinion, due to her medical condition she is not fit for work until the symptoms clearly improve.*
>
> *With a combination of psychotherapy/counselling and medication, improvements in her condition over the coming weeks are likely"*.

In the Medical Certificate completed by Dr J. on 10 February 2018, he advises that the condition which gave rise to the First Complainant having to cancel the Complainants' trip was

> *"panic disorder…first consultation was on 03-02-18. Her GP referred the patient to me"*.

In his letter dated 9 March 2018, the First Complainant's GP, Dr K. advised, as follows:

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> *"*[The Complainant] *is suffering from Panic Attacks and is attending a Psychiatrist in Dublin. Her symptoms started in Dec 2017 and she continues to engage with myself and the Psychiatrist on a regular basis".*

In his letter dated 13 March 2018, Dr J. advised, as follows:

> *"*[The Complainant] *is seeing me on a regular basis. She presents with the symptoms of generalised anxiety and panic attacks …*
>
> *So far, we have had scheduled appointments on 3 February, 10 February, 3 March (cancelled due to weather) and 13 March. From a medical perspective, I recommend weekly appointments for the next four weeks, followed by bimonthly and then monthly appointments. With a combination of psychiatric medication and psychotherapy a substantial improvement should be attainable over the coming months"*.

In his letter dated 17 April 2018, Dr J. advised, as follows:

> *"*[The Complainant] *was not formally referred to me by her GP. She booked her own appointments using my online scheduling system and was not on a waiting list to see me.*
>
> *Her first appointment with me was on 3rd February, which she booked online on 27th January. She consulted me also on 10th February and 13th March. An appointment on 3rd March had to be cancelled due to the inclement weather conditions"*.

In his letter dated 19 April 2018, Dr K. advised, as follows:

> *"This is to certify that I have examined* [the Complainant]*. I have no records on file from 29/03/16 to 29/03/18 inclusive. She presented with panic attacks as a result of her mother's death on 28/12/17. No medication was administered. She was given information regarding counselling and a psychiatrist if she required such services in the future".*

Based on the contents of this correspondence, I am satisfied that it was reasonable for the Provider to seek medical confirmation as to whether the First Complainant's declared medical condition of panic attack was stable at the time she purchased the Complainants' travel insurance on 12 January 2018, given that she had presented to her GP with that condition on 28 December 2017, 16 days earlier, and then first attended a psychiatrist for that condition on 3 February 2018, 18 days after she declared her condition was stable.

In requesting the *"computerised medical records for 28/12/2017, 03/02/2018, 10/02/2018 and 13/03/2018"* from First Complainant's treating physicians as part of its claim assessment, the Provider was seeking medical confirmation that the information that the First Complainant provided when purchasing the travel insurance, that is, that her condition was stable and that she was not at that time receiving or awaiting any treatment, consultation or further investigation, was correct, and I am satisfied that the terms and

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conditions of the Complainants' travel insurance policy permit the Provider to do so; such a step is a normal and acceptable part of the claim assessment process.

In this regard, the 'General Conditions' section of the applicable Travel Insurance Policy Document provides, *inter alia*, as pg. 7, as follows:

> *"**IMPORTANT NOTE: Certain sections of this Policy have particular conditions attaching to them, but the conditions set out below apply to all sections:***
>
> *1. Before we consider a claim, it is a condition that:*
>
> *a. the answers in any proposal and declaration for this insurance are true and complete to the best of Your knowledge and belief and such proposal and declaration form the basis of this Policy …*
>
> *3 Any medical information supplied to Us in a medical declaration will be treated in the strictest of confidence and will be used solely for Our own internal purposes for the assessment of the risk, and will not be disclosed to any third party or authority without the specific approval of the person whose details are given in the Medical Declaration*
>
> *…*
>
> *5. You must declare to Us all material facts, which are likely to effect this insurance. Failure to do so may prejudice Your entitlement to claim. If You are uncertain as to whether a fact is material, You should declare it to Us".*

In addition, Section 1, 'Cancellation and Curtailment Charges', of this Policy Document provides, *inter alia*, at pg. 10, as follows:

> *"**Cancellation or Curtailment***
>
> *In addition to the General Exclusions You are not covered for: …*
>
> - *Any circumstances known to You which are likely to cause cancellation or Curtailment, prior to booking your Trip and/or insurance".*

Furthermore, I also note that the 'Claims Procedure' section at pg. 21 of the Policy Document provides, *inter alia*, as follows:

> *"**PLEASE NOTE***
>
> ***As the circumstances of different claims are not the same it may be necessary for Us to request additional information/documentation in respect of a claim**".*

In this regard, the 'Strict Medical Health Requirements' section of the Policy Document provides, *inter alia*, at pgs. 4 & 5, as follows:

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"This insurance operates on the following basis:

- *No claim shall be paid where at the time of taking out this insurance (and in the case of Annual Multi-trip at the time of booking each Trip), the person whose condition gives rise to a claim:*

    - *is receiving, or is on a waiting list for treatment in a hospital or nursing home"*.

Regardless that the First Complainant declared her medical condition of panic attack, whilst purchasing the Complainants' travel insurance by telephone on 12 January 2018, I am satisfied that the Provider must assess the subsequent claim arising from the Complainants' cancelling their holiday on 10 February 2018, due to her *"Panic Disorder"* on the advice of the First Complainant's Psychiatrist. The Provider is entitled to do so, as it would any other claim submitted for any other cause, that is, in line with the full terms and conditions of the Complainants' travel insurance policy.

When the Preliminary Decision issued, the Provider had confirmed that it remained open to the future consideration of the Complainants' claim, subject however to the provision of the First Complainant's computerised medical records from her treating physicians as requested, showing the notes recorded at the time of the consultations on 28 December 2017, 3 February, 10 February and 13 March 2018. I was therefore satisfied that it was a matter for the First Complainant whether she wanted to furnish the Provider with the information required, to enable the Provider to assess the Complainants' travel insurance claim fully, in accordance with the terms and conditions of their travel insurance policy. I took the view that the Provider was entitled to maintain its position, unless those records were made available to it by the Complainants, and that it had not acted wrongfully in that regard.

Since the Preliminary Decision issued, the Complainants have furnished medical records to the Provider, and I am pleased to note that it has confirmed that it will now proceed to assess the Complainants' claim on the policy. In the event that, in due course, the Complainants are unhappy with the outcome of that claim assessment, it will of course be open to the Complainants to maintain another complaint, regarding the provider's assessment of the medical records in considering the claim under the policy.

Insofar as this complaint is concerned however, ie the Complainants' complaint that the Provider acted wrongfully in refusing to admit the Complainants' claim, without sight of the First Complainant's medical records, I am satisfied for the reasons outlined above, that the provider was entitled to maintain the position which it did, and that there is no reasonable basis upon which to uphold that complaint.

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Conclusion

My Decision is that this complaint is rejected, pursuant to ***Section 60(1)*** 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.

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION AND LEGAL SERVICES

11 October 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.