An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0024
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - pre-existing condition
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

On **30 April 2015**, the Complainant took out a health insurance policy with the Provider. 9 months later, on **25 January 2016**, the Complainant was diagnosed with endometriosis following a laparoscopy under the care of a doctor in the UK.

In May 2018, the Complainant submitted a pre-authorisation request for coverage from the Provider for surgery. On **14 June 2018**, the Complainant underwent surgery and a laparoscopic excision of her advanced endometriosis. The Complainant and her partner paid for the operation in the sum of £10,642.

On **3 August 2018**, the Provider wrote to the Complainant declining cover for the claim on the basis that she had symptoms related to endometriosis prior to cover being put in place, and on that basis, a five year waiting period applied to be covered for a pre-existing condition. As the Complainant's claim was submitted within five years, the Provider declined the claim.

The Complainant appealed but this appeal was not upheld, by letter dated **26 October 2018.**

The Complainant's Case

The Complainant's case is set out in the complaint form and the associated letters and documentation made available.

First, the Complainant says that the first time she was diagnosed with endometriosis was on **25 January 2016** after the laparoscopy that she underwent. The Complainant says that the symptoms that she suffered from were normal for many women, but that she did not have a diagnosis. The Complainant says that she did not receive any treatment, advice or care in relation to endometriosis before she was diagnosed with it. The Complainant, therefore, says that it is unfair of the Provider to reject her claim as she did not know that she suffered from this condition at the material time. The Complainant also states that the surgery that she underwent was unconnected to the symptoms that she originally suffered from, and was in fact related to symptoms that she experienced after the inception of the policy. In respect of her medical examination, the Complainant said that her GP in February 2015 took a note that she had suffered from period pain and heavy periods as a part of her genealogical history.

Second, the Complainant states that the Provider delayed in processing her claim. On **25 May 2018** a request was made by the Complainant for pre-authorisation of policy benefits and the decision to decline the claim was delivered on **3 August 2018.** The Complainant states that this is an excessive delay.

The Provider's Case

The Provider's case is set out in its formal response to the complaint and in the documentation submitted in support of its position.

First, the Provider states that the terms and conditions of the health insurance policy have the following requirements. A "pre-existing condition" is defined as one where the symptoms began prior to the inception of the policy, as opposed to a diagnosis being made. The waiting period for a pre-existing condition is five years of membership. Consequently, if a policyholder wants to claim for benefits in respect of a pre-existing condition, then five years must elapse before doing so. The Provider notes that these conditions were brought to the Complainant's attention and are clearly set out in the literature provided.

Second, in support of its position, the Provider notes the medical report of a GP dated **6 February 2015** two months before the policy was incepted. In that report, the GP notes symptoms of menorrhagia and on examination the Complainant was noted to have dysmenorrhea. Fertility issues were raised as well. The Provider says that these symptoms are consistent with symptoms of endometriosis. The Provider refers to the scientific literature on the definition of endometriosis and notes that dysmenorrhea is specifically linked to the condition. The Provider accepts that the Complainant was not diagnosed until **25 January 2016**, but states that the date of diagnosis is not the relevant date. Rather the Provider states that the definition of pre-existing conditions includes the situation when an insured is not aware that they may have a particular condition, but the symptoms related to that condition are present. If that situation exists, then the Provider states that a five year period must be served, in order to be covered for such a condition.

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In this particular case, the Provider states that the surgery was in 2018 and the policy was incepted in 2015. Accordingly, the five years had not elapsed and the Provider was not obliged to pay for the surgery. Further, the Provider notes that the Complainant accepts that she had suffered from the symptoms for 20 years and that she had self-medicated in respect of those symptoms over that time.

Third, in respect of delay, the Provider denies that it delayed in processing the Complainant's complaint. The Provider states that it received the pre-authorisation request on **5 June 2018** and that it replied on **7 June 2018**. On **13 June 2018**, the Provider stated that the pre-authorisation request would take no longer than 10 working days, provided that all information was furnished. Frequent correspondence then ensued between **13 June 2018** and **28 June 2018** while the Provider attempted to collate the relevant medical information. On **5 July 2018** and **19 July 2018**, the Provider contacted the Complainant's GP directly to seek further information. On **3 August 2018**, the letter declining cover was sent to the Complainant.

The Complaint for Adjudication

The complaint is that the Provider wrongfully refused to admit the Complainant's claim pursuant to her health insurance policy, and was guilty of delay in dealing with the Complainant's 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.

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.

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A Preliminary Decision was issued to the parties 10 December 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.

In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

First, it is necessary to set out the terms and conditions that apply.

A pre-existing condition is defined as:

> '*Any disease, illness or injury that a person has which began, or the symptoms of which began, before that person started his or her current continuous period of membership of the scheme. Note that an illness or injury may be present for some time before giving rise to symptoms or being diagnosed. So when deciding if a disease, illness or injury began before membership started, it is the date when it began that counts – not the date when a person became aware of having the disease, illness or injury, or its symptoms.'*

There is a limitation on cover in the policy in respect of a pre-existing condition which states that a waiting period of five years applies from the inception of cover, before an insured can claim for benefit in respect of such a condition. This is reiterated at the back of the policy documentation under the heading '*Important Information*.' It states that a five year period must pass before an insured can claim for any '*disease, illness or injury which began or the symptoms of which began before membership started.*'

It is clear, therefore, that the material issue in determining if cover applies is whether or not the Complainant's symptoms began before the inception of the policy on **30 April 2015**. If the symptoms began prior to that date, then the terms of the policy do not cover the Complainant, as the claim was made within five years of the inception of the policy.

The most relevant information in this regard is the report of a GP the Complainant attended dated **February 2015**, two months before the inception of the policy. In this report, the Complainant is noted to have had dysmenorrhea, menorrhagia and fertility problems. I am satisfied that the Provider was entitled to take the view that these are symptoms associated with endometriosis, as the scientific literature appears to confirm. Whilst there is no suggestion that the Complainant had been treated for endometriosis, or that she had any knowledge whatsoever that she suffered from this condition, the terms of the policy do not require such. All the terms of the policy require is clarity as to whether the symptoms existed at the material time when the policy came into being, in April 2015. The terms of the policy are written in clear understandable terms and as the symptoms of endometriosis were present before the Complainant's cover began, the relevant policy clauses apply to exclude her claim for benefit payments because the 5 year waiting period had not been served. Whilst the Complainant states that it was her new symptoms in 2018 that caused

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her to undergo the surgical treatment, it does not appear that the symptoms were different, but rather that such symptoms intensified. On that basis, the exclusion applies in the same manner.

In relation to the delay, it is apparent from the correspondence log submitted and that narrative made available by the Provider that the investigation was conducted in a reasonably prompt manner. The promise of 10 working days is subject to the requirement of the provision of medical information. As is often the case, it can take time to have all of the relevant medical professionals furnish information to a health insurer, such as the Provider. In the timeline set out above, the application was submitted on **5 June 2018**, 9 days before the surgery which had been scheduled. The Provider responded on **7 June 2018**. Investigations were then undertaken and then concluded and the formal declinature issued on **3 August 2018.**

I note that the Provider had to contact medical professionals directly to properly investigate the matter. This is not unreasonable or unfair and I am satisfied that it was appropriate for the Provider to ensure that all of the relevant evidence was gathered and considered, before it proceeded to make its decision to decline the Complainant's claim.

In all of the circumstances, on the basis of the evidence before me, I take the view that it would not be appropriate to uphold this complaint. I am satisfied in that regard that the Provider was entitled to decline the Complainant's claim and that the period of time taken to gather and consider all of the relevant medical evidence was not inappropriate in the circumstances.

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

8 January 2020

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,

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(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.