An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0134
Sector:	Insurance
Product / Service:	Travel
Conduct(s) complained of:	Rejection of claim - pre-existing condition
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns the decision of the Provider to decline a claim made by the Complainants on a travel insurance policy.

The Complainants' Case

The Complainants incepted their travel policy online on **12 September 2017**.

The Complainants' representative submits that on **11 December 2017** the first Complainant presented to his GP due to a bad cough and during this appointment the first Complainant advised his GP that he had suffered an instance of shortness of breath while running. It seems that the first Complainant suggested to his GP during this appointment on **11 December 2017**, that he was due to attend a routine health screening, as it had been four (4) years since his previous screening. Accordingly, it was agreed that the GP was to arrange the health check on behalf of the first Complainant.

The Complainants booked their trip on **10 January 2018** and were due to depart on **2 June 2018** but due to the subsequent ill health of the first Complainant, the Complainants had to cancel the scheduled trip. The Complainants submitted the claim to the Provider in order to be reimbursed for the cost of the cancelled trip and the Provider repudiated the claim.

The Provider submits in its final response letter dated **1 November 2018** that the claim was declined because the *"medical condition that gave rise to the cancellation of the trip and the referral on **11/12/2017** are both cardiac related"* and the policy terms exclude cover for any

medical condition for which the Complainants were awaiting investigation, at the time the trip was booked.

The Complainants' representative submits that the first Complainant's medical appointment in **December 2017** was *"relatively nonchalant"* and that, at the time the trip was booked in **January 2018**, the first Complainant had not received any feedback from his general practitioner in relation to the planned health screening and had no *"knowledge/inkling of what was to follow"*. The Complainants' representative submits that the shortness of breath reported by the first Complainant to his GP in **December 2017** was a common and benign symptom suffered when a person chases cattle.

The Complainants' representative also submits that because there had been no feedback from the doctor in relation to the planned health screening, the first Complainant telephoned the GP in **February 2018** and further to this call, a health check-up was arranged. The Complainants' representative submits that, as a result of this check-up, the first Complainant's health came into question and further diagnostic tests were recommended.

The Complainants' representative submits that the first Complainant's health issues came into question after the trip was booked and that the trip was booked in good faith without any prior knowledge of the first Complainant's cardiac condition.

By way of letter to this Office dated **5 November 2019**, the Complainants' representative states that the Complainants *"have had a travel policy for 15-20 years…it is important to acknowledge that* [the Complainants] *have always appreciated the importance of having a travel policy and had the Insurer been the Insurer for the past 15-20 years then perhaps their approach might be more open minded."*

Ultimately, the Complainants want the Provider to cover the claim in dispute for their costs of the cancelled trip at €3,979.

The Provider's Case

The Provider has set outs its response to the Complainants' complaint in its final response letter dated **1 November 2018** as well as in its submissions to this Office in response to this complaint.

The Provider says that the claim was declined as the *"medical condition that gave rise to the cancellation of the trip and the referral on **11/12/2017** are both cardiac related"* and the policy terms exclude cover for any medical condition for which the Complainants were awaiting investigation, at the time the trip was booked.

In its submissions to this Office, the Provider refers to the relevant clauses of the Complainants' travel insurance policy in support of its position. I note in that regard that commencing at Page 8, the policy includes "**Important Information**" and continuing on to Page 9, the policy prescribes as follows:-

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*"**Strict Medical Health Requirements**:*

…

- *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 the claim:*
  - *Is receiving, or is on a waiting list for or have the knowledge of the need for surgery, treatment or investigation at a hospital, clinic or nursing home;…"*

The Provider refers to the policy definition of a "***Pre-existing Medical Condition***" which I note is contained within a text box drawn around the definition:-

> ***Pre-existing Medical Condition:***
>
> - ***Any medical or psychological sickness, disease, condition, injury or symptom of which You are aware, or that has affected You, which has required treatment, medical consultation (s) or investigation (s), or prescribed medication at any time during the last 3 years prior to the commencement of cover under this Policy/Schedule of Cover and/or prior to each and every Trip.***
> -
>
> ***…***
>
> ***Should illnesses occur between the date the Policy was incepted and the date of departure, We should be advised".***

The Provider states that the medical condition referred to on the claim form, confirms that the condition that gave rise to the cancellation of the trip was "*non sustained ventricular tachycardia"* which required three stents. The Provider states that the medical certificate and subsequent further medical information received also confirms that the first Complainant was referred to a cardiologist for a stress test, ECHO and review, following his consultation with his GP on **11 December 2017** which was before the trip was booked.

The Provider states that in assessing this claim, it consulted with its medical panel and it is the medical panel's opinion that the condition which gave rise to the cancellation of the trip and the referral on the **11 December 2017** were both cardiac related.

Furthermore, the Provider states that the outcome of the investigations carried out following referral from the first Complainant's GP, show that the first Complainant's cardiac situation was serious and advanced and that his shortness of breath was a symptom of this underlying condition.

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The Provider states that the medical records from the GP visit on **11 December 2017** state that the first Complainant was *"getting short of breath on exertion, such as walking uphill"* and it says that the records do not support the implication that the shortness of breath was only experienced once, while chasing cattle. The Provider further suggests that if the first Complainant commonly experienced shortness of breath, it is unlikely that he would have reported it to his GP.

By way of letter to this Office dated **5 November 2019**, the Provider accepted that the Complainants have held a travel policy for 15-20 years but it points to the fact that the relevant policy for the purpose of this complaint was one which was only incepted on **12 September 2017**.

In essence, the Provider states the evidence of symptoms and investigations, and extent of medical findings, confirm that the medical condition which resulted in the cancellation of the trip, was a pre-existing condition at the time when the policy came into existence and consequently, no benefit is payable on foot of the claim.

The Complaint for Adjudication

The complaint is that the Provider unreasonably and unfairly refused to admit the Complainants' claim, for payment of benefit.

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.

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A Preliminary Decision was issued to the parties on 24 March 2020, 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.

I note that at Page 19 of the policy provisions, the following information is set out:-

> "**General Exclusions**
> **IMPORTANT NOTE**: **Certain sections of the Policy have particular exceptions attaching to them and some apply to all sections**:
> …
>
> No Section of this Policy shall apply in respect of:
> …
>
> b) Claims arising from circumstances known to You at the latter of:
> - applying for this insurance or
> - at any time prior to the commencement of the Period of Insurance or
> - booking Your Trip or
> - the commencement of any Trip,
>
> or claims arising as a result of a material fact or facts, which have not been disclosed to Us prior to the latter of
>
> - the commencement of the Period of Insurance or
> - booking Your Trip or
> - the commencement of any Trip.
>
> …"

I note that the travel insurance policy defines a pre-existing medical condition as:

> *"any cardiac, cardiovascular, hypertensive or cerebrovascular illness, disease, condition or symptom of which You are aware, that has occurred at any time prior to the commencement of cover under this Policy/Schedule of Cover and/or prior to any Trip."*

Having carefully considered all of the evidence before me, I accept the Complainants' submission that they were unaware of the severity of the medical difficulties suffered by the first Complainant at the time of taking out the policy. Nevertheless, it is clear that the investigations carried out on the first Complainant by his GP on **11 December 2017** as well as the GP's referral of the first Complainant to a cardiologist for a stress and ECHO test, was

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relevant information regarding the Complainant's state of health and indeed, these circumstances clearly come within the definition of a "*pre-existing medical condition*" as defined within the policy.

I note in that regard that in the section concerning claims for *"Cancellation or Curtailment"*, the policy provides certain exclusions specifying that:-

> *"You are <u>not</u> covered for:*
> *…*
>
> - *Any Pre-Existing Medical Condition affecting You that would cause You to cancel or Curtail Your Trip, unless You have declared the condition to Us and We have written to You accepting it for insurance.*
>
> *…"*

It appears that in this instance, the relevant information was not made available to the Provider either at the time when the policy was incepted, which I note was prior to the Complainant visiting his GP or alternatively, bearing in mind the discussions which the Complainant had with the GP, neither was the information made available to the Provider prior to the Complainants booking their trip.

While the events surrounding the Complainants' claim are most unfortunate, I accept that the first Complainant was suffering from *"shortness of breath"* prior to the booking of the trip and that this was a symptom of his underlying cardiac condition and should have been declared to the Provider, if he wished for it to be covered by the policy.

Whilst I accept that the Complainants have held a travel policy for 15-20 years, the relevant policy for the purpose of this complaint was only incepted on **12 September 2017,** and it is the terms of this policy which are relevant. It is important for the Complainants to understand that travel insurance policies, like all insurance policies, do not offer cover for every possible eventuality. Rather, the cover made available by the policy will be specifically subject to the terms and conditions and indeed the exclusions which have been agreed between the policyholder and the insurer.

Accordingly, on the basis of the evidence available, I accept that the heart condition of the first Complainant was a pre-existing medical condition which the first Complainant was having investigated at the time when the Complainants booked their trip. Consequently, I accept that any claim arising directly or indirectly from this set of circumstances is not covered under the terms of the Complainants' policy with the Provider. Accordingly, while I understand the Complainants' upset, I must accept that the Provider was not obliged to admit the Complainants' claim under their travel insurance policy and accordingly the complaint cannot be upheld.

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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 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

17 April 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,
(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.