An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0236
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

The Complainants made a claim on their travel insurance policy in respect of an injury suffered whilst on holiday. The claim was declined by the Provider, which relied on the specific provisions of the policy.

The Complainant's Case

The Complainants incepted a travel insurance policy with the Provider on **2 May 2018**.

The First Complainant dislocated her hip whilst holidaying in North America in **September 2018**.

The Provider declined the Complainants' resultant claim as it concluded that the First Complainant's hip dislocation was related to non-declared, pre-existing medical conditions that she had failed to disclose when incepting the policy, specifically osteoarthritis. In addition, the Provider noted from her medical records that the First Complainant had previously dislocated her left hip after a fall on 4 March 2018 (two months prior to incepting the policy) which was corrected under general anaesthesia.

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

> *"Claim declined re medical treatment received in the U.S., declined for non-disclosure of a pre-existing medical condition. Previous to inception* [of] *the policy, I had an incident in which my hip popped out of the socket. This was a standalone incident which I would never had expected to reoccur. When incepting the policy we did not have a clear understanding as to what was meant by a pre-existing injury. We did not advise the Provider of the fact my hip popped out in the past. We did not consider this a condition, as it was a once-off incident.*

> *We feel* [the Provider] *are using our lack of knowledge against us in order to escape any liability for the medical expenses. My hip dislocation is not due to a medical condition. It is a freak incident which unfortunately happened to me twice. Despite it happening to me once, I would never had anticipated it occurring a second time, while in the U.S. There is no evidence to suggest that my hip dislocated due to an underlying condition. A hip dislocation is not classified as a condition – it is an occurrence for which I have no explanation for.*
>
> *May I also add that* [the Provider] *have kept the policy in force despite declining my claim as they recently wrote to me regarding the expiry of the policy – this would appear to be a contradiction of their actions"*.

The First Complainant advises that *"this matter has caused me so much stress and sleepless nights"*. The Complainants *"want* [the Provider] *to honour the policy and cover the medical costs incurred due to my hip dislocating…totalling over $50,000"*.

The Complainants' complaint is that the Provider wrongly or unfairly declined the Complainants' travel insurance claim in respect of medical expenses incurred by the First Complainant whilst holidaying in North America.

The Provider's Case

The Provider maintains that it was entitled to decline the claim owing to the Complainants' failure to disclosure certain pre-existing conditions.

The Provider has identified the following provisions from the *'Policy Cover Summary (Key Facts)'* section of the insurance policy:

> *The policy excludes any claim arising directly or indirectly from any Pre-Existing Medical Condition affecting any person insured on the policy unless that condition has been declared to and accepted by Us in writing.*

The policy defines 'Pre-Existing Medical Condition' as*:*

> *Any medical or psychological sickness, disease, condition, injury or a symptom of which You are aware, or that has affected by You or any Close Relative, Travelling Companion or person with whom You intend to stay during Your Trip, which has required treatment, medical consultation (s) or investigation (s), or prescribed medication at any time during the last 2 years prior to the commencement of cover under this Policy/Schedule of Cover (inside front cover) and/or prior to each and every Trip.*

Section 2 of the policy entitled *'*Medical and Other Expense Incurred abroad' provides as follows under the exclusions section:

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Pre-Existing Medical Conditions unless you have declared these to Us and We have accepted them for insurance cover.

The Provider highlights the following questions which were asked of the Complainants during the call, before the inception of the policy:

In the last two years have you or any person insured on this policy suffered from or received any form of medical advice or treatment, medication or investigation for any medical sickness, disease, condition, injury or symptom?

Have you or any person insured on this policy ever had treatment or hospital consultation for any cardiac, cardiovascular, hypertensive, or cerebrovascular illness, disease, condition or symptom?

The Provider says that the information made available in response to these questions was not in fact accurate.

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 18 June 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.

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This complaint relates to a claim made on a travel insurance policy in relation to medical expenses incurred by the Complainants arising from a dislocated left hip suffered by the First Complainant whilst in North America in September 2018.

At the point of inception of the insurance policy in May 2018, the Complainants did not disclose the fact that the First Complainant, 2 months earlier, had suffered a hip dislocation in March 2018 which was subsequently corrected under general anaesthesia. Neither was the First Complainant's history of osteoarthritis and certain other conditions disclosed.

The Complainants argue that when they took out the policy, they "*did not have a clear understanding of what is meant by pre-existing condition*". The Complainants maintain that they understood a pre-existing condition to refer to "*an illness or ongoing condition*".
The Complainants state that they did not disclose the previous hip dislocation as they viewed it as "*a one-off incident which we would never had expected to recur.*" The Complainants contend that the Provider is "*using their lack of knowledge*" against them.

The Provider highlights the following questions which were asked of the Complainants during the call, before the inception of the policy:

> ***In the last two years*** *have you or any person insured on this policy suffered from or received* ***any form of medical advice or treatment, medication or investigation*** *for* ***any medical sickness, disease, condition, injury or symptom?***
>
> [My emphasis]
>
> *Have you or any person insured on this policy ever had treatment or hospital consultation for any cardiac, cardiovascular, hypertensive, or cerebrovascular illness, disease, condition or symptom?*

The Provider points out that Raynaud's Disease was the only medical condition declared by the Second Complainant regarding the First Complainant's medical history.

I am satisfied that the March 2018 hip dislocation suffered by the First Complainant, and the treatment provided in respect thereof, was a condition or injury or event that required medical advice or treatment in the previous 2 years. I note however, that this event or incident which required the First Complainant to have medical treatment at that time, was not declared to the Provider when the policy was being put into place. The above question was in my opinion, entirely clear and it is difficult to understand why the Complainants believed the question to concern only what they refer to as "ongoing conditions".

The fact that the Complainants may have thought that it was "*a one-off incident which we would never had expected to recur*" did not absolve them of an obligation to respond with accurate information to the questions asked of them. The question was not limited in any fashion by reference to what the policy holder thought likely to recur. This is entirely unsurprising, as insurance companies are entitled to decide themselves what risk a previous condition or injury might present, and whether that might result in a greater premium being charged or a decision being made not to offer cover or to provide limited cover only.

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Accordingly, the failure to refer to the previous hip dislocation amounts, in my view, to a non-disclosure.

It is important therefore to form an opinion as to whether this non-disclosure related to a material fact. A material fact is one which would have influenced a reasonable provider, if it had been disclosed. I note that in its final response letter, the Provider stated as follows:

> *Had you declared all of your pre-existing medical conditions as set out above; namely your previous hip dislocation, Osteoarthritis, Aortic stenosis, and Gastro-oesophageal reflux disease, in addition to your Raynaud's condition, we would have offered you a policy but could not have offered cover for any of your pre-existing medical conditions.*

The foregoing makes clear that the Provider would have been influenced by the fact of the previous hip dislocation and that the information would have led to it declining to offer cover in relation to any further injury to the hip. Indeed, I am satisfied that a reasonable provider would have been influenced by the said information which was not disclosed by the Complainants, if it had been disclosed.

Travel insurance contracts, like all insurance contracts, are contracts of utmost good faith; the failure by a policyholder to disclose material information, allows the Insurer to void the policy from the outset and to refuse or cancel cover. Once non-disclosure takes place – whether innocent, deliberate or otherwise – the legal effect of that non-disclosure can operate harshly, and it entitles an Insurer to, amongst other things, refuse cover, as the Provider has done in this instance.

As the Provider was not made aware of the First Complainant's previous medical history regarding hip dislocation, when it agreed to incept the policy, it was denied the opportunity to assess the level of risk being insured, and the policy was put in place on the basis of a false premise.

This Office is aware that the courts have long considered the issues surrounding non-disclosure of material facts. In this regard, in *Aro Road and Land Vehicles Limited v. Insurance Corporation of Ireland Limited* [1986] I.R. 403, the Court determined that representations made in the course of an insurance proposal form should be construed objectively, with Henchy J stating that a person *"must answer to the best of his knowledge any question put to him in a proposal form"*.

In *Coleman v. New Ireland Assurance plc t/a Bank of Ireland Life* [2009] IEHC 273, Clarke J held that a party could only be subject to having his or her policy of insurance voided because of the manner in which they answer a proposal form, if he or she failed to answer "*such questions to the best of the party's ability and truthfully*".

I am also cognisant of the views of the High Court in *Earls v. The Financial Services Ombudsman* [2014/506 MCA], when it indicated, *"The duty arising for an insured in this regard is to exercise a genuine effort to achieve accuracy using all reasonably available sources"*.

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In this instance, I am satisfied that the questions put to the Second Complainant for the purpose of policy inception were clear and comprehensible and I am satisfied that a reasonable proposer for insurance would have declared the First Complainant's history of hip dislocation 2 months earlier, in March 2018, when asked about having ever had treatment or hospital consultation over the previous 2 years

The Provider maintains that it would not "*have offered cover for any of your pre-existing medical conditions"* had full disclosure been made. I understand this to mean, that if the previous hip dislocation had been disclosed, the Provider would, at a minimum, have excluded cover in respect of any further dislocation of, or injury to, the same hip or perhaps both hips. In the circumstances, I am satisfied that the Provider was entitled to decline the claim.

In light of the entirety of the foregoing, and in the absence of evidence of wrongdoing by the Provider or conduct within the terms of ***Section 60(2)*** of the ***Financial Services and Pensions Ombudsman Act 2017*** that could ground a finding in favour of the Complainants, I am not in a position to uphold the complaint.

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
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

10 July 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.