An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0295
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 complaint relates to a Travel Insurance Policy.

The Complainants' Case

The Complainants submit that on **14 March 2019** they booked return flights to the USA departing on **4 April 2019** and returning on **15 April 2019**. They further submit that on Tuesday **19 March 2019** they purchased travel insurance with the Provider.

The Complainants assert that the Second Complainant's symptoms in existence prior to the policy being purchased on the **19 March 2019** were unrelated to the reason for them cancelling their travel arrangements. The Complainants say that they were advised on Wednesday **20 March 2019** by their medical advisors not to travel due to the Second Complainant's condition.

In a letter submitted by the Complainants, dated **2 April 2019**, from [Hospital A] the Consultant details:

> *"While in hospital she had neuroimaging and multiple other investigations. She was reviewed by the Acute Medical Consultant as well as the Consultant Neurologist. She was advised not to travel to her upcoming trip to the States. Of note she would not have known about this at the time of booking her trip".*

The Complainants state that they cancelled their flights with the airline on **3 April 2019**. They further state that the airline refunded them the taxes relevant to the flights that they were due to take on the **4 April 2019**. On **30 May 2019** the Complainants submitted a formal

complaint to this Office, as the Provider had declined their ensuing claim under the travel insurance policy.

The Provider's Case

The Provider, in its letter to the Complainants on the **16 August 2019**, quotes a statement from the Complainants' medical advisor supporting its decision to decline the claim on the grounds that it was a pre-existing medical condition that resulted in the flights being cancelled and a claim being made:

> "[Second Complainant] *who is complaining of left side headache since Saturday (16/3/19), worsening up to 7/10 in severity. Last night (18/3/19) at 12 midnight went to mirror and noted right lip drooped. Thought she was getting Bells' Palsy again".*

Following a request, to the Provider from this Office, on **9 October 2019** for confirmation that the letter dated **16 August 2019** was in fact a Final Response Letter, a Final Response Letter was issued by the Provider on the **18 October 2019**. In this letter the Provider detailed that it had undertaken a full investigation into the reasons for the claim being denied and advised that its decision, communicated in its letter of **16 August 2019**, was being upheld, based on the evidence related to the knowledge of a pre-existing condition at the time of the purchase of the policy. The Provider again refers to the medical evidence to support its decision:

> *"… We assert this is self-evident, as the policy was purchased at 09:42am on the morning of the 19 March 2019 after the onset of symptoms, but immediately prior to presentation to the GP who notes symptoms to be in existence for '12 hours'".*

The Provider has made available a timeline of events which I have summarised as follows:

14 March 2019	• Complainants book trip.
19 March 2019 (9.42 AM)	• Travel insurance purchased.
19 March 2019	• Complainant attended GP who confirms in Medical Certificate attached to Claim Form, that cancellation of the trip was recommended on this date.
20 March 2019	• Consultant recommends cancellation of trip.
1 April 2019	• The first named Complainant contacted [the Provider] and advised that his wife had been in hospital for the preceding week due to a severe migraine and he advised

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	that she could no longer travel to America. He also confirmed that no accommodation had been pre-booked. A Claim Form was sent to the Complainant on the same date.
3 April 2019	• Flights Cancelled.
4 April 2019	• Intended departure date.
15 April 2019	• Intended return date.
16 April 2019	• Completed Claim Form returned to the Provider.
22 April 2019	• The Provider contacted the Complainants seeking additional documentation.
7 May 2019	• The Provider received the additional documents requested on 22 April 2019.
20 May 2019	• The Provider declined the Complainants' claim.
23 May 2019	• The first named Complainant contacted [the Provider] and advised that they did not understand why their claim was being declined. [The Provider] referred to [its] decline letter and again advised that the symptoms were in existence before the period of insurance. [the First Complainant] requested a refund of his premium and we advised that this was not possible as the 14-day cooling-off period post purchase had elapsed and he had already claimed on the policy (notwithstanding the decline of same). [The Provider] advised that [it] *would refer the matter for further review.*

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1 July 2019	• First Complainant contacted the Provider and informed it that he was not happy with the result. • The First Complainant "*advised that the condition was unrelated to any previous condition; it was a different kind of headache. He advised that his wife did have a headache on the Saturday but that she was fine on the Sunday and Monday. However, on Tuesday there was a new headache that only started on the Tuesday.* [The Provider] *advised that* [it] *would further check the file".*
23 July 2019	• First Complainant contacted the Provider for an update. The Provider informed the First Complainant that it would have an update the end of the week.
16 August 2019	• The Provider informed the Complainants that it was maintaining its decision to decline their claim.
9 October 2019	• FSPO contacted the Provider and notified it that the Complainants had made a complaint. • FSPO sought clarification as to whether the Provider's letter on the 16 August 2019 was a Final Response Letter. • The Provider noted *"no FRL had issued as the Complainants had not pursued this matter further following our re-decline of the 16/08/2019"*.
18 October 2019	• The Provider issued its Final Response Letter.

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The Complaint for Adjudication

The complaint is that the Provider wrongfully declined to indemnify the Complainants for losses relating to their cancelled flights.

The Complainants want the Provider to refund the balance of their fares, following the refund of relevant taxes from the airline.

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 August 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.

Policy Terms and Conditions

I note that at page 3 of the Policy Document, the following is set out:

> *"**Introduction***
> *Thank you for insuring with us. Here is Your new* [Insurance Name] *Travel Insurance Policy document. The Schedule of Cover from this Policy contains full details of the protection provided by this Policy. Please ensure that you carry this document with You on Your Trip.*

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This Policy (which includes and should be read as one document with the Schedule of Cover, Endorsements and Proposal Form) is evidence of the contract of insurance between you and [the Provider].

Details of cover are laid out in this Policy, and we recommend that You read it to satisfy Yourself that this insurance meets Your requirements. However, We would ask You to especially note the following:

We agree to pay for damages, liabilities, ***losses or costs as set out in this Policy occurring during the Period Of Insurance*** *within the Geographical Limits."*

'Medical Condition' is defined at page 6 of the Policy Document as:

"*Any disease, illness, injury or symptom".*

The requirements to be eligible for cover under the Policy Document are stated on page 4 as:

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

This insurance operates on the following basis:

- *To be covered under this Policy, You must be healthy, fit to travel and fit to undertake Your planned Trip.*
- *The insurance will NOT cover You when you are travelling against medical advice of a qualified Medical Practitioner or with the intention of obtaining a medical treatment abroad.*
- ***No claim arising directly or indirectly from any Pre-Existing Medical Condition affecting You will be covered unless that condition has been declared to and accepted by Us in writing****. Please note the definition of Insured Person(s) under Definitions.*
- *Medical Declarations are valid only during the Period of Insurance in which they are made. On renewal of the Schedule of Cover/Policy, Pre-Existing Medical Conditions must be re-declared to Us. Any Pre-Existing Medical Condition not declared to us during the current Period of Insurance will not be covered under Your Schedule of Cover/Policy.*
- ***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 or investigations in a hospital or nursing home; or*

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- *has received a terminal prognosis; or*
- *is travelling against the medical advice of a qualified practitioner or for the purpose of obtaining treatment abroad; or*
- ***Any medical condition in respect of which You or Your Close Relative or Travelling Companion have not received a diagnosis**.*
- ***Any circumstances You are aware of that could reasonably be expected to give rise to a claim on this Policy**"*

*'**Cancellation**'* is covered on page 9 of the Policy Document and is defined as follows:

"***Section 1 – Cancellation and Curtailment Charges***

*We will cover you up to the amount shown on Your Schedule of Cover per Insured Person in total under this Policy for financial loss suffered by You during the Period of Insurance, being non-refundable deposits and amounts You have paid (or have contracted to pay), for travel to/from Your holiday destination and accommodation You do not use because of Your inability to commence travel or You curtail the Trip as a result of any of the following events **occurring after payment of the policy premium (and at the time of booking Your Trip in respect of an annual policy) and occurring within the Period of Insurance**. Your cancellation or Curtailment must be necessary and unavoidable in order for You to claim.*

You are covered for:

Cancellation

- *The death, Bodily Injury, **or Illness of You**, Your Travelling Companion, any person with whom You have arranged to reside temporarily during Your Trip, Your Close Relative, or Your Close Business Associate".*

Analysis

The Policy was incepted on the **19 March 2019** for a trip which was scheduled to take place between **4 April 2019** to **18 April 2019**. The Complainants' claim was declined by the Provider by reference to the terms and conditions of the policy.

I note that in its initial rejection of the Complainants' claim on the **18 October 2019**, the Provider, having cited the policy terms and conditions above, reasoned as follows:

"*We took the decision to deny liability for your claim on the basis:*

A. At the time of the purchase on 19 March 2019 at 09.42 [Second Complainant] *was aware of a medical condition (symptoms), but had not at that point had a diagnosis.*

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B. It is also our assertion, the event giving rise to the claim did not occur unexpectedly within the period of insurance.

C. And finally, the circumstances of which you were aware (at the time of the purchase of the policy), could reasonably be expected to have given rise to a claim."

Subsequent to the Complainants' complaint to this Office, the Provider in its submissions to this Office, recited the policy terms and conditions, stating that cover was not provided for any medical conditions if, at the time of the purchase of the policy, the Policyholder had symptoms that pre-dated the purchase of the policy. The Provider went onto state:

> "*We assessed the Complainant's claim having been furnished by the Complainant with a Medical Certificate completed by her GP in which it was confirmed on the 09/03/19, which we must accept as fact. However, it is also relevant to note that irrespective of when cancellation was recommended, it is clear from the Complainant's own submissions that the issue that gives rise to cancellation, i.e. the symptoms, pre-date the purchase of the policy. The symptoms which eventually led to the cancellation of the trip were already in existence when the policy was purchased".*

Furthermore the policy states that:

> "*No claim shall be paid where at the time of taking out this insurance … the person whose condition gives rise to a claim is aware of:*
>
> - *Any circumstances … that could reasonably be expected to give rise to a claim on this Policy".*

I am of the view, based on the evidence made available to this Office that the Provider was entitled to decline the claim as the Second Complainant was aware at the time of the purchase of the policy on the **19 March 2019**, of a medical condition (symptoms) although she did not yet have a diagnosis. The Complainants in their submission to this Office state as follows:

> "*YES* [Second Complainant] *HAD A HEADACHE BUT IT DID NOT SEEM TO BE A MAJOR CONCERN".*

I have considered the computerised Medical Records from the Second Complainant's GP and note the following:

> "[Second Complainant] *who is complaining of left side headache since Saturday, worsening up to 7/10 in severity*
> *Last night at 12 midnight went to mirror and noted right lip drooped".*

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The Provider has stated that:

> *"…the policy was purchased at 09:42am on the morning of 19 March 2019 after the onset of symptoms, but immediately prior to presentation to the GP who notes symptoms to be in existence for "12 hours."*

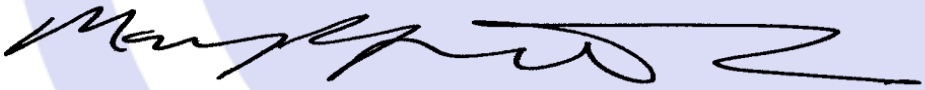
I am satisfied that the Provider was entitled in those circumstances, to decline the Complainants' claim based on this term of the policy because the symptoms that the Second Complainant had at the time of the purchase of the policy, could in my opinion, reasonably have been expected to give rise to a claim.

On the basis of the evidence made available by the parties, I am satisfied that the Provider's conduct in refusing to admit the claim was a reasonable one based upon the evidence available, details of which are outlined above. I am satisfied that the Provider acted in accordance with the terms and conditions of the policy, and for that reason I do not consider there to be any reasonable basis upon which it would be appropriate to uphold this 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

9 September 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.