An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0330
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

The complaint concerns the Complainant's health insurance policy with the Provider.

The Complainant's Case

The Complainant submits that upon agreement to take out a health insurance policy with the Provider, she received a welcome pack dated **30 December 2016**. She further submits that a covering letter enclosed with the welcome pack stated:

> *"You are now a customer of ... Your policy is now live and will continue for 12 months."*

The Complainant accepts that she was advised by the Provider to review all documents contained within the welcome pack to ensure all her needs were covered but that she did not review these documents upon receipt as, *"I saw no need to do so"*. She further states that she assumed her cover had started on **30 December 2016**, based on the wording in the welcome letter.

The Complainant states that on **9 January 2017** she suffered a neck injury after being struck on the head with a ball. She acknowledges that she dated this incident as the **23 January 2017** when she went to the healthcare provider for her surgery and states that she *"may have been confused at that time"* but that she *"now know*(s) *that this was on **9 January**"*.

The Complainant submits that she was referred by her doctor for a MRI scan which she attended on **3 February 2017** and that the Provider covered the cost of this scan.

The Complainant states that she met with a specialist neurosurgeon on a later date, who advised that surgery was required to remedy her injury and suggested that the Complainant make enquiries with the Provider to ensure the costs of this procedure would be covered. The Complainant states that she contacted the Provider on **27 June 2017** and gave details of all the procedure codes as well as any other information requested. She submits that when she was asked about the nature of her injury, she stated *"I said it was a new condition, which it was, having originated on **9th January**"*.

The Complainant states that at this point the Provider *"confirmed I was covered for the operation, which took place on the **27th July**"*. The Complainant contends that this confirmation from the Provider resulted in her decision to proceed with the surgery on **27 July 2017**.

The Complainant states that the Provider declined her claim following the procedure on the grounds that her injury was a pre-existing condition. The Complainant states, *"It is unfair and unreasonable for them to turn around after the operation and contend that I was not covered"*. In a later submission, the Complainant submits that she is now involved in legal action taken against her by the health care provider which is seeking payment for the procedure she underwent.

Ultimately, the Complainant wants the Provider to cover the full payment amount to the health care provider, for the services provided for her.

<u>The Provider's Case</u>

The Provider issued a Final Response Letter on **27 June 2018** and stated that its records show that the Complainant's policy commenced on **25 January 2017**. The Provider states that the Complainant received a welcome pack which included a membership handbook and table of cover, both of which confirmed the starting date of the policy as **25 January 2017**. The Provider states that the Complainant was advised to review these documents to ensure that she was fully aware of the applicable terms and conditions of her policy.

The Provider has referenced a phone call it received from the Complainant on **24 February 2017** wherein she enquired about her eligibility to claim for a procedure. The Provider informed the Complainant that because she had no previous health insurance prior to this policy, she would not qualify to claim because *"the 5-year waiting period for a pre-existing condition had not been served, however new conditions would be covered after 26 weeks"*.

The Provider has referenced another phone call from the Complainant dated **27 June 2017**. The Provider states that the Complainant enquired about her eligibility to claim for a procedure. The Provider states that whilst on this call, the Complainant advised that her injury was a new condition. The Provider states that based on the information provided by the Complainant, it advised that she was entitled to claim for the cost of the procedure, citing that the 26 week waiting period for new conditions would be served in **July 2017**.

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The Provider asserts that the Complainant was advised correctly at the time of the call stating *"that if the condition was new since the inception of the policy you would be covered for the procedure"*. The Provider states that the date provided in relation to the onset of symptoms was recorded on the Complainant's claim form as an accident that occurred on the **23 January 2017**. The Provider submits that this was *"two days prior to the inception of the policy"*.

The Provider acknowledges that the Complainant disputes the date of symptoms on the claim form but contends that no alternative date was made available despite numerous requests for clarification.

The Provider also refers to phone calls received from the Complainant dated **24 May 2018** and **18 June 2018** wherein she enquired as to why her policy documents were provided to her on **30 December 2016** and yet her policy only commenced on **25 January 2017**. The Provider submits that it has listened back to the phone call of the sale of the policy on **30 December 2016** and it notes that it was at the specific request of the Complainant, that her policy would begin on **25 January 2017**. The Provider also states that the Complainant requested the premiums to be collected on the **25th** of every month starting in **January 2017**.

The Provider also addressed the Complainant's MRI scan and stated that this was paid *"in line with the benefits on your plan and the Terms and Conditions of your policy. This claim was settled in full with a payment directly to the treatment centre"*. The Provider advised that it may review the claim, if it is confirmed that the MRI was related to the accident dated the **23 January 2017**.

Essentially, the Provider states that the Complainant had no cover for any condition which was already present at the time of joining the Provider on **25 January 2017**, for a period of 5 years. The Provider states that as the accident occurred prior to the Complainant joining the Provider, the applicable 5 year waiting period for pre-existing conditions applied and the Complainant's claim was rejected.

The Provider made further submissions to this Office dated **23 March 2020**. The Provider states in these submissions that on **30 August 2017** it received a claim from a healthcare provider relating to the Complainant. The Provider states that part one of the claim form, completed by the Complainant, noted that she had received an injury as a *"ball hit side of my head"* on **20 February 2017**. The Provider states that part two of the claim form, completed by the treating consultant, notes in Section 8, that the primary diagnosis was *"severe degenerative change at c4/5 and c5/6 with bilateral neural stenosis"* with no mention as to any incident involving a ball.

In these further submissions, the Provider also addresses the fact that the wording in its welcome pack dated **30 December 2016** stated: *"Your policy is now live and will continue for 12 months"*. The Provider states that it recognises that this wording *"could have been confusing, however in the context of this complaint, we do not believe that this was the case."*

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The Provider believes that the wording was not confusing to the Complainant in this matter as:

- the Complainant specifically requested that the start date of the policy be put forward to **25 January 2017**;
- the member certificate which formed part of the welcome pack at that time documented the policy start date correctly; and
- the Complainant admits she did not view these documents so the statement concerning the policy being *"live"* had no impact on her.

The Provider also notes, in the interests of completeness, that it has now removed that statement from further policy documentation. The Provider also states that the Complainant had opportunities to query the start date if she thought it was wrong; for example, the Complainant states that during the call regarding eligibility to claim, on **24 February 2017**, the Provider's representative said *"so when you joined with us there on the 25th January…"* and the Complainant did not stop and query this.

Similarly, the Provider states that on the call regarding eligibility to claim, some 4 months later, on **26 June 2017**, the Provider's representative stated: *"So you've been with us since January on this plan?"* to which the Complainant responded *"yes"*.

Finally, the Provider states that during a telephone conversation between the Complainant and the complaint handler on **27 April 2018**, the complaint handler advised the Complainant, multiple times, that the date of the accident on the MRI claim form (**23 January 2017**) pre-dated the start date of the policy (**25 January 2017**); the Provider states that at no point during these calls did the Complainant stop and query the start date of the policy.

Furthermore, the Provider submits that there has been no substantiation of the date of the accident and there has been no medical evidence provided which documents the accident. The Provider states that the only information it has received concerning the date of the accident has been from the Complainant, via the claim form or in her calls/letters to the Provider. The Provider states that on the basis of the information it has received to date, there have been 5 separate dates given by the Complainant as the date of the accident:

- **23 January 2017** – noted by the Complainant on the claim form for an MRI scan (received by the Provider on **14 March 2017)**
- **20 February 2017** – noted by the Complainant on the claim form for the admission to the health care provider (received by the Provider on **30 August 2017)**.
- **End of January 2017, definitely** – referred to by the Complainant during her telephone conversation with the complaint handler on **27 April 2018**.
- **6 January 2017** – noted on the claim appeal letter written by the Complainant and received by the Provider on **2 August 2018**
- **9 January 2017** – noted by the Complainant on the Complaint Form, received from this Office on **14 August 2019**.

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The Provider states that given the medical evidence provided in the claim form, and her GP notes, it is clear to the Provider that the Complainant was experiencing signs and symptoms of a condition (which ultimately required her to have surgery) prior to taking out her health insurance policy with the Provider. The Provider also states that the Complainant's claim has been reviewed extensively by the Provider's team of medical advisors and the Provider's medical director and it is the opinion of these medical experts, that *"the signs and symptoms of the member's condition existed within 6 months prior to taking out insurance"* with the Provider. The Provider again highlights that there are no medical notes actually referring to the date of the accident and that the primary diagnosis giving rise to the need for the surgery, was *"severe degenerative change"*.

Therefore, the Provider states that it had no option but to decline the Complainant's claim as the treatment she was claiming for related to a condition which was present, prior to inception of her health insurance policy.

The Complaint for Adjudication

The complaint is that the Provider was guilty of maladministration in that it:

1. Issued misleading documentation at the point of sale which led the Complainant to believe she was covered from **30 December 2016** as opposed to from **25 January 2017**;
2. Incorrectly advised or misled the Complainant on **27 June 2017**, by confirming she was eligible to claim for the cost of the procedure, despite having been informed that the Complainant's injury occurred prior to the inception of the policy;
3. Contradicted the advice provided to the Complainant on **27 June 2017** and refused her claim on the grounds that her injury was a pre-existing condition that occurred prior to the inception of the policy;
4. Put the Complainant in a difficult position due to the issuing of the incorrect information, whereby legal proceedings are being pursued against the Complainant by the health care provider as a means of recovering the costs of treatment.

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.

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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 **9 September 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 the Complainant contacted the Provider to enquire about taking out a health insurance policy on **30 December 2016**. At this point, the Complainant was taken through a full health review and a policy was purchased. I note that the welcome back received by the Complainant via email on **30 December 2016** made reference to the policy being *"live".* However, I accept that this is unlikely to have impacted upon the Complainant, as she had specifically requested that her policy only start on **25 January 2017**.

In this regard, I note that the audio evidence submitted to this Office discloses that it was at the specific request of the Complainant that the policy began on **25 January 2017** and that premiums in relation to the policy were to be collected on the **25th** of every month. I further note that the welcome member certificate which formed part of the welcome pack and the health insurance certificate issued to the Complainant via email on **30 December 2016,** documented the policy start date correctly. In any event, I note that the Complainant accepts that she did not read the welcome pack, so any detail contained within that pack concerning the start date of the policy could have had no material effect on her belief that the start date was **25 January 2017**.

I also note that in telephone conversations with the Provider on **24 February 2017**, **26 June 2017** and **27 April 2018**, the start date for the policy was mentioned as **January 2017** and the Complainant raised no issue with this. Therefore, I accept that the start date of the Complainant's policy was **25 January 2017** and that the Complainant was at all times aware of this start date.

Furthermore, I note that the date of the accident concerning the ball hitting the side of the Complainant's head renains uncertain. The Complainant has provided a multitude of different dates on which the accident is said to have occurred, in her claim forms and over the course of her correspondence with the Provider and this Office. I accept the submissions of the Provider that there has been no substantiation of the date of the accident and there has been no medical evidence provided which documents that accident.

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I also note that part two of the Complainant's claim form, completed by the treating consultant, notes in Section 8 that the primary diagnosis for which the Complainant was seeking treatment was *"severe degenerative change at c4/5 and c5/6 with bilateral neural stenosis"*. I have had further regard to the Provider's submission that the Complainant's claim has been reviewed extensively by the Provider's team of medical advisors and the Provider's medical director, and that it is the opinion of these medical experts that *"the signs and symptoms of the member's condition existed within 6 months prior to taking out insurance"* with the Provider.

It is important to note that health insurance policies, like all insurance policies, do not provide cover for every eventuality; rather the cover will be subject to the terms, conditions, endorsements and exclusions set out in the policy documentation.

Page 24 of the policy handbook deals with *"pre-existing conditions"* and states that:

> *"Where you make a claim which relates to a pre-existing condition, a pre-existing condition waiting period will apply. A pre-existing condition is an ailment, illness or condition, the signs or symptoms of which existed at any time in the six months before you took out health insurance for the first time or before you took out health insurance after your health insurance lapsed for 13 weeks or more.*
>
> *You will not be covered for a pre-existing condition during your pre-existing condition waiting period. Our medical advisors will decide whether your claim relates to a pre-existing condition. Their decision is final"*

I note that page 24 of the policy, sets out the "pre-existing condition" waiting period which applies for different types of benefits. In respect of all in-patient benefits, the applicable pre-existing waiting period is specified as a period of 5 years from the date of membership.

As a result, I am satisfied that it was reasonable for the Company to conclude from the documentary evidence before it, that the treatment undergone by the Complainant was for a condition which pre-existed the start date of the Complainant's policy on **25 January 2017**. All of the evidence before this Office indicates that the Provider was reasonable in forming the opinion that the degenerative change to the Complainant's spine took place prior to **25 January 2017,** in the absence of substantive evidence that the Complainant was hit in the side of the head by a ball, causing her injuries, on a date after **25 January 2017.**

In relation to the complaint that the Provider incorrectly advised or misled the Complainant on **27 June 2017**, by confirming she was eligible to claim for the cost of the procedure, I note that the audio evidence submitted to this Office shows the Complainant clearly responded *"New"* when asked by the representative of the Provider whether her injury was a new or pre-existing condition. I note that it was on this basis, that the Provider's representative advised the Complainant that she was entitled to claim for the cost of the procedure, citing that the 26 week waiting period for new conditions would be served in **July 2017**.

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I am satisfied therefore, that the Provider did not incorrectly advise or mislead the Complainant on **27 June 2017**, nor did it contradict this advice at a later date, as it was offering guidance to the Complainant at that time, on the basis of the Complainant's indication that the issue was new, as opposed to being a pre-existing condition. Accordingly, I am satisfied that the Provider acted in accordance with the terms and conditions of the Complainant's policy when it declined the Complainant's claim.

Finally, I note that the Provider acknowledges that it made an error in the welcome pack issued to the Complainant on **30 December 2016** when it stated *"Your policy is now live"*. In noting this administrative error, I take the view for the reasons referred to above, that it did not adversely affect the Complainant or result in the Provider wrongly assessing the Complainant's claim. Accordingly, while I understand and appreciate the difficulties the Complainant now faces in paying the healthcare provider for the cost of the treatment undergone, I am satisfied that there is no 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

2 October 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.