An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0355
Sector:	Insurance
Product / Service:	Travel
Conduct(s) complained of:	Rejection of claim - non-disclosure
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 while travelling abroad in April 2019, the Second Complainant fell ill and had to be hospitalized *"due to severe epistaxis, and had to undergo urgent Angiography with Embolization, after repeated nasal packing and chemical cauterizations".*

The Complainants submit that when they contacted the Provider, they were disappointed with the Provider's response and they "*believe that they have prematurely decided on the issue".* The Complainants also state that they felt they were "*deceived and scammed".*

The Complainants also had issues with the customer service and communications from the Provider, during the period when the Second Complainant was in hospital:

> *"On my husband's communication with them via phone, my husband asked them many times if they have spoken to our attending doctor in the* [Country] [Complainants Attending Doctor, Hospital and City], *and they said they did, but upon discharge, we discovered that our doctor said he did not receive any call from* [the Provider].

The Provider's Case

In its Final Response Letter, the Provider has acknowledged its error in declining the claim:

> "*It's now clear that* [Agents of the Provider's] *didn't have enough information to make this decision. The question you were asked on the telephone on 4 April 2019 when you purchased the policy was whether you were 'waiting for investigation or referral, or the results of any investigation, medical treatment or surgical procedure'. I've listened to our recording of this call and you answered "no" to this question. However, while the information from your GP strongly implied you were under referral at the time of purchasing the policy, it wasn't conclusive because the dates were not confirmed".*

The Provider has offered to re-assess the claim and has confirmed that corrective feedback has been given:

> *"…*[the Agents of the Provider] *should not have declined your case unless they were absolutely sure of the information provided by your GP. I've provided feedback to ensure this doesn't happen again".*

The Provider goes on to say that:

> "*…*[the Agents of the Provider] *have written to your GP again. Once they receive a reply, your claim will be reassessed and you will be updated. If the decision is taken to cover your claim, our claims team will be in contact to arrange reimbursement of the costs you have paid."*

The Complaint for Adjudication

The complaint is that the Provider failed in its level of communication to the Complainants and wrongfully repudiated the Complainants' claim.

The Complainants are "*seeking payment for the sum of money we incurred from the hospitalization and for other subsequent loss we incurred".*

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.

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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 **23 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 in the Provider's Final Response Letter to the Complainants, dated **27 June 2019**, the Provider has stated as follows:

> "*I've reviewed the circumstances of your claim and it is clear that* [the Provider's] *decision to decline the claim was premature. Please allow me to explain.*
>
> *You were admitted to hospital in* [Location Name] *on 22 April 2019 for severe nose bleeds, and I understand you had an operation to rectify this.* [The Provider] *made the decision to decline the claim when they reviewed the medical history provided by your GP, which indicated a history of high blood pressure since 2015 and a recent hospital referral to monitor this. This condition wasn't declared when you purchased the policy on 4 April 2019, so* [the Provider] *believed this invalidated the policy.*
>
> *It is now clear that* [the Provider] *didn't have enough information to make this decision. The question you were asked on the telephone on 4 April 2019 when you purchased the policy was whether you were "waiting for investigation or referral, or the results of any investigation, medical treatment or surgical procedure". I've listened to our recording of this call and you answered "no" to this question. However, while the information from your GP strongly implied you were under referral at the time of purchasing the policy, it wasn't conclusive because the dates were not confirmed.*
>
> *Therefore* [the Provider] *are revisiting this decision again. They have re-opened your claim and have written to your GP to obtain more information".*

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I am therefore satisfied that the Provider has adequately met the complaint in circumstances where the Complainants requested on the **29 May 2019** for their case to be re-reviewed and a proper explanation given as to why the claim was declined. The Provider wrote to the Complainants , less than a month later, on the **27 June 2019** informing them that it had re-reviewed the claim and had decided to re-open their claim as it should not have declined their claim without clarifying with the Complainants' GP first.

In considering the Complainants' complaint under *Section 2.1* and *Section 2.2* of the Consumer Protection Code I am not satisfied that the Provider has met its obligations under these Sections, which states as follows:

> *"A regulated entity must ensure that in all its dealings with customers and within the context of its authorisation it:*
>
> *2.1 acts honestly, fairly and professionally in the best interests of its customers and the integrity of the market;*
>
> *2.2 acts with due skill, care and diligence in the best interests of its customers;"*

I am not satisfied that the Provider met its obligations under these provisions and indeed the Provider itself acknowledges that it had declined the Complainants' claim prematurely as "*there was insufficient information to make the decision".*

The Provider has submitted that:

> "*It wasn't clear whether* [the Second Complainant] *was referred for the high blood pressure test before or after the policy was purchased on 04/04/10. We instructed* [our Agents] *to re-open the claim and obtain this, as well as paid* [the Second Complainant] *€100.00 for the trouble and upset caused…* [the Provider's Agents] *should have and could reasonably obtained this information before their initial decision to decline".*

I am satisfied that the Provider has met its obligations under the Consumer protection Code, because, when the Complainants emailed the Provider on the 29 May 2019, to inform it that they were not happy with the declinature of the claim, the Provider opened an investigation into the matter and quite swiftly found that it had indeed been premature in declining the Complainants' claim. The Provider then re-opened the Complainants' claim and offered the Complainants €100.00 by way of compensation for declining the claim prematurely.

In circumstances where the Provider found from its investigation that it had declined the claim prematurely as there had been insufficient information, on which to base its decision, and in circumstances where it wasn't clear whether the Second Complainant was referred for the high blood pressure test before or after the purchase of the policy, I note that the Provider quickly re-opened the claim to obtain this information. The Provider also gave the Second Complainant €100.00 for the trouble and upset caused. In the circumstances, I am of the view that the Provider adequately met the complaint made to it at that time.

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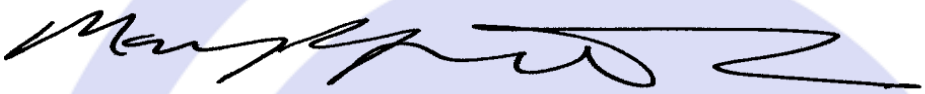
Whatever the outcome of the further re-assessment of the claim by the Provider in due course, that re-assessment of the claim does not form part of this complaint made by the Complainants in July 2019, which concerns only the initial response of the Provider to the Complainants, at the time when their claim was initially assessed. Accordingly, for the reasons outlined above, I do not consider it 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

15 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.