An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

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| **Decision Ref:** | 2020-0395 |
| **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 a travel insurance policy.

### The Complainant's Case

The Complainant contends that her Doctor:

> *'found a heart murmur on the **26/09/2018** and because* [the Complainant] *was also getting dizziness and short of breath* [the doctor] *told* [the Complainant] *not to travel until* [she] *had seen cardiologist and had an echo done to ensure there were no leaky heart valves – she confirmed to* [the Complainant] *the reason for* [the Complainant] *not travelling was because of this new heart murmur so* [the Complainant] *took her advice and cancelled holiday'.*

The Complainant says that she made a claim to the Provider which subsequently declined her claim.

### The Provider's Case

The Provider in its Final Response Letter of **15 January 2019** contends that the Complainant's:

> *'holiday was booked on **11 March 2018** with planned travel dates of **2t October 2018** to **31 October 2018**. The Insurance policy in question was incepted on **23 September 2018**'.*

According to the Provider the extent of cover is defined in the Policy Booklet. The Provider asserts that under the General exclusions in the policy, it will not provide cover:

> *"…from claims arising directly or indirectly from:*
>
> *Any circumstances known prior to the date that this insurance is purchased or the time of booking any Trip which could reasonably be expected to give rise to a claim".*

The Provider contends that there is an onus on the insured to familiarise themselves with the terms and conditions of the policy document to ensure that their needs are met.

**The Complaint for Adjudication**

The complaint is that the Provider unreasonably and unfairly refused to admit the Complainant's claim, for payment under the policy.

**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.

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 October 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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**Chronology of Events**

- **11 March 2018:** The Complainant booked her holiday with planned travel dates of 21 October 2018 to 31 October 2018.
- **23 September 2018:** The Complainant incepted the travel insurance policy with the Provider.
- **26 September 2018:** The Complainant attended her doctor.
- **29 September 2018:** The Complainant attended the Emergency Department.
- **3 October 2018:** The Complainant attended her doctor again.
- **5 October 2018**: The Complainant attended for medical attention again.
- **10 October 2018:** The Complainant advised the Provider that she needed to cancel the trip and she sought to claim for her losses.
- **15 January 2019:** The Provider issued its Final Response Letter to the Complainant.

**Policy Terms and Conditions**

I note from page 10 of the terms and conditions of the policy which the Complainant purchased, the following definition is specified in relation to an Existing Medical Condition:

> ***"Existing Medical Condition***
> *-means*
>
> *1. Any*
> *a) respiratory condition (relating to the lungs or breathing),*
> *b) cardiovascular condition (including any condition relating to the heart, arteries, veins, cholesterol, or blood pressure),*
> *c) stroke including a cerebrovascular (CVA) or a transient ischaemic attack (TIA),*
> *d) diabetes, or*
> *e) cancer*
>
> *for which You have ever received treatment (including surgery, tests or investigations by Your doctor or a consultant/specialist, or prescribed drugs or medication).*
>
> *2. Any Medical Condition for which You have received surgery, treatment or investigations in a hospital or clinic within the last six months.*

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*3. Any Medical Condition for which You are on a waiting list for or have knowledge of the need for surgery, in patient treatment or investigation at a hospital, clinic or nursing home. (In the case of 3. No cover will be provided under Section A – Cancellation or Curtailment charges").*

On page 22 of the policy terms and conditions I also note the following:

***"Section A***
***Cancellation or curtailment charges***

***What is covered***
*If Your Trip is cancelled or Curtailed due to one of the reasons below We will pay You up to the amounts shown in the Features and Benefits table for the policy You have purchased for any irrecoverable unused travel and accommodation costs (including excursions up to the amount shown in the Features and Benefits table) and other pre-paid charges (including green fees up to the amount shown in the Features and Benefits table where the appropriate Golf Cover premium has been paid) which You have paid or are contracted to pay together with any reasonable additional travel expenses incurred.*

*Reasons for Cancellation or Curtailment:*

*1. The death, Bodily Injury or Serious Illness of:*
*a) You*
*b) Your Travelling Companion*
*c) any person with whom You have arranged to reside temporarily during Your Trip*
*d) Your Close Relative*
*e) Your Close Business Associate".*

*…*
**"What is not covered**

*3. Any claims arising directly or indirectly from:*

*b) Circumstances known to You prior to the date that this insurance is purchased by You or the time of booking any Trip which could reasonably have been expected to give rise to the cancellation or Curtailment of the trip".*

Furthermore, on page 15 of the policy terms and conditions I note the following General exclusion:

***"General exclusions applicable to all sections of the policy***

*We will not pay for claims arising directly or indirectly from:*

*18. Any circumstances known prior to the date that this insurance is purchased or the time of booking any Trip which could reasonably be expected to give rise to a claim".*

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Furthermore, on page 12 of the policy, I note the following in relation to cancellation of the policy:

> ***"Cancellation***
> ***Statutory Cancellation Rights***
> *You may cancel this policy within 14 days of receipt of the policy documents (new business) or for annual policies the renewal date (the cancellation period) by writing to the address shown on Your policy schedule during the cancellation period. Any premium already paid will be refunded to You providing You have not travelled and no claim has been made or is intended to be made and no interest likely to give rise to a claim has occurred".*

**Analysis**

I note from the evidence made available to this Office that the Complainant booked her trip on **11 March 2018**, with scheduled travel dates of 21 October 2018 to 31 October 2018. The Complainant incepted the insurance policy with the Provider some 6 months later, on **23 September 2018**.

It is clear from the policy terms and conditions *(Section A – Cancellation and Curtailment Charges)* that claims are not covered where the circumstances giving rise to a claim, are known to the insured and which at the time of booking the trip (or at the time of purchasing the insurance) could reasonably be expected to give rise to the cancellation of the trip.

Similarly, I note the policy terms and conditions contain "*General Exclusions*" that apply, which included the following:

> *"18. Any circumstances known prior to the date that this insurance is purchased or the time of booking any Trip which could reasonably be expected to give rise to a claim".*

If the Complainant was not satisfied, having reviewed the terms and conditions of the policy, it was open to her to cancel the policy within 14 days and receive a full refund of the premium, as explained on page 12 of the policy terms and conditions.

I further note that when the Complainant incepted the policy on the **23 September 2018**, she signed the Customer Declaration form, in which she confirmed the following:

> *"I have read and understand the Important Information, in particular relating to Existing Medical Conditions, as set out in the policy document provided to me. I am aware that the policy is a contract of insurance and by purchasing the insurance I am entering into a contract which has terms, conditions, exclusions and limits which I must accept for all persons to be covered by the policy. If the circumstances of anyone insured by this policy changes, I undertake to contact the location at which I purchased the insurance without delay.*

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> *I will make all the persons insured by this policy immediately aware of this declaration, which applies to each of them, including the parents or guardians of insured persons less than 18 years of age. Where persons less than 18 years of age are insured on this policy I agree to act as an agent for them in relation to any dispute for the reasons outlined above".*

I note that immediately above this declaration, the form specified the "**Important Information**" in question, which included the following:-

> "*You may not be covered for any existing medical conditions unless you call us and we have agreed to provide cover. It is essential that you refer to the "**Important Conditions" Relating to Health**" section in the policy wording. To apply for cover for an existing medical condition call us on* [Tel. No.]"

I note from the Complainant's medical evidence available that on **3 October 2018** when seen by her doctor, it was noted that the Complainant was

> "*still getting shortness of breath on exertion. For 6/12 but definitely worse*."

This suggests that the Complainant had been suffering from shortness of breath for the previous 6 month period. I further note that the medical notes 2 days later, bear out this opinion, as on **5 October 2018**, the Complainant was:

> *"More breathless the last couple of weeks on background more several months breathless".*

The Provider in its submissions to this Office has stated the following:

> *"…the holiday was booked on **11th March 2018** at which point no insurance was taken with* [the Provider's Agent].
>
> *On **23rd September 2018** the Complainant incepted the insurance and did not make any disclosures. Three days later she was seen by her GP for "shortness of breath symptom".*

It would therefore appear from the evidence submitted to this Office that in September/October when the Complainant attended for medical attention, she was suffering from symptoms which she had been dealing with for a number of months previously.

It is clear from the **Important Information** above the declaration which the Complainant signed on **23 September 2018**, that she was clearly on notice that she would not be covered for any existing medical condition, unless she made contact with the Provider in order to ensure that cover could be made available on agreed terms. This however, did not happen regarding the Complainant's condition at that time, which was giving rise to a shortness of breath.

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I further note in the Provider's submissions the following:

> *"The policy was sold face to face in store on 23rd September 2018. During the sales process the customer was made aware of the benefits of cover and was also made aware of the policy terms and conditions and agreed with same prior to purchase. Also the Complainant used to work with* [the Provider's Agent] *and so would have been knowledgeable about the policy.*
>
> *All customers are provided with a 14 day cooling off period following receipt of the policy term and conditions. There is a duty on all policy holders to read their policy terms and conditions carefully and if they are not happy with said terms and conditions, they may within 14 day cooling off period, cancel the policy free of charge".*

It is clear from the evidence made available in this matter that the Complainant did not make contact with the Provider in order to put cover in place for an existing medical condition. While the events surrounding the Complainant's claim are unfortunate, I accept that the Complainant was suffering from "*shortness of breath"* prior to the policy purchase which was not declared to the Provider in order to put the appropriate cover in place for an existing medical condition.

The Provider was therefore entitled to conclude that the Complainant's circumstances were known to her and could reasonably have been expected to give rise to cancellation of the trip or an associated claim on the policy, at the time when the policy was purchased. Consequently, I accept that the Provider was entitled to form the opinion that any claim arising directly or indirectly from this set of circumstances was not covered under the terms of the Provider's policy.

Accordingly, I must accept that the Provider acted correctly in declining to admit the Complainant's claim under her travel insurance policy and accordingly 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**

3 November 2020

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**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.**