Decision Ref:	2021-0028
Sector:	Insurance
Product / Service:	Travel
Conduct(s) complained of:	Rejection of claim - pre-existing condition Disagreement regarding Medical evidence submitted Rejection of claim - non-disclosure
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns a decision by the Provider to decline a claim made by the Complainants on a travel insurance policy.

The Complainants' Case

The Complainants incepted a travel insurance policy with the Provider on **4 January 2019** with a cover period of one year. The Complainants paid additional premia to extend the policy for a trip that was planned **June 2019** to **August 2019**.

The Complainants submit that on **12 December 2018** the Second Complainant first presented to her general practitioner with persistent back pain which she thought at the time was muscle pain due to a sports injury that occurred in **August 2018**, and the general practitioner recommended physiotherapy and painkillers to resolve the pain.

The Complainants submit that at the time of purchasing the travel insurance policy they were completely unaware of the extent of the Second Complainant's medical condition. The Complainants submits that the Second Complainant continued to experience pain in her back for several weeks and she was referred for a MRI, which took place **March 2019** as well as further scans and test. The Complainants submit that the Second Complainant was subsequently diagnosed with a spinal cord condition caused by a condition related to the brain and she underwent surgery in **Summer 2019** for the condition.

The Complainants state that as the Second Complainant was unfit to travel they cancelled their trip which was scheduled for a number of weeks before the surgery and they submitted a claim to the Provider.

The Provider refused to admit the claim for the cancelled travel expenses and following an appeal of the declined claim the Complainants state that the Provider wrote to them on **15 November 2019** informing them of its decision to uphold the declinature of the claim and in this correspondence the Provider noted the following:

> *"…whichever interpretation of the evidence is used, it is certain this policy cannot provide cover for your claim because you did not make a medical declaration, treatment and/or investigation was awaited or being received when the policy was purchased and/or you were aware of symptoms, but had not received a diagnosis"*

The Complainants reject the Provider's position and submit that it is not reasonable for one to assume that a simple back pain should be considered a medical condition which ought to be declared on a travel insurance policy. The Complainants also state that the Second Complainant is a young, active and healthy person who has engaged in contact sports for most of her life and it is not uncommon for her to receive physiotherapy for sports injuries. It is the Complainants' position that the Provider is acting in an unreasonable manner in its declinature of the claim.

The Complainants submit that they do not accept the Provider's position that *"treatment and/or investigation was awaited or being received when the policy was purchased and/or you were aware of symptoms, but had not received a diagnosis"* as the Second Complainant was unaware of the extent of her condition and thought that she had received a diagnosis of back pain caused by a sports injury which merely required physiotherapy, prior to purchasing the policy.

The Complainants submit that within the policy handbook it is stated that *"…you do not need to contact us if you have one of these…"* which includes myalgia which the Complainants submit is defined in the Collins Dictionary as *"pain muscle or muscle group"*. The Complainants state that to the best of their knowledge the Second Complainant had only been aware that she had back pain which they submit could easily have been mistaken as muscle pain by both herself and the medical professionals given her involvement in sports from a young age. The Complainants submit that as such it could be reasonable to assume that her condition was a muscle pain or "myalgia" and would not require a declaration on the insurance policy.

The Complainants contend that their claim has been wrongfully declined by the Provider and want the Provider to reimburse them under the policy for the cost of their cancelled trip including the cost of the cancelled flights, accommodation and holiday itinerary. The Complainants have attached receipts/proof of purchase in relation to these incurred costs and the total sum amounts of €6,168.82.

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The Complainants made further submissions to this Office dated **18 August 2020** wherein they declined the Provider's offer of 50% compensation and indicated that they were willing to accept a sum of 90% of the total amount claimed.

The Provider's Case

The Provider set out the timeline of events in its submissions to this Office dated **24 July 2020**. In these submissions the Provider states that the First Complainant called the Provider on **3 May 2019** and advised that he was calling regarding the possibility that the Complainants would have to cancel their trip due to the Second Complainant's recent diagnosis and the likelihood that she would require surgery with a lengthy recovery time. During this phone call, the First Complainant advised the Provider that the Second Complainant was diagnosed with a complex condition requiring surgery.

The Provider states that it forwarded a claim form to the Complainants on **8 May 2019** and received a medical certificate completed by the Second Complainant's GP stating that the cancellation of the holiday was recommended on the **15 May 2019**. The Second Complainant then underwent surgery shortly afterwards and the Complainants notified the Travel Agent of the cancellation of the trip on **28 May 2019**

The Provider states that the Complainant presented to her GP in **December 2018** with un-resolving symptoms following a sports injury in **August 2018** and the GP referred her to physiotherapy to try to resolve the symptoms. When the efforts of the physio failed to resolve the symptoms, an MRI scan was requested and the Complainant then received a medical diagnosis of the condition requiring surgery. The Provider states that the GP note of the Second Complainant dated **12 December 2018** states that the Second Complainant has had *"back trouble since August"*

The Provider states that the medical condition that gave rise to this claim is excluded from cover because even though it had not been diagnosed, the Second Complainant was aware of the unresolved symptoms on the date the policy was purchased. The Provider submits that page 4 of its travel insurance policy states clearly that *"any medical condition for which you are aware of but have not had a diagnosis"* and *"any medical condition for which you are receiving or are on a waiting list for or have the knowledge of the need for surgery, treatment or investigation at a hospital, clinic or nursing home"* and on the basis that the undeclared, pre-existing issue was excluded from cover.

The Provider further states that the policy further asks the Complainants to state whether they have *"any medical condition for which you are taking or have taken prescribed medication or are waiting to receive or have received treatment (including surgery, tests or investigations) within the last 2 years"* and states that you will not be covered for *"any claims arising directly or indirectly from this medical condition unless you contact us on the above telephone number and we have agreed in writing to cover your medical condition"*. The Provider states that had the Second Complainant notified it that she had back symptoms and was being treated but had no diagnosis, she would have been advised that nothing directly or indirectly related to the back pain would be considered for cover.

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The Provider states that it empathises with the Complainants' position and the impact of the eventual diagnosis and on that basis made a formal offer of €3,084.41 which represents 50% of the value of the Complainants' claim.

The Complaint for Adjudication

The complaint is that the Provider wrongfully refused the Complainants' travel insurance claim for the costs incurred by the Complainants as a result of their cancelled/rescheduled trip.

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 8 January 2021, outlining my 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, I set out below my final determination.

I note that at Page 9 of the policy provisions (as opposed to page 4 as stated by the Provider in its submissions), the following information is set out:-

> "**Exclusions that apply to all insured persons**
>
> *"(i) any medical condition for which you are aware of but have not had a diagnosis"*

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> *(iii) any medical condition for which you are receiving or are on a waiting list for or have the knowledge of the need for surgery, treatment or investigation at a hospital, clinic or nursing home …"*

Page 9 further states that if *"at the time of taking this cover do you or have you had any medical condition for which you are taking or have taken prescribed medication or are waiting to receive or have received treatment (including surgery, tests or investigations) within the last 2 years?"* and states that claimants will not be covered for *"any claims arising directly or indirectly from this medical condition unless you contact us on the above telephone number and we have agreed in writing to cover your medical condition"*.

The policy further states on page 10 that:

> *"the following exclusions apply to all Insured Persons at all times:*
>
> *v) Any surgery, treatment or investigations arising from investigations or tests for which you were pending the results of prior to your departure from Ireland"*

and states on page 16 that:

> *"**General Exclusions Applicable to All Sections of Your Cover:***
>
> *11. Any circumstances you are aware of at the time of taking out this Cover that could reasonably be expected to give rise to a claim on this cover"*

I note that the travel insurance policy defines a medical condition on page 7 as:

> *"disease, illness, injury or symptom"*

I also note that page 10 of the policy states it is not necessary to contact the Provider if you suffer from *"myalgia"* and I accept that this is commonly referred to in the vernacular as normal muscle pain/aches.

Having carefully considered all of the evidence before me, I accept the Complainants' submission that they were unaware of the severity of the medical difficulties suffered by the Second Complainant at the time of taking out the policy. Nevertheless, it is clear that at the time the Complainants incepted the insurance policy, the Second Complainant had been attending her GP and physiotherapist for a condition that had existed for a period of over four months and the pain in her back was not improving. Therefore, I accept that at the very least this should have been brought to the Provider's attention prior to the inception of the policy. Bearing in mind the medical information and reports submitted as well as the details of the physiotherapy undertaken which were furnished, it is clear these circumstances disclose that the Second Complainant had a medical condition which she was aware of but which was not diagnosed and for which she was receiving on-going treatment.

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It appears that in this instance, the relevant information was not made available to the Provider at the time when the policy was incepted and therefore while the events surrounding the Complainants' claim are most unfortunate I accept on the basis of the evidence available that the condition of the Second Complainant was a medical condition which should have been disclosed to the Provider when the Complainants incepted their policy. Consequently, I accept that any claim arising directly or indirectly from this set of circumstances is not covered under the terms of the Complainants' policy with the Provider. Accordingly, while I understand the Complainants' upset, I must accept that the Provider was not obliged to admit the Complainants' claim under their travel insurance policy.

I note that the Provider has made an offer of €3,084.41 which represents 50% of the value of the Complainants' claim. I welcome this offer by the Provider and on the basis that that offer is still available to the Complainants, I do not 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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

2 February 2021

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,

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and

(b) **ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.**