An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0035
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

This complaint arises from the Provider's decision to decline payment of a claim made by the Complainants, who are insured on the health insurance policy they hold with the Provider. The claim relates to a procedure the First Complainant underwent in **March 2018,** which the Provider refused to cover, under the policy in place.

The Complainants' Case

The Complainants say that they took out health insurance with the Provider in **April 2017.** The First Complainant says that they *"had no underlying health conditions"* and had no claims on the "*health insurance policy for the first year or so".*

In **March 2018,** the First Complainant attended a private Hospital for a *"hysteroscopy procedure",* which she says:

> *"had been detected following a scan in [a Public Hospital] on 9 February 2018. This scan has been arranged following consultations with a [private fertility clinic], in January 2018".*

The First Complainant says that her GP had referred her to the private fertility clinic which had subsequently referred her to the Private Hospital and that she had no *"awareness that [she] would require this treatment until [they] commenced fertility related consultations".*

The First Complainant contends that she gave the Private Hospital her insurance details and following the hysteroscopy procedure she received correspondence from the Provider advising that it would not pay the claim because:

> *"[It] deemed [her] to have an underlying medical condition prior to having taken out the health insurance policy in April 2017".*

In **July 2018,** the First Complainant contacted the Provider to appeal the decision.

The First Complainant contends that when she attended her GP in **April 2017,** it was for a *'viral infection'* and that she did not have an underlying medical condition when the policy was incepted. The First Complainant says that the Provider had already paid a related claim for a scan in a Public Hospital. She contends that at the time of her appeal, she was advised by the Provider *"to complete a GP questionnaire as part of the appeals process",* however, her GP's surgery "*delayed on completing this form",* and the Provider told the First Complainant that her "*medical notes for the 6 months prior to taking out the health insurance would suffice".* The First Complainant says that subsequently the Provider said that it did require the questionnaire and asked for it to be completed by her GP.

The First Complainant says that this process "*ensued…for a prolonged period of almost 6 months"* and the Complainants contend that it was "*a deliberate strategy"* by the Provider "*to find whatever they could in order to decline [her] claim/appeal".*

The First Complainant contends that the Provider "*hardly ever made proactive contact"* with her and that in **January 2019,** "*over 5 months after initially advising that [she] wished to appeal the decision not to pay the claim"* she contacted the Provider and was told that her appeal "*was still under review".* At this point the First Complainant says that she "*became quite agitated"* about the delay and was put on hold, and subsequently cut off, so she phoned back and was then told by the Provider's agent that "*a decision had just been made that day, that due to something in the notes from [her] GP"* their claim had been declined.

The First Complainant says that she asked what the notes said and the Provider's agent told her:

> *"(something along the lines of) trying to have a baby got 'x' length of time, along with the referral to [the fertility clinic]".*

The First Complainant says that she requested a copy of the notes and "*a formal letter clearly outlining why [her] appeal had been declined",* which she says she did not receive.

The First Complainant contends that:

> "*[The Provider] have unfairly and without objective evidence concluded that because [she] informed [her] doctor in/or around December 2016 that [she] was trying to conceive, that [she] had an underlying medical condition which required minor surgery on 11th March 2018, when [her] doctor/ GP had earlier confirmed in a questionnaire that [she] has no symptoms of the matter to which the surgery related".*

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The First Complainant says she has "*since had to have another minor surgery (November 2018)"* and believes that the decision of the Provider to decline the original claim on the procedure in **March 2018,** will impact on the payment on this claim and other related claims.

The First Complainant says that:

> "*the fact [they] were trying to conceive was not solely or purely indicative or definitive confirmation that [she] had any underlying medical condition and/or the medical condition for which [she] was treated on 11th March 2019".*

The Complainants have said in their letter on **30 May 2019,** to this office, that they:

> *"do not consider that there is any medical evidence to factually and objectively prove that [the First Complainant] had an underlying medical condition when [they] took out the policy in April 2017".*

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

In its Final Response Letter dated **20 May 2019**, the Provider says that it declined the claim because there was "*evidence of the condition going back to December 2016"* prior to the policy inception. The Provider further says that the First Complainant had:

> *"attended [her] doctor the day after the inception of the policy, 25 April 2017, and presented with symptoms in relation ….to this condition and subsequent treatment".*

The Provider contends that the information it has on file and as outlined in its Final Response Letter is "*all indicated that there were signs/symptoms of the condition"* prior to inception of the policy on **24 May 2017,** and says that because the First Complainant:

> *"did not have health insurance prior to joining [the Provider], the claim was to remain declined as [she] did not have the industry standard 5 year waiting period served for pre-existing conditions".*

The Provider in its Final Response Letter, has stated amongst other things, that:

> *"Having reviewed the file and claim again, the decision to decline the claim will remain. The information that we have on file that is outlined above all indicated that there were signs/symptoms of the condition prior to you joining us on the 25th April 201[7]. The claim has also been clinically reviewed on three occasions, including by our medical director. As mentioned above, their decision regarding a claim is final".*

Similarly, the Provider in its Final Response Letter dated **9 December 2019** stated that:

> *"Our clinical review team completed their review of the claim on the 17th January 2019. They determined that the decision to decline the claim would remain.*

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Their reasoning behind this was that there was evidence of your condition going back to December 2016, which was prior to the inception of the policy. In addition, they noted that you attended your doctor the day after the inception of the policy, 25th April 2017, and presented with symptoms [in] relation to this condition and subsequent treatment.

As the signs/symptoms of your condition arose prior to the inception of the policy on the 25th April 2017, and you did not have health insurance prior to joining us, the claim was to remain declined as you did not have the industry standard 5 year waiting period [served] for pre-existing conditions".

The Complaint for Adjudication

The complaint is that the Provider wrongfully refused to indemnify the First Complainant's claim under the health insurance policy, following a procedure on **11 March 2018**, and was guilty of delay in dealing with the claim, and providing poor customer service.

The Complainants want the Provider to accept that the medical condition requiring the procedure was not pre-existing and they say they *"are seeking redress in the form of settlement/payment of the account to [the Private Hospital] (amounting to €795) and any related expenses covered under [their] policy".*

Chronology of Events

- **25 April 2017:** The First Complainant telephoned the Provider to take out health insurance for herself and her husband. The First Complainant told the Provider's agent she was looking for a standard package. The Provider's agent went through the options available to the Complainants. The Provider's agent explained to the First Complainant that there would be an excess of €500 on the policy. The Provider's agent explained the waiting periods that apply to the policy including the "pre-existing" waiting period. The Provider's agent told the First Complainant that the waiting period for a pre-existing condition, was 5 years.

- **25 April 2017:** The Provider sent the Complainants a quote for health insurance.

- **26 April 2017:** The Provider's agent telephoned the First Complainant, following up on the quote she received "*yesterday*". The Provider's agent summarised the policy for the First Complainant. The Provider's agent again confirmed the waiting periods to the First Complainant, including the waiting period for pre-existing conditions, and went through the terms and conditions with the First Complainant. The Provider's agent asked the First Complainant if she had any questions in relation to the waiting periods and the Complainant said that she did not. The First Complainant purchased the policy and the Provider's agent confirmed that the start date for the policy was **25 April 2017** and the Provider sent the First Complainant the policy documentation.

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- **9 January 2018:** The First Complainant telephoned the Provider to check if a procedure was covered under the policy. The Provider's agent told the First Complainant that he would check and call her back.

- **9 January 2018:** The Provider's agent telephoned the First Complainant and left a voicemail to call him back, and when the First Complainant telephoned he said that the Provider would need the Consultant's name to confirm cover. The Provider's agent told the First Complainant that she was covered in the public hospital for a semi-private room and that if she went into a private room, the Provider would only cover the semi-private rate. The Provider's agent told the First Complainant that because it was a day case she was fully covered. The Provider's agent told the First Complainant to call back when she got the name of her Consultant because if the Consultant was not registered with them, she might be liable to pay the Consultant's fee.

- **9 February 2018:** The Complainant underwent a medical procedure (which on 25 May 2018 the Provider confirmed in writing had been settled).

- **12 March 2018.** The First Complainant was admitted to hospital and a claim was then made to the Provider for policy benefits.

- **24 May 2018:** The Provider sent the First Complainant's Consultant a letter requesting the First Complainant's referral letter.

- **24 May 2018:** The Provider emailed seeking additional information to process the claim, including the First Complainant's Certificate of Insurance from her previous health insurer.

- **25 May 2018:** The Provider sent the First Complainant a letter and informed her that it had settled her claim for an admission on 9 February 2018.

- **29 May 2018:** The First Complainant telephoned the Provider and enquired about a claim she had on their policy. The Provider's agent told the First Complainant that the claim for a procedure on 9 February 2018 was paid out and settled. The Provider's agent told the First Complainant that it required further information for the procedure in March 2018, to rule out a pre-existing condition. The Provider's agent told the First Complainant that it would need the GP referral letter, medical notes and details of previous medical insurance. The First Complainant told the Provider's agent that the waiting periods were waived, with the exception of the one for a pre-existing condition. The Provider's agent told the First Complainant that the only waiting period that was waived was the initial waiting period of 26 weeks and that the medical team would review all the medical documentation and would determine whether or not the procedure related to a pre-existing condition. The Provider's agent told the First Complainant if it was a new condition she would be covered and if it was a pre-existing condition the waiting period would apply.

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- **5 June 2018:** The Provider sent the First Complainant's Consultant a Final Reminder letter requesting the First Complainant's referral letter.

- **14 June 2018:** The Provider sent the First Complainant a letter saying that her claim was declined because "*… your treatment was for a condition that existed before you had health insurance and so you still have an exclusion period on your policy for treatment for this condition".*

- **18 June 2018:** The First Complainant telephoned the Provider and said that she received a letter saying that the claim for a procedure in March 2018 was declined as it related to a pre-existing condition and the waiting periods applied. The First Complainant said that she wanted to appeal the decision. The Provider's agent told the First Complainant that it was waiting for a referral letter from the First Complainant's Consultant and had not received it. The Provider's agent told the First Complainant that the referral letter may help her appeal.

- **26 June 2018:** The First Complainant's Consultant sent the Provider a letter saying that he did not have a GP referral letter on file.

- **26 July 2018:** The First Complainant's Consultant wrote to the Provider and said that the First Complainant attended him as a self-referral.

- **27 July 2018:** The First Complainant emailed the Provider appealing the Provider's decision to decline payment for a procedure she underwent in March 2018.

- **31 July 2018:** The Provider emailed the First Complainant and told her that it would issue the First Complainant's GP with a questionnaire as this would note the duration of symptoms in relation to the claim and whether the claim would remain declined due to the condition being a pre-existing condition.

- **2 August 2018:** The Provider sent the First Complainant's GP a letter requesting medical notes for the First Complainant for the period 25 October 2016 – 25 April 2017.

- **16 August 2018:** The Provider sent the First Complainant's GP a final reminder seeking her medical notes from 25 October 2016 - 25 April 2017.

- **27 August 2018:** The First Complainant telephoned the Provider to check the status of her appeal. The Provider's agent told the First Complainant that it was still awaiting the notes from the First Complainant's GP.

- **4 September 2018:** The First Complainant telephoned the Provider to check the status of her appeal. The Provider's agent told the First Complainant that it had received the referral letter "*today*" but told her that it had already received this and had still not received the GP notes.

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The First Complainant asked the Provider's agent how long it takes to reach a decision for an appeal and the Provider's agent told the First Complainant that it would take a few weeks.

- **8 October 2018:** The First Complainant telephoned the Provider to check the status of her appeal. The Provider's agent told the First Complainant that it still had not received the GP notes. The Provider's agent told the First Complainant that as long as the Provider could see that the condition was not pre-existing, the claim should be paid.

- **18 October 2018:** The First Complainant telephoned the Provider and told its agent that she had received the GP notes and was wondering what was the quickest way to send the notes to the Provider to have her appeal reviewed. The Provider's agent gave the First Complainant the email address to send the documents.

- **18 October 2018:** The First Complainant emailed the Provider the requested medical notes.

- **19 October 2018:** The Provider's agent confirmed that it received the First Complainant's medical notes.

- **2 November 2018:** The First Complainant telephoned the Provider to check the status of her appeal. The Provider's agent told the First Complainant that the appeal was still being reviewed and it would revert "*early next week*".

- **8 November 2018:** The Provider emailed the First Complainant's GP a questionnaire and asked the GP to complete it.

- **9 November 2018:** The First Complainant telephoned the Provider and said that she had received a voicemail "*a few minutes ago*" that a decision had been made on the appeal. The Provider's agent told the First Complainant that he would put her through to the agent dealing with the appeal. The call was transferred to the Provider's agent dealing with the matter and she told the First Complainant that it had to send the questionnaire to the First Complainant's GP to determine the date of onset of symptoms. The First Complainant was frustrated with this due to the delay and the Provider's agent told her that it was necessary to determine the onset date of symptoms.

- **22 November 2018:** The Provider emailed the First Complainant's GP a Final Reminder to complete the questionnaire on the First Complainant's behalf.

- **22 November 2018:** The First Complainant telephoned the Provider and enquired as to whether her GP had sent the Provider the questionnaire. The Provider's agent tried to transfer the First Complainant to the Provider's claims department, but could not get through, and told the First Complainant that the claims department would call her back.

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- **22 November 2018:** The First Complainant telephoned the Provider to check if the Provider had received the questionnaire from her GP. The Provider's agent told the First Complainant that it had not received the questionnaire from her GP and had sent the GP a final questionnaire "*today*" to complete.

- **30 November 2018:** The First Complainant telephoned the Provider to check if a decision had been made on the appeal she had made. The Provider's agent told the First Complainant that it had received the GP questionnaire in the "*past day or two*" and the Provider's medical team had not reviewed it yet, as it was only attached to the claim "*this morning*". The First Complainant asked the Provider's agent if it was likely her claim would be paid. The Provider's agent told the First Complainant that he was not medically trained and would not know. She asked for a specific date when she would have a decision.

  The First Complainant told the Provider's agent that she did not have a pre-existing condition and asked the Provider's agent again for a timeline as to when she would have the outcome of the appeal. The First Complainant was frustrated because when she went to her GP to seek her GP notes, she could have asked her GP to fill out the questionnaire when she was there. The Provider's agent told the complainant he would log her complaint and he would call her back when he had an update. The First Complainant said that she did not think there was anything in the questionnaire that would stop her receiving the claim payment. The Provider's agent told the First Complainant that once it had exhausted all options, she could go to the Ombudsman if she was not satisfied with the outcome.

- **1 December 2018:** The Provider's agent sent the First Complainant a letter and told her that an investigation was underway and it would notify her when a resolution was reached.

- **6 December 2018:** The Provider sent the First Complainant's GP a letter and sought further information as to the treatment she received.

- **18 December 2018:** The First Complainant telephoned the Provider and said that she had received a voicemail yesterday in relation to the outcome of her appeal. The Provider's agent transferred the First Complainant to the complaints department and she was told that a letter had been sent to her. The Provider's agent told the First Complainant that it required further information before a decision of the appeal could be made.

  The Provider's agent told the First Complainant that the Medical Director reviewed the information and needed further information to identify the onset date of symptoms. The Provider's agent told the First Complainant that it needed the "*GP notes from the consultation on 15 December 2017 and any GP referral letter from that same date"*. The Provider's agent said that he would call her if he had any updates.

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- **18 December 2018:** The Provider sent the First Complainant a letter and notified her that the claim remained declined.

- **31 December 2018:** The Provider sent the First Complainant's GP a letter and sought further information as to the treatment she received.

- **3 January 2019:** The First Complainant emailed the Provider and told it that her GP would post the notes of the First Complainant's consultation on 15 December 2017 and the referral letter of 15 December 2017.

- **17 January 2019:** The First Complainant telephoned the Provider to check if a decision had been made on her appeal. The Provider's agent told the First Complainant that she would put her on hold to check.

- **17 January 2019:** The First Complainant telephoned the Provider and told the Provider's agent that she had been on hold for 12 minutes and wanted an update on the appeal. The Provider's agent told the First Complainant that he would transfer her to the agent she was previously speaking to. The Provider's agent apologised for putting her on hold for so long. The Provider's agent told the First Complainant that her claim had been reviewed by the medical team "*today*", there was no change in the decision and that the claim remained declined based on the GP notes and the referral letter to the fertility clinic on 15 December 2017. She was told that based on this information there appeared to be fertility concerns dating back to December 2016 prior to the inception of the health insurance policy. The First Complainant asked if the Provider would send out a confirmation letter.

- **7 May 2019:** The First Complainant telephoned the Provider and asked for the correct postal address so she could send a written request to the Provider seeking a Final Response Letter and she wrote to the Provider that day, requesting a Final Response Letter.

- **10 May 2019:** The Provider's agent sent the First Complainant a letter and acknowledged the letter of 7 May 2019. The Provider's agent told her that it would notify her when a resolution had been reached.

- **16 May 2019:** The First Complainant's Consultant wrote a letter to the First Complainant's GP in which he advised the next steps he would recommend for the First Complainant in relation to her medical condition.

- **17 May 2019:** The Provider's agent telephoned the First Complainant in relation to the complaint and the Final Response Letter and said that he had reviewed everything again. The Provider's agent told the First Complainant that he would send the Final Response Letter "*next week*".

- **20 May 2019:** The Provider sent the First Complainant its Final Response Letter.

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- **30 May 2019:** The Complainants sent submissions to the FSPO.

- **1 August 2019:** The First Complainant's Consultant sent the Provider a letter and told it that he did not have a referral letter from the First Complainant's GP, as she had been referred for surgery by himself in the context of a follow-up appointment.

- **9 December 2019:** The First Complainant sent the FSPO further submissions in relation to her complaint.

- **9 December 2019:** The Provider sent the Complainants an additional Final Response Letter.

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 **19 January 2021**, 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.

The First Complainant and her husband were covered by a healthcare policy held with the Provider incepted in April 2017. The extent of the cover available is laid down by the relevant terms and conditions of that policy and I note the following in relation to waiting periods:

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"WAITING PERIODS

A waiting period is the amount of time that must pass before you will be covered under your plan or before you will be covered to the level of cover available under your plan. There are a number of different types of waiting periods:

- *Initial waiting periods*
- *Pre-existing condition waiting periods*
- *Upgrade waiting periods*

…..

PRE-EXISTING CONDITION WAITING PERIODS

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 had 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 advisers will decide whether your claim relates to a pre-existing condition. Their decision is final.

Pre-existing condition waiting periods do not apply in the following circumstances:

- *To claims made in respect of children who have been added to your policy within 13 weeks of the date of their birth*
- *To claims made in respect of adopted children who have been added to your policy within 13 weeks of the date of their adoption.*

The following table sets out the pre-existing condition waiting periods applied by [the Provider]. These waiting periods will apply from the date you took out health insurance for the first time (with [the Provider] or another insurer), or from the date you took out health insurance (with [the Provider] or another insurer) after your health insurance had lapsed for 13 weeks or more.

Pre-Existing Condition Waiting Periods		
Benefit	***Under 55 years old***	***55 years and older***
All In-patient Benefits *PET-CT Scans* *Health In the Home*	*5 years*	
Medical and Surgical Appliances	*2 years*	
All Maternity Benefits	*52 weeks*	
All Day to Day Benefits *All Out Patient Benefits*		

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Lifestyle, family & emotional wellbeing coaching *Medicall Ambulance Cost* *Companion expenses* *Employee Assistance Programme* *Convalescence Benefit* *Child Home Nursing* *Parent Accompanying Child* *Parent Accompanying Child (no minimum stay)* *In-patient Support Benefit* *Cancer Support Benefit*	*None*

I note that the First Complainant is the policyholder and incepted the health insurance policy with the Provider on **25 April 2017**; the Second Complainant is insured as an adult dependent on the policy. The policy remains active.

The Complainants' submissions to this Office, have stated that:

> *"[The Provider] have unfairly and without objective evidence concluded that because I informed my doctor in/around December 2016 that I was trying to conceive, that I had an underlying medical condition which required minor surgery on 11th March 2018, when my doctor/GP had earlier confirmed in a questionnaire that I had no symptoms of the matter to which that surgery related.*
>
> *The significant delay and extremely poor service are purely ancillary matters to my complaint [to] the Ombudsman; my complaint is on a point of fact, or lack of factual evidence by the Health Insurer in making their decision".*

I note in the Provider's Final Response Letter dated **20 May 2019,** the Provider has stated that:

> *"Our clinical review team completed their review of the claim on the 17th January 2019. They determined that the decision to decline the claim would remain. Their reasoning behind this was that there was evidence of your condition going back to December 2016, which was prior to the inception of the policy. In addition, they noted that you attended your doctor the day after the inception of the policy, 25th April 2017, and presented with symptoms [in] relation to this condition and subsequent treatment.*
>
> *As the signs/symptoms of your condition arose prior to the inception of the policy on the 24th April 2017, and you did not have health insurance prior to joining us, the claim was to remain declined as you did not have the industry standard 5 year waiting period serviced for pre-existing conditions.*
> *…..*

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> *…The information that we have on file that is outlined above all indicated that there were signs/symptoms of the conditions prior to you joining us on the 25th April 201[7]. The claim has also been clinically reviewed on three occasions, including by our medical director. As mentioned above, their decision regarding a claim is final".*

Furthermore, in its Final Response Letter dated **9 December 2019,** the Provider stated that:

> *"Our clinical review team completed their review of the claim on the 17th January 2019. They determined that the decision to decline the claim would remain. Their reasoning behind this was that there was evidence of your condition going back to December 2016, which was prior to the inception of the policy. In addition, they noted that you attended your doctor the day after the inception of the policy, 25th April 2017, and presented with symptoms [in] relation to this condition and subsequent treatment.*
>
> *As the signs/symptoms of your condition arose prior to the inception of the policy on the 25th April 2017, and you did not have health insurance prior to joining us, the claim was to remain declined as you did not have the industry standard 5 year waiting period serviced for pre-existing conditions.*
> *….*
> *Having reviewed the file & claims again, the decision to decline the claims will remain. The information that we have on file that is outlined above all indicated that there were signs/symptoms of the condition prior to you joining us on the 25th April 2017. The claim has also been clinically reviewed on three occasions, including by our medical director. As mentioned above, their decision is final".*

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.

In reviewing the terms and conditions of the parties' contractual arrangements, which have led to this complaint, I note that a "pre-existing condition" is not when the Insured becomes aware of the condition, but it is based on when the Insured first had medical signs and symptoms. Furthermore, it is specifically stated that whether a condition is pre-existing or not, will be determined by the Medical Advisors and their decision is final.

Therefore, cover for the First Complainant's condition was not available if, under the above terms, the First Complainant had signs or symptoms of the condition for which treatment was received, that existed at any time in the period of six months immediately prior to taking out the policy.

I note from the Provider's submissions that the First Complainant's claim was declined by the Clinical Team on the following grounds:

> *"The World Health Organisation (WHO) defined Infertility [as] "a disease of the reproductive system defined by the failure to achieve clinical pregnancy after 12 months or more of regular unprotected sexual intercourse"*

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The medical notes received from the First Complainant's GP contain an entry for 15th December 2017 noting that the Complainants have been "trying for pregnancy x 12 months" (Document 31). On the same day a referral letter was written by the First Named Complainant GP [Hospital] stating that the Complainants "have been trying for pregnancy x 12 months" (Document 31). Using that information, along with the WHO'S definition of fertility, our Clinical Team concluded that the onset of this issue would have been December 2016, which pre-dated the policy.

In addition to the above entry and referral letter, the GP notes contain an entry for 26th April 2017, the day the First Complainant spoke to [the Provider] to proceed with the sale of her policy, noting "trying for pregnancy day 16 of cycle….ovulation strips, start pregnacare" (Document 20).

The clinical team had three distinct clinical notes provided by the GP that indicated the First Complainant had a pre-existing condition of infertility prior to taking out health insurance".

I note from the First Complainant's GP consultation notes dated **26 April 2017,** the following:

"…ovulation strips, start pregnacare, augmentin to hold"

Similarly, I note from the First Complainant's consultation notes from **15 December 2017,** the following:

"Trying for pregnancy x 12 months, last period 11 days, no imb, smear done, cervix normal, [hospital] fertility unit..."

Furthermore, the First Complainant's GP referral letter dated **15 December 2017,** states the following:

"Dear Fertility Clinic,

Please could you review [First Complainant] and her husband.

They have been trying for pregnancy x 12 months.

[The First Complainant] recently had a period lasting 11 days. She has a regular 25-28 day cycle

Kind regards"

I am satisfied that the terms and conditions of the policy in question, make clear that if a policyholder takes out health insurance, any benefits for pre-existing conditions will be subject to waiting periods before the benefits are available. The waiting period for pre-existing conditions are also stated in clear terms, as outlined above.

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I further note that a Pre-existing condition is defined as:

> *"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 had lapsed for 13 weeks or more".*

As a result, I am satisfied that it was reasonable for the Clinical Team to conclude from the documentary evidence before it, that the First Complainant had a pre-existing condition of infertility prior to the policy inception on **25 April 2017**, given firstly that the Insured attended her General Practitioner on 26 April 2017 and the GP notes document *"…ovulation strips, start pregnacare, augmentin to hold"* and also that on the 15 December 2017, the GP notes revealed: *"Trying for pregnancy x 12 months, last period 11 days, no imb, smear done, cervix normal, [hospital] fertility unit..".*

I note that similarly, the First Complainant's GP Referral Letter stated "*They have been trying for pregnancy x 12 months".* Consequently, I am satisfied that the Provider was entitled to form the opinion that there were signs of the condition present in the six month period before the First Complainant purchased the health insurance policy from the Provider.

Accordingly, I am satisfied that the Provider acted in accordance with the terms and conditions of the Complainants policy when it assessed the Insured's claim taking into account the 5-year waiting period to be covered for pre-existing conditions.

Having listened to the audio files submitted to this Office, I am satisfied that the Provider's agents were professional and fair with the Complainants. During a call on **25 April 2017,** the Provider's agent explained to the First Complainant that there was an additional waiting period for pre-existing conditions, also explained the waiting periods that applied to the policy including the pre-existing waiting period, and told her that the waiting period to be covered for a pre-existing condition, was 5 years.

On **26 April 2017,** the Provider's agent telephoned the First Complainant, following up on the quote she received the previous day. The Provider's agent summarised the policy for the First Complainant and again confirmed the waiting periods to her, including the waiting period to be covered for pre-existing conditions. The Provider's agent went through the terms and conditions with the First Complainant and asked her if she had any questions in relation to the waiting periods and the Complainant said that she did not.

I note that the Provider's agent explained to the First Complainant that because she did not hold health insurance since 2014, and the Second Complainant did not hold any health insurance previously, they would be subject to the industry standard waiting periods. `

In considering the Complainants' submission that there were "*significant delays*" in addressing her claim and that the Provider tried to "*not to pay the claim/appeal*", I note that the Complainants in their submissions to this Office contend that:

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"…subsequent to this however [the Provider] changed their mind and said that they did in fact need the questionnaire to be completed, so I got back in touch with my GP again. I subsequently forwarded the completed questionnaire form to [the Provider], again being lead to believe that a decision was imminent on receipt of the completed questionnaire. The GP verified within the completed questionnaire that I had no prior symptoms of any underlying condition, ie the condition which I was treated in [the hospital] on 11th March 2018. However, some time later and a 3rd attempt by [the Provider] to find their 'needle in a haystack' they informed me that they were now seeking my medical notes from my GP from December 2017".

The Provider in addressing this submission contends that:

"The First Complainant's claim was declined on 14th June 2017 (Document 10). The appeals process is available to members if they wish to dispute [the Provider's] decision on their claim. The appeals process is designed for members to submit further information in order to have the outcome of the claim changed. The claim remained declined unless sufficient information is received to change the outcome of the claim. Each time the First Named Complainant contacted [the Provider] in relation to her appeal she was advised that the decision had remained unchanged i.e. the claim remained declined.

It can be seen from the timeline provided that on receipt of any medical information provided by the First Named Complainant, or her GP, the [Provider's] Clinical Team conducted their review without delay. The delays that occurred were due to [the Provider] not receiving the requested information."

I note from the documentation that when the Complainants submitted their Claim Form to the Provider, the First Complainant signed the Claim Form which stated:

"Consent
I declare that at the time I underwent medical treatment I was a party to a health insurance contract and was entitled to treatment under [plan name]. I declare that my doctor, including accident and emergency referral, recommended the treatment and referred me to the appropriate consultant for further treatment. I declare that to the best of my knowledge, the information provided in Part 1 of this form is accurate, true and complete. I authorise the doctors, consultants or hospital to ***furnish [the Provider],*** *or any authorized agent it may appoint to act on its behalf,* ***with any information requested, including access to my hospital/medical records, where this is necessary in relation to any claim regarding treatment or services received by me or my named dependants****. I authorise the direct payment by [the Provider] to the doctors/consultant/hospitals as appropriate for the services set out in this claim form to the extent provided for under my [Provider's] plan. I verify the details of the accounts submitted on my behalf by the doctor/hospital/consultant as an accurate reflection of the treatment I received. I understand that the details of these amounts will be included in my [policy] statement of payment and I will have the opportunity to contact [the Provider] directly with any queries.*

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> *Charges not covered under the [Provider] plan to which I subscribe will remain my responsibility or that of the named dependant who received the treatment to settle directly with the doctors, consultants or hospital concerned. In consideration of [the Provider] discharging my hospital and medical expenses to the extent of cover limits. I undertake to [the Provider] to include these expenses as part of my claim against a third party and to inform my solicitor or Personal Injury Assessment Board to this effect when pursuing any claim.*
>
> [my emphasis]
>
> ***Declaration***
> *I/we confirm that all the details, answers and information given in this form are true and accurate and complete. I/we confirm that I/we am/are giving my/our permission to you to use the information I/we have given on this form for the purposes set out in the Dara Protection section on page three of this form".*

I am satisfied that the Provider was entitled to seek additional information in accordance with this consent from the First Complainant. I am also satisfied from the evidence available that much of the delay which ensued, was because of an absence of a response to the Provider's requests for further information. In addition, I am also satisfied that when such details and information was received, it was dealt with by the Provider in a timely manner.

For the reasons outlined above, I take the view that at the time when the First Complainant decided to incept the policy, the Provider properly advised her as to the waiting periods that applied for cover for any pre-existing condition. Furthermore, I am satisfied that the Provider dealt with the Complainant's claim in a fair and professional manner.

Having considered the matter, I am satisfied therefore that the Provider's conduct in refusing to admit the claim was reasonable, based upon the evidence available to it, details of which are outlined above. I accept that the Provider acted in accordance with the terms and conditions of the policy, in declining the claim for the First Complainant's treatment, and accordingly I take the view that it would not be reasonable 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

10 February 2021

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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.