Decision Ref:	2021-0225
Sector:	Insurance
Product / Service:	Travel
Conduct(s) complained of:	Rejection of claim - pre-existing condition Rejection of claim - cancellation
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint relates to a Travel Insurance Policy.

The Complainant had to cancel his holiday due to a pre-existing medical condition. The Provider refused to pay the claim as the Complainant had not availed of the additional cover for his pre-existing medical conditions.

The complaint is that the Provider wrongfully repudiated the Complainant's claim.

The Complainant's Case

The Complainant submits that when he needed to cancel a trip due to a medical condition, his claim was repudiated by the Provider who stated that he was not covered due to the fact that his medical condition was pre-existing. The Complainant contends that he was advised by the Provider that his medical condition would be covered, and states that:

> *"If you listen to the call recordings of my talk with the insurance company you will see that I answered all questions. You will also hear that I believed my diabetes was covered…"*

The Complainant states on his claim form that the reason for cancelling the trip was "*Blood Sugar"*. In relation to his claim, the Complainant submits: *"I'm an insulin dependent diabetic..".*

The Complainant wants the Provider to accept he was covered and pay his claim.

The Provider's Case

In a letter dated **25 May 2019**, repudiating the claim, the Provider states that the condition which prevented the Complainant from traveling was subject to a policy exclusion.

The Provider, in its Final Response Letter, contends that the Complainant was made aware of the exclusion applicable in his case and was offered the opportunity to extend his policy to cover the pre-existing conditions, but that the option was declined. The Provider states:

"During the second call to the medical screening line you explained that your General Practitioner had confirmed that you had not suffered a mini stroke. At this point you were asked if you would like to add on the cover for your pre-existing medical conditions (Diabetes, Cataracts, Eczema & Cholesterol) at a cost of €24.95 and you replied 'no, there's no need'".

The Provider further states, in its Final Response Letter, that it had explained that the Complainant would not be covered for a pre-existing condition; it acknowledges that there was some confusion around this to begin with, but states that the Complainant confirmed he understood at the end of the call. In this regard the Provider stated that:

"A discussion followed where the medical screening agent explained that if you did not pay the additional premium, there would be no cover for your pre-existing medical conditions. At first you misunderstood and questioned what the insurance was for if it didn't cover your health, however at the end of the call you confirmed that you understood that only new unforeseen medical conditions would be covered as you had opted not to purchase cover for your pre-existing medical conditions."

The Provider's position is that the Complainant did not avail of the additional cover, and therefore was not covered for the cancellation claim.

The Complaint for Adjudication

The complaint is that the Provider wrongfully repudiated the Complainant's claim.

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.

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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 **01/06/2021**, 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.

By way of letter dated **06/06/2021**, the Complainant advised that even though he considered he should be getting all his money back, he accepted the decision and had nothing further to add. By way of e-mail of **16/06/2021** the Provider advised it had no further submission to make on this matter

Following the consideration of these additional submissions from the parties, the final determination of this office is set out below.

The travel insurance claim was submitted to the Provider under "*Section A: Cancellation or Curtailment Charges*".

This claim was for cancellation of the Complainant's holiday. Under the following section, the policy states:

> *"What is Covered*
> ***We** will pay **You**, up to the amount shown in the **Policy Schedule**, for any irrecoverable unused travel and accommodation costs and other pre-paid charges (including sports, concert and entertainment tickets) which **You** have paid or are legally contracted to pay together with any reasonable additional travel expenses incurred if*
> *a) cancellation of the **Trip** is necessary and unavoidable*
> *as a result of any of the following events occurring:*
> *1. The death, **Bodily Injury**, **Serious Illness** or **Complication of Pregnancy and Childbirth** of:*
> *a) You"*
>
> "What is not Covered
> *6. Claims arising directly or indirectly as a result of **Your** failure to comply with the important conditions relating to health shown on pages 12-14.*"

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Page 12 of Policy Booklet

"Important Conditions Relating to Health

Please note certain medical conditions will incur an additional premium.

***You** must comply with the following conditions to have full protection of **Your** policy. If **You** do not comply **We** may at **Our** option cancel the policy or refuse to deal with **Your** claim or reduce the amount of any claim payment.*

At the time of taking out this policy:
*Do **You** have or have **You** had any **Medical Condition(s)** 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?*

*If No (including if **You** have had no **Medical Conditions**) Please read the conditions below to see if they apply to **You**. (if none of them apply then **Your Medical Condition(s)** will be covered).*

*If Yes – It is a condition of this policy that **You** will not be covered under Section A – Cancellation or curtailment Charges, Section B – Emergency Medical and Other Expenses, Section C – Hospital Benefit, and Section D – Personal Accident for any claims arising directly or indirectly from this **Medical Condition(s)** unless **You** contact **Us** on **08….** and **We** have agreed in writing to cover **Your medical condition(s)**.*

The policy in question was incepted on 08 April 2019. The Provider states that on this date the Complainant contacted the Medical Screening Service line at 11:01am and again at 11:24am. During the first call the Complainant advised of his medical conditions and medication.

There was a query during this call as to whether or not the Complainant had suffered a mini stroke and so he was advised that it would be best to clarify this with his General Practitioner and call the medical screening line again.

During the second call to the medical screening line the Complainant explained that his General Practitioner had confirmed that he had not suffered a mini stroke.

At this point the Complainant was asked if he would like to add on the cover for his pre-existing medical conditions (Diabetes, Cataracts, Eczema & Cholesterol) at a cost of €24.95 and the Complainant clearly replied "*no, there's no need*".

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A discussion followed where the medical screening agent explained that if the Complainant did not pay the additional premium, there would be no cover for his pre-existing medical conditions.

The Provider states that at first the Complainant misunderstood and questioned what the insurance was for if it didn't cover his health. The Provider however submits that following clarification from the agent, at the end of the call the Complainant confirmed that he understood the cover and that only new unforeseen medical conditions would be covered as he had opted not to purchase cover for his pre-existing medical conditions.

Following this call, the medical screening quotation documentation was issued to the Complainant and this documentation also detailed the following:

> *"Please note, if you do not contact us and pay the additional premium there is NO cover in place under your travel insurance policy for any claims related to any pre-existing medical condition(s), as defined within the policy."*

Analysis

I accept that the Complainant's cancellation of holiday claim did not meet the requirements set out in the policy provisions for payment by the Provider. I accept the Provider clearly explained in the policy provisions that an extra premium was required to cover pre-existing medical conditions. The policy stated:

> *"Please note certain medical conditions will incur an additional premium".*

The Complainant had declared his medical conditions and was advised on **08 April 2019** (in a telephone call and a follow up letter) of the extra payment he would have to make to cover his pre-existing medical conditions.

That said, while I accept that the policy wording is clear, and that the claim cannot be covered, I do consider that the Provider could have been clearer in its communications with the Complainant concerning the need / the reason for, pre-existing medical condition cover.

In the telephone call of **08 April 2019** it is clear that the Complainant and the Provider's representative were at cross purposes as to what was meant by pre-existing medical conditions. The Complainant appeared to be of the understanding that the request for an additional payment for his pre-existing medical conditions, meant that the Provider would cover him if he were to seek elective treatments as opposed to emergency treatment for the medical conditions. The Complainant used an example where spectacles were needed abroad. From considering the content of this call recording it appears that it was on that basis that the Complainant had said there was no need for this additional cover. In this telephone conversation the Complainant appeared to still consider that he would be covered were anything to go wrong in other events for the conditions that he had declared.

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I also note that in this telephone call, the Provider explained what would happen if the Complainant did not have the cover for his pre-existing medical conditions. However, all of the discussion centred on what could happen if the Complainant needed medical attention, when the Complainant was on holiday abroad. At no point in this telephone call was it explained by the Provider, having regards to the policy cover, what would happen if the Complainant's medical conditions were to prevent him from travelling abroad on holiday.

I appreciate that a Provider could not and does not have to outline all eventualities when verbally explaining cover, but here there were limited events where the particular policy cover applied, and it was clearly evident that the Complainant did not understand the need for the additional payment to cover his declared medical conditions. I believe that an explanation of there being no cancellation cover for him should the Complainant not be able to travel due to some of his medical conditions, may have greater informed the Complainant of the need for the cover offered by the Provider in respect of his pre-existing medical conditions. That said, I accept that a Provider cannot be responsible in circumstances where its explanation of the insurance cover is not understood by a policyholder, no matter how much it is explained (absence of the Provider being advised of some difficulty in that regard).

I note that the Provider did follow up with a written communication to the Complainant on **08 April 2019**. In this letter the Provider requested an additional premium for cover in respect of the declared pre-existing medical conditions. The letter stated:

"We are pleased to provide the quote under the above mentioned Travel Insurance Policy. An additional premium of €24.95 (inclusive of all insurance taxes) is required to cover the pre existing medical conditions of the person explicitly mentioned below. ..

Below are the condition(s) declared, questions asked during the medical screening, and the answers provided.."

The letter then states:

"Declared Medical Condition(s);

[Complainant's name] conditions covered
Eczema
Cataracts
Diabetes
Cholesterol"

The wording ***"[Complainant's name] conditions covered"*** is stated a second time in this correspondence when the Provider refers to the medical questionnaire that was completed for the Complainant.

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I accept that the Provider (in the above letter) could have better identified the Complainant's declared medical conditions as being the pre-existing medical conditions that required the extra payment for cover to apply. The Provider advised these as "Declared Medical Condition(s)" and "conditions covered". I accept that greater clarity on this was required.

I accept that the Provider could have specifically linked the extra payment to what it had stated earlier in the letter by simply inserting, for example, the following words: ***"conditions covered if the above payment of €24.95 is made by you",*** which is a more accurate position regarding the pre-existing medical conditions cover that was being offered by the Provider.

I also note that the Decline Letter that initially issued to the Complainant on **25 May 2019** incorrectly advised him that:

"Unfortunately as you have not declared your Diabetes to us and it is the reason you are claiming, I regret to advise you that your claim has been unsuccessful on this occasion".

In the Complainant's reply to the above of **16 June 2019** he correctly advised that he had notified his medical conditions to the Provider on **08 April 2019**.

In a further letter dated **25 June 2019** the Provider correctly explained why the Complainant's claim was not covered, that is, because he had not paid the required extra payment to cover his declared pre-existing medical conditions.

The Consumer Protection Code states:

> *A regulated entity must ensure that all information it provides to a consumer is clear, accurate, up to date, and written in plain English. Key information must be brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information.*

Having considered all of the submissions and evidence, I accept that the Complainant's claim for the cancellation of his holiday was not covered by the policy. However, I consider that the Provider communications could have been better. In particular, it could have explained the cover more fully to the Complainant in its telephone and subsequent written communications with him. Therefore, I partially uphold the complaint and I direct the Provider to pay the Complainant compensation of €250 (two hundred and fifty euro).

<u>Conclusion</u>

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially upheld, on the grounds prescribed in ***Section 60(2)(g)*** the conduct complained of was otherwise improper.

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- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainant in the sum of €250, to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

- The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

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

29 June 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,

and

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