An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0324
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - waiting periods apply Rejection of claim - pre-existing condition
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns Provider declining the Complainants' claim under her health insurance policy in relation to treatment for her son "R".

The Complainant's Case

The Complainant states that she incepted a health insurance policy on behalf of her minor son, R, on **4 January 2019**. The Complainant submits that R was healthy at time of the policy inception and had no known underlying or existing health conditions.

The Complainant says that R became unwell and was hospitalised on two separate occasions as follows:

1. **29 April 2019** R was admitted to hospital as a day patient and required surgery at a cost of €996 (nine hundred and ninety-six euro).
2. **1-2 July 2019** R was admitted to hospital overnight and required surgery at a total cost of €1402.00 (one thousand four hundred and two euro)

The Complainant states that she submitted two separate claims for the cost of this treatment. She further states that the Provider declined both claims, in its final response letter dated **13 February 2020**, and that the reason for the declinature, was because it said that R had a pre-existing medical condition, at the time of policy inception.

The Complainant denies this assertion and makes the argument that the GP referral letter dated **19 December 2018** did not state that R had a pre-existing medical condition and rather, it specified that R had no previous history of tonsillitis. Furthermore, the Complainant contends there was no mention of any adenoid issue, nor was there any history of impaired breathing through the nose, chronic infections or recurrent earaches. The Complainant submits there was no basis for the Provider to decline her claims, in particular for the adenoidectomy, and she maintains that the condition developed quickly after the inception of the policy.

The Complainant also submits that she had to provide consent to the Hospital for the release of all documentation which was requested by the Provider. She also states that she had to complete three separate requests from the Provider, to satisfy it in relation to medical records. The Complainant contends that this sporadic and piecemeal demand for information was designed to encourage customers to drop claims. The Complainant states that the various requests for information could have been avoided, if the Provider had set out the records required at the beginning of this process

The Provider's Case

The Provider contends that it declined both claims as outlined above because R had a pre-existing medical condition as defined in the contract between the parties. The Provider maintains that that the GP referral letter dated **19 December 2018** indicated that the referral had taken place before the inception of the policy, and therefore, a five year waiting period applied to be eligible for the cost of the treatment for this condition. The Provider contends that this decision was made by the Provider's internal medical advisors, based on the information provided with the claim.

The Provider states that there was an additional follow up referral letter dated **13 February 2019** which stated that the symptoms were pre-existing to **4 January 2019**, being the date of the inception of the policy.

The Provider states that R's adenoids and tonsils issues are related. It further contends that R underwent an adenoidectomy to resolve ongoing symptoms with his tonsils, which were present prior to his re-joining date with the Provider. The Provider says that R's Consultant suggested an adenoidectomy initially, given his age. When this was not successful, he subsequently underwent a tonsillectomy to completely resolve these ongoing issues.

The Provider has submitted that it is impossible to detail at the start of an appeals process exactly what information and from whom, may be required in the appeal, to complete a full assessment. The Provider further states that gathering notes can be a time-consuming business and it would not ask for such records unless it deemed it absolutely necessary. The Provider states that as per the Consumer Protection Code general principle 2.1, it acted honestly and fairly and professionally in the best interest of the Complainant. It adds that despite being provided with a referral letter for this procedure which stated that the symptoms were present since before re-joining on **4 January 2019**, it requested further clinical information to clarify the onset of symptoms, because it needed a complete picture.

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The Complaints for Adjudication

The Complainants' complaint is that the Provider unfairly and incorrectly declined the Complainant's claim under the policy in relation to the cost of treatment for her son, R.

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. Recordings of telephone calls have been furnished in evidence. I have considered the content of these calls.

A Preliminary Decision was issued to the parties on **30 August 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.

Chronology

On **2 March 2017** the Complainant called the Provider and added R to the policy starting from the day before, **1 March 2017**.

On **25 July 2018**, some 16 months later, the Complainant called the Provider and removed R from the policy, from the renewal date of **1 July 2018.**

On **19 December 2018,** R attended his GP with the Complainant. Following the consultation the GP issued a letter regarding this attendance, stating as follows:

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"Dear Dr,
Thank you for seeing [R], aged [xx] months. *Unwell with tonsillitis, currently day three of Calvepen, drinking, not eating much, having wet nappies, reduction in stools, no hx of previous tonsillitis [...] throat swab has been taken, dose of Calvepen increased today to 5 mls bd, advised to attend if reduced fluid intake and temperature and not improving. "*

On **4 January 2019**, R once again attended his GP practice, and this time he was seen by another GP. The input to the GP's system by the second GP from this examination was provided in evidence to this Office. The GP's electronic notes state as follows:

Subjective symptoms: *Sore throat ongoing. No improvement post calvepen. Note swab – commensals Seen Stephens day in [hospital] - bloodwork taken. Verbal report Mam. - WCC normal, crp 10, throat swab – nil grown. Given another antibiotic 'Zentec' not with today. Mam feels no reprieve since initial. Mam and dad both suffered with tonsillitis and had tonsillectomy. ICE – Mam anxious for tonsils to be removed. Another antibiotic. Cough. No Sputum. No wheeze. Intermittent pyrexia. Controlled by pmol. Fluids ≥50% poor solid intake, passing urine – not foul smelling. No vomiting or diarrhoea. No rash. In good form in consult.*

Objective findings: *Temp 36.2, hr 110 at 07.30, Bright. Crt ≤2. Moist mm, no rash. Ears, nose – nad. Throat inflamed , + tonsillar adenopathy + pustules. + neck LN. Chest clear.*

Assessment: *Tonsillitis – likely viral*

Plan of action: *Pmol, ibuprofen reg. Fluids ≥50%, monitor output. PIL. Long discussion re viral aetiology and criteria for tonsillectomy. Agree hold off antibx and r/v in 5/7 to track sx and ? Improvement. Will consider childrens practice [private hospital]. Early r/v if worse.*

On the same day, **4 January 2019,** the Complainant called the Provider and sought to add R to the policy. The Provider says that R's cover policy was subject to a five-year waiting period for pre-existing conditions upon rejoining, because of his break in cover for longer than 13 weeks.

The relevant portions of the telephone conversation during **4 January 2019** were as follows:

Provider's agent: "*[the Complainants' children] have been set up from today. Just because [R]…had a break in cover for longer than 13 weeks, they would have a five-year waiting period for anything pre-existing issues they might have, before they could avail of their cover…"*

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Complainant: *"Ok, so what does that mean?"*

Provider's Agent: "*So they had any symptoms at the moment for anything or getting treatment for anything at the moment or are unwell to do with anything or attending a consultant for anything or getting treatment for anything, that would be classed as a pre-existing issue, which means when you have a break in policy for longer than 13 weeks, you have a five year waiting period before you can avail of private healthcare…so if they were suffering with anything at the moment, that would be their pre-existing issue*"

Complainant: "*Ok that wasn't explained to me when I was speaking with somebody else…"*

Provider's Agent: "*Do they have any issues at the moment?"*

Complainant: "*No they don't…but I had [child who was not R] down today he has a viral –*"

Provider's Agent: "*Oh ya, the poor divil*"
Complainant: "*Ya, this is what brought this to a head…it's a virus, it comes and goes*"

Complainant: "*…so something like that wouldn't be classed as pre-existing?*"

Provider's Agent: "*Unless…God forbid, it was ongoing, if he had something following that infection. Cold and flues, that doesn't count. It would be things like, just for ourselves, we had a dodgy knee...we're taking pain medication for it, we're attending a doctor, we're getting treatment or a procedure…that's pre-existing.*"

The Complainant goes on to say

"*we just get a bit nervous as it's so long [5 years] and one person's interpretation is different than another person's interpretation…it's a long loop hole that the [Provider] wants to use in four and a half years' time….*"

The Provider's agent again confirmed

"*if they have any new issues…they would be covered, from today's date*."

The Complainant then asked if it would be possible to go back and "*bridge the gap*" and "*pay for that gap*", to which the Provider's agent confirmed this was not possible, as the Provider could only backdate it for a maximum of 14 days. The Provider's agent stated that she would send out the policy details.

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The Provider emailed the Complainant on **7 January 2019,** stating that R's updated policy document was available to view online.

On **9 January 2019**, R was seen by his GP, who after examining him wrote a referral letter to a Consultant Otolaryngologist in a Children's Hospital.

> *Dear Dr [Consultant Otolaryngologist]*
>
> *Thank you for seeing R aged [xx months] with recurrent tonsillitis. I value your opinion and query need for further investigation.*
>
> *R has been seen five times by HCP since 10/12/18. Initially seen by my colleague with sore throat. At this time he was prescribed calvepen 5ml bd x 10/7. Mam reports no improvement with this. broad swab showed commensals. Presented to [General] Hospital on 26/12/2018. Bloodwork [verbal report from Mam] revealed WCC / normal , crp 10 at the time. Swabs revealed commensals. Given second course of antibiotics cerfuxime bd x 1/52. Reported improvement until 5/7 into antibiotic course.*
> *I reviewed R on 04/01/2019 with sore throat x 1/52. Cough no sputum. No wheeze. Intermittent pyrexia. Controlled by antypyretics. Fluids ≥50% poor solid intake, passing urine - not foul smelling. No vomiting or diarrhoea. No rash. In good form in consult. Examination at that time - Temp 36.2, hr 110,Bright. Crt ≤2. Moist mm, no rash. Ears, nose – nad. Throat not inflamed , + tonsillar adenopathy + scanty pustules but much improved. No neck LN. Chest clear.*
>
> *I felt viral in nature given timeline and poor response to antibiotics. I reviewed R again today the 09/01/2019. No disimprovement. Remains apyrexial. Intake ≥50% Tonsils – ongoing pustules but less erythema*.
>
> *I explored at length with Mam. Both her & her partner had tonsillectomies and she queries if this is the next step. She is concerned re intake and that R remains unwell.*
>
> *I discussed likely viral aetiology, timeline of same, criteria for tonsillectomy and ENT waiting list. I am concerned about over exposure to antibiotics given young age. I have asked to hold the line on 3rd antibiotic and would only dispense new pyrexia.*
>
> *Mam and I would both value a 2nd opinion."*

On **13 February 2019,** R was again examined by his GP, who wrote a referral letter to the Consultant Otolaryngologist in the children's hospital. This letter again stated that R had "*recurrent tonsilitis*" and sought the Consultant's opinion.

On **21 March 2019**, R was examined by the Consultant Otolaryngologist. The Consultant wrote to R's GP on the same day, stating:

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"Thank you for your letter regarding R who I saw accompanied by both parents. ... Presents with a persistent sore throat for the last 4 months. He has received two antibiotics over that time period and has had one hospital emergency department attendance in [General] Hospital. He is eating only a soft diet. His parents report snoring which is heroic [sic] in nature and constant but without witnessed apnoeas. He does have a tendency to drooling. There is no speech concerns and he is attending the newborn hearing screening.

Examination revealed a child who is obviously mouth breathing with evidence of middle ear fluid on the left and an intact tympanic membrane on the right. The tonsils were markedly enlarged but not completely obstructing the airway. There was decreased nasal air entry and obvious hyponasality. I had a long discussion with R's parents today. Whilst he has evidence of adenotonsillar hypertrophy it's difficult to recommend tonsillotomoy at this stage given the relative infrequency of infection and the absence of apnoeic pauses. I have suggested adenoidectomy using microdebrider technique in an attempt to improve his nasal airway and tendency towards mouth breathing. explained the operation and its risks to R's parents. they appreciate that they may tonsillotomy [sic] the later date but it would be safest to avoid this until he is older unless absolutely necessary."

On **29 April 2019,** R attended the children's hospital and underwent an adenoidectomy operation. The Provider stated in its correspondence with this Office, that the Complainant did not call or use the online cover checker facility to check cover for this procedure, prior to the procedure.

On **27 May 2019,** the Complainant submitted a claim under the policy (claim xxxx9402). This claim was for a day case procedure for an adenoidectomy on **29 April 2019** in the Children's Hospital. The total cost of the claim was €996 (nine hundred and ninety-six euro). This document was supplied to this Office, and was completed by the Consultant Otolaryngologist. Under the box which stated "*Nature of presenting symptoms*;" the Consultant input "*Snoring*." The claim sheet further stated "*Date you first saw patient with symptoms*" under which the Consultant input **20 April 2019**. Finally, under the question "*duration of symptoms prior to this*" the Consultant input "*28 days and 1 month*".

The notes of R's GP from **3 June 2019** record that he had "*enlarged tonsils, had his adenoids removed a few weeks ago and it's hard for him to breathe at night*." and "*as per mum co sore throat, not drinking this am but is swallowing , did have episodes of sleep apnoea*." The note went on to state that the GP advised that R should be transferred to the Emergency Department of the hospital, which is what appears to have occurred, following consent from the Complainant.

On **1 July 2019**, R underwent tonsillotomy procedure. The Provider stated in its correspondence with this Office, that the Complainant did not call or use the online cover checker facility to check the cover for this procedure.

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On **9 July 2019,** the Complainant submitted a claim under the policy (claim xxxx1629). This claim was for a day case procedure for an adenoidectomy on **1 July 2019** in the children's Hospital. The total cost of the claim was €1402.00 (one thousand four hundred and two euro). This document was provided to this Office, and was completed by the Consultant Otolaryngologist. Under the box which stated "*Nature of presenting symptoms*;" the Consultant input "*Snoring, obstructive sleep apnea*." The claim sheet further stated "*Date you first saw patient with symptoms*" under which the Consultant input **20 May 2019**. Finally, under the question "*duration of symptoms prior to this*" the Consultant input "*1 day and 1 month*".

On **10 July 2019** the Provider requested the referral letter for claim xxxx9402 from the children's Hospital. On **6 August 2019**, a letter was received by the Provider from the Children's Hospital, which was the **19 December 2018** letter to the Consultant Otolaryngologist from R's GP. On **13 August 2019**, claim xxx9402 was rejected by the Provider and this was notified by way of email to the Complainant.

The Provider said that because the letter of referral received by the Children's Hospital was dated **19 December 2018** this was prior to R rejoining for cover and therefore the treatment cost was subject to the pre-existing condition waiting period of five years. The Provider issued the Complainant with a document called a statement of claim, in this regard.

On **10 October 2019** claim xxxx1629 was rejected by the Provider and this was notified by way of email to the Complainant. The Provider said that the letter of referral was again dated prior to R's rejoining cover.

During a **27 November 2019** call between the Provider's agent and the Complainant, the Complainant stated that the Provider was using a "*hidden term and condition*" and "*did not bring this to the attention of the* [Complainant]". The Complainant also stated that the policy which was uploaded to the system, was not the policy she had taken out.

The Provider's agent stated that the policy quotation remained the same, it is just the scheme that had changed. The Complainant also stated that she was not notified about the refusal of the payment of her claims on the policy, but the Provider had only notified the hospital. The Provider's agent stated that these notifications had been sent out by way of email, to which the Complainant stated that she did not receive these emails.

On **6 December 2019** the Complainant called the Provider and requested to appeal the decision to reject both claims. An appeal was opened on **6 December 2019**.

- On **16 December 2019** the Provider contacted both R's GP and the children's hospital information surrounding all relevant medical notes.

- On **6 January 2020** the Provider requested information from the Consultant and send a letter to the Complainant on the same day informing her that it was gathering this said information from the relevant doctors.

- On **15 January 2020** the Provider sent a second request to the R's GP.

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- On **31 January 2020** the Provider sent a second request to the consultant.

- On **13 February 2020** the Provider stated that it received no further information and its internal complaints procedure for appeals was closed and it issued a final response letter to the Complainant.

- On **6 August 2020** the Complainant submitted admission notes concerning both of R's admissions to the Children's Hospital, to the Provider.

- The Provider was also given R's GP records and consultant notes on **16 September 2020**.

Analysis

I note that the relevant General Rules policy booklet states as follows:

"*Pre-existing policy condition*

Pre-existing condition: An ailment, illness or condition, where, on the basis of medical advice, the signs or symptoms of that ailment, illness or condition existed at any time in the period of 6 months immediately proceedings:

a) *The day you took out a Health insurance contract for the first time: or*
b) *The day you took out a Health insurance contract again after your previous Health insurance contract had lapsed for 13 weeks or more.*

Please note that our medical advisors will determine whether a condition is a pre-existing condition. Their decision is final."

At page 12 of the booklet, Section 9 explains what is not covered by the policy, and states:

"*Pre-existing condition waiting period is – the first five years of membership*"

Finally, at **Page 36** of the booklet, it states:

"*Important information to note:*

Waiting periods
….
How long before you can claim for any disease, illness or injury which began or the symptoms of which began before membership started?

5 years for all age groups"

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It is clear to me that the material issue in determining if cover applies, is whether or not R's symptoms began before the inception of his policy cover on **4 January 2019**. If the symptoms began prior to that date, then the terms of the policy do not cover R, because the claim was made for treatment for a pre-existing condition, within five years of the inception date of his policy cover.

In this regard, the Provider's external advisor compiled two reports, which were made available to this Office. Those reports stated that

> " … *in a child of this age the tonsils and the adenoids are basically the same organ and most often reacting simultaneously to infections*."

and

> "… *if a tonsillectomy is performed in a young child, adenoidectomy should be performed simultaneously*. *In this case the surgeon chose adenoidectomy as a first step due to the low age of the patient*…"

The Complainant has stated that the Provider's reliance on the letter of **19 December 2018** as the referral letter is misplaced, because this letter is unrelated to R's adenoids, and makes no reference to snoring or sleep apnoea, as these symptoms did not occur until later. The Provider has submitted however that this was the referral letter that was made available to the Provider by the relevant hospital, on **6 August 2019**.

The Complainant further argues that the correct referral letter is the one of **13 February 2019**, which she says only related to symptoms regarding R's tonsils. The Complainant, therefore, contends that the issues regarding R post-date him being named on the policy. She also argues that his adenoids came on quickly and he deteriorated suddenly to the point which the consultant felt they should be removed. The Provider in this regard states that no action was taken following the original referral letter dated **19 December 2018** and R was again referred for the same ongoing issues on **13 February 2019**.

In my opinion, the Provider was entitled to form the opinion that the report of the GP dated **19 December 2018** (confirming that the Complainant and R attended two weeks before the inception of the policy) was of relevance. In this letter, it is noted that R had tonsillitis. Again, on the day that R was put on cover, under the policy on **4 January 2019**, the GP letter states "*Throat inflamed, + tonsillar adenopathy*".

I am satisfied that the Provider was entitled to take the view that these symptoms are associated with both tonsillitis and adenoid issues, as the Provider's expert confirms. Whilst there is no suggestion that R had been treated specifically for his adenoids, the terms of the policy do not require such. The terms of the policy call for confirmation as to whether the symptoms existed at the material time when the policy came into being, in **January 2019**. The terms of the policy are written in clear understandable language and because the symptoms regarding the tonsils and adenoids have been shown by the evidence to have been present before R's cover began, I am satisfied that the Provider was entitled to take the view the relevant policy clauses applied to exclude the claim for benefit payments because the five year waiting period had not been served.

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Whilst the Complainant contends that the **18 December 2018** letter makes no mention of the adenoids, there is clear reference to tonsilitis, a connected symptom. On that basis, I accept the position of the Provider that the exclusion applies in the same manner.

I also note the Complainant stated that the Provider was using a "*hidden term and condition*" and "*did not bring this to the attention of the* [Complainant]*"* in respect of her policy and R's cover. I do not accept that this was the case, as I am satisfied that the Provider's agent during the call on **4 January 2019** specifically explained the part of the policy concerning pre-existing conditions.

The Complainant further refers to the Provider ascribing the incorrect gender to her other child, who is not R. The Complainant stated she previously addressed this issue several times with the Provider and though the appeal is unrelated to her other child, it was troubling to her, and the Complainant struggles to accept that this is purely an innocent mistake.

In this regard it is noted that the Provider made a full apology and recognised the mistake stating that it was a genuine error on its part. I accept from the evidence that this was an innocent mistake on the part of the Provider.

The overall requirement of the Provider to seek the medical records was not in my opinion, unreasonable or unfair. However, I note the Complainant's contention that all this documentation should have been sought before the initial rejection of the claims. In this regard, the Provider only began to seek all relevant medical notes, after an appeal was lodged by the Complainant in **December 2019**.

I am satisfied however that it was appropriate for the Provider to make a decision on the basis of the documentation which it held when the claim was originally made by the Complainant. I am also satisfied that when the Complainant was unhappy with the outcome of that claim, insofar as the claim had been declined, and she sought to have the Provider reconsider its decision to decline the claim, that it was reasonable for the Provider to then explore what additional evidence was available as to R's medical history and to seek additional medical documentation at that time. Whilst the delay in securing a reply from the relevant medical professionals, contributed to the timeline, this is not a matter for which the Provider bears responsibility and I do not believe that in the overall circumstances, the Provider has a case to answer to the Complainant in that regard.

Accordingly, for the reasons outlined above, I do not consider it appropriate to uphold this complaint.

Conclusion

My Decision, pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017*** is that this complaint is rejected.

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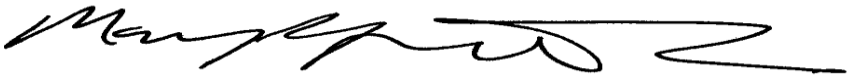
The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.



MARYROSE MCGOVERN
Deputy Financial Services and Pensions Ombudsman

21 September 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.