An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0348
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - waiting periods apply
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant incepted a health insurance policy with the Provider on **1 January 2017**, upgrading the level of cover he had held with his previous health insurer. The complaint concerns a declined health insurance claim, which the Provider declined when it concluded that the claim was made in respect of a condition that pre-existed the commencement of the Complainant's cover with it.

The Complainant's Case

The Complainant was admitted to a private hospital in **June 2017** for a *"Detailed Prostate Volume Study"*.

The Provider declined the ensuing health insurance claim on **11 December 2018** as it concluded that symptoms of the Complainant's rising PSA levels pre-existed the commencement of his cover with it, on **1 January 2017**, a decision which it subsequently stood over on appeal, on **6 February 2019**.

The Complainant sets out his complaint, as follows:

> *"I have had health insurance for more than thirty years with a number of different Health Insurance companies.*

During the course of 2016, as part of my regular review process I could see that I could switch provider and increase my cover to include treatment in certain private hospitals for an amount similar to my existing premium at that time. On that basis, I contacted [the Provider] *and purchased* [my policy]*, with this to take effect on 1st January 2017. I would have preferred to have upgraded my policy earlier in 2016 but it was impossible to switch* [insurer] *mid-year without penalty.*

The new plan provided cover in certain private hospitals, while previous to 1st January 2017, I was insured with [a previous insurer] *in a plan which did not provide cover in any private hospital.*

I have always understood that there are conditions attached to waiting periods, after upgrading, before obtaining cover for the treatment of pre-existing conditions …

[The Provider] *is refusing to pay this claim stating that "the symptoms of this condition existed before the scheme benefits were increased" … I do not agree with this …*

[The Provider] *is basing the rejection of my claim on information provided in a letter written by my GP…on 27th October 2016.* [My GP] *wrote "his PSA has been slightly elevated recently … hasn't much in the way of symptoms".*

My PSA on 25th October 2016 and which was referred to in this letter was 5.1 and would indeed fall into the category "slightly elevated".
I had a PSA test carried out one year earlier, in October 2015. It was measured at 4.7 and would also fall into the category "slightly elevated" …

On [**29 October 2015**] [my GP] *performed a digital rectal examination (DRE) and concluded that this elevated PSA resulted from an enlarged prostate which was smooth, i.e. BPH with no signs/symptoms of any lesion.*

On 29th October 2015, [my GP] *diagnosed me as having benign prostatic hyperplasia (BPH) and this was associated with the then raised PSA level of 4.7. I received no treatment for this condition and it was decided to monitor the situation. I had a PSA test carried out on 10th February 2016 which showed a level of 4.9. As I wasn't received treatment, this was consistent with BPH …*

… I had a PSA test in October 2016 and this showed a level of 5.1. Although [my GP] *doesn't show it in his recorded notes, he performed a DRE on me about that time and this continued to confirm no prostate condition, other than BPH.*

[My GP] *referred me to an Urologist…him being one with more expertise in the management of problems of the urinary system and not particularly to suspicions of prostate cancer.*

/Cont'd…

> [The Urologist] *made an appointment for me to have an MRI … See CONCLUSION item 3 of this report:*
>
> > *"Benign prostatic hypertrophy, with mild modular indentation of the bladder base"*.
>
> *This does confirm the 2015 and 2016 diagnoses of BPH with the "indentation of the bladder base" giving rise to any mild physical symptoms that I had.*
>
> *However, the MRI report also concludes in item 1 that there was a lesion present and is "suspicious for tumour". This was the first medical indication of the condition, prostate cancer, for which I was eventually treated and which is the subject of this disputed claim …*
>
> *I did have "elevated PSA". My GP diagnosed my only prostate condition in 2015 and 2016 as being BPH. My MRI in 2017 confirmed the presence of BPH. There is no evidence that any signs or symptoms prior to 1st January 2017 were related to prostate cancer.*
>
> *It is not reasonable for* [the Provider] *to state that my PSA level was associated with prostate cancer when it was clearly shown to be only associated with BPH. Any other association by* [the Provider] *is pure speculation.*
>
> *I brought my October 2015 GP consultation and diagnosis to the attention of* [the Provider] *in my appeal letter, but* [its] *claims assessor didn't take it into consideration"*.

The Complainant refers to a number of sources and says, for example, that the American Cancer Society, the HSE in Ireland and the NHS in the UK each compiled a list of the symptoms of prostate cancer and each made no reference to elevated PSA and, separately, the Complainant says that most men with elevated PSA do not have prostate cancer, that prostate cancer can have no symptoms, and that there are many conditions that affect PSA other than prostate cancer, BPH being one of them, which the Complainant says he himself was diagnosed with in **October 2015**.

in his email submission to this Office on **30 January 2020**, the Complainant submits that:

> *" In October 2015, I had a blood test indicating elevated PSA. GP carried out digital rectal examination (DRE) and diagnosed BPH. GOP found me to have smooth prostate, ie no tumour*
> *In October 20916, blood test showed little change to my PSA level, and still smooth enlarged prostate*
> *GP referred me to Urologist …*
>
> *There is a strong correlation between PSA levels and BPH*
> *Only a small number of men with a PSA level similar to mine, are subsequently diagnosed with prostate cancer*

/Cont'd…

Many men with normal PSA levels are diagnosed with prostate cancer

Given that I was medically diagnosed with BPH in 2015, it is highly likely that in 2015 and 2016, my elevated PSA with due to BPH with no suspicion of cancer being present.

There is no evidence linking my elevated PSA to prostate cancer until the result of my MRI and biopsy in 2017. Given my BPH diagnosis and DRE, there was no reason to see my PSA level as a symptom of prostate cancer. It is very likely that my prostate cancer developed during January 2017, there is no evidence for anything otherwise, nor should there have a suspicion of such.

It is not logical for [the Provider] *to insist that my elevated PSA was a symptom of prostate cancer while I, at the same time, had a diagnosed condition of BPH which was a known symptom of elevated PSA …"*

The Complainant notes that after he made this complaint to the FSPO, the Provider referred his claim to a third party firm for review and in this regard, in his email submission to this Office on **30 January 2020**, he submits that:

" … It is noteworthy that [the Provider] *did not bring my diagnosis of BPH to the attention of the Expert before asking that Expert to speculate on the likelihood that my slightly elevated PSA was an 'indication for prostate cancer'. For this reason, I do not think* [the Provider] *operated in a fair manner in this case.*

I note that the Expert is employed by [a third party firm]. [Its] *website claims that* [its] *clients are, primarily, health insurers. One could therefore conclude that* [the Provider] *would be a valued client company of* [the third party firm].

In view of these, I do not regard [the third party firm] *as providing an independent review of this case"*.

The Complainant seeks for the Provider to admit his health insurance claim for treatment costs in the amount of **€18,793.16** (eighteen thousand seven hundred and ninety-three Euro and sixteen cent).

The Provider's Case

Provider records indicate that the Complainant incepted a health insurance policy with it online on 8 December 2016 for both himself and his wife, with a start date of 1 January 2017. This was the first policy the Complainant took out with the Provider.

The Provider notes that the Complainant previously held health insurance with a different insurer from 1 January 2011 to 1 January 2017 and that this cover was at a lower level of cover than that he chose with the Provider.

/Cont'd…

The Provider says that the upgrade rules are set out at each stage of the online quotation and confirmation stage of the policy application process and are also included in the policy terms and conditions.

In this regard, the Provider notes that Section 8, '**What is covered under the scheme'**, at pgs. 10 – 11 of the applicable **General Rules Policy Booklet**, advises of the two year upgrade rule and that no treatment will be covered while a waiting period is being served, as follows:

> *"In the case of a person who was covered under a Health Insurance Contract within 13 weeks before their membership start date, we will only pay benefits for treatment received during their additional cover waiting period if benefits of the treatment would have been payable under that Health Insurance Contract. And we will only pay the benefits for such a treatment during the additional cover waiting period up to the amount that would have been payable under that Health Insurance Contract if the amount is less than would otherwise be payable by us under the scheme.*
>
> *A person's additional cover waiting period of this purpose shall be: …*
>
> - *the first two years following their membership start date for all other benefits".*

The Provider refers to Section 9, '**What is not covered under the scheme'**, at pg. 11 of the **Policy Booklet** which states:

> *"We will not pay the benefits for the following*
>
> *(a) Treatment which a person requires during any waiting period that may apply to the treatment under their scheme. All waiting periods commence on a person's membership start date or the date of the change to their policy/schemes …*
>
> *the pre-existing condition waiting period – this only applies to treatment which a person requires for a pre-existing condition".*

Section 2, '**Policy Definitions'**, at pg. 5 of the **Policy Booklet** defines a 'Pre-existing condition', as follows:

> *"**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 preceding:*
>
> *a) the day you took out a Health insurance contract for the first time; or*
>
> *b) the day you took 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**".*

/Cont'd…

In addition, the Provider says 3 telephone calls took place with the Complainant after he took out his policy and before his procedure in **June 2017** took place, when waiting periods and the upgrade rule were advised.

On **13 December 2016**, the Complainant telephoned to add his daughter to the policy and he was advised on the two-year upgrade rule for any pre-existing condition.

On **5 May 2017**, the Complainant telephoned and the Customer Service Advisor advised him that if symptoms were deemed new, then the policy cover would apply immediately, but if the symptoms were deemed pre-existing then the Complainant must have continuity of cover and have joined the Provider within 13 weeks of leaving his previous insurer and, in addition, if he had gained any hospital cover over and above the cover from his previous health insurer's policy, then he would be covered at that insurer's lower level of cover for 2 years. The Provider says that the Complainant understood this point, but was adamant that his was a new condition, since he incepted his policy with the Provider on **1 January 2017**.

On **8 May 2017**, the Complainant telephoned to discuss cover on his policy in a particular private hospital, as he understood after looking on the Provider's website that he would be covered, subject to all other conditions being met. The Customer Service Advisor advised that his policy covered selected private hospitals only, and that the particular private hospital was covered by his policy. The Complainant said that his symptoms started in January 2017 as this was the date when he sought treatment.

The Provider says that the Advisor told the Complainant that it is not when the Complainant visited the consultant or sought treatment, that is taken as the onset date but rather when the condition first started. The Advisor said that because the Complainant was with a different insurer before he incepted his policy with the Provider on **1 January 2017**, that if his condition was deemed "pre-existing" then the cover would revert to the level of cover he had held with his previous insurer. The Complainant did not believe he had been covered in the particular private hospital on his plan with the previous insurer.

The Provider says the Advisor then advised the Complainant to check with his previous insurer whether he had been covered in that private hospital, because if his condition was deemed to be pre-existing and if the Complainant did not have cover previously in that private hospital, then his claim would not be covered. The Complainant said he knew the rules and understood that all along, but said that this was not a pre-existing condition. The Advisor then advised, based on it being a new condition, that it would be covered in that private hospital with a **€375** (three hundred and seventy-five Euro) policy excess. The Advisor again urged the Complainant to check the level of cover he had held with his previous insurer.

The Provider received the Complainant's claim on **19 July 2017**. As part of its claim assessment, the Provider says it requested the initial referral letter, the MRI report, histology and the GP information. The Provider says that this process began on **24 August 2017**, with the final piece of information being received some 16 months later, on **6 December 2018**.

/Cont'd…

The Provider says that once the timeline was reviewed, it was clear to it that the referral process which led to the Complainant's MRI on **23 January 2017**, 23 days after he incepted his health insurance policy with it, was initiated before the Complainant incepted his cover on **1 January 2017**.

In this regard, the Provider notes the following timeline:

27 October 2016: Initial referral letter from the Complainant's GP to the Urologist, as follows:

> *"I would be most grateful if you could see* [the Complainant] *as a private patient; his PSA has been slightly elevated recently. He hasn't much in the line of symptoms other than having to go twice in the mornings sometimes."*

1 January 2017: The Complainant incepted his health insurance policy with the Provider and in doing so, upgraded his level of health insurance cover from his previous insurer to include some private hospitals.

18 January 2017: Following a consultation, the Urologist referred the Complainant for an MRI, as follows:

> "*Could I trouble you to arrange a 3 tesla MRI scan of the prostate on* [the Complainant] *who was kindly referred by* [his GP] *who has noticed the PSAs rising over the last year form 4.7 to 5.76 …*
>
> *On examination of the prostate it is not very large but I thought there was a slight change in texture between the right lobe on the left side."*

23 January 2017: The MRI reports a suspicious lesion present.

29 March 2017: Referral letter from the Urologist to the Oncologist, as follows:

> *"I would appreciate if you could see* [the Complainant] *who has been diagnosed with prostate cancer: 3+4=7. This is on the basis of* [name redacted] *kind referral with an elevated PSA and subsequent 3T scan which Identified a focal lesion in the right mid base Fusion biopsies were performed and the histology is enclosed. I enclose a copy of the 3T MRI as well. The PSA has gone from 4.7 to 5.6 … I would be grateful if you send him an appointment for consideration of brachytherapy …"*

/Cont'd…

The Provider says that its medical examiners were satisfied that on the basis of this timeline, the signs and referral process which led to the hospital admission in **June 2017** were initiated before the Complainant upgrading his cover **on 1 January 2017**, and as a result, the claim was rejected on **11 December 2018**.

The Provider received a letter from the Complainant on **25 January 2019** disputing this rejection of the claim and an appeal was opened as requested. The Provider says the appeal team (which is separate from the team who initially assessed the claim) reviewed the clinical information available and concluded that the timeline as set out above made the Complainant's condition a "pre-existing condition", within the meaning of the policy, and so the appeal was rejected on **6 February 2019**.

The Provider says that the timeline is very clear. Even taking any other diagnosis in to account, the Provider says that the Complainant's GP, being concerned about the continuing rise in the PSA levels from 4.7 to 5.75, initiated the referral process on **27 October 2016** (which led to the Complainant's diagnosis, and ultimately to his hospital admission and procedure) prior to the Complainant upgrading his level of cover on **1 January 2017**.

The Provider says it has a rigorous claim assessment and appeals process where all medical information is reviewed before any decision is made on a claim. Internally, the Provider has medical advisors whose opinion can be sought at any stage. The Provider says that both the initial assessment and appeals review are conducted independently of each other to ensure the fairest outcome possible for a claimant.

At both of these stages, taking all of the medical reports into account and in conjunction with the health insurance policy terms and conditions, the Provider says that the Complainant's claim was rejected because, based on the medical information received, the signs and symptoms of his condition were present before he upgraded his cover, thus making his condition a pre-existing condition under the policy terms and conditions.

The Provider says it has two external options available to it, if additional medical advice is required. This is again to ensure that the claims assessment process is fair to all its claimants. For any claims where an additional opinion is required, the Provider has access to a Medical Advisor panel. The Provider says that this panel consists of a number of Irish Consultants as well as a GP, who are familiar with Standards of Care practiced in Ireland.

The Provider says it was not necessary to refer the Complainant's claim for this review because, once all the medical information was available, its internal medical advisors were able to ascertain that the Complainant's condition was a pre-existing conditions, per the policy terms and conditions and so the claim was rejected.

The Provider notes that the third party firm referred to by the Complainant is the other external option available to it if an external independent review is required. This third party's goal is to provide a professional, independent and unbiased opinion to assist clients to provide an external source to determine medical necessity and appropriateness of care of clinical cases.

/Cont'd…

The Provider says that this third party firm employs clinicians who are experts in international best practice and they work with a number of health insurers internationally. As these clinicians are aware of not only international standards of care, but also health insurers' rules, they help to maintain the integrity of the market.

The Provider also says that this third party firm dispatch these cases based on speciality match, in this case to an urologist, who then reviews the clinical information and provides answers to the questions. The firm's clinical quality team reviews the answers for completion, quality and reference to evidence-based literature and only then is a report ready for the insurer.

The Provides says that this third party firm's reviewers are all active specialists in their area and are acting as consultants for the firm. Each individual has to go through the firm's recruiting process which includes credentials reviews, personal interviews, training and confirmation of their familiarity with evidence-based literature.

The Provider says that before accepting a case, reviewers must confirm their ability to review the case without any bias, or previous familiarity with the specific case, as there is an ethical consideration that the reviewer must be independent. The reviewers are being paid only for their time and the pay is not related in any way to the nature of their recommendation.

In this case, the Provider says that the third party firm's opinion was only sought by the Provider's Complaints Resolution Specialists when the Complainant made a complaint to the FSPO, in order to gain an outside opinion at that time, from a source not involved in the original decision making process.
The Provider says that this again demonstrates that it has at all times acted honestly, fairly and professionally in relation to the assessment of the Complainant's claim.

The Provider says that it was an urologist who conducted the third party firm review and it confirms its opinion that this was the correct clinician, because during the normal course of events when a GP is referring a patient for possible prostate cancer issues, they would firstly be referred to an urologist. It says that if you are a prostate cancer patient, the urologist is most likely the physician who would do a biopsy, give the diagnosis, a Gleason Score, and discuss possible treatment options. The urologist may discuss prostate surgery (prostatectomy), especially if he/she is a surgeon. In prostate cancer, a medical oncologist is often the third doctor the patient will see, after the urologist and the radiation oncologist.

The Provider notes that the Complainant's GP referred the Complainant to an Urologist and he then in turn referred the Complainant to an Oncologist on **29 March 2017**, but it notes that this referral was only after a diagnosis of prostate cancer, had been made.

The Provider says that the Complainant was only referred on to an oncologist because the surgical option was not being considered but radiotherapy was. As a result, the Provider says that the correct speciality conducted the third party firm review, as it mirrored the Complainant's care pathway.

/Cont'd…

The Provider says that it is the opinion of the medical advisors, that the results documented in the MRI which took place 23 days after the Complainant upgraded his cover, could not have developed in 23 days. This was the conclusion of both its internal medical advisors and also of the third party firm of external advisers who also reviewed the case.

The Complaint for Adjudication

The complaint is that the Provider wrongfully or unfairly declined to pay the Complainant's health insurance 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.

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 **10 September 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.

It is important to note that it is not the role of this Office to adjudicate in conflicts of medical evidence. Rather, it is the role of this Office to examine the totality of the medical evidence which was before the Provider at the time it made its decisions on the Complainant's claim, in order for the FSPO to determine whether the decisions made by the Provider in this matter were reasonable decisions, based upon the medical evidence that was available to it at those times.

/Cont'd…

I am satisfied that this is in accordance with the views of the High Court in *Baskaran v. FSPO* [2016/149MCA], where the Court confirmed that:

> *"The function of the* [Financial Services and Pensions Ombudsman] *in considering the…complaint was, in general terms, to assess whether or not* [the Provider] *acted reasonably, properly and lawfully in declining the claim of the Appellant"*.

The Complainant's health insurance policy, like all insurance policies, does not provide cover for every eventuality; rather the cover is subject to the terms, conditions, endorsements and exclusions set out in the policy documentation, as well as the level of cover provided by the policy itself.
I am satisfied that it is an industry wide standard that waiting periods apply to cover under health insurance policies for any "pre-existing" condition, i.e. when the medical condition or the symptoms or signs of the medical condition were present, before the commencement of cover or prior to an upgrade in cover.

Recordings of telephone calls have been supplied in evidence and I have considered the content of these calls and am satisfied that the Complainant was clearly informed by the Customer Service Advisers of the Provider, who he spoke with during these calls, of the upgrade and pre-existing condition policy rules. In addition, I note that in his complaint letter to this Office, the Complainant advises that:

> *" … I have always understood that there are conditions attached to waiting periods, after upgrading, before obtaining cover for the treatment of pre-existing condition".*

The Complainant's complaint is that the Provider was wrong to conclude that symptoms of prostate cancer were present prior to **1 January 2017**, in circumstances where he had been previously diagnosed with benign prostatic hyperplasia (BPH) in **October 2015**, which the Complainant contends is why his PSA levels were slightly elevated both at that time, and again when tested in **October 2016.**
I note from the documentary evidence before me that the Complainant's GP wrote a referral letter for the Complainant to a Consultant Urologist on **27 October 2016**, as follows:

> *"I would be most grateful if you could see* [the Complainant] *as a private patient; his PSA has been slightly elevated recently. He hasn't much in the line of symptoms other than having to go twice in the mornings sometimes"*.

I note that this referral letter was written just over two months before the Complainant incepted his upgraded health insurance policy with the Provider on **1 January 2017**.

I also note that the Consultant Urologist wrote a referral letter for the Complainant for an MRI on **18 January 2017**, as follows:

> *"Could I trouble you to arrange a 3 tesla MRI scan of the prostate on* [the Complainant] *who was kindly referred by* [his GP] *who has noticed the PSAs rising over the last year form 4.7 to 5.76 …*

/Cont'd…

On examination of the prostate it is not very large but I thought there was a slight change in texture between the right lobe on the left side".

I note the **Diagnostic Imaging Report** dated **23 January 2017** states:

*"**Examination***
MRI Pelvis Prostate …

CONCLUSION:
1. *Lesion 1: T2-jypointense focus with restricted diffusion (2cc) in the right mid-gland to base posterior peripheral zone is suspicious for tumour. Possible minimal extracapsular extension due to broad-based capsular contact.*
2. *No other suspicious lesion identified.*
3. *Benign prostatic hypertrophy with mild modular indentation of the bladder base".*

I note that thereafter, the Consultant Urologist wrote a referral letter for the Complainant to the Consultant Urology Oncologist on **29 March 2017**, as follows:

"I would appreciate if you could see [the Complainant] *who has been diagnosed with prostate cancer: 3+4=7. This is on the basis of* [the Complainant's GP's] *kind referral with an elevated PSA and subsequent 3T scan which Identified a focal lesion in the right mid base Fusion biopsies were performed and the histology is enclosed. I enclose a copy of the 3T MRI as well. The PSA has gone from 4.7 to 5.6 … I would be grateful if you send him an appointment for consideration of brachytherapy".*

I take the view on the basis of this medical evidence, which included the GP letter dated **27 October 2016** referring the Complainant to a Consultant Urologist, that it was reasonable for the Provider to conclude that the symptoms that led to the Complainant's hospital admission and procedure in **June 2017** were present and pre-existing on **1 January 2017**, when the Complainant incepted his health insurance policy with the Provider and upgraded his level of cover from that which he had held, with his previous insurer.

I am satisfied that the Provider was therefore entitled to decline the Complainant's claim, given that when he upgraded his level of cover on **1 January 2017** to include a selected list of private hospitals, this upgraded level of cover was subject to a two year additional cover waiting period, for any pre-existing condition, in accordance with the policy terms and conditions. As a result, the Complainant's claim fell to be assessed under the previous level of cover which he held with a different insurer, before **1 January 2017**.

In this regard, I note that the Complainant's hospital admission in **June 2017** was to a medical facility that was not covered by his previous level of cover with the previous insurer.

/Cont'd…

It is the Complainant's contention that:

> "*it is not reasonable for [the Provider] to state that my PSA level was associated with prostate cancer, when it was clearly shown to be only associated with BPH. Any other association by [the Provider] is pure speculation.*"

I do not accept the Complainant's contention that it was "*clearly shown*" that his symptoms before January 2017 were associated only with BPH. I am satisfied that the Provider was entitled to form the opinion from the medical evidence available to it, that in relation to the treatment which the Complainant ultimately underwent in June 2017, there were symptoms or signs of that condition already in existence in January 2017, even if that condition had not yet been diagnosed at that time, when the Complainant upgraded his cover by incepting a health insurance policy with the Provider.

Having regard to all of the above, I take the view that the evidence does not support the Complainant's complaint that the Provider wrongfully or unfairly declined to pay his health insurance claim. On the evidence before me therefore, this complaint cannot be upheld.

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

4 October 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.