An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0351
Sector:	Insurance
Product / Service:	Travel
Conduct(s) complained of:	Rejection of claim – partial rejection Dissatisfaction with customer service
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The complaint concerns a declined travel insurance claim, which the Complainant made under a travel insurance policy she held with the Provider.

The Complainant's Case

The Complainant travelled abroad with her three children in **August 2019**, with return flights scheduled for 10 days later.

During this trip, one of the Complainant's children became ill. The Complainant brought this child to a medical centre for treatment and, on the day before the return flight, following a consultation with the treating doctor, her child was deemed unfit to fly at that time due to [illness].

The Complainant says that while her two other children were able to take the return flight to Ireland as scheduled, she and her sick child were unable to travel on that date. due to her child's illness.

The Complainant says that on the day after the return flight they had been unable to take, she once again brought her child to the medical centre, at which time the treating doctor deemed her child to be fit to fly. The Complainant and her child took a flight home to Ireland the following day, 2 days after the originally scheduled return flight.

The Complainant sets out her complaint in the Complaint Form she completed, as follows:

> *"On my return I contacted* [the Provider] *who informed me it would be* [my health insurance insurer] *who would be responsible, who in turn said it was* [the Provider]*. I was transferred back and forth for over an hour, eventually* [the Provider] *took my* [claim] *and sent me an email rejecting the claim. I was unhappy with this so followed their advice and wrote to the manager and again it has been declined. I am unhappy with this decision. I am not looking for any expenses related to* [child's] *illness as she is not on the policy. I was seeking some payment for my flights that I had to reschedule as I could not leave a minor on their own, ill or not. I really don't see the point of travel insurance, seems to be a get out clause in the fine print, what was I expected to do? I have incurred substantial costs over the unforeseen extra stay and I am only seeking MY rescheduled fare for flight home"*.

The Complainant seeks for the Provider to admit her travel insurance claim for her rescheduled one-way flight to Ireland, in the amount of **€553.79** (five hundred and fifty three Euro and seventy-nine cent).

The Provider's Case

The Provider says that its records indicate that the travel insurance policy held by the Complainant, is one that provides a standard level of cover to customers of a certain health insurance provider.

The Provider says that the Complainant first telephoned in early **September 2019** and a Claims Team Agent took the details of the incident from the Complainant.

The Provider says that a claim form was not issued, because it was determined during this initial call that due to the nature of the claim, it was the Complainant's health insurance provider who would deal with such a case, as medical-related claims under **€100,000** (one hundred thousand Euro) fall within that provider's remit.

The Provider says that its Claims Team Agent explained this to the Complainant and advised that her health insurance provider would deal with such a claim, and her call was transferred to that provider.

The Complainant telephoned later that day, saying that she had been advised by her health insurance provider to contact the Provider to make her claim. The Claims Team Agent again advised the Complainant that her health insurance provider deals with any such claims up to a value of the first **€100,000**.

The Complainant telephoned again for a third time, later that day, saying that she had again been advised to contact the Provider to make a claim. The Claims Team Agent in question advised the Complainant that he would arrange for the Provider to issue her a claim declinature letter, as this might then make it easier for her, when dealing with her health insurance provider.

As a result, the Provider wrote to the Complainant that day as follows:

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"Under the Emergency medical and associated expenses section of your policy, we are only able to consider claims arising as a result of one of the following reasons:

Your [Provider] *Travel Insurance policy provides cover for emergency medical and associated expenses incurred by you during your journey if the cost of your medical treatment is over the €100,000 limit provided by your* [health insurance provider] *Health Insurance policy, where we will pay any amount above this sum, up to €5 million in total (subject to the policy terms and conditions).*

I regret to advise that as you informed your [child] *was ill and was unfit to return on the original flight, as a result had to extend your stay and book new flights. Unfortunately we are unable to accept liability as the first €100,000 of any medical associated claim is dealt* by [health insurance provider] *and not* [the Provider]*, we are unable to pay your claim on this occasion"*.

The Provider says that on **18 September 2019,** it received a letter from the Complainant dated **16 September 2019**, and accompanying documents, in which she requested that the Provider reassess her claim.

Following its assessment, the Provider wrote to the Complainant on **26 September 2019**, as follows:

"Please be advised under the Emergency medical and associated expenses section of your policy it states:

"Your [Provider] *Travel Insurance policy provides cover for emergency medical and associated expenses incurred by you during your journey if the cost of your medical treatment is over the €100,000 limit provided by your* [health insurance provider] *Health Insurance policy, where we will pay any amount above this sum, up to €5 million in total (subject to the policy terms and conditions)"*.

Kindly note if your [child]*…was covered under this policy the reasons for why yourself and* [child] *had to return home at a later date and the expenses you have incurred would be known as an associated expense, but as it is just yourself covered and it was not your medical reason why you could not fly home on the original date there would be no cover under this section of the policy.*

Please note you would also not be able to claim under the cancellation section of this policy as cancellation cover is provided if you had to cancel your trip before it begins for the following reasons stated in the policy:

"WHAT YOU ARE COVERED FOR

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- *The death, serious injury or serious illness of you, someone you were going to stay with, a travelling companion, or a relative or business associate of you or a travelling companion.*
- *You or a travelling companion is called for jury service in your home country or as a witness in a court in your home country*
- *You or a travelling companion is needed by the Gardaí following a burglary, or damage caused by serious fire, storm, flood, explosion, subsidence, vandalism, fallen trees, impact by aircraft or vehicle at your home or their home"*.

In view of the above, I regret that no liability can be accepted for your claim on this occasion as your claim would not be covered under any section of our policy".

The Complaint for Adjudication

The complaint is that the Provider wrongfully or unreasonably declined to pay the Complainant's travel insurance claim and that it provided her with poor customer service.

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.

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I note that the Complainant telephoned the Provider in early **September 2019** to claim the cost of her one-way flight to Ireland, in the amount of **€553.79** (five hundred and fifty three Euro and seventy-nine cent). In this regard, the Complainant had been unable to take her original return flight to Ireland 2 days earlier as scheduled, because one of her children who was travelling with her, was deemed medically unfit to fly at that time, due to [illness].

The Provider advised the Complainant by telephone that day that the Complainant's health insurance provider would deal with such a case, as medical-related claims of a value under **€100,000** fall within that provider's remit.

The Complainant telephoned the Provider twice more that day, saying that her health insurance provider had redirected her to the Provider.

The Claims Team Agent who the Complainant spoke with, during her third telephone call to the Provider, advised that he would arrange for a claim declinature letter to issue to her, as this might then make it easier for her when dealing with her health insurance provider. I note that the Provider subsequently emailed the Complainant a claim declinature letter that day.

The Complainant's travel insurance policy with the Provider, like all insurance policies, does not provide cover for every possible eventuality; rather the cover will be subject to the terms, conditions, endorsements and exclusions set out in the policy documentation.

I note that Section 10, 'Emergency medical and associated expenses', at pg. 20 of the applicable **Travel Insurance Policy** document [edition of 05/19] states:

> *"**WHAT YOU ARE COVERED FOR***
>
> ***We** will pay **you** or **your** Personal Representative for necessary and unforeseen emergency expenses if **you** die, are injured, have an accident or are taken ill during **your journey**.*
>
> ***Your** [health insurance* provider*] Health Insurance policy provides cover for emergency medical and associated expenses incurred by **you** up to **€100,000** (subject to the policy terms and conditions) as long as these are not as a result of a **winter sports** related injury. Full details of the cover provided may be found in **your** [health insurance* provider*] Health Insurance policy.*
>
> ***Your*** [Provider] *Travel Insurance policy provides cover for emergency medical and associated expenses incurred by **you** during **your journey** if the cost of **your** medical treatment is over the **€100,000** limit provided by **your*** [health insurance provider] *Health Insurance policy, where **we** will pay any amount above this sum, up to **€5 million** in total (subject to the policy terms and conditions).*
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> [underlining added for emphasis]

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WHAT YOU ARE NOT COVERED FOR

*Any medical claim that is not covered by **your*** [health insurance provider] *Health insurance policy …"*.

I am satisfied that for the cover under the Complainant's travel insurance policy, provided by this '**Emergency medical and associated expenses'** section to be triggered, the policyholder's health insurance provider must first accept an emergency medical and associated expenses claim from the policyholder and then, in circumstances where that claim amount exceeds **€100,000.00** (one hundred thousand Euro), the Complainant's travel insurance policy with the Provider will then provide cover for that portion of the claim amount that exceeds **€100,000.00**, but not the portion of any claim amount greater than **€5,000,000.00** (five million Euro).

I note that the **Travel Insurance Policy** document contains the following different sections of cover:

- Cancellation or curtailment charges
- Loss of passport
- Delayed personal possessions
- Personal possessions
- Personal money
- Personal accident
- Missed departure
- Delayed departure
- Personal liability.

The Complainant seeks to recover the cost of her one-way flight to Ireland, which she purchased in order to travel home 2 days later than originally scheduled. The cost incurred was **€553.79** (five hundred and fifty three Euro and seventy-nine cent).

As she did not take her original flight to Ireland because her child was at that time deemed medically unfit to fly, but instead travelled home 2 days later (after her child was subsequently deemed medically fit to fly), I am satisfied that the Complainant's trip was neither cancelled nor curtailed (cut short), nor did she miss the departure of her original flight, due to delayed transit to the airport, all of which are circumstances which are within the cover offered by her travel insurance policy. As a result, I am satisfied that the Provider was entitled to decline the Complainant's travel insurance claim in accordance with the policy terms and condition.

Recordings of the 3 telephone calls that the Complainant made to the Provider in early **September 2019** have been supplied in evidence and I have considered the content of these calls. I note that the different Claims Team Agents who the Complainant spoke with on that day, each correctly explained that her health insurance provider would deal with the circumstances she mentioned, because medical-related claims under a value of €100,000 fall within that health insurance provider's remit. I am satisfied in that regard, that the Complainant was appropriately redirected to her health insurance provider.

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In addition, as the Complainant, subsequent to her initial telephone call to the Provider in early **September 2019**, telephoned 2 further times that day saying that her health insurance provider had referred her back to the Provider to make a claim, I am satisfied that it was appropriate, given the circumstances, for the Claims Team Agent she spoke with during her third call to the Provider that day, to arrange to issue the Complainant with a claim declinature letter, and I note that this Agent clearly advised:

> *"What I can do, I can send out a claims letter from ourselves confirming there is no cover in place, that gives you documentation for you to go back to* [the health insurance provider] *with, and advise them that's the situation".*

Having regard to all of the above, I am satisfied that the evidence does not support the complaint that the Provider wrongfully or unreasonably declined to pay the Complainant's travel insurance claim or that it provided her with poor customer service in the course of its interactions with her. Rather, I am satisfied that the Provider tried on a number of occasions to explain the limits of cover to the Complainant, and it arranged to issue a declined claim letter to her, to assist her in her dealings with her health insurance provider. Accordingly, on the evidence before me that this complaint cannot reasonably 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.