An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0394
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - late notification Dissatisfaction with customer service Failure to advise on key product/service features
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant holds a private health insurance policy with the Provider. The Provider's scheme included a rule that claims for out-patient medical expenses must be submitted within 12 months of the treatment date. The complaint arises from the Provider's implementation of that rule, and the way in which the Provider notified the Complainant of its implementation.

The Complainant's Case

The Complainant had a practice of submitting claims to the Provider every two to three years, for medical treatments received over the course of those periods. These claims were not rejected by the Provider at those times, although they were submitted more than 12 months after the date of treatment.

On **9 April 2019,** the Complainant submitted a claim for a number of treatments that had taken place during 2017 and 2018.

On **3 May 2019**, the Provider rejected the Complainant's claim for six receipts from 2017, amounting to €507 (five hundred and seven Euro), on the basis that the claims had been submitted after the time limit of 12 months had elapsed.

The Complainant wrote to the Provider by letter on **23 May 2019** to appeal the decision, noting that his practice of submitting claims spanning multiple years had been always been accepted. In response, the Complainant received two letters from the Provider, by way of email.

In the first letter, dated **20 June 2019**, the Provider explained that notification of the change in policy had been communicated to the Complainant on **18 October 2018** via email ('the renewal email'). The Provider had emailed a 'renewal pack', containing a renewal booklet that identified the implementation of the 12-month time limit for submitting claims, and confirmed a 12-month grace period for submitting outstanding claims that would otherwise be deemed late and inadmissible.

In the second letter, dated **9 July 2019**, the Provider clarified the correct date of the renewal email to have been **23 October 2017.** As a result, the Complainant was advised that his receipts did not fall within the grace period for submitting late claims.

The Complainant says that the Provider's email of **23 October 2017** advised that his renewal of his policy was due on **1 December**, and stated that all renewal documents could be accessed in the Member Area of the Provider's website. A hyper-link to the Member Area was included in the email, which provided access to (i) a renewal letter, (ii) a renewal booklet, and (iii) a Membership Certificate. At page seven of the booklet, it was stated that the Provider would implement the existing rule of a 12-month time limit for submitting claims, and the grace period of 12 months was also set out.

In a complaint made to this office of **5 October 2019**, the Complainant stated:

> *"My complaint is that a change of this magnitude in the terms of the policy should have been highlighted in the renewal letter and not hidden as a single paragraph on page 7 of a 14 page document which was only provided on-line…*
>
> *I believe that the fact that even [Provider] staff were confused over the year this came into effect, adds weight to my complaint."*

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

In a submission to this office of **26 August 2020**, the Provider noted that the 12-month time limit has always been a part of the Provider's terms and conditions.

The Complainant took out a private insurance policy with the Provider in **2009**. The Provider's 2009 rules booklet stated that benefits would only be paid on receipt of a written claim within 12 months from the date of treatment.

In **2013**, the Complainant upgraded his level of cover with the Provider, and the 2013 rules booklet reiterated the policy of the 12-month time limit for submitting claims.

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The Provider acknowledges that the time limit policy was not strictly enforced until **1 December 2018**, following notification to all customers in their 2017 renewal documents. As the Complainant's contact method is email, the Complainant was provided with his policy renewal notice by way of email on **23 October 2017**. The Provider says that this email advised that the renewal pack was contained in the secure Member Area of the Provider's website. The notification of the implementation of the 12-month time limit, and the grace period to submit late receipts, were stated on page 7 of the booklet in the Member Area.

The Provider says that on **30 November 2017**, the Complainant renewed his policy online, accepting all terms and conditions of the renewal.

In relation to the rejection of the Complainant's claim, the Provider noted that the receipts he submitted were for treatments received in the period of **1 December 2016** to **30 November 2017**. The cut-off date for the submission of those claims was **30 November 2018**, and the Provider received the claims on **11 April 2019**.

The Provider also refers to the refusal of an additional receipt, which had been included in the Complainant's claim form, relating to a type of treatment not covered by the policy. This refusal is not the subject of the Complainant's complaint.

The Provider was asked by this office how the key information of the implementation of the time limit had been relayed to the Complainant '*in a manner that did not disguise, diminish, or obscure it*'.

The Provider responded in a submission of **26 August 2020:**

> *"The 12 month rule has always been a part of the terms and conditions of [Provider] as mentioned in Q2, however, it was not strictly enforced until August 2018 onwards. [Provider] gave all members notice of this in their 2017 renewal documents, giving them a one year grace period to submit older receipts which the Complainant did not avail of.*
>
> *The Complainant's contact method is email, therefore on 23/10/2017 [Provider] emailed the Complainant his policy renewal notice for his upcoming renewal on 01/12/2017. Within the secure member area all renewal documents are available including a [renewal] booklet. Within this booklet, it was confirmed that an existing rule would be implemented, which states that claims should be made within 12 months of the treatment date on the receipt. It was also stated that the Complainant had an additional 12 months to submit these receipts, which had not previously been claimed for assessment."*

When the Provider was asked whether it considered that it had met its obligations under the ***Consumer Protection Code 2012*** (CPC), General Principles 2.1 and 2.2, with regard to its interactions with the Complainant, it stated in a submission of **26 August 2020:**

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"In all interactions with our members, [Provider] aim[s] to abide by and apply the Consumer Protection Code and principles, including the above two subsections.

In this instance, our assessment of the disputed claim and the application of the 12 month rule was reasonable and professional.

Notification of the rule implementation was given to the member in his renewal documents one year prior to the cut-off date for submitting these receipts. The Complainant was given significant notice to submit these receipts on time. The Complainant did not avail of this one year grace period that [Provider] allowed.

[Provider] must treat all members fairly and equally. If [Provider] were to pay the Complainant's claim… on an ex gratia basis, without an error on [Provider's] part or a justifiable reason to do so, this would not be fair to all other [Provider] members who have submitted their receipts in the allowed timeframe."

The Complaint for Adjudication

The complaint is that the Provider wrongfully and incorrectly declined the Complainant's claim, and failed to clearly communicate a significant change in the operation of the policy scheme, to him.

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.

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

I note that the timeline for the conduct complained of in this matter is as follows:

Date	Event
2009	Complainant becomes a customer of the Provider
2013	Complainant upgrades customer package with the Provider
24/01/2017	Receipt date for expense
29/06/2017	Receipt date for expense
11/07/2017	Receipt date for expense
13/07/2017	Receipt date for expense
23/10/2017	Provider sends renewal email to the Complainant
27/10/2017	Receipt date for expense
16/11/2017	Receipt date for expense
30/11/2017	Complainant renews policy with the Provider online
01/12/2018	Provider implements the time limit policy
09/04/2019	Complainant submits a claim form for expenses spanning 2017-2018
11/04/2019	Provider receives the Complainant's claim form
03/05/2019	Provider rejects the Complainant's claim relating to six expenses from 2017
23/05/2019	Complainant writes to the Provider to appeal decision
20/06/2019	Provider responds to Complainant confirming its decision
09/07/2019	Provider responds to Complainant with final letter
05/10/2019	Complainant makes a complaint with the FSPO

Evidence

I note that the Provider's **2009** rule booklet stated at page 15:

"9. Making a claim

(a) When possible, you should tell us about any treatment you are going to have. This gives us the chance to tell you if you can claim for benefits. We may ask your consultant or other registered medical practitioner to provide us with full written details of the treatment.

(b) We will not pay benefits while you are breaking any of the terms of your membership.

(c) You should send your claims to us as soon as possible. We will only pay benefits if we receive all of the following:

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- *A written claim within twelve months from the date of any non-surgical out-patient treatment and six months from the date of any other treatment (unless this was not reasonably possible). You must make the claim in the way that we reasonably ask you. We may change the procedure for making a claim. If we do change the procedure, we will write and let you know…"*

In the Provider's renewal email of **23 October 2017**, the following was stated:

> *"Dear [Complainant],*
>
> *At [Provider], we are proud of what we do and are committed to looking after our members, always. We wish you thank you for your membership and to let you know your policy will renew on December 1st.*
>
> ***What do I need to do?***
>
> *In an effort to maintain quality health insurance, we have carried out a full review of our schemes. As a result price and benefit changes may apply to your policy from your renewal, including the addition of our new… benefit exclusive to [Provider] members on all healthcare policies. Please take the time to review the below and all other policy documents to ensure you are aware of any changes to your policy.*
>
> *…*
>
> *Your renewal premium is €[redacted], to make a secure payment or pay by instalments, log in to your Member Area or call our team.*
>
> *…*
>
> *To view all your [Provider] renewal documents you must log in to your secure Member Area, where you will also find details of the great benefits and offers available to you."*

The copy of the renewal email provided to this office is not dated.

The date of **23 October 2017** is confirmed by the Provider in the document of the Contact History for the Complainant, at page 11. This date is not disputed by the Complainant.

The Provider's renewal letter, dated **16 October 2017** and which formed a part of the renewal pack in the Member Area, stated:

> *"Dear [Complainant],*
>
> *…*

/Cont'd…

In an effort to maintain quality health insurance, we have carried out a full review of our schemes. As a result, price and benefit changes may apply to your policy from your renewal, including the addition of our new… benefit exclusive to [Provider] members on all healthcare policies. Please take the time to review the below and all other policy documents to ensure you are aware of any changes to your policy.

…

Your renewal premium is €[redacted], to make a secure payment or pay by instalments, log in to your Member Area at [Provider web address] or call our team."

The renewal letter does not specifically refer to the implementation of the 12-month time limit.

The Provider's renewal booklet, which was accessible in the Member Area of the website, is 13 pages in length. At page seven, it stated in bold type:

"From your renewal, we will be implementing an existing rule which states that out-patient claims should be submitted within 12 months of the treatment date on your receipt. In order to help you with this transition, we will pay out-patient benefits for any receipts that you have not previously submitted if you send them to us within the next 12 months."

Analysis

In my opinion, the reasonableness of the Provider's notification depends on both (i) the accessibility of the notifying documents, and (ii) the presentation of the notification within the renewal documents.

In relation to the first factor, although the language of the Provider's letter of **20 June 2019** is that the Provider 'emailed a renewal pack' to the Complainant, I note that there were no documents attached to that renewal email of **23 October 2017**.

The renewal email was the only direct piece of correspondence sent to the Complainant on this issue. This email noted that benefit changes "*may apply*" to the Complainant's policy, but it did not refer to the new approach of the Provider, in the implementation of the time limit rule, to which the Complainant had not been subject for nearly a decade.

Similarly, the renewal letter, which could only be accessed after signing into the Member Area of the Provider's website, did not refer either to this change of approach in implementing a rule which had been in place for the previous eight/nine years of the Complainant's contractual relationship with the Provider, but had never before been relied upon.

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I note that both documents asked the Complainant to view his policy documents in the Member Area, to ensure that he was aware of any changes.

As noted on page 14 of the Contact History for the Complainant, supplied by the Provider, the Complainant was informed on **9 December 2016** that he would receive all documentation online, and he would have to update his preferences to continue to receive documents by post. Although the Complainant complains that the renewal booklet was "*only provided on-line*", there is no suggestion that he contacted the Provider to change his correspondence preferences, so that he could receive hard copy communications through the post.

Provision 4.3 of the Central Bank of Ireland's Consumer Protection Code ("CPC") states that:

> *"4.3 A regulated entity must ensure that, where it communicates with a consumer using electronic media, it has in place appropriate arrangements to ensure the security of information received from the consumer and the secure transmission of information to the consumer."*

As a result, it was not unreasonable in my opinion, for the Provider to provide policy documentation to the Complainant in an online form, and for him to secure this documentation through a signing-in procedure for the Member Area.

In relation to the second factor, I note that the notification of the change in the implementation of the Provider's policy rule, was included in the renewal pack, placed at page seven of a 13-page policy document.

Although the wording was in bold, there were no other factors to draw the paragraph to the Complainant's attention. The notification was placed on a page of full text, containing many other paragraphs, both before and after it.

Provision 4.1 of CPC states:

> *"4.1 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."*

When asked how it relayed the notification to the Complainant in a manner that did not '*disguise, diminish, or obscure*' the information, the Provider stated that notice was provided in the 2017 renewal documents. The Provider did not further explain how the presentation of this information in the renewal documents, met the standard required of it under Provision 4.1 CPC.

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Since the Preliminary Decision of this Office was issued however, the Provider has advised that:

> *"To comply with this requirement, [Provider] provided the member with a Check-Up document as part of his renewal pack. This Check-Up document is the primary means of informing members of any changes or updates since their last renewal and is designed in such a way to make changes (both additions and removals) easily accessible to members. The Complainant's Check-Up document is a 16 page document, as opposed to the complete Rules booklet which can run to 40 pages. The express purpose of this Check-Up document is to specifically advise members of rule and benefit changes at their renewal. We consider the Check-Up document to be clear, accurate and written in plain English and is in fact designed in such a way so as to bring key information to the attention of the member and in no way attempts to disguise, diminish or obscure any important information.*
>
> *The notification of this change to outpatient claiming was provided under a very specific heading '**Daily Medical Expenses'** in the Check-Up document, and further the relevant text was emboldened on page 7 to actually draw attention to the paragraph. Highlighting the text in bold font was to bring focus to the information, rather than any attempt to disguise, obscure or diminish such information. In addition to that a 12 month grace period was also afforded to the Complainant to submit any old receipts. We consider that by allowing this grace period we have been very fair to all members when submitting outpatient receipts, given the 12 month provision was always contained in the Rules booklet."*

I accept the Provider's submission that it did not seek to disguise, obscure or diminish the information it was making available to the Complainant, by placing this paragraph in bold in the centre of the Check Up document. I am conscious however that whilst this may have been adequate for relatively recent members of the Provider's health care scheme, in my opinion, it was not adequate to draw the Complainant's attention to such a significant change, which fundamentally altered the timing of when he would now be required to submit his claims for outpatient expenses, contrary to his long established practice with the Provider of doing so, effectively at his leisure.

I note that within the Check-Up document, at page 3, there was a heading entitled "**Out-Patient Receipts and Claims**, which referred only to being able to claim "*at any stage of the year using the Provider's App*". The paragraph also advised that:

> Alternatively you can keep all your original out-patient receipts during the year and send them in at your renewal attached to an out-patient claim form. Please see further information on how easy it is to make a claim on page 7.

No information was offered at this location regarding the change in the Provider's approach to the rule regarding time limits, for submitting such claims.

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Likewise, I take the view that another opportunity was lost by the Provider to suitably highlight its fundamental change in its approach to the time limit for such claims, insofar as the covering letter addressed to the Complainant, in advance of the policy renewal on 1 December 2018, omitted to refer to any such difference in approach, or to identify that very significant change as part of the **Important Information** which is reproduced below, although other arguably less important issues were specifically identified:

IMPORTANT INFORMATION

- **We have based your renewal on the scheme you currently hold.**
- **Please contact us if there have been any material changes in your circumstances or in your health insurance needs.**
- **Please contact us before your renewal date to discuss your health insurance needs as we may have a more suitable scheme for you.**
- **If you do not contact us prior to your renewal date your current scheme will be renewed for a further 1 year period.**

I take the view accordingly, that the placement of the notification in the renewal booklet, without any further reference in the supplementary correspondence did not adequately bring this significant information to the Complainant's attention, given his longstanding practice of submitting his receipts for assessment and payment of his claims, long after the time limit referred to in the scheme rule which the Provider had never previously enforced. In my opinion, the location of this information had the effect of somewhat obscuring this important information to him, because of that longstanding practice. Because of his history of dealings with the Provider, I take the view that he ought to have been more specifically notified of this fundamental change.

I note that the Provider's 2009 rule booklet states that if there are any changes to the procedure for making a claim, the Provider would "*write and let [the Complainant] know".* Although the 12-month time limit existed in the Provider's rules before 2018, it is clear that the Provider did not enforce this in practice, during the previous 9 years. This is apparent not only from the Provider's historical practice of accepting 'late' claims from the Complainant, but also from the Provider's decision to notify its customers of the change in its practice.

I consider that, in order for the Provider to 'write' to the Complainant in the manner set out in the 2009 rule booklet, there should have been a more specific notification by way of correspondence. I do not consider the inclusion of the notification within the policy renewal document, to have been sufficient in this regard to notify the Complainant of this change to what for him, was an established practice, without having his attention more specifically drawn to it. As a result, I believe that the Provider failed to act fairly in the best interests of the Complainant, and it has a case to answer to him in this regard.

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In the circumstances, I believe that the conduct of the Provider was unreasonable and unfair to the Complainant, within the meaning of **Section 60(2)(b**) of the **Financial Services and Pensions Ombudsman Act 2017**. I believe that the Provider did not clearly communicate a significant change in the operation of the Complainant's policy varying what was an established practice over the previous 8-9 years. As a result, I am satisfied that the Provider then wrongfully declined the Complainant's subsequent claim, in reliance on that change in practice which had not been adequately notified to the Complainant.

For those reasons, I consider it appropriate to uphold the Complainant's complaint and to direct the Provider to rectify the conduct complained of, pursuant to ***Section 60(4)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, by way of admitting the claim regarding the six relevant claim expenses from 2017, for assessment of benefit payment in the usual manner.

The Complainant should note that since this issue first arose, he has been very clearly on notice of the Provider's new approach to the time limit for such claims, and he should ensure that any future claims are submitted by him to the Provider, in adequate time to meet the newly implemented time limit which was previously not enforced.

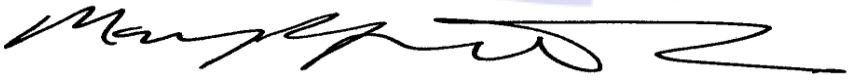
Conclusion

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

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to rectify the conduct complained of by admitting the Complainant's claim regarding the six relevant claim expenses from 2017, for assessment of benefit payment in the usual manner, and payment of the appropriate benefit, within a period of 35 days from today's date.

- 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.



MARYROSE MCGOVERN
Deputy Financial Services and Pensions Ombudsman

2 November 2021

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Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that—

(a) ensures that—

(i) a complainant shall not be identified by name, address or otherwise,

(ii) a provider shall not be identified by name or address,

and

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