Decision Ref: 2021-0406

Sector: Insurance

Product / Service: Private Health Insurance

Conduct(s) complained of: Rejection of claim - pre-existing condition
Rejection of claim - waiting periods apply

Outcome: Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns a health insurance policy incepted by the Complainants with the Provider on **9 October 2017**, pursuant to an application made on **5 October 2017**.

The Complainants' Case

The Complainants assert that they submitted a claim on **9 March 2018** under their health insurance policy in respect of a hospital stay required by the First Complainant *"following strokes in [early* ***2018]****"* and that the Provider has *"refused"* the claim.

The Complainants state that *"other* [medical] *conditions* [had been diagnosed] *subsequent to taking out policy"* and that *"full disclosure"* had been made to the Provider as *"per hospital release documents"*.

The Complainants state that during the Provider's investigation of the claim, it requested that the Complainants provide *"further details"* which involved visits *"to GP and hospital consultant"*. The Complainants contend that they have had to meet the additional costs for these medical reports.

The Complainants want the Provider to pay their claim of €2,436 in respect of *"two periods of hospitalisation totalling 29 nights"* in early **2018.**

The First Complainant states that he made the application *"in good faith"* and *"had made full disclosure"*. He states that the Provider's representative informed him that any matter under investigation which had not been confirmed as a health condition did not need to be declared. The First Complainant states that subsequent to his application to join the health insurance scheme he was seen by a hospital consultant who carried out tests and concluded that he had a slightly irregular heartbeat. The First Complainant also outlined the significant and substantial interferences with his domestic and recreational lifestyle that his strokes have caused him.

The Provider's Case

The Provider wrote to the First Complainant on **13 March 2018**, noting his claim and requesting further details concerning his medical history. The Provider requested that the First Complainant provide the information requested on a questionnaire attached the letter.

The Provider asserts that the additional information submitted by the Complainants on **22 March 2018** *"only indicated the year* [the First Complainant] *was diagnosed"* and that based on this *"limited information"* it was unable to assess whether the First Complainant had been *"treated for a cardiovascular condition before or after the issue of* [the] *policy on **9 October 2017**"*. The Provider contends that it wrote to the Complainants again on the **22 March 2018** requesting confirmation from the First Complainant 's *"GP or consultant confirming when* [the First Complainant was] *first prescribed Edoxaban, the date* [the First Complainant] *underwent the cardioversion procedure and the date when* [the First Complainant was] *diagnosed with hypertension and atrial fibrillation"*.

The Provider states that on **26 March 2018**, the First Complainant rang and spoke with a claims assessor for the Provider who advised the First Complainant that further information was needed from his treating practitioners in order to grant his claim. During this phone call, the Provider asserts that the First Complainant disputed that he had any pre-existing conditions.

The Provider states that on **14 June 2018** it received a letter from the Complainants dated **13 June 2018** which *"did not contain any confirmation from* [the First Complainant 's] *GP or consultant but…did confirm that* [the First Complainant was] *diagnosed with hypertension and atrial fibrillation in **September/October 2017**"*.

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The Provider goes on to state that *"based on this limited information* [it] *declined* [the] *claim as pre-existing to the issue of* [the] *policy on **9 October 2017**"*.

Based on this information, the Provider made the decision that the treatment undergone by the First Complainant was treatment for a heart condition that had pre-dated the commencement date of the policy and a letter rejecting the claim was issued to the Complainants on **21 June 2018**.

The Provider submits that the First Complainant spoke with one of the Provider's managers on **25 June 2018** disputing that the strokes he suffered from were in any way related to his previous medical history. The First Complainant allegedly advised the Provider that he was dealing with his consultant and GP to get the information/dates required to validate his claim.

In its Final Response Letter dated **30 July 2018**, the Provider states that during the course of investigating the Complainants' claim, it noticed that the First Complainant *"had a previous history of hypertension, atrial fibrillation and had undergone a previous cardioversion"*, and that it wrote to the First Complainant requesting *"additional information which included the dates* [the First Complainant was] *diagnosed and the date* [the First Complainant] *underwent a cardioversion(s)"*.

The Provider states that, although it declined the Complainants' claim, it invited them to *"provide the information requested in* [its] *letter of **22 March 2018** from either your GP or consultant so that we have sufficient information to review your claim"*.

In response to this complaint, the Provider made submissions to this Office dated **24 July 2020**. In these submissions the Provider states that it believes that *"this situation"* was caused by the First Complainant failing to disclose all of his existing medical conditions on his medical declaration form dated **5 October 2017** and that his reluctance to provide exact dates of these existing medical conditions extended the assessment of the claim.

The Provider states that *"it is clear from the letter dated 3 March 2020 signed by Consultant Cardiologist that* [the First Complainant 's] *own GP had diagnosed him on **1 August 2017** with atrial fibrillation. The letter also confirmed that* [the First Complainant] *had previously been prescribed a beta blocker and aspirin to take for his condition. On **15 September 2017** his Consultant increased his prescription for a beta blocker and discontinued the aspirin, and started him on Edoxaban. An appointment was arranged for a cardioversion to be conducted on **18 October 2017**"*.

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The Provider states that when the First Complainant filled out his medical declaration form on **5 October 2017** he disclosed that he had asthma/chest problems and hiatus hernia (both in **2010**) but did not disclose other health issues. The Provider states that the application is clearly marked that *"to withhold or failure to disclose relevant facts (or to knowingly give false information) about the health and/or treatment of all persons to be covered could affect the benefits we are able to offer or could seriously influence your cover in the event of a claim"*. The Provider states that had the First Complainant declared atrial fibrillation and/or high blood pressure it would have advised him that there was a waiting period of five years before claims could be accepted under certain categories (including hospitalisation) for anything related to heart problems. The Provider states that this heart condition exclusion was outlined in the welcome pack for his spouse as it was declared on the medical declaration. The Provider notes that the claim form from the First Complainant indicated that the reason for his hospital stay was a result of a stroke.

In respect of the additional costs the First Complainant states that he incurred due to medical reports from his GP and consultant, the Provider states that page 20 of its policy document sets out that *"any fee for medical statements cannot be reimbursed by [Provider]"* but that any costs incurred arising out of his GP visits would be covered up to €19 per visit.

The Provider made further submissions dated **12 March 2021** wherein it stated that while it is sorry to hear of the First Complainant 's ongoing health issues, it is unable to pay for his hospital claim as *"the stay related to a condition under investigation prior to the start date of the policy which* [the First Complainant] *did not declare on his application form"*.

The Complaint for Adjudication

The complaint is that the Provider wrongly rejected the Complainants' claim under their health insurance policy and provided poor customer service throughout.

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 Complainants were 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 5 October 2021, outlining my preliminary determination 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, I set out below my final determination.

I note that on the application by the First Complainant in **October 2017** for entry onto the health insurance policy operated by the Provider it is clearly marked that *"to withhold or failure to disclose relevant facts (or to knowingly give false information) about the health and/or treatment of all persons to be covered could affect the benefits we are able to offer or could seriously influence your cover in the event of a claim"*. On this form, the First Complainant indicated that he had issues with *"asthma/chest problems, hernia, depression, high blood pressure"*. I note that no details of his diagnosis of atrial fibrillation by his GP in **August 2017** or the blood thinner (Edoxoban) and beta-blockers which he was taking at that time were indicated by the Applicant on this form. Similarly, the referral by the First Complainant to a cardiologist in **August 2017** was not referenced on the application form and it is further notable that within two weeks of signing up to the health policy a cardioversion was performed on the First Complainant by his cardiologist.

I further note that page 18 of the insurance policy states that the set waiting period for pre-existing conditions is 5 years and that such conditions include *"any conditions which existed or for which symptoms were present before your cover began; any development of existing conditions; any recurrence of conditions which have existed in the past…and any which previously existed but were not disclosed"*.

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On the basis of the foregoing, while I understand the difficulties and hardship the Complainants have suffered, the evidence demonstrates that the First Complainant had pre-existing heart issues which he did not declare, for whatever reason, on his application form for health insurance cover with the Provider. If he had declared these difficulties, he would have been precluded for claiming for them for a period of 5 years post-inception of the policy.

In respect of the complaint that the Provider furnished poor customer service to the Complainants, I note that no evidence to support this complaint has been submitted by the Complainants. The Complainants made a claim on **9 March 2018** which was noted and initially responded to by the Provider on **13 March 2018**. As outlined above, there was frequent correspondence and communication between the parties between **March 2018** and **July 2018** and the Provider was at all times clear to the Complainants that it would re-assess their claim if further medical information was provided. On this basis, I cannot accept that the Provider furnished poor customer service to the Complainants.

Therefore, based on the foregoing and on the basis that the First Complainant failed to disclose his pre-existing heart condition at the time he applied for his health insurance policy with the Provider and on the basis that there is no evidence of poor customer service, I do not 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.

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

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

5 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.