An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0415
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - pre-existing condition
Outcome:	Substantially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint concerns the repudiation of a claim made under a Health Insurance Policy.

The Complainant's Case

The Complainant states that she took out a Health Insurance Policy with the Provider on **30 April 2015**. The Complainant asserts that on **14 May 2015** her husband (who is insured under the policy) attended his GP for a condition and that during his consultation, he mentioned to his GP that he was also *"having a bit of a problem at the back of [his] right leg"*. The Complainant contends that her husband's GP referred him for an X-Ray which was conducted on **19 May 2015.**

The Complainant asserts that following the X-Ray *"there was no suggestion of an operation or treatment other than a course of anti-inflammatories".* The Complainant states that *"this solved the problem for a considerable period"* but that his condition *"flared up again in **2016**"* and that he was referred to a *"Consultant Orthopaedic Surgeon"* by his GP. The Complainant asserts that the consultant wrote to her husband's GP on **7 June 2017** following his consultation stating that:

> *"*[The Complainant's husband] *had a very stiff and painful right hip joint. I have referred him for up-to-date X-Rays in…Hospital. I have also put him on the urgent waiting list for surgery in…Hospital."*

The Complainant states that at this juncture she contacted the Provider and sought *"clarification on cover for a hip replacement if needed"*. The Complainant asserts that their *"understanding"* following *"a number of contacts* [with the Provider] *on the issue was that if the symptoms began post entry to insurance and if that was confirmed by the consultant,* [the Complainant's husband] *would be covered."*

The Complainant states that her husband *"went ahead with the operation"* on the **6 October 2017** *"on the basis and .. understanding of* [the Provider's] *position"* and that if she *"had doubted eligibility, I could not have gone ahead as we were not in a position to pay."* The Complainant asserts that on the claim form *"the Consultant listed a post entry onset and recorded 'no previous episodes or related symptoms'."*

The Complainant states that she received a letter from the Provider dated **12 March 2019** which *"notified that* [the] *claim had been declined."*

The Complainant asserted that:

> *"I assume that, by definition, if a symptom exists one would be aware of it. The logic of the Insurer's position, is that [the Complainant's husband] must have been [aware] – a position I reject."*

In a submission dated 25 June 2020 – The Complainant states she relies on the following statements from the Provider in the telephone contacts with the Provider:

27 March 2017 – *"What Consultant writes on claim"*
03 July 2017 - *"We would go the consultant and GP and get an onset date between them"*
04 July 2017 – *"We would check with the consultant"*

The Complainant states that assumptions appear to have been made in relation to the Complainant's husband's physical condition in 2015 based on the quite different circumstances of 2017. The Complainant states that the Provider made no attempt to clarify what it saw as a "contradiction" in the Consultant's position.

The Complainant submits that the Provider's medical reviewer is less than categorical on an onset date when the reviewer states:

> *".. an approximate time-frame for the first experienced symptoms from the right hip could be 9th February 2015 until the 14th May 2015".*

The Complainant wants the Provider to pay the claim of €4,519.00 for the medical procedure undergone.

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The Provider's Case

The Provider submits that the x-ray report dated **19 May 2015** states *"advanced OA changes in the right hip joint"*. Its medical advisor's opinion is that advanced changes could not have occurred since the original date of joining the plan on **30 April 2015**.
The Provider says, the letter from the GP dated 1 October 2018 gives the onset as 10 days prior to the first GP consultation, which brings the onset back to **4 May 2015**. The Provider states, as the Complainant's husband only joined on 30 April 2015 advance changes could not have occurred in 5 days.

The Provider states that the letter from the GP to the consultant dated **27 March 2017** refers back to the 2015 x-ray with the Complainant taking anti-inflammatories in the meantime.

The Provider submits that the consultant's letter to the GP dated **7 June 2017** states that *"According to his x ray in 2015 there is no question he needs a hip replacement".* The Provider says the Complainant's husband needed the hip replacement at the time of the x-ray in 2015, but continued for another 2 years taking anti-inflammatories on at least one documented occasion until "He has very severe symptoms and is struggling with all aspects of his daily life".

The Provider says that the consultant lists a new onset on the claim form of 1 year prior to **7 June 2017** making it **7 June 2016** but this date is at odds with what the consultant said in his letter above to the GP dated **7 June 2017** and so the Provider took the earliest onset as given by this consultant. The Provider states that it is not necessary to establish an exact onset date of this condition. It states that its rules provide that any condition that exists on the date of joining is subject to a 5 year waiting period. The Provider says the Complainant and her husband took out private medical insurance on **30 April 2015**, then he saw his GP on **14 May 2015** which in turn resulted in an x-ray of the right hip which was carried out on **19 May 2015** and this x-ray showed "Advanced Changes".

The Provider submits that "Advanced Changes", are defined in the medical context as in a late or critical stage of development. The Provider states that in the opinion of its medical advisors it would not be possible to show advanced changes within 20 days of taking out private medical insurance and therefore the Complainant's husband was suffering from this condition when he joined the Provider and all pre-existing conditions carry a 5 year waiting period before they are eligible for benefit.

The Provider states that it reviews all medical information when determining an onset including the claim form, a referral letter, consultation notes and GP notes.

The Provider says as advised on calls **27 March 2017**, **21 April 2017**, **3 July 2017** and **4 July 2017**, the Complainant was made aware that if this were a pre-existing condition then there would be no cover for this procedure.

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The Provider's position is that it has at all times acted in line with the Consumer Protection Code, in that, the Complainant upon joining the plan was advised on waiting periods for any pre-existing conditions. A Welcome Pack which contained a rules brochure which outlines the pre-existing rule was issued on **2 May 2015**. The Provider states that prior to the Complainant's husband having the procedure done the Complainant was advised on approximately 5 telephone conversations that if this procedure was pre-existing there would be no cover as they were serving a 5-year waiting period for any pre-existing conditions.

The Provider states that on **8 March 2019**, an appeal was opened for the claim as requested by the Complainant; this appeal is conducted independently of the claims team who carried out the initial assessment. The Provider says the claims appeal team reviewed all of the information regarding this claim and following their review a decision was made that the claim would remain rejected due to pre-existing waiting periods.

The Provider states that the entity that carried out the review is a global provider of high quality independent medical reviews. The Provider says the review entity has the largest international network of medical specialists in all areas of medicine who provide recommendations based on international standards of care and evidence-based medicine.

The Reviewer's report advises as follows:

> *"As the patient attended the doctor's office the 14th May 2015 with right hip pain and the osteoarthritis (OA) was confirmed with a x-ray 19th May 2015. As the x-ray demonstrated advanced OA of the right hip, it is very likely the patient has felt pain in his right hip several months before that date. However, when the patient attended the doctor's office 9th February 2015 or even earlier, 30th October 2014 there is no notation of any hip pain. Based on the provided documentation an approximate time frame for the first experienced symptoms from the right hip could be 9th February 2015 until 14th May 2015".*

As regards the Complainant's position that they had sought clarity from their GP and Consultant as the condition being post entry to the plan, the Provider states that it cannot comment on what the GP or Consultant in question may or may not have advised the Complainant. However, it states that the medical information provided indicate this was a pre-existing condition and the Provider states it made the Complainant aware that there would be no cover prior to the procedure, if this was deemed a pre-existing condition.

The Provider's position is that it assesses claims based on the clinical information available to it. The Provider says this information is recorded in real time by the medical practitioners involved in the case in accordance with the guide to Professional Conduct and Ethics for Registered Medical Practitioners 2019, as compiled by the Medical Council. The Provider states that practitioners have a duty of care to ensure that their records are accurate and up to date. Therefore, it says, it is reasonable for it to be able to rely on these records when assessing claims.

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The Provider states that under the terms of Statutory Instrument. No. 79/2015 - Health Insurance Act 1994 (Open Enrolment) Regulations 2015 states that a "pre-existing condition" means 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 ending on the day on which the person became insured under the contract.

The Provider states it cannot comment on what "signs or symptoms" the Complainant's husband was suffering with prior to taking out a private medical insurance policy however it asserts that "advanced changes" as outlined on the x-ray report carried out within 20 days of taking out a private medical insurance policy could not have occurred in such a short space of time.

The Provider states that the rule on pre-existing conditions is clearly outlined in the Provider's rules brochures along with the definition included under the Heath Insurance Act 1994 and the Complainant was made aware on calls prior to the procedure if the procedure was deemed a pre-existing condition there would be no cover.

The Provider says that it cannot comment on whether or not the Complainant's husband was aware that he was suffering from "advanced changes in the right hip joint". The Provider states that this claim was assessed based on the medical information provided by both the GP and Consultant along with an x-ray report which was carried out on 19 May 2015, and this x-ray report showed "advanced changes" which medically could not have developed within 20 days of taking out a private medical insurance policy.

In the Provider's submission of **26 June 2020** it states that while the Customer Service Representative did advise the Complainant "what the consultant writes on claim", you can also see that the Customer Service Representatives also advised "we go to the consultant and GP and get an onset date between them". The Provider states that this was in fact what the Provider did throughout the claim assessment process. The Provider says that given the medical notes from the consultant to the GP and also the x-ray report determined that the condition was pre-existing as defined in the rules.

The Provider states it is not necessary as per the definition of a pre-existing condition to show an exact onset date for a condition. It says, what is required is a sign or symptom that the Complainants condition predates their joining date and the medical advisors are satisfied that these advanced changes as documented in the Complainant's husband's x-ray report could not have occurred within 20 days of joining the plan.

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Evidence

Policy Provisions

Section 2. Policy Definitions, upon the Complainant first joining in April 2015, page 4:

> *"Pre-existing condition*
>
> *Any disease, illness or injury that a person has which began, or the symptoms of which began, before that person started his or her current continuous period of membership of the scheme.*
>
> ***Note that an illness or injury may be present for some time before giving rise to symptoms or being diagnosed. So, when deciding if a disease, illness or injury began before membership started, it is the date when it began that counts – not the date when a person became aware of having the disease, illness or injury, or its symptoms****".*

8 what is not covered under the scheme page 10:

> *"We will not pay benefits for the following*
>
> *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 and upgrade start date …*
>
> *There are three waiting periods that apply under the scheme.*
>
> - *The initial waiting period – this applies to any treatment that a person may require*
> - *The pre-existing condition waiting period – this only applies to treatment which a person requires for a pre-existing condition …*
>
> *The pre-existing condition waiting period is*
>
> - *The first five years of membership for those age under 55 on their membership start date .."*

On the above the Provider states: "NB – For policies taken out since 1 May 2015, the maximum waiting period for pre-existing conditions is 5 years. This new rule would also apply to existing members at their next renewal date therefore reducing the above time".

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Subsequent Policy Renewal Wording 2016/2017

> *"Pre-existing condition*
> *Pre-existing condition. An aliment, illness or condition where, on the basis of medical advice, the signs or symptoms of that aliment, 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 out a Health Insurance contract again after your previous Health Insurance contract had lapsed for 13 weeks or more.*
> ***Please note that our medical advisors will determine whether a condition is a Pre-Existing condition. Their decision is final**."*

Timeline of events furnished by the Provider

29 April 2015 - the Complainant contacted the Provider to take out a Private Medical Insurance policy. The Provider states that as set out in the contact log a Customer Service Representative advised the Complainant of waiting periods for any pre-existing conditions. This rule was also outlined in the rules brochure issued to the Complainants on **2 May 2015**.

14 May 2015 - The Complainant's husband attended his GP in relation to pain radiating from his right pelvis to his knee. The Complainant's husband was referred for an x-ray of his hip.

19 May 2015 - The Complainant's husband underwent an x-ray of his hips. The x-ray report documented *"advanced changes in the right hip joint".*

20 March 2017 - The Complainant called the Provider as the Complainant's husband was waiting to see a consultant following an x-ray in 2015 and may need a hip replacement. During this call a Customer Service Representative advised if symptoms existed prior to joining on 30 April 2015 then there would be no cover for 5 years. If symptoms began prior to taking out the policy the pre-existing waiting period would not be served until 2020.

27 March 2017 - The Complainant's husband was referred to a Consultant Orthopaedic Surgeon, in relation to "right hip pain and arthritis confirmed on x-ray".

27 March 2017 - The Complainant called the Provider to check cover for her husband as he had attended his GP that morning and may need a hip procedure, during this call a Customer Service Representative advised if he was suffering prior to the **30 April 2015** he would have no cover for 5 years.

21 April 2017 - the Complainant called the Provider to check cover for her husband, during this call a Customer Service Representative advised if it is a pre-existing condition prior to joining then there would be no cover for 5 years.

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7 June 2017 - a letter from the Consultant Orthopaedic Surgeon to the Complainant's husband's GP documented that he presented with "advanced right hip osteoarthritis". The Consultant Orthopaedic Surgeon documented that *"according to his x-rays in 2015 there is no question he needs a hip replacement".*

3 July 2017 - the Complainant called the Provider to check cover in a particular hospital for a hip replacement. During this call a Customer Service Representative advised if the onset date of symptoms was before joining the plan on the 30 April 2015 there would be no cover for 5 years.

4 July 2017 - the Complainant called the Provider again to check cover, during this call a Customer Service Representative advised if symptoms existed before joining the plan there would be no cover for 5 years.

[Date Redacted] 2017 - the Complainant's husband was admitted into hospital for a hip replacement.

[Date Redacted] 2017 - the Complainant's husband was discharged from hospital following a hip replacement.

November 2017 - Claim for the Complainant's husband's operation was received from the hospital.

1 October 2018 - Referral letter received from Consultant Orthopaedic Surgeon. The Provider however says no clear onset date, letter sent by the Provider to GP for further information.

3 November 2018 - letter from GP received.

14 November 2018 - letter sent from the Provider to GP for medical notes relating to the procedure.

23 November 2018 – The Provider advised hospital that it would need a copy of the referral letter in order to assess the claim.

12 January 2019 – The Provider sent a further letter to the GP for the referral letter as no response to its previous letter was received.

1 February 2019 – The Referral letter as requested above was received.

1 February 2019 – The hospital called the Provider to check status of the claim. A Customer Service Representative advised the hospital the claim is still under assessment.

22 February 2019 – The claim for the Complainant's husband was rejected due to pre-existing waiting periods.

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2 March 2019 – The Provider returned a call to the Complainant, during the call a Customer Service Representative advised that the claim was rejected due to it being a pre-existing condition.

4 March 2019 - The Complainant called following the conversation on 2 March 2019 and advised the Provider this is not a pre-existing condition. A Customer Service Representative advised if symptoms existed prior to joining then a 5-year waiting period would apply.

5 March 2019 - Following the Complainant's previous call, the Provider called the Complainant to advise to open an appeal on the claim.

7 March 2019 – The Provider called the Complainant and a Customer Service Representative advised based on the x-rays and medical notes present before joining the plan, this is what determined the rejection of the claim. The Customer Service Representative offered to open an appeal on the claim.

8 March 2019 - Appeal opened on claim.

3 April 2019 - Appeal closed and claim remained rejected due to pre-existing waiting periods.

<u>GP and Consultant correspondence</u>

27/03/2017 – GP letter to the Consultant

> *"Many thanks for seeing this .. man with right hip pain and arthritis confirmed on x-ray. He first attended me on 14/05/2015 complaining of pain radiating down the lateral aspect of his leg with clinical signs of pain with hip rotation. An x-ray five days later reported "advanced OA changes" in his right hip".*

07/06/2017 – Consultant letter to GP

> *"According to his x-rays in 2015 there is no question he needs a hip replacement. He has very severe symptoms and is struggling with all aspect of his daily life"*

<u>Claim Form</u>

Treatment Claim Form – completed by Consultant on **11/10/2017**

> *"Date you first saw patient with symptoms – **07/06/2017***
>
> *Duration of symptoms prior to this – **1 year***
>
> *Have there been previous episodes of this or related symptoms – **"No"**."*

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Telephone communications

20 March 2017 – telephone call from the Complainant to the Provider querying whether a hip replacement would be covered under the policy.

The Provider's call handler advised that:

"For pre-existing – where symptoms began prior to taking out policy – not covered for first 5 years"

"If began prior to taking out policy – pre-existing period would be 2020"

The call handler then asks – *"When symptoms began" "When started to trouble him first"*

"When did symptoms begin" "When did he start to suffer first"

The Complainant then asks if the symptoms were after taking out cover, what information would the Provider need.

The call handler answered that they would need:
- Name of Consultant, and
- Procedure number

The Call handler then advised: *"We will be able to then check it for him"*

27th March 2017 – the Complainant to the Provider

Complainant states: *"Did not have before 30 April 2015"*

Call handler states - *"If he had symptoms which started prior to 30 April 2015 – If he did, there would be no cover for 5 years"*

The Complainant stated: *"Started after joining"*

Call handler states: *"When do you think his condition did develop?"*

The Complainant answered: "first went to doctor in May 2015"

Call handler stated: *"We don't go by what GP would say, but also go by what Consultant would write on the claim – If Consultant says this giving him symptoms / trouble for 3 or 4 years, then claim would be rejected"*

The Complainant stated: *"Well he hasn't"*

The Call handler stated: *"Then you would be ok so"*

21 April 2017 – telephone call between the Complainant and Provider

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In this call the Call handler asked: *"When did he first start experiencing symptoms in regard to this?"*

Complainant – *"After first joining [the Provider]"*

The 5 year pre-existing waiting period was explained.

3 July 2017 – telephone call between the Complainant and the Provider's call handler

The Call handler advised:

"We ask 4 questions when we're confirming cover:
- *The Hospital*
- *The Consultant's name*
- *Procedure Code*
- *Onset Date of Symptoms*

"So when did it first happen"

The Complainant's response was that: *"Diagnosed after first went to [Provider]"*

The Call handler states:

"We will ask onset date from [the Consultant]
"If he said before [insured] joined us – April 2015 - we will not cover for 5 years. …

The Consultant will get on to his GP – They would make onset date between them.

We would not decide here in [the Provider] – depends on what they tell us is what we go by.
.. Just leaving you know all scenarios just in case if onset date is different from the GP or Consultant".

Complainant: " That is what the GP will say"

Call handler: "That is prefect , if that is the case he will be covered …"

Call handler: "Cannot confirm 100% cover on the phone here today I will need to know those 4 exact pieces of information ..

Cant confirm 100% cover today … when you call us back with onset date and procedure code we will then be able to confirm .."

The Complainant: "May 15"

Call handler – "If May 15 is onset date that is fine, just want to know from GP..

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We'll believe what you say on phone" "When the claim comes in we will get onset date from GP"

04 March 2019 – telephone call between the Provider and the Complainant

Call handler - *"If symptoms started before joining us, would not be covered".*

The Complainant questions a date communicated to her by the Provider, for symptoms going back to 2014.

7 March 2019 – telephone call between the Complainant and the Provider

As regards the pre-approval – the Complainant stated that: *"that was all checked – gave all the information"*

Complainant asks: *"Is it possible that [husband] had it, and did not know about it"*

The Provider's call handler - *"If there weren't symptoms present, would not count as pre-existing"*

Call handler then gave the following example:
"Say example – heart condition, won't know of condition – would not count as pre-existing until get the scan"

The Complainant's response to this is that: *"Did not know he had it" "We checked up this to get approval"*

The Complaints for Adjudication

The complaint is that the Provider has wrongfully repudiated the claim under the policy, and proffered 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.

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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 **11 October 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 a correspondence dated **18 October 2021**, the Complainant confirmed her satisfaction with the content of the Preliminary Decision. By e-mail of **28 October 2021** the Provider advised it had nothing further to add.

In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

Analysis

On the evidence submitted I accept that the Provider could not have come to an alternative conclusion, other than that the Complainant's medical condition was a pre-existing medical condition subject to the policy's 5 year waiting period. The objective evidence, that is, the x-ray from **19 May 2015** which documented *"advanced changes in the right hip joint"* is noted in this regard.

That said, I do consider that the Provider could reasonably have done more to clarify the position regarding cover from the outset with the Complainant verbally and in writing. At the very least, I accept that the Provider could have greater highlighted that it was the Provider's medical professionals that would be deciding on the onset date of symptoms.

The Complainant's position is that she did do all the necessary checks with the Provider when seeking approval for the medical treatment. I accept that in all the telephone calls the Provider's representative did advise the Complainant that if the condition was a pre-existing condition it would have a waiting period. However, having noted the content of the telephone calls, I accept that there was a lot more discussion between the Provider's call handlers and the Complainant around when symptoms arose, and the relevance of this information. I accept that the information that the Complainant received otherwise from the representatives, in the telephone calls, would have led her to believe that the treatment would be covered.

In all the telephone calls the Provider's representatives asked when did the symptoms first occur. I accept that for, a person in general, 'symptoms' mean the complaint (ache or pain

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for example) that they have or are experiencing and are generally the reason that caused them to attend the doctor. A symptom can therefore be said to be subjective. The objective evidence of the disease or illness is completely different and will be identified and given a time frame by the medical professionals.

Again the Provider's use of the word "onset" of the symptoms – can also have a subjective meaning. For the patient the "onset" could easily be taken to be when they themselves first noted a change in their usual health status, for example when they began to experience pain or discomfort to a degree that required them to attend a doctor. Which appears to be the position here.

In the above regard it is noted that while the Provider used the phrase "onset of symptoms" in its communication with the Complainant, those words are not actually set out in the policy documentation. The Policy refers to "signs or symptoms" and not "onset date of symptoms". The Provider's call handlers used the following phraseology to query the history of the Complainant's condition: "*When did he first start experiencing symptoms", "When symptoms began"*, *"When started to trouble him first" "When do you think his condition did develop?".* All of those phrases have distinct meanings (medically and in the ordinary sense) and I consider that, the Provider should ideally use the wording contained in the policy provisions in its communications with policyholders, and also provide the definitions for those words in the policy. The Provider's policy provisions here, do not define what is meant by "onset" "signs" or "symptoms".

While I accept that the Health Insurance Act 1994 (Open Enrolment) Regulations 2015 (S.I. No. 79/2015) does not define "Signs" or "Symptoms", this does not mean that a Provider cannot give a definition or explanation, when it uses these words in its policy documentation, or when otherwise communicating with its customers.

On the above basis, I consider that the Complainant reasonably considered she was giving the Provider the correct information it was seeking from her, and that all was in order for her husband to have his operation.

I accept that greater clarity should be given as to the possibility of a claim not been met where the medical condition is one that most probably existed for a time before cover started and where there was no outward symptoms of note, for the claimant to report.

I accept that it would have been reasonable to expect that that the Provider would follow up its telephone calls with a written communication, to make sure cover was fully explained. In such written communication, the Provider could reasonably include the policy definition of pre-existing condition, and any clarification that was necessary regarding medical conditions that may be existing, but not showing any symptoms.

It is noted that in the telephone calls, the Complainant was never directed to the relevant policy wording, nor was such wording communicated in the telephone calls.

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Of particular note is the Provider's representative clearly advised the Complainant that once the GP and Consulted confirmed that the date of symptoms were post joining the Provider, the treatment would be covered.

The Complainant was never advised by the Provider, that if, the Provider had a doubt about the GP's and Consultant's stated opinions as to the onset of symptoms, that the Provider could / would further review the claim and possibly reject the two medical doctor's opinions, and indeed reject the claim.

The Provider in its response to this office, advised that it did not go back to the Consultant to query the alleged contradiction in his reports. I accept that further communication with the Consultant was reasonably necessary in the circumstances.

The Complainant advised the Provider's call handler that her husband had not suffered with symptoms prior to going on cover, that he was actively at work and involved in sports' training.

I find no evidence of the Provider seeking to discuss matters directly with the Complainant's husband. I consider that this may have assisted in establishing more information relative to his condition and his symptomology.

It is noted that the Provider's call handlers, while courteous and helpful to the Complainant, were at time not so clear themselves on how the Provider would look on the position where an insured did not have symptoms, but where the objective evidence was that the condition was pre-existing. An example of this is found in the call of **07 March 2019** where the Complainant was advised: *"If there weren't symptoms present, it would not count as pre-existing"*.

Overall, I accept that the objective evidence is that the condition was pre-existing. However, I accept that the Provider could have engaged and communicated better with the Complainant in advance of the proposed treatment, to establish cover and allow the Complainant to make an informed decision. I accept that this is so particularly in relation to the last recorded telephone call before the proposed treatment was to take place. The last telephone call before the treatment, was the call of **3 July 2017**. Having noted the content of the telephone call, I accept the Complainant was advised that once the GP and Consultant confirmed an onset date post start of the policy, the treatment would be covered. I accept that the GP and Consultant duly did give an onset date of symptoms that post-dated the start of the policy.

Having regard to all of the above I substantially uphold this complaint and direct that the Provider pay the Complainant a compensatory payment of €3,000 (three thousand euro).

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Conclusion

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

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainant in the sum of €3.000, to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the Provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

- 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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

11 November 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.