An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0474
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - late notification
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant held a health insurance policy from the **1 December 2018** with the Provider.

The Complainant's Case

The Complainant's health insurance policy with the Provider was held from the **1 December 2018**.

On **27 August 2020,** the Complainant sought to submit his out-patient medical expenses under his health insurance policy for the year 2018-2019.

The Complainant says that his claim is in the amount of €1,055.00 (one thousand and fifty five euro) and arises from Consultant/Doctor fees and prescriptions. The Provider refused to reimburse the Complainant's out-patient medical expenses under the health insurance policy on the basis that a deadline of six months applied beginning at the end of the Complainant's health insurance policy year. The Complainant submits that he was not aware of the **10 August 2020** deadline for submission of receipts, and that the deadline was not made sufficiently clear in the Provider's **Membership Handbook.** He also says that he did not receive a reminder email to submit receipts from the Provider, in advance of the deadline.

By email dated **9 February 2021**, the Complainant said that:

> *"contrary to the assertion made by [the Provider], it is not clear that there is a six month time limit on claims. The membership handbook is a 52 page document with over 43,000 words, it is not a reasonable expectation that the average customer reads this cover to cover and memorizes all the details. Each section is to be referenced when the relevant situation arises. This particular term is buried in the small print of the "How to claim" section. There is no reason that an individual should go to the "How to claim" section of the handbook until such time as they would go to submit a claim."*

By email dated **8 March 2021**, the Complainant submitted that:

> *"this is not a matter of 'providing cover for every eventuality'. It is a matter of key information being brought to the attention of the consumer as per section 4.1 of the consumer code. This term is much more powerful than all other t&cs as it overrides them all. This rule supersedes the others irrespective of the benefit type, cost or other criteria and overrides all the other terms thus it is a very significant term and should be brought to my attention. It shouldn't feature indiscriminately in a section titled 'how to claim'. In this section you would expect to find information on how to claim, not how your claim will not be accepted*."

The Complaint submits that the Provider "*is using its size to dismiss my claim which is unreasonable given that the terms were not made clear*."

Additionally, the Complainant does not accept that the Provider sent the Complainant a reminder email on **14 May 2020** about the deadline for the receipts and he submits by email dated **9 February 2021** that:

> *"the reference to the e-mail is surprising, as there is no evidence of it being delivered. I certainly did not receive it. I receive many mails from [the Provider], I don't delete any in case I need to look up any relevant information. I have received mail from [the Provider] before and after this date. It is surprising that I have not received the mail that contains the most important information on my policy/ability to claim."*

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The Provider's Case

The Provider asserts that receipts must be submitted under the terms and conditions of the health insurance policy by the deadline, which in the Complainant's case meant that receipts were ordinarily due by the **1 June 2020**. However, by telephone call on the **8 September 2020**, the Provider confirmed that the deadline had been extended to **10 August 2020** due to the COVID-19 situation. The Provider said as follows:

> "*unfortunately as you had passed the six months plus the COVID extension deadline which brought us up to the 10th of August, to make claims in respect of your last policy year which ended in November last year we wouldn't be able to accept any claims in respect of that policy year now at this point*."

The Provider, by letter dated 2 February 2021, noted that the Complainant attempted to submit receipts on **27 August 2020** for the 2018-2019 year but it says that

> "*as his six month deadline had expired at this point, the online claiming tool would not allow [the Complainant] to proceed with submitting his claim. Therefore, we have no claim on file for the policy year 2018-2019*."

The Provider, by letter dated **8 September 2020,** states that the Complainant was supplied with its **Membership Handbook**. The Complainant's policy began on **1 December 2018** and so was covered by the **Membership Handbook** dated **1 November 2018.** The Provider, with reference to the six months deadline, submits the following by letter dated **8 September 2020**:

> "*This rule has been updated into our membership handbooks published from the 1st November 2018. The rule only applies to those policies which renewed or were taken out for the first time on or after this date. In your case, this applies to your policy year from the 1st December 2018 to 30th November 2019, and subsequent years…The membership handbook compiles the terms and conditions, exclusions and the benefit definitions of your plan."*

The Provider by letter dated **2 February 2021** said

> "*[the Provider] are satisfied we have complied with 4.1 of the Consumer Protection Code. On page 7 of the November 2018 Membership Handbook (Document 1) under 'How to Claim', members are advised how and when to submit day to day out-patient expenses*."

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By letter dated **22 February 2021** the Provider said that

> "*in relation to making an out-patient claim, it is clear from [The Complainant's] Membership Handbook that receipts must be submitted within six months of the end of the member's policy year. Notwithstanding the above, [the Provider] have incorporated a process to communicate directly with the customer in advance of the six-month cut-off date*."

The Provider also asserts that it issued a mail merge email reminder to the Complainant on **14 May 2020.** The Provider by letter dated **2 February 2021** submits that:

> *"we sent [The Complainant] an e-mail (Document 2 (B)) on 14th May 2020 at 16:01:50, in advance of the six month cut off, to the e mail address we held on file for [The Complainant] : [Complainant Email Address]. This e-mail advised him that now would be a good time to submit his everyday health expenses, it explained how to claim; and that he could claim expenses covered on his plan up to six months after his renewal date. [the Provider] can also confirm that we have checked our records and we have no evidence of a bounce back/failed email delivery from [The Complainant's] email address…."*

In this letter the Provider also noted that "in the interests of treating all members fairly, we cannot make an exception for [the Complainant] in this case."

The Provider by letter, dated **2 February 2021,** said in relation to the reminder email they say was issued on **14 May 2020** that

> "*this email was sent as part of a mail merge / bulk communication we do not have a copy of the individual email to [The Complainant] however the contents of the email issued as part of the communication are provided in the schedule of evidence Document….[the Provider] received no 'bounce-back' / failed delivery e-mail from this address*."

The Provider is satisfied that it assessed the Complainant's claim in accordance with the terms and conditions of the Complainant's health insurance policy and that in May 2020, it issued an adequate email, reminding the Complainant to submit receipts under the health insurance policy.

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The Complaint for Adjudication

The complaint is that the Provider wrongfully repudiated the Complainant's claim for medical expenses. The Complainant wants the Provider to reimburse him the net amount due of medical expenses totalling €1,055.00 (one thousand and fifty five euros).

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

The Complainant raises two aspects of the conduct of the Provider (1) whether the information in the **Membership Handbook** regarding the time limit was clear, accessible and consumer friendly; and (2) whether a reminder email was issued by the Provider to the Complainant on **14 May 2020**. In relation to (1) above, by email dated **27 August 2020** the Complainant wrote to the Provider and said:

> *"I went to start inputting some health insurance claims and I have receipts for the last year (2019). It's telling me that I have missed the six month deadline. This is my first time making a claim with [the Provider], I was unaware that this deadline existed, can I get an extension? I am less than 2 months over. It has obviously been a challenging year due to COVID etc so this one slipped under the radar."*

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By email dated **28 August 2020**, the Provider responded saying that

> "*unfortunately, you have missed the six-month deadline for claiming your medical receipts from us for policy year 01/12/2018 to 30/11/2019 and so we cannot accept your receipts*."

By email dated **28 August 2020** the Complainant responded by email to the Provider saying:

> *"I understand that I have missed the deadline but what I am seeking is a dispensation as this is my first time. I was aware of this deadline. I am just seeking some compassion here."*
>
> [My emphasis]

Since the preliminary decision of this Office was issued on **10 September 2021**, the Complainant has submitted that this email above he sent to the Provider, in fact contained a typographical error, and that he had intended to communicate the fact that he "*was unaware of this deadline".*

The Provider submitted in its reply to the investigation by this Office, by letter dated **2 February 2021,** that:

> *"[The Complainant] subscribed to electronic documentation to his online member area. All documents were issued to the Complainant's* (sic) *via e-documents to their* (sic) *online Member Self Service Area….*
> *A Welcome Pack was issued to [The Complainant] electronically to his online Member Self Service Area."*

By letter dated **2 February 2021** the Provider enclosed a screenshot of evidence "*from our system displaying that they were issued electronically*." The screenshot shows a programme which says that an "*e-Travel Policy Letter*" and an attachment "*eWel1 Welcome Letter TH*" were created at 31/12/2018 at 16:33:16 and 16:33:19 respectively.

I note that the Provider sent a letter, dated **31 December 2018,** addressed to the Complainant entitled "**A very warm welcome to [the Provider]!"** I note that within this letter the Provider enclosed documentation including a **Membership Handbook**. This letter also enclosed the Terms of Business which. under the heading "Your Contractual Documentation", said as follows:

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> *"Your contractual documentation includes: the Membership Handbook….the Membership Handbook must be read in conjunction with the Table of Cover, which sets out the level of benefits you are entitled to under your plan."*

Since the preliminary decision of this Office was issued on **10 September 2021**, the Provider advised this Office in a submission dated 21 September 2021 that:

> *"Two reminders in respect of the relevant policy year were issued by SMS to the Complainant on 07/12/2020 and 03/04/2021 reminding him of the upcoming deadline. The SMS was issued to the mobile number we hold on file. Our records show no issue in respect of any bounce back or non-delivery of these messages."*

In response, the Complainant has said that he did not receive the communications in question. He says:

> *"Neither of those texts were received. I have only ever received a single text from* [Provider]*. This was to advise that my address had been changed. I have attached a screenshot of this as evidence.*
>
> *I have also attached a screenshot of my message inbox from the dates mentioned by ILH to show that there is no message from them in that time period.*
>
> *I did not receive the e-mail reminder that was claimed to be sent in 2020. I also have not received text messages that were claimed to be sent in 2020 & 2021.*
> *E-mail & text are two entirely separate communication mediums. However they are both incredibly reliable modes of communication.*
>
> *The likelihood that not one but both of these methods failing to deliver their messages is extremely improbable.*
> *Surely this indicates that they are either not getting sent at all or there is a glitch in the system?"*

In those circumstances on **5 October 2021**, the Provider has supplied this Office with a "*snip*" of its mainframe system, displaying the communications issued to the Complainant since 30 October 2020, and has advised that the three SMS messages it has highlighted in the copy table shared as part of the evidence, were all generated to the mobile number on file for the Complainant, and that it has no record of any bounce back or non-delivery of these messages or e-mails.

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The Provider previously by letter dated **22 February 2021** submitted that:

> *"[The Complainant's] membership handbook forms a key part of his contract with us. It sets out the Terms and Conditions that apply to his plan and should be read in conjunction with the other documents that form part of his contract with us.*
> *Health insurance policies, like all insurance policies, do not provide cover for every eventuality; rather the cover will be subject to the terms, conditions, endorsements, and exclusions set out in the policy documentation.*
> *Taking into consideration the number of material conditions, exclusions etc, it would be impractical to attempt to add significance to one rule while not doing so for the remaining rules.*
>
> *In this regard, the policy documentation provides detailed information about what is covered under the policy and any restrictions that may apply. In renewal documentation [the Provider] clearly communicates the importance of the customer reviewing the Terms & Conditions of the policy, to ensure that they are familiar with the product and how it works. If a customer is not happy with the product that they have purchased they have the right to change their mind within 14 working days, this is known as a cooling off period….*
>
> *In respect of [The Complainant's] assertion that this element of the Terms and Conditions are 'the single most important term of the entire agreement', day to day and out-patient expenses are just one element of a comprehensive list of benefits available under the policy. Therefore, we do not agree that this is 'the single most important term of the entire agreement.' As above other members may place higher significance to other benefits than day to day and out-patient expenses and therefore it is imperative that the customer is aware of the full Terms & Conditions of the policy before commencement."*

The Provider by that letter dated **22 February 2021** also asserted that:

> *"[the Provider] needs to ensure it can meet its obligations to all its customers. A key part of those obligations is paying claims which the company is liable for under its insurance contracts. The company must estimate the liability for claims incurred in the past and those not yet reported. If members can submit claims without any time limit this significantly increases the uncertainty surrounding this estimate.*
> *Therefore, not to apply a time limit on members submitting claims results in additional financial risks for the company which are potentially significant. As a result, a time limit on claims submission is necessary. [The Provider] consider that allowing claims to be submitted for up to six months' after the renewal date is fair and reasonable."*

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I note that the Central Bank of Ireland's Consumer Protection Code, 2012, ("CPC") page 7, says at paragraphs 2.1 and 2.2:

> "*A regulated entity must ensure that in all its dealings with customers and within the context of its authorisation it:*
> *2.1 acts honestly, fairly and professionally in the best interests of its* ***customers*** *and the integrity of the market;*
> *2.2 acts with due skill, care and diligence in the best interests of its* ***customers***"

The CPC page 21, says at paragraph 4.1 that:

> "*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*."

Article 3 (1) of the EU Council Directive 93/13/EEC of 5 April 1993 says as follows.

> "*A contractual term which has not been individually negotiated shall be regarded as unfair if, contrary to the requirement of good faith, it causes a significant imbalance in the parties' rights and obligations arising under the contract, to the detriment of the consumer*."

By email dated **9 February 2021**, the Complainant asserts that:

> "*if fairness for all customers is truly the goal, then such a critical term should be brought to the fore and communicated with the same level of importance as the implications of the term itself. This is in direct contradiction to items 2.1 & 2.2 of the consumer code as it is not 'in the best interests of its customers' to define an arbitrary cut-off point, beyond which otherwise legitimate claims are void. This is contrary to Article 3, item 1 of the EU COUNCIL DIRECTIVE 93/13/EEC of 5 April 1993 on unfair terms in consumer contracts, as it creates a significant imbalance in the parties' rights to the detriment the consumer insofar as it completely voids an otherwise legitimate claim that meets the criteria of the contract*."

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The Provider, by letter dated **22 February 2021**, says:

> "*in respect of [The Complainant's] assertion that [the Provider] did not act in accordance with the General Principles 2.1 and 2.2 of the Consumer Protection Code 2012 and the EU COUNCIL DIRECTIVE 93/13/EEC of 5 April 1993 on unfair terms in consumer contracts we believe that the customer orientated issuance of a reminder communication in advance of the cut-off period adequately addresses any concerns around treating customers fairly to include addressing any perceived imbalance between the insurer and the customer*."

I am satisfied that health insurance policies, like all insurance policies, do not provide cover for every possible eventuality; rather the cover will always be subject to the terms, conditions, endorsements and exclusions set out in the policy documentation. In this regard, I note that the Provider submits by letter dated **2 February 2021** that the Complainant:

> "*… subscribed to electronic documentation to his online member area. All documents were issued to the Complainant's* (sic) *via e-documents to their* (sic) *online Member Self Service Area*."

I have considered the evidence of the screenshots showing that the welcome letter was created on the **31 December 2018** and I have also considered the welcome letter, dated **31 December 2018,** from the Provider and addressed to the Complainant enclosing the **Membership Handbook**. I am satisfied that the Complainant received the **Membership Handbook** and that it was available to the Complainant to read and to consider the terms and conditions housed within the **Membership Handbook** from the time of the inception of the health insurance policy.

Although the Complainant says that he was unaware of the deadline, I am satisfied that he was put on clear notice of that membership rule by the Provider's communications to him, and that the **Membership Handbook** was fairly communicated and laid out in a clear and reasonable manner. By email dated **8 March 2021**, the Complainant submitted that:

> "*it shouldn't feature indiscriminately in a section titled '**How to claim'**. In this section you would expect to find information on how to claim, not how your claim will not be accepted*."

I don't accept this. I am satisfied that the "**How to Claim**" section housed beneath the "**Day-To-Day and Out-Patient Benefits**" was suitably placed to offer clear information both about the claims process and about the restrictions of the claims process.

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I also accept the Provider's explanation by letter dated **22 February 2021** that:

> "*taking into consideration the number of material conditions, exclusions etc, it would be impractical to attempt to add significance to one rule, while not doing so for the remaining rules" and that "other members may place higher significance to other benefits than day to day and out-patient expenses and therefore it is imperative that the customer is aware of the full Terms & Conditions of the policy before commencement*."

I note that the **Membership Handbook**, dated **November 2018**, at page 7, under section 2.1, includes details regarding "Day-To-Day and Out-Patient Benefits", and this includes a sub-heading entitled "**How to claim**". The subheading in question sets out that:

> *"You must submit your receipts within six months of the end of your policy year. If your receipts are not received within these six months, your claim will not be paid"*

I take the view that the language used by the Provider was clear and definitive in its meaning. I am satisfied that a prudent customer seeking to find deadlines for receipt acceptance, would readily locate this information in the "**How to Claim**" section where it is most likely to be found. Furthermore, I am satisfied that the Provider's conduct does not breach the Central Bank of Ireland's **Consumer Protection Code 2012** and that supplying the **Membership Handbook**, inviting customers to read it, and issuing a reminder to submit receipts, is in keeping with the Provider exercising its obligations towards "*the best interests of its customers*."

I also accept that the information the Provider supplied in the **Membership Handbook** was "*clear, accurate, up to date, and written in plain English*", that key information was "*brought to the attention of the consumer*" and that the method of presentation did "*not disguise, diminish or obscure important information.*"

By email dated **8 March 2021**, the Complainant asserted that:

> "*the request for key information to be brought to the attention of the consumer does not affect your ability to meet your obligation to all your customers. I have not requested an unlimited timeline for claims. What I have requested, is for such significant information to be made clear to the consumer."*

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I accept the Provider's explanation for imposing a deadline for acceptance of receipts and note in particular the evidence submitted by the Provider by letter dated **22 February 2021** that "*the company must estimate the liability for claims incurred in the past and those not yet reported*." I also note the evidence supplied by the Provider, by letter dated **22 February 2021,** from the HIA website confirming that other health insurance providers operating in the Irish market impose similar deadlines.

Recording of a telephone call has been furnished in evidence, which has also been considered. During the telephone call on the **8 September 2020** the Provider confirmed that an additional COVID extension had been applied to the six months to bring the extension deadline up to **10 August 2020**. I am satisfied that the Provider's extension of the deadline due to COVID-19 was reasonable.

I do not accept that the contractual terms of the health insurance policy "*causes a significant imbalance in the parties' rights and obligations arising under the contract, to the detriment of the consumer*." On the contrary, I take the view that the rights and obligations under the contract have been communicated fairly to the Complainant such that no significant imbalance arises between the parties.

In relation to the second aspect of the Complainant's complaint about the Provider's conduct in refusing his claim for assessment, I note that the Complainant says that no reminder email was received from the Provider. I have considered the evidence submitted by the Provider of a screen shot of a zoomed in mail merge programme which reads at the top as follows:

> *"[undisclosed] month Receipt Jan-March [initials]:Sent: 14/05/2020: 16:01:50"*

Under the words *"total marketable recipients: 3618"* it reads:

> *The Recipient name: [the Complainant's name]*
>
> *Email Address: [the same email address as that provided by the Complainant to this Office]*
>
> *Contact Group: 6 Month Receipt [initials of the Complaint's Company] Email List*
>
> *Receiving Marketing Email: Yes*

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I note that the body of the Provider's reminder email says:

> "*now could be a good time to submit your everyday health expense receipts. Simply take a photo and upload them through our **website** or through our member app - download the app below. You can claim expenses covered on your Plan up to six months after your renewal date*."

By email dated **8 March 2021**, the Complainant said:

> *"the screenshots provided are not evidence of any communication having taken place. The particular application (that manages the mailing list) does sound quite intelligent insofar as it can decipher whether or not such a deadline exists in a given year, however it has failed in its primary objective which is to get the e-mail to me. That such a mailing list exists surely supports my previous assertion of the importance of this term?....*
> *regarding the issuance of reminder communication, I feel it is important to reiterate that this mail was not received. I have no idea how your system works or what sort of glitches it may be susceptible to. All that I do know is that the mail did not reach the destination which is pretty rare nowadays. If it did reach the destination, all this frustration would have been avoided"*

By email dated **26 March 2021**, the Complainant said:

> *"I feel compelled to stress that this is not sufficient to be treated as evidence of communication having occurred and thus should not be treated as such. This is a screen shot of an unknown system, of unknown reliability. If an e-mail did successfully get sent, it is extremely unlikely that it would not make it to me in this day and age. However, I have not received it despite the fact that I have received numerous mails from [the Provider]."*

The Complainant submits by email dated **9 February 2021** that:

> *"Interestingly, I went back through my mail and I did not receive the mail in May 2019 either; as I was a member at that time I would expect that I would have been on the same mailing list at time of distribution."*

The Provider by letter dated **22 February 2021** said "*in relation to the question [The Complainant] raises about not receiving a similar e-mail in May 2019, I can confirm that there was no e-mail issued by [the Provider] in respect of a claims deadline as no deadline existed at that time for [The Complainant]. (As this was his first policy year with [the Provider], he would not have had any claims to submit for any previous policy year)."*

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I note that the email address furnished by the Complainant in his complaint to this Office matches the screen shot of the Provider's mail merge software. Having assessed the documentary evidence submitted by the Provider, I consider it more likely than not, that the reminder email was issued to him on **14 May 2020,** and that this was in keeping with the Provider seeking to protect "*the best interests of its customers*."

I note the Complainant's comment that, regarding the provider's emails and SMS messages, that "*the likelihood that not one but both of these methods failing to deliver their messages is extremely improbable*."

I agree. It is entirely unclear why the Complainant did not receive those various communications from the Provider, but I am satisfied that the Provider, in addition to already having placed the Complainant on clear notice of the relevant deadline, within the terms of the membership handbook issued to him, also took it upon itself to issue a number of reminders to the Complainant, with a view to further drawing his attention to the deadline in question. Having taken those steps, I do not believe that it would be appropriate to find that the Provider was guilty of some element of wrongdoing.

In summary, I am satisfied that the Provider acted in accordance with the contractual terms and conditions of the Complainant's health insurance policy when it declined, as it was so entitled, to accept the Complainant's receipts for assessment. In addition to the Provider's SMS messages that the Complainant has said were not received by him, I am also satisfied, on balance, that the Provider issued a reminder email on the **14 May 2020** to the Complainant, as part of a mail merge, even if, for reasons unknown, the Complainant did not receive that communication.

Accordingly, I do not accept that there is any reasonable basis upon which it would be appropriate to uphold this complaint against the Provider.

Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is rejected.

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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 December 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.