An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0525
Sector:	Insurance
Product / Service:	Travel
Conduct(s) complained of:	Rejection of claim - pre-existing condition Disagreement regarding Medical evidence submitted
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint arises from the Provider's suggested failure to fully indemnify the Complainant's insurance claim on her travel insurance policy. The Complainant was the main insured on the policy and her daughter Ms. A. was also insured. Reference to "the Complainant" below should be taken to include both the main policyholder and her daughter, but primarily refers to Ms. A.

The Complainant states that the Provider rejected the travel insurance claim when she was diagnosed and hospitalised with a medical condition which happened after the policy was incepted.

The Complainant's Case

The Complainant submits that she was expecting to travel abroad on **31 May 2019** and that she purchased a travel insurance policy from the Provider in April 2019. The Complainant further submits that on **14 April 2019** she was diagnosed with a medical condition and "*hospitalised later on that day*".

The Complainant advises that the doctor informed her that she was "unfit for travel" and issued a letter to her, to provide to her insurance company. The Complainant further advises that her General Practitioner ("GP") provided her with a medical history form, which did not indicate that she had a pre-existing condition.

The Complainant states she provided proof of "*no show flights and hotel*" and the medical files to the Provider. The Complainant advises that the Provider rejected her claim, stating that she had a pre-existing medical condition, when she incepted cover.

The Provider's Case

In the Provider's final response letter dated **8 January 2020**, the Provider submits that the insurance policy operates on the basis that "*no claim arising directly or indirectly from any pre-existing medical condition affecting you, will be covered unless that condition is declared to, and accepted by us, in writing*."

The Provider submits that the definition of a "pre-existing medical condition" is defined on page 6 of the policy wording. The Provider states that it notes from the Complainant's medical information, that she contacted her GP on **1 March 2019** and was referred to a dietician and psychology clinic. The Provider further submits that the Complainant was referred for consultations following a review with a psychologist on **19 March 2019**.

The Provider contends that it has checked its records and that none of these consultations were declared upon inception of the policy on **4 April 2019**. The Provider further contends that it referred the medical detail to its medical panel, who confirmed that the admission that led to the cancellation of the Complainant's trip was directly related to the undeclared specialist involvement in **March 2019**.

The Provider contends that these issues had not resolved and were still in existence when the policy was purchase in **April 2019**, before exacerbating in **May 2019,** resulting in the cancellation of the trip.

The Complaint for Adjudication

The complaint is that the Provider wrongfully rejected the Complainant's travel insurance claim when she was diagnosed and hospitalised with a medical condition, after the travel policy was incepted.

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. Recordings of telephone calls have been furnished in evidence. I have considered the content of these calls.

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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 **24 November 2021**, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter. In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

Prior to considering the substance of the complaint, it is useful to set out the chronology of events (quoting certain correspondence) as well as the relevant terms and conditions of the policy.

07 February 2019	Trip booked
01 March 2019	The Complainant presented to her GP with amenorrhea for five months, the GP described an over focused attitude to food and significant weight loss. Referred to psychology advice clinic dietician.
12 March 2019	The Complainant attended a psychologist and she reported she had become "*obsessive with food*", psychologist recommended referral to Child & Adolescent Mental Health Service (CAMHS).
15 March 2019	GP made referral to psychiatrist at CAMHS
26 March 2019	Letter indicating that the Complainant had been placed on waiting list for CAMHS appointment
4 April 2019	Insurance policy purchased by Complainant.
9 April 2019	Complainant's mother telephoned the GP stating that there remained an issue with the Complainant's menstrual cycle due to the weight loss, but the Complainant's eating was "*slowly improving*" [as per the GP's notes of the telephone call].
10 May 2019	The Complainant presented to GP and sought for CAMHS appointment to be advanced as soon as possible.

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14 May 2019`	The Complainant was admitted to the hospital. She was discharged on **24 April 2019**.
21 May 2019	The Complainant's mother contacted the Provider stating that the Complainant was ill and that the holiday had to be cancelled.
22 May 2019	The Provider sent the claim form to the Complainant.
30 May 2019	The Provider sent a letter to the Complainant seeking: (a) Cancellation invoices showing cancellation charges from the airline and her accommodation (b) Confirmation of "no show" from the airline (c) Full hospital admission report and documents outlining the Complainant's symptoms and medical history. The Provider contended it stated that it could not accept retrospectively written letters in this regard.
14 June 2019	The Provider sent a letter seeking the information required for the claim under the policy. The Complainant telephoned the Provider for an update. The Provider stated that the Complainant would receive correspondence from them early the following week.
19 June 2019	The Complainant telephoned the Provider concerning its request for her information. The Complainant stated she would get the hospital admission report. She also advised that the first Travel Agent was charging her £25 (twenty five pounds) sterling for a cancellation invoice and that she had emailed the first Travel Agent and was awaiting its response.
19 July 2019	The Complainant telephoned the Provider stating she had not heard anything back from the first Travel Agent or the second Travel Agent. The Provider advised the Complainant to send all email correspondence made with the Travel Agents along with all other documents required.
7 August 2019	The Provider wrote to the Complainant and advised her that her claim had been declined. The Provider stated it was declined because the Complainant's symptoms which led to the cancellation of the trip, were already in existence when the insurance policy was purchased.
16 August 2019	The Complainant confirmed that she would be appealing the decision to decline.

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22 August 2019	The Provider received an email from the Complainant which outlined her appeal
28 August 2019	The Provider wrote to the Complainant requesting the following: a. Medical records from **1 January 2019** to date of letter. b. Original cancellation charges form the flights and accommodation providers c. Clarification as to why the policy was purchased after the trip was booked.
26 September 2019	The Complainant's mother contacted the Provider seeking an update by telephone. The Provider stated it had a backlog and responded to her request by seeking more time to respond.
10 October 2019	During a phone call between the Provider and the Complainant's mother, the Complainant's mother stated she had sent the requested information by way of email some time ago. The Provider stated to her that it did not receive the email. During this call there seemed to be some confusion as to what email address was used by the Complainant's mother to forward on the documentation.
15 October 2019	The Provider submitted it carried out a search for the email, but submits the email was never received.
24 October 2019	The Provider wrote to the Complainant that it was dealing with a high volume of claims and that the Complainant's earlier email did not include the attachments of the GP records.
28 October 2019	The Complainant forwarded the relevant documentation by way of email.
11 November 2019	The Provider responded seeking the full documents to be sent again in hard copy, or as a pdf.
12 November 2019	The Provider received the correspondence.
20 November 2019	The Provider confirmed it received the documentation and stated it was rejecting the Complainant's claim.
22 November 2019	The Provider wrote to the Complainant stating that it was still processing her claim.

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28 November 2019 The Provider registered the Complainant's complaint.

11 January 2020 The Provider issued a final response letter.

I note that under the Policy Terms and Conditions ("the policy document"), it provides as follows a page 4:

> *"Strict medical Health Requirements:*
> *…*
> *No claim arising directly from any Pre-Existing Medical Condition affecting you will be covered unless that condition has been declared to and accepted by Us in writing"*

The policy document at page 6 provides the definition of pre-existing medical condition as follows:

> *"Pre-existing Medical Condition: Any medical condition or psychological sickness, disease, condition, injury or symptoms of which You are aware, or that has affected You, which has required treatment medical consultations (s) or investigation(s), or prescribed medication at any time during the last 2 years prior to the commencement of cover under this cover/Schedule of Cover (inside front cover) and/or prior to each and every trip. And/or any cardiac, cardiovascular hypertensive, or cerebrovascular illness, disease, condition or symptom of which You are aware, that has occurred at any time prior to the commencement of cover under this cover/Schedule of Cover and/or prior to any Trip."*

At page 3 of the policy document, it concerns the introduction cover to the policy and states:

> *"Thank you for insuring with us. Here is your new [insurance company] insurance cover, which is Underwritten by [Provider].*
> *It contains details of cover, conditions and exclusions relating to each Insured Person and is the basis on which all claims will be settled. It is validated by the issue of the validation certificate which must be attached to Your cover. In return for having accepted your premium We will in the event of /bodily injury [sic], death, illness, disease, loss, theft, damage or other specified events happening within the Period of Insurance provide insurance in accordance with the operative sections of Your cover as referred to in Your schedule of cover. Words and expressions to which specified meanings have been given any part of the contract of insurance, have such specific meaning wherever they may appear."*

I note that on **1 March 2019**, the Complainant attended her GP. The relevant section of the medical report from that date states as follows:

> *"amenorrhea x 5 months…has lost weight due to the gym. Describes that she has an overfocussed attitude to food – checks calorie content of foods. A lot of days she does not eat as much as 1,000 calories.*

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> *She knows she does not eat enough for the amount she exercvises [sic] but does not want to gain weight…I asked if her family are worried about her and she advised that they are – they see that she has lost a lot of weight…denies stressors. Has good friends. Likes school. Good relationships within the family."*

The same notes set out the GP's "*plan of action*":

> "*with [the Complainant's] consent, I phoned her mother and discussed issues and management plan with her regarding psychology advice clinic, dietician, bloods. She was happy with all of this. I phoned secretary in psychology advice clinic to get consent for [E] to attend with her mum – advised that this was fine*
> *discussed OCP for bone health – [E] not keen for now but will think about it – also discussed with mum on the phone."*

The notes further indicate that her GP was checking bloods, as well as vitamin B123, Folate, Ferritin and Vitamin D.

On the same day, the Complainant's GP wrote a referral letter to the psychologist setting out the details of the above notes and seeking advice. The letter included the following:

> "*I am satisfied that she does not meet the criteria for anorexia but I am anxious to give her support/advice to help with her complicated relationship with food*."

On **1 March 2019**, the Complainant's GP also sent a referral letter to a dietician regarding her "*overfocussed attitude to food*." This letter also stated she had a systolic blood pressure of 105 and diastolic blood pressure of 73.

On **15 March 2019**, the Complainant's GP made a referral to a psychiatrist seeking an appointment for her, again setting out her "*overfocussed attitude to food*".

On **20 March 2019**, the psychologist wrote to the Complainant's GP regarding her examination of the Complainant on **12 March 2019**. The psychologist stated that the Complainant had become "*obsessive with food*" and had "*feelings of guilt, shame and distress if she eats one sweet or piece of 'unhealthy food*'". The letter went on to recommend a referral to CAMHS based on "*the nature of [the Complainant's] negative thought processes and behaviors in relation to food intake and weight loss*." The psychologist further suggested contact with an eating disorder association.

On **15 March 2019**, the Complainant's GP made a referral to a psychiatrist seeking an appointment for the Complainant, again setting out her "*overfocussed attitude to food*".

On **4 April 2019**, the Complainant incepted the travel insurance policy.

On **9 April 2019** the Complainant telephoned the GP stating that there remained an issue with the Complainant's menstrual cycle due to the weight loss, but her eating was "*slowly improving*" [as per the GP's notes of the telephone call].

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On **10 May 2019**, the Complainant attended her GP unaccompanied. The GP's note of this consultation noted continued weight loss and that the Complainant advised that she finds her situation is not improving. The GP sent further letters to a cardiologist seeking an ECG check. On 10 May 2019, the GP wrote a further letter to the psychiatrist seeking a CAMHS appointment to be scheduled as soon as possible.

On **14 May 2019** CAMHS assessed the Complainant. In its medical report dated **15 May 2019**, it noted that the Complainant said the problem started "*approximately a year and a half ago*". The letter also described that the Complainant said that recently she realised she was "*thinking about food all the time and had a strict routine about eating and was beginning to lose weight and all her life was about losing weight*". She stated that it was at this time she returned to the GP and was then referred to CAMHS.

The letter from CAMHS further stated that the Complainant had no previous CAMHS history and no significant family history of mental health difficulties. It noted that her difficulties are in context of food restriction and anorexic behaviour with comorbid physical symptoms. The letter concluded by stating that the Complainant currently met the Diagnostic and Statistical Manual of Mental Disorders (DSM V) criteria for anorexia nervosa restrictive type.

On **23 May 2019** the hospital wrote a letter regarding the Complainant which stated:

> "*To whom it may concern,*
> *[E] was an inpatient in [the hospital] from 15/05/19 to 23/05/19 under the care of [hospital doctor]. She has deemed unfit to travel on her upcoming holidays by the medical team.*
> *If you have any further queries please do not hesitate to contact me*."

There was an update current progress dated **24 May 2019** from the psychiatrist which also noted that the Complainant was admitted to the hospital emergency department on **14 May 2019**. The letter also noted that the Complainant was medically stable and would be discharged from the hospital soon and had an appointment with CAMHS on **28 May and 30 May 2019** follow up post hospital discharge.

On **7 August 2019** the Provider wrote to the Complainant declining cover. The letter stated the Provider had completed its assessment of the claim taking into consideration the terms and conditions which apply to the travel insurance policy. In particular, the letter stated the following:

> "*…you will see from the introduction to your policy we will only provide insurance for specified events which occur during the period of insurance. This means only new events which occur after you have purchased your insurance can be considered should a claim arise.*

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The letter also referred the Complainant to the "*Section 1 Cancellation or Cancellation charges*" on page 9 of the policy document which stated:

> "*What is Covered: We will pay You: up to the amount shown in the policy schedule, for your irrecoverable unused travel and accommodation costs and other prepaid charges (including sports, concert and entertainment tickets) if you have paid or are contracted to pay together with any reasonable additional travel expenses incurred if: a) Cancellation of the trip is necessary and unavoidable as a result of any of the following events occurring after payment of policy premium and incurring within the period of insurance*".

The letter also stated that the Provider noted from the medical certificate completed by the Complainant's GP that that she had been suffering from symptoms relating to the condition of dehydration and low blood pressure since **March 2019**. As the policy was not purchased until **4 April 2019**, the Provider stated in that event, that the condition was not covered because the symptoms which eventually led to the cancellation of the trip were already in existence when the policy was purchased. Accordingly, the claim fell outside the scope of cover and was declined. The letter went on to cite the policy terms about pre-existing medical conditions. Again, the letter reiterated that in light of the policy terms and conditions, there was no cover because the Complainant's symptoms first began in **March 2019** and these later gave rise to the cancellation claim in **May 2019**.

The letter concluded by stating that should the Complainant wish to appeal the decision and or have further information which may affect the assessment of the claim, to please contact the Provider with a detailed explanation so that it could review the outcome of the claim.

On **22 August 2019** the Complainant emailed to the Provider stating that she wished to appeal the decision to decline her cover under the policy. The email stated as follows:

> *"I wish to appeal your decision to deny my claim. You state that your decision is based on a medical certificate completed by [the GP]. You write that on a visit to my doctor in March, I displayed symptoms which led to my hospital stay in May. This is incorrect, during that consultation there was nothing to indicate that my then symptoms were likely to lead to hospitalisation. Furthermore, Neither I [sic], nor my mother, were given any cause for concern regarding my health at that time. As such, when I took out my insurance in April, I took it out in good faith. I did not disclose any existing health problem, because there was none to disclose. I've since been in touch with [the GP] and I enclose a letter from her supporting these facts.*

The letter from her GP, dated **14 August 2018**, which was attached to the email stated as follows:

> *"[the Complainant's mother] Advised me that she took out holiday insurance on 4 April and that the claim was declined as [the Complainant] was suffering from low blood pressure and dehydration. I would like to clarify the sequence of events as follows*

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> *In March 2019, [the Complainant] presented with amenorrhea x 6 months. This was her reason for attending. I explored her risk factors for this and found she was exercising a lot in the gym and had lost weight due to healthy eating that had become very focused. Her BP at that visit was normal at 105/73 enter BMI was normal at 18.9. She was not accompanied by her mother at that visit as her mother was not worried about her. She was felt to be fit and healthy and following a strict fitness regime.*
>
> *I referred her to psychology as I had some concerns about her restrictive eating patterns and arranged blood tests. The psychologist saw her on 15 March and suggested psychiatry referral for assessment. Blood results came back on 26 March and did not show dehydration. Urea was 5.1 and creatinine 86, sodium was 139. [The Complainant] was not seen in the practice again until May."*

On **28 August 2019**, the Provider sent a follow up letter stating that it acknowledged the recent letter supplied from the complainants GP which "*now casts a shadow of doubt on this particular element*", being the first onset of symptoms.

On **20 November 2019**, the Provider sent a letter to the Complainant wherein it stated that it "*cannot consider her claim*". The letter also stated:

> "*We have referred your case and medical records to our Medical Panel who have confirmed that their symptoms were occurring prior to the inception of your policy and that this would be considered as pre-existing medical condition."*

On **28 November 2019**, the Provider wrote a letter to the Complainant acknowledging the complaint made by the Complainant. After a complaint was filed, the Provider sent its final response letter on **8 January 2020**. The letter stated:

> *"We note from the medical information provided that [the Complainant] consulted her GP on 01/03/2019 with amenorrhoea and was referred to a dietician and psychology clinic due to weight loss and eating disorder issues. She was also referred to CAMHS an eating disorder association support following a review with psychologist on 19/03/2019. We have checked our records and none of these consultations were declared upon inception of the policy on 04/04/2019. We have referred the medical detail to our medical panel who have confirmed the admission which led to the cancellation of your trip is directly related to the undeclared specialist involvement in March.*
>
> *We have further explained in our previous correspondence that your policy only covers unforeseen, fortuitous events which occur after the purchase of the policy. It is written into your policy introduction that we will only provide insurance for specified events which occur during the period of insurance. The medical certificates confirmed [the Complainant] had been suffering from symptoms related to the conditions dehydration and low blood pressure since March 2019. These issues had not resolved and were still in existence when the policy was purchased in April 2019 before exacerbation in May 2019 and resulting in the cancellation of the trip.*

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Whilst we truly empathise with your situation and understand that you may not have envisaged that [the Complainant's] issues and symptoms would worsen to the point of have to cancel your trip, we must assess your claim against the terms of your policy and due to the reasons outlined above your claim has regrettably been declined."

Analysis

The Complainant stated in her complaint form as follows:

"On May 14th 2019 I was diagnosed with anorexia nervosa by the child and adolescent mental health services and hospitalised later on that day. I knew during my 10 day hospitalisation that I was expecting to go away on May 31st and when I informed the doctor she told me I am unfit for travel and gave a letter to send to my insurance company. She told me they don't have the right to ask any personal questions about my illness however they did need all the details so I went and got a form filled out by my GP with all previous medical history, none of which showed it was pre existing condition which the insurance company are claiming it is and is the reason they will not payout. I was never underweight in any doctor appointments and my GP wrote a formal letter with proof of this. I also provided proof of no show flights and hotel which the insurance company requested and later as the claim was progressing they requested my medical files which they now have and then went on to reject my claim saying it was pre existing condition although I took out the insurance in April and there is no diagnosis till may. I fail to see how they can reject this as I took out this policy with utmost good faith. Further details can be provided if necessary thank you in advance.

I note that the wording of the policy is very clear, stating

"No claim arising directly from any Pre-Existing Medical Condition affecting you will be covered <u>unless that condition has been declared to and accepted by Us in writing</u>."

[My underlining added for emphasis]

The pre-existing illness is defined as

"Pre-existing Medical Condition: Any medical condition or psychological sickness, disease, condition, injury or symptoms of which You are aware, or that has affected You, which has required treatment medical consultations (s) or investigation(s), or prescribed medication at any time during the last 2 years prior to the commencement of cover under this cover/Schedule of Cover (inside front cover) and/or prior to each and every trip. And/or any cardiac, cardiovascular hypertensive, or cerebrovascular illness, disease, condition or symptom of which You are aware, that has occurred at any time prior to the commencement of cover under this cover/Schedule of Cover and/or prior to any Trip."

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I note the Complainant's GP had stated

> "*amenorrhea x 5 months…has lost weight due to the gym. Describes that she has an overfocussed attitude to food – checks calorie content of foods. A lot of days she does not eat as much as 1,000 calories. She knows she does not eat enough for the amount she exercvises [sic] but does not want to gain weight…*
> *I asked if her family are worried about her and she advised that they are – they see that she has lost a lot of weight…denies stressors. Has good friends. Likes school. Good relationships within the family.*"

The same notes set out the GP's "*plan of action*":

> "*with [the Complainant's] consent, I phones her mother and discussed issues and management plan with her regarding psychology advice clinic, dietician, bloods. She was happy with all of this. I phoned secretary in psychology advice clinic to get consent for [E] to attend with her mum – advised that this was fine*
> *discussed OCP for bone health – [E] not keen for now but will think about it – also discussed with mum on the phone.*"
>
> [My underlining added for emphasis]

I am cognisant that the GP wrote a referral letter to both a dietician on **1 March 2019** and to a psychologist on 1**5 March 2019** seeking an appointment. I also note that under the policy, pre-existing illness is broadly defined to include:

> "*Any medical condition or psychological sickness, disease, condition, injury or symptoms of which You are aware, or that has affected You, which has required treatment medical consultations (s) or investigation(s), or prescribed medication at any time.*"

Therefore, any symptoms which required treatment, before the policy came into being, come within the definition of a pre-existing condition. Putting a name or a diagnosis on such symptoms is not required, for those symptoms to constitute a pre-existing medical condition under the policy.

Accordingly, I accept that the GP medical certificates confirmed the Complainant had been suffering from symptoms related to the conditions of dehydration and low blood pressure since **March 2019**.

As a result, I am satisfied that for the Complainant to be covered by the policy for the condition that ultimately gave rise to the cancellation of her trip, she was required to specifically declare to the Provider in writing that she had sought medical advice for these symptoms. This would have enabled the Provider to examine (i) what additional risk existed to be covered by the policy, if any, (ii) whether the Provider was willing to offer cover for that pre-existing medical condition, and (iii) in that event, what additional premium was payable by the Complainant, if any.

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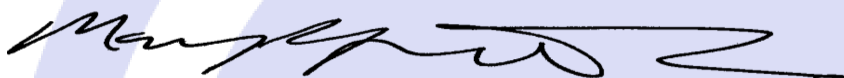
As the Complainant did not however declare these symptoms to the Provider, I accept the Provider was entitled to take the view that she was not covered under the policy for the cancellation of her trip.

Accordingly, I am satisfied based on the evidence before me that it is not appropriate to uphold the Complainant's 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.



MARYROSE MCGOVERN
Deputy Financial Services and Pensions Ombudsman

16 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.