An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0008
Sector:	Insurance
Product / Service:	Travel
Conduct(s) complained of:	Claim handling delays or issues Rejection of claim - pre-existing condition
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns a claim on the Complainants' travel insurance policy which was incepted on **28 October 2019**.

The Complainants' Case

The Complainants have submitted this complaint in relation to the Provider's failure to admit and pay their travel insurance claim.

The Complainants booked flights on **28 October 2019** to travel on the **2 March 2020** for a two week period and had booked return flights to Ireland on the **16 March 2020**.

The First Complainant says that prior to booking the flights in **September 2019** she was informed that she had a Fibroid on her womb. The First Complainant has submitted that these are quite common and often treatment is not necessary. She was referred for a scan scheduled for the **14 November 2019** but states that "*it was not anticipated by the health professionals that I would need treatment that would prohibit me to travel*".

Following the scan on **14 November 2019** the Complainant states that she was advised that she would need to have the Fibroid removed but this was not likely to happen before **May 2020**. The Complainants continued with their travel plans as they were supposed to be home well before the anticipated surgery date.

In early **January 2020** the First Complainant's operation was brought forward to **27 February 2020.** The First Complainant was instructed that due to necessary recovery times, she was advised not to fly on **2 March 2020**. The Complainant submits that accordingly she decided to cancel the travel plans and on the **6 January 2020** called the Provider, to discuss submitting a claim on their travel insurance policy.

The First Complainant, upon receipt of the travel insurance claim form on the **17 February 2020** submitted evidence from her GP and Consultant confirming her surgery and recovery dates, which deemed her unfit for airline travel for six weeks after the procedure. It is not clear when the Provider issued its response because the Complainants submit that it was not received by them until June but the letter is dated **15 April 2020** and states that the Provider declines cover citing the "*pre-existing*" section of its medical exclusions, as listed in the travel policy documents.

The Complainants submit that at the time of booking their flights they had expected to travel on **2 March 2020** as the medical condition discussed with her doctor at the **September 2019** appointment, was not such as to warrant any concern over inability to travel. The Complainant asserts that at the time of booking her flights and incepting the policy, she had no knowledge of any impeding travel constraints. Additionally, the Complainant submits even after finding out that she needed surgery, she was not aware of any reason why she could not travel.

The Complainant states that the constraint to restrict her ability to travel was as a result of the surgery being brough forward to **27 February 2020.** The Complainant maintains that it was from this date, when her surgery date was changed, that she became aware that she would not be able to travel. The Complainant states that she contacted the Provider on **6 January 2020** to submit a claim for compensation under her policy.

The First Complainant in response to her claim under the policy being denied, has submitted that she does not believe the Provider "*reached out to the medical professionals to fully understand the background of [her] situation*". The First Complainant contends that her condition as initially diagnosed in September 2019 is common and most patients don't need any form of treatment and at the time of booking her flights, in **October 2019** there was no "*professional opinion*" that she should not travel.

The Complainant refers to a number of medical sources to evidence that it was not anticipated that she was likely to require medical treatment and not indeed anticipated that she would require such extensive surgery thereby rendering her unable to travel during the planned dates.

The Complainants want the Provider to refund them the cost of the flights, which is stated to be **€1,528.00.**

The Provider's Case

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The Provider submits that its position is that under the policy purchased by the Complainants in October 2019, there is "*no cover for conditions that were diagnosed prior to the Complainants booking [their] trip*".

The Provider states that the Complainants' travel insurance claim falls "*under the exclusions for medical related claims*".

The Complaint for Adjudication

The complaint is that the Provider has wrongfully or unfairly failed to indemnify the Complainants' Travel Insurance Claim

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainants were given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint. Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on **10 December 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.

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I note that the Complainant states that she did not receive the policy documents at the time when the policy was purchased, though I note that there is no evidence available that the Complainants contacted the Provider to query outstanding policy documents, until the correspondence dated **16 September 2020** from them to the Provider.

The Provider has submitted that the policy would have been sent to the Complainants on the date of purchase and it refers to its system showing that these were sent in **October 2019.** Additionally, the Provider states that at the time of purchase of the policy, the Complainants would have had to select that they read the terms and conditions, in order to conclude the purchase.

The Provider says that the Complainants will have received the policy in the confirmation email.

I note the timeline of events to be as follows:

- **September 2019** – First Named Complainant attends medical care, Fibroid first discovered. Referred for MRI scan;
- **28 October 2019** – Complainants purchase flights and they also incept the policy with the provider for their intended trip on 2 March 2020;
- **14 November 2019** – First Named Complainant's MRI Scan;
- **5 December 2019** – First Named Complainant consultation with Doctor re scan, told of need for surgery but likely to be in May 2020;
- **2 January 2020** – Complainant advised operation being brough forward to February & informed of need to rest for 4/6 weeks post operation;
- **6 January 2020** – First Named Complainant calls the Provider to submit a claim under the policy;
- **27 February 2020** – First Named Complainant has surgery;
- **25 March 2020** – Provider denies cover for claim under the policy;

Policy Provisions

I note from the Policy Provisions that the cover pages provide particularly clear information designed to ensure no misunderstanding on the part of the policyholder.

Indeed, I consider it appropriate to re-produce below, a section of the information on the opening page which includes warning signs suitably coloured and makes clear the basis of the cover made available by the policy.

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What is insured?

- ✓ **Cancelling / cutting short your journey** - Loss of pre-paid travel and accommodation expenses.
- ✓ **Emergency medical expenses** - hospital fees, repatriation, in-patient benefit, funeral and dental costs incurred if taken ill or injured on your journey.
- ✓ **Loss of passport** - costs to obtain temporary documents on your journey plus reimbursement of the remaining value of lost passport.
- ✓ **Delayed personal possessions** - costs to replace essential items temporarily lost by the transport provider on your outward journey.
- ✓ **Personal possessions** - Items lost, stolen or damaged on your journey.
- ✓ **Personal money** - money, travellers cheques and travel tickets lost, stolen or damaged on your journey.
- ✓ **Personal accident** - Compensation if you die, lose your sight or limb or are unable to ever work again following an accident on your journey.
- ✓ **Missed departure** - Extra transport or accommodation costs to continue your journey, if you miss your outbound or return transport.
- ✓ **Delayed departure** - A benefit after a major delay to outbound or return transport at the departure point. Alternatively the costs to abandon your journey on the outbound leg only.
- ✓ **Personal liability** - Costs for damage you cause to a third party or their property (including your journey accommodation if not owned by you, a family member or friend).

What is not insured?

- ✗ Claims where you cannot provide sufficient supporting evidence.
- ✗ Taking part in activities where there is an increased risk of injury, unless we have agreed otherwise.
- ✗ More than the maximum benefit limits (and sub limits when these apply) shown in each section.
- ✗ The policy excess that is applicable to each person, section and/or claim.
- ✗ Claim circumstances you were aware of before your policy was issued or journey was booked (whichever is the later).
- ✗ Claims that are caused as a direct or indirect result of something you are claiming for such as loss of earnings as a result of being delayed in returning.

Are there any restrictions on cover?

- ! Cover is only available to residents of the Republic of Ireland.
- ! Claims relating to existing medical conditions are excluded.
- ! Certain levels of cover may be restricted according to the age of the insured persons.
- ! There is a limit on the length of the journey that can be covered.
- ! There are General Conditions that you have to meet for cover to apply.
- ! General exclusions apply to the whole policy and each section contains exclusions specific to that section.

I note in that regard that under the heading "***What is not insured****?",* it provides:

> "*Claim circumstances you were aware of before your policy was issued or journey was booked (whichever is later)*".

Under the heading "***Are there any restrictions on cover*?"** it is stated that:

> "*Claims relating to existing medical conditions are excluded*".

I note the subheading under the title "*Travel Insurance Policy*" states:

> "*This policy does not cover claims relating to existing medical conditions".*

I also note that page 8 of the Policy contains a prominent heading "***Health declaration and health exclusions***" which states as follows:

> *"Exclusions relating to your health*:
>
> *1. You will not be covered for any directly or indirectly related claims … arising from the following <u>if at the time of taking out this insurance or booking your journey</u> (whichever is later) you :*
>
> …

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b) have received treatment for or had a consultation with a doctor or hospital specialist for any medical condition in the past 12 months;
c) are being referred to, treated by or under the care of a doctor, or a hospital specialist;
d) are awaiting treatment or the results of any tests or investigations;
…

5. You will not be covered if you were waiting for medical treatment or consultation at any medical facility or were under investigation for a medical condition when your policy was issued."

The First Complainant refers to the Claim Form submitted to the Provider dated **17 February 2020** and points to the fact that her doctor filled out part of the form under the questions "*on the date of the issue (Shown in Part A above), was the condition considered to be stable*" and her GP selected "*Yes*" and wrote "*not diagnosed*".

Furthermore, the doctor states that the First Complainant was first diagnosed in **December 2019**.

The First Complainant states that the GP answered in the negative, to the question of whether:

"*On the date of issue (Shown in Part A) was the patient having medical condition investigated or were they awaiting test results?"*

In my opinion however, an answer in the negative was not correct.

I note from the claim form which the Complainants submitted to the Provider seeking policy benefits, that a question was asked regarding health conditions, as follows:-

"At the date of purchasing your insurance or booking your holiday (whichever is the later) did any of the following points apply to you or the person whose illness is causing the claim:
…
(iii) Were you referred to a doctor or specialist or were you awaiting treatment or the results of any tests or investigations?"

I note that the Complainant confirmed (correctly) that the answer to this question was yes. In explaining why the answer was yes, she supplied additional details confirming the discovery of the fibroid in September 2019 and the resulting referral for an MRI scan.

I accept that the Complainant may not have understood the potential seriousness of her condition and I also accept that in many instances, the discovery of a fibroid will not give rise to the situation in which the Complainant found herself.

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I am satisfied however that because the condition which ultimately led to the Complainants' cancellation of their trip, pre-existed the purchase of the travel insurance policy in October 2019, the Provider was entitled to refuse the claim and to refuse to make payment of benefit to them because the claim was excluded given that it arose from a medical condition that existed when the policy was put in place. It is clear that the policy in question which the Complainants purchased, does not provide cover for pre-existing medical conditions under any circumstances.

As outlined above, the policy of insurance excludes claims arising from any health issues for which a consultation was previously sought with a doctor in the previous 12-month period. As the Complainant was at the time "*being referred*" for an MRI, was "*awaiting treatment or the results of [a] test or investigations"*, I accept that the policy did not provide cover for the circumstances that the Complainants found themselves in.

Accordingly, I am satisfied that the Provider was entitled to decline the Complainants' claim in accordance with the terms and conditions of the policy and for that reason I cannot uphold this complaint.

Conclusion

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

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

MARYROSE MCGOVERN
Deputy Financial Services and Pensions Ombudsman

6 January 2022

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.