An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0052
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - late notification Delayed or inadequate communication Failure to advise on key product/service features
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint relates to the communication to the Complainant of an extended time limit for the submission of health insurance claims with the Provider.

The Complainant's Case

The Complainant holds a health insurance policy with the Provider. On **31 August 2020,** the Complainant contacted the Provider via webchat to seek information regarding the submission of claims for **2019** receipts.

The Provider's Agent informed the Complainant that the deadline for submission had ended two weeks prior to that conversation. The Complainant submitted that she asked for an extension of time "*in light of the circumstances this year*", referencing the Covid-19 pandemic.

The Agent told the Complainant that an extension had been granted by the Provider, which had expired two weeks earlier, and that all policyholders had been informed of the extension by email or SMS. The Complainant submitted that she did not receive this notification of an extended deadline, in any form.

The Complainant has argued that the contractual six-month time limit for submitting claims to the Provider became "*null and void*" when the extension of time was made. She stated that she cannot be expected to comply with a time limit, of which she not informed.

On **5 March 2021**, the Provider made an offer on an exceptional basis to process the Complainant's claim. The Complainant rejected this offer "*on point of principle*", as the Provider's handling of this issue caused "*undue stress*" during an already difficult year.

The Provider's Case

In its final response to this Office of **6 May 2021**, the Provider noted that the Complainant's policy had been renewed on **21 January 2019**. The Provider points to the **Membership Handbook** provided to the Complainant as part of the renewal process, and in particular to the information specified at page 7 of the handbook, under the heading "**How to claim**", which stated that receipts regarding 'day to day' and out-patient expenses must be submitted within six months of the end of the policy year:

> *"You need to pay the practitioner/health care provider yourself and then claim the amount that is covered back from us during your policy year by scanning your original receipts and submitting them through our online claims tool ([Provider] Health Online Claiming) in your member secure area on www.[provider].ie. 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."*

The Provider submits that a reminder email was sent to the Complainant on **22 April 2020**, which highlighted that there was a six-month time limit for submitting claims. It states that its records show that the Complainant opened this email on **22 April 2020**.

The Provider states that it is satisfied that it complied with Provision 4.1 of the ***Consumer Protection Code 2012*** (CPC) in this regard.

In relation to the extension of time, the Provider states that it elected to process claims for any receipts that it received from its members before **10 August 2020**, when the six-month time limit had already elapsed during **2020**. The Provider says that this was an "*internal claiming rule and was not communicated to members*".

The Provider submits that the Complainant was made aware of this internal rule, owing to the error of its Agent on **31 August 2020** during the webchat. It stated that *"[t]his, along with other pieces of misinformation*" formed the basis for an offer to process the Complainant's claim without the application of the six-month time frame. The Provider states that this was "*an absolute exception to the rule*", which was provided "*in good faith*" as it was in fact the resolution which had been requested by the Complainant. This offer was made on **5 March 2021**, and rejected by the Complainant on **21 April 2021**.

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The Complaint for Adjudication

The complaint is that the Provider unfairly declined the Complainant's request to submit legitimate claims for medical expenses incurred during **2019** despite her argument that she was not informed that the timeframe for submission had been extended.

The Complainant wants the Provider to allow her to submit claims from **2019** as she was:

> "*omitted from the alleged circulation regarding [the Provider] extension of the deadline due to Covid so was never informed of the new deadline*".

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 **18 January 2022**, 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 submits that the extension of the time limit for submitting a claim was not communicated to her, and therefore she could not have complied with it. The Provider submits that the "extension" was an internal policy, which should never have been communicated to the Complainant as it was not communicated to any members. To remedy this error, it offered to process the Complainant's claim for 2019 expenses, but she declined.

I have considered the documentation and reminder email relating to the six-month time limit for making claims, and I am satisfied that the Provider complied with Provision 4.1 of the Consumer Protection Code, in making the relevant information available to the Complainant, in a clear and accurate way.

I accept in that regard that the Complainant was put clearly on notice by the Provider, that she did not have a contractual entitlement to have her **2019** claim processed by the Provider if she did not "*submit* [her] *receipts within six months of the end of your policy year",* in this instance, by **21 July 2020**.

I note in that regard from the Provider's evidence, that an email was sent to the Complainant on **22 April 2020**, in advance of the 6-month cut-off point, to the email address held on file for the Complainant, advising that "*now would be a good time*" to submit her everyday health expenses. The email in question explained how to claim, and that a claim could be made for expenses covered on her plan, for up to 6 months after her renewal date. The Provider points out that it can see that the Complainant opened this email on the same date that it was issued to her. I am satisfied on the basis of that evidence that, whether not she opened the reminder email of 22 April 2020, the Complainant had already been clearly put on notice of the relevant timeline for submission of a claim for her everyday expenses.

In relation to the "*extension of time*", I accept that this formed a part of the Provider's internal approach to such claims, when received strictly outside of the 6 month timeline. I accept that it was not appropriate for this concessionary approach to be communicated to the Complainant, because the Provider's members had not received this information. Rather, this generous internal approach to claims received later than strictly permitted, was an internal policy applied by the Provider. The Provider has acknowledged that such information, was incorrectly given to the Complainant on **31 August 2020**.

That said, the Provider's internal approach, is not part of the Complainant's contract, and the Provider was not contractually obliged to grant the extension of time or to communicate that to the Complainant.

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Consequently, I accept that the offer made by the Provider in **March 2021** to accept the Complainant's claim for policy benefits for the everyday medical expenses she incurred in 2019, was made in good faith to address this error in its communication. I am satisfied in that regard that by March 2021, the Provider had adequately addressed the issue which had arisen, even before it supplied its formal response to the investigation of this Office. The Complainant however, declined to accept the Provider's offer to accept her claim for expenses, although I note that this had originally been the redress she had sought, when making her complaint to this Office.

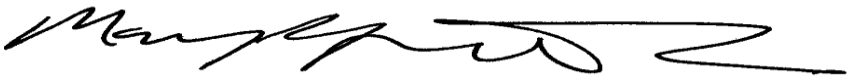
I am mindful that at the time when the Complainant engaged in a webchat with the Provider, this was 4 months after she had been sent the email reminding her of the timeline for the submission of a claim. At this point in time, it was already too late for her to make that claim, even with the Provider's generous internal approach to permitting a certain latitude, in terms of strict time limits. In those circumstances, I note that the incorrect information, made available to the Complainant during the webchat, did not in fact prejudice her in any way, insofar as, by that particular date, there was nothing she could do to bring her claim for 2019 medical expenses, within time.

Having regard to the evidence, I do not accept that the Provider failed to inform the Complainant of the "extension", or unfairly declined her request to submit her claims for medical expenses from **2019**. Whilst the Provider gave confusing information to the Complainant in its communication of **31 August 2020**, I am satisfied that in addressing this complaint, it acknowledged that error at an early stage of the process, and offered the appropriate redress to the Complainant with a view to providing what I believe to have been a fair and reasonable resolution. As a result, I do not consider it 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
Financial Services and Pensions Ombudsman (Acting)

9 February 2022

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Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that—

(a) ensures that—

(i) a complainant shall not be identified by name, address or otherwise,

(ii) a provider shall not be identified by name or address,

and

(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.