# Ombudsman's Digest of Legally Binding Decisions

# Travel Insurance

**Volume 7 | Published February 2022**

**Themed Digest of Decisions featuring legally binding decisions on complaints concerning travel insurance.**

An tOmbudsman Seirbhísí Airgeadais agus Pinsean

Financial Services and Pensions Ombudsman

# Contents

# The Financial Services and Pensions Ombudsman (FSPO)

The FSPO was established in January 2018 by the **Financial Services and Pensions Ombudsman Act 2017**. The role of the FSPO is to resolve complaints from consumers, including small businesses and other organisations, against financial service providers and pension providers.

We provide an independent, fair, impartial, confidential and free service to resolve complaints through either informal mediation, leading to a potential settlement agreed between the parties, or formal investigation and adjudication, leading to a legally binding decision.

When any consumer, whether an individual, a small business or an organisation, is unable to resolve a complaint or dispute with a financial service provider or a pension provider, they can refer their complaint to the FSPO.

We deal with complaints informally at first, by listening to both parties and engaging with them to facilitate a resolution that is acceptable to both parties. Much of this informal engagement takes place by telephone.

Where these early interventions do not resolve the dispute, the FSPO formally investigates the complaint and issues a decision that is legally binding on both parties, subject only to an appeal to the High Court.

The Ombudsman has wide-ranging powers to deal with complaints against financial service providers. This Office can direct a provider to rectify the conduct that is the subject of the complaint. There is no limit to the value of the rectification that can be directed. The Ombudsman can also direct a provider to pay compensation to a complainant of up to €500,000. In addition, the Ombudsman can publish anonymised decisions and can also publish the names of any financial service provider that has had at least three complaints against it upheld, substantially upheld, or partially upheld in a year.

In terms of dealing with complaints against pension providers the Ombudsman's powers are more limited. While the Ombudsman can direct rectification, the legislation governing the FSPO sets out that such rectification shall not exceed any actual loss of benefit under the pension scheme concerned.

Furthermore, the Ombudsman cannot direct a pension provider to pay compensation. This Office can only publish case studies in relation to pension decisions (not the full decision), nor can it publish the names of any pension provider irrespective of the number of complaints it may have had upheld, substantially upheld, or partially upheld against it in a year.

Formal investigation of a complaint by the FSPO is a detailed, fair and impartial process carried out in accordance with fair procedures. For this reason documentary and audio evidence and other material, together with submissions from the parties, is gathered by the FSPO from those involved in the dispute, and exchanged between the parties.

Unless a decision is appealed to the High Court, the financial service provider or pension provider must implement any direction given by the Ombudsman in a legally binding decision. Decisions appealed to the High Court are not published while they are the subject of an appeal.

# Publication of FSPO decisions

## Section 62 of the **Financial Services and Pensions Ombudsman Act 2017** requires the Ombudsman to publish legally binding decisions in relation to complaints concerning financial service providers.

The legislation requires that decisions should be published in a manner that ensures that a complainant is not identified by name, address or otherwise, and a provider is not identified by name or address. Publication must also comply with Data Protection legislation and regulations. Decisions appealed to the High Court are not published while they are the subject of legal proceedings.

When the Ombudsman issues a legally binding decision, that decision may be challenged by way of statutory appeal to the High Court within 35 calendar days from that date. For this reason the FSPO does not publish decisions before the elapse of the 35 day period available to the parties to issue a statutory appeal to the High Court. In addition, decisions which have been appealed to the High Court are not published, pending the outcome of any such court proceedings.

Before any legally binding decision is published by the FSPO, it undertakes a rigorous and stringent review to ensure that the non-identification requirements of the Act are adhered to in order to protect the confidentiality of the parties.

The legislation also provides the FSPO with the power to publish case studies of decisions relating to pension providers, but not the full decision.

This Digest contains short summaries of a selection of 20 decisions. Some details within the summaries referenced in this Digest, such as names and locations, have been altered in order to protect the identity of the complainants. It is important to keep in mind that these are only short summaries , but the full anonymised decisions issued to the parties by the FSPO can be accessed by clicking on the link at the top of each page.

This Digest of Ombudsman's decisions is the seventh volume in a series of digests.

Each of the digests and all published decisions are available at www.fspo.ie.

Information on how to access decisions and search for areas or decisions of specific interest in the decisions database is included on page 9 of this Digest.

In addition to the periodic Digests that feature summaries and case studies of decisions issued, the Ombudsman publishes an Overview of Complaints for the previous year, by the end of quarter one each year, which includes:

- a summary of all complaints made to the FSPO
- a review of trends and patterns in the making of complaints to the FSPO
- a breakdown of the method by which all complaints made to the FSPO were dealt with
- a summary of the outcome of all complaints concluded or terminated during that calendar year

# Message from the Ombudsman

Travel insurance, like other types of insurance, is purchased by consumers in order to provide them with some protection if things go wrong. We all hope we will never be in the position where we need to make a claim on a travel insurance policy, but if things do go wrong, we want to be sure that the policy provides the cover we expected when purchasing the policy. With all financial products, it is so important to understand what you are buying and to be aware that not all insurance policies are the same. Some of the decisions in this Digest highlight that the consumer believed they had cover under their travel insurance policy for certain events or circumstances, only to make a claim that was refused.

This is the seventh Digest of Decisions to be published by this Office since it was established. This is the first Digest published by this Office that focuses exclusively on travel insurance and the issues that have given rise to complaints to the FSPO. The Digest features summaries of legally binding decisions that arose from complaints concerning travel insurance. These decisions were issued over the years 2018 to 2021 and highlight situations that led to a claim being made on a travel insurance policy and complaints arising from those claims.

The purpose of these Digests of Decisions is to ensure that the legally binding decisions of this Office are accessible to the widest possible audience and that the issues leading to complaints to this Office are highlighted to consumers, financial service providers and policy-makers. Publishing these Digests of Decisions, in addition to publishing the full text of legally binding decisions, increases awareness of the role of this Office and promotes a greater understanding of the types of complaints we receive, how we deal with complaints, and how such complaints might have been prevented.

## Pre-existing medical conditions

A number of the decisions in this Digest highlight matters concerning pre-existing medical conditions and their impact on people's ability to successfully make a claim on their policy. Many of the complaints in this Digest concern circumstances where policy holders cancelled their holiday arrangements due to medical issues. With travel insurance policies, it is very important to be aware that cancellations arising from medical conditions that existed before the policy was taken out, may not be covered. For example, one the decisions in this Digest concerns Jack and Jennifer's travel insurance policy. Before their trip, Jennifer experienced persistent back pain. Jennifer was subsequently diagnosed with a spinal cord condition and underwent surgery. Because Jennifer was unfit to travel, Jack and Jennifer cancelled their holiday and claimed cancellation expenses of over €6,000. The insurance company said that Jennifer's medical condition was not covered by the policy because, even though her specific condition had not been diagnosed, Jennifer was aware of unresolved symptoms on the date when the policy was purchased. Under the policy Jack and Jennifer were obliged to disclose details of any medical condition for which they were taking prescribed medication or waiting to receive treatment, within the last 2 years. In addition, under the policy, Jack and Jennifer were not covered for any claims arising directly or indirectly from the medical condition, unless it was agreed in writing that the medical condition would be covered by the policy. The complaint was not upheld, but a previous offer of 50% of the value of the claim had been made by the insurer and was noted to still be available to Jack and Jennifer to accept.

## Medical investigations

While many people may be aware that claims arising from pre-existing medical conditions may not be covered, one of the decisions in this Digest highlights the potential impact of medical investigations that were not disclosed at the time the policy was purchased. Maeve and John booked a holiday and took out a travel insurance policy on 17 March 2015. They were due to travel in April 2015 but had to cancel their trip due to Maeve suffering severe pain when walking. Maeve and John made a claim on their travel insurance policy, but this claim was rejected by the insurer due to the existence of a pre-existing medical condition, namely, osteoarthritis. Maeve and John said that, although Maeve had undergone investigations and x-rays in February 2015 to identify the cause of her pain, she had not been informed at that time that she had osteoarthritis, and in fact she only became aware of this when the claim was rejected by the insurance company. The insurer noted that, in February 2015, Maeve had an x-ray on her hip to establish the cause of the pain and discomfort that she was suffering. It said that although Maeve had not received a diagnosis in March 2015, the policy had been purchased in the knowledge that Maeve had symptoms for which a diagnosis had not been given. The insurance company submitted that it was reasonable to expect on the date of purchase of the policy, that the symptoms could give rise to a claim. The insurer pointed to an exclusion regarding undiagnosed symptoms, which was clearly set out in the policy terms and conditions. The complaint was not upheld.

## Not all medical conditions may be covered

When purchasing travel insurance, it is important to be aware that not all medical conditions will always be covered. For example, Emma and Ross booked a holiday in Italy and were due to travel in September 2016. They purchased a travel insurance policy for this trip in January 2016. Emma visited her doctor in early September complaining of pain. Following this visit, Emma and Ross decided to cancel their trip to Italy. The insurance company rejected Emma and Ross's claim because the policy terms and conditions specifically excluded claims arising directly or indirectly from anxiety. Emma submitted that her condition of anxiety was directly caused by her pain, which began earlier that summer. The insurance company said that Emma and Ross had cancelled their holiday due to medical advice received from Emma's doctor, who had specified "anxiety" as the main condition, on the medical claim form completed. The insurance company further submitted that according to Emma's doctor, Emma had attended her doctor for anxiety in early September, after which the doctor advised her to cancel the upcoming holiday. While Emma could explain her anxiety as being due to her severe back pain, this Office noted that the reason for the cancellation of the holiday was confirmed by her doctor to be her anxiety, which was specifically excluded in the policy.

## Conflicting or confusing policy provisions

In a number of decisions contained in this Digest, it is clear that the clarity of the wording of policy provisions, could be improved. In one of the decisions contained in this Digest, Chapter 4 of the Central Bank of Ireland's Consumer Protection Code 2012 was referenced, as it provides 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". In order to avoid difficulties for policy holders in understanding their policy, and determining whether their circumstances are covered, insurers need to ensure that the terms and conditions of a policy are clear, comprehensible and as easy as possible for insured persons to negotiate. A focus on ensuring this clarity would serve policy holders well and potentially lead to fewer complaints arising from claims not being admitted, or a misunderstanding of the policy cover.

For example, one of the decisions in this Digest concerns Mark and Sandra, who took out a travel insurance policy for their holiday to Spain in January 2018. While in Spain, their rental vehicle was broken into and items were stolen from the boot. They explained that they had locked all of their items in the boot of the car and went for a walk for approximately 3 and a half hours. The travel insurance company declined Mark and Sandra's claim on the basis that their travel insurance policy did not provide cover for the loss, theft of, or damage to valuables left unattended at any time, including those left in a motor vehicle. Mark and Sandra complained to the FSPO, stating that their policy also contained a provision that baggage contained in an unattended vehicle would not be covered, unless in a locked boot. The wording of these exclusion clauses created a confusing situation making it nearly impossible for a policyholder to understand whether or not they would be covered. In the decision, the Ombudsman took the view that the information in the two exclusions in the insurance policy, when read together, was unclear, and was not in line with the requirements of the Consumer Protection Code 2012. The complaint was upheld and the travel insurance company was directed to pay the claim and an additional compensatory payment of €500 to Mark and Sandra.

In another decision, Tara purchased travel insurance in April 2018 and the following month, she went on holiday abroad. During her flight, she placed her personal items in a backpack which she placed in the overhead locker in the cabin. However, on landing, Tara could not find her backpack and reported it stolen. Tara subsequently made a claim to her insurance company. Tara's claim was rejected on the grounds that her personal possessions were not kept on her person and therefore were not covered by the policy and she could not show proof of ownership of the items in question. Tara argued that the insurance company's decision to decline her claim was unfair and unreasonable. She said that the policy only extended cover if an insured personal had their personal possessions on their person, but this was misleading, given that there was no definition of "one's person" in the policy itself, even though this allowed the insurance company to decline claims which should otherwise be valid. The Ombudsman formed the opinion that the clauses in the insurance company's policy were potentially confusing and that if the insurance company had included a clear definition of "*on your person*" in its terms and conditions, it may have been clear to Tara that if she stowed her backpack in the overhead compartment, it may not be considered to be on her person, but it had not done so. The Ombudsman concluded that while there was no obligation to exhaustively set out all of the circumstances where a claim would be declined, a consumer may reasonably expect the most relevant circumstances to be included. The Ombudsman accepted that it was reasonable for the insurance company to ask Tara to supply proof of ownership for items held in her backpack, but given the lack of definition of "*on your person*" in the policy, the Ombudsman concluded that it was unreasonable for the insurer to reject Tara's claim. The Ombudsman partially upheld Tara's complaint and directed the insurance company to pay Tara €600 in compensation.

## Complaints arising from impact of Covid-19 on travel plans

This Digest features two decisions on complaints that arose against the background of the outbreak of COVID-19. While the pandemic has continued to impact every aspect of our lives, these complaints highlight the immediate impact on people who were travelling at the time of the outbreak.

Bethany and Luke boarded a cruise in February 2020, which was scheduled to make a number of stops. However, due to COVID-19 restrictions, the cruise itinerary changed a number of times during the course of the cruise. The captain made a series of announcements about the impact

of COVID-19 restrictions at various places and ultimately, all crew and staff had to remain on board for more than a month, until its final destination, in April 2020.

Bethany and Luke said that their trip was "curtailed', due to COVID-19 restrictions. Bethany and Luke also claimed that they were not allowed to socialise and were essentially in quarantine for 33 days, in addition to the cruise not making the stops scheduled in the itinerary.

Although the captain of the cruise had described the trip as having been "curtailed", the insurance policy clearly set out a limited number of curtailment situations which would be covered. The decision outlined that while it was disappointing that the definitions within Bethany and Luke's policy did not include a definition of "quarantine", there was no evidence to suggest that Bethany and Luke were required to stay in strict isolation within their cabin. While this undoubtedly reduced Bethany and Luke's enjoyment of the trip, the insurance policy offered no cover for what was essentially a loss of enjoyment and the complaint was not upheld.

In another decision, Sebastian had travelled abroad and was due to return home to Ireland on 28 March 2020. Due to the outbreak of COVID-19, the Department of Foreign Affairs released a statement while Sebastian was abroad, advising all Irish citizens to return home. Sebastian cut his trip short and returned to Ireland on 19 March 2020 and he submitted a claim seeking to recover the cost of unused accommodation, and additional travel expenses, as a result of curtailing his trip (a total of more than €1,000). The insurer argued that under the "cutting your trip short'' section of Sebastian's policy, he was insured against specified events but the circumstances leading to his claim did not come within those specified events. Sebastian was not suggesting that his circumstances fell under any of the specified events outlined in the "cutting your trip short'' section of his policy and instead contended that his claim would have been successful if it fell within the "cancellation" provisions of the policy. The Ombudsman's decision noted that if Sebastian's trip had not yet begun, he would have been entitled to make a claim under the cancellation provisions of the policy. However, because he had already departed on his trip, that entitlement ceased. This was unfortunate timing for Sebastian, but the specific circumstances of his claim were not covered by the provisions of his travel insurance policy.

## Importance of definitions in policies

When a complaint is investigated by this Office, the investigation will consider the policy documentation and any definitions relied upon by a policy holder or insurer in their submissions. In one of the decisions in this Digest, the insurer referred to wording that did not reflect the wording in the policy.

In March 2017, Liam missed a flight from Germany to Ireland as his rental car would not start when he went to leave for the airport. He had managed to resolve the issue with the car himself within 20 minutes, but still missed his flight by 5 minutes. The insurance company argued that Liam had failed to allow sufficient time to account for "*possible delays*". The Ombudsman noted that the insurance company's reference to "possible delays" did not reflect the wording of the policy. The policy required an insured person to allow sufficient time for "*delays which are expected*" as opposed to "*possible delays*". The decision noted that there is a significant distinction between the two and although the breakdown of the hire car could be categorised as a possible delay, there was no evidence to support the proposition that it was a delay that should have been expected. Therefore, the Ombudsman was satisfied that this exclusion, based on the precise wording of the policy, should not have been applied. The Ombudsman also addressed the insurance company's reference to the period of time generally recommended by airlines to passengers, to allow for check-in and security.

He noted that although it may very well be a sensible matter to include in a travel insurance policy, the policy in this instance, did not stipulate any specific time period which insured individuals should allow. The complaint was upheld and the insurer was directed to pay the claim.

Another decision concerned a flight that was cancelled due to an air traffic control strike in France. Seamus booked an alternative flight home from France to Ireland for the following day. Seamus' claim was rejected by the insurance company on the basis that he had prior knowledge of the possible disruption of his travel plans, due to air traffic control disputes in France. Seamus disputed this, stating that he had no such knowledge and neither did the airline in question, which had a fully booked flight from France to Ireland on the date of the original flight. The insurance company made reference to a number of media websites which had announcements about scheduled air travel disruptions affecting flights from France on the date in question, in advance of the dates Seamus booked his trip and purchased his travel insurance. Seamus submitted that he was not informed of these notifications until after he had submitted his claim to the insurance company. The Ombudsman noted that the insurance company's submissions made reference to strike action being "*announced*" rather than "*forecast*", as provided for in the policy. The Ombudsman observed that neither word, "*announced*" or "*forecast*", appeared to be defined in the policy and questioned what the insurance company relies on to establish if a strike has been "forecast". The Ombudsman concluded that even if Seamus had given careful consideration to the content of all of these articles, he would have had difficulty knowing whether or not his particular flight would be cancelled on the date in question. The Ombudsman noted that, in circumstances where the insurance company did not define what it meant by "forecast" and had then gone on to use the word "announced" in its place, it was unreasonable to decline the claim in question.

The Ombudsman upheld the complaint and directed that the insurance company pay the claim, of just over €600.

## Acknowledgements

Many of the decisions in this Digest highlight the very difficult circumstances leading to the complaints made to this Office. Matters concerning illness, cancellation of much-anticipated holiday plans and thefts while abroad are difficult events for the people concerned. I want to thank all our customers, both complainants and providers, for their cooperation with our various processes, as we seek to resolve the complaints we receive.

I wish to extend my thanks and acknowledge the support of the Chairperson, Maeve Dineen, and the members of the Financial Services and Pensions Ombudsman Council.

Finally, and in particular, I want to thank and pay tribute to the previous holder of this Office, Mr. Ger Deering, who departed this organisation in February 2022, after seven years leading this Office. Many of the decisions referenced in this Digest were made by Mr Deering, during his tenure.

I also want to thank the FSPO Senior Management Team and all our staff for their ongoing commitment to delivering for our customers.

**MaryRose McGovern**

**Financial Services and Pensions Ombudsman (Acting)**

*February 2022*

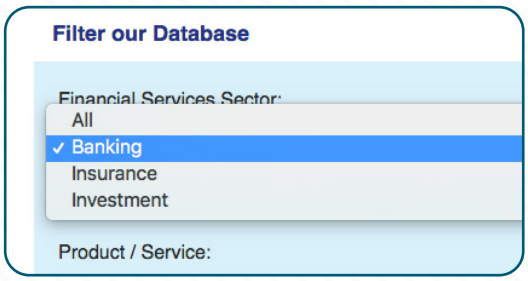
# How to search our decisions on **www.fspo.ie**

## Accessing our database of decisions

Our database of legally binding decisions is available online at www.fspo.ie/decisions.
To refine your search, you can apply one or a number of filters.

### 1 Applying **filters** to narrow your search

To filter our database of decisions, you can firstly select the relevant sector:

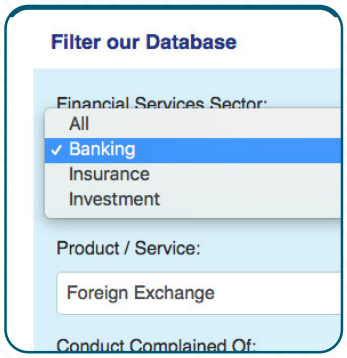



### 2

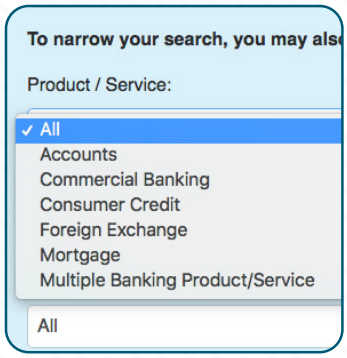
Having filtered by sector, the search tool will then help you to filter our **decisions** further by categories relevant to that sector such as:

- product / service
- conduct complained of

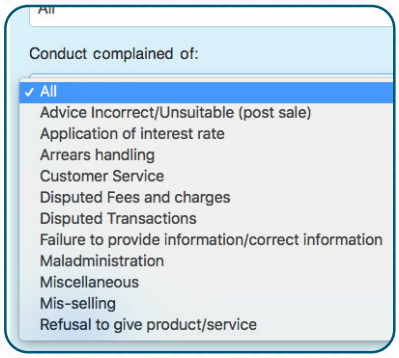
✓ **Sector**




✓ **Product / Service**

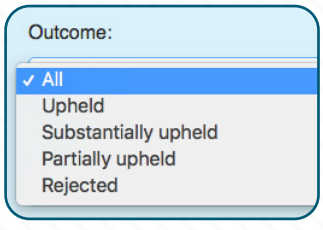



✓ **Conduct complained of**




### 3

**You can also filter our database of decisions by year, and by the outcome of the complaint, i.e. whether the Ombudsman Upheld, Substantially Upheld, Partially Upheld or Rejected the complaint.**




Once you have found the decision you are looking for, click **View Document** to download the full text in PDF.

# Travel Insurance

**Decision Reference: 2018-0033**

Read the full decision

## Medical investigation not disclosed when purchasing insurance

Maeve and John booked a holiday and took out a travel insurance policy on 17 March 2015. Maeve and John were due to travel in April 2015 but had to cancel their trip due to Maeve suffering severe pain when walking. Maeve and John made a claim on their travel insurance policy, but this claim was rejected by the insurance company due to the existence of a pre-existing medical condition, namely, osteoarthritis.

Maeve and John were dissatisfied with this and made a complaint to the Ombudsman. They complained that the insurance company had incorrectly or unreasonably declined their claim under the policy. They said that, although Maeve had undergone investigations and x-rays in February 2015 to identify the cause of her pain, she had not been informed at that time that she had osteoarthritis, and that in fact she only became aware of this when the claim was rejected by the insurance company. Maeve said that she purchased the policy in good faith and sought reimbursement of the cost of their cancelled holiday, less the policy excess.

The insurance company noted that, in February 2015, Maeve had an x-ray on her hip to establish the cause of the pain and discomfort that she was suffering. It said that although Maeve had not received a diagnosis in March 2015, the policy had been purchased in the knowledge that Maeve had symptoms for which a diagnosis had not been given. The insurance company submitted that it was reasonable to expect on the date of purchase of the policy, that the symptoms could give rise to a claim. The insurance company pointed to an exclusion regarding undiagnosed symptoms, which was clearly set out in the policy terms and conditions.

The Ombudsman concluded that although Maeve and John said that they were unaware of the existence of osteoarthritis at the time of taking out the policy, Maeve's investigations the month before the policy was bought, should have been disclosed to the insurance company, at the time of purchasing cover.

The Ombudsman noted that Maeve, John and the insurance company were bound by the terms and conditions of the policy. The Ombudsman was satisfied that the policy document clearly set out that the insurance policy would not cover undiagnosed symptoms and that the investigations carried out on Maeve subsequently showed that she had osteoarthritis.

The Ombudsman concluded that the insurance company was entitled to decline the claim and therefore, the complaint was not upheld.

# Travel Insurance

**Decision Reference: 2019-0064**

Read the full decision

## Theft of property from boot of a locked vehicle – conflicting policy provisions

Mark and Sandra took out a travel insurance policy for their holiday to Spain in January 2018. While in Spain, their rental vehicle was broken into and items were stolen from the boot. Mark and Sandra notified the travel insurance company of this loss by telephone and then submitted a claim form detailing the circumstances, which explained that they had locked all of their items in the boot of the car and went for a walk for approximately 3.5 hours. When they returned, the back window had been forced down and everything in the boot of the car had been stolen.

The travel insurance company declined Mark and Sandra's claim on the basis that their travel insurance policy did not provide cover for the loss, theft of, or damage to valuables left unattended at any time, including those left in a motor vehicle.

Mark and Sandra complained to the Ombudsman, stating that their policy also contained the following section:

> *"What is not covered: baggage contained in unattended motor vehicle between 9am and 9pm unless it is in the locked boot which is separate from the passenger compartment for those vehicles with a boot and for those vehicles without a separate boot, locked in a vehicle and covered from view".*

Having reviewed the matter, the travel insurance company concluded that the applicable section of the policy provided that loss, theft or damage to baggage left unattended (including in a vehicle) was not covered.

The Ombudsman considered the policy documents and noted that the definition of *"Baggage"* included valuables. He further noted the definition of *"Valuables"* included the items stolen from Mark and Sandra's car. The Ombudsman considered the definition of *"Unattended"* in the policy which is described as meaning *"when you cannot see or are not close enough to your Baggage, Personal Money, property or vehicle to stop it being damaged or stolen".*

The Ombudsman was satisfied that it was reasonable for the insurance company to conclude that Mark and Sandra's vehicle was left *"unattended"* for over 3 hours. The Ombudsman considered the exclusion relied upon by the insurer when declining the couple's claim but noted that the exclusion relied upon by Mark and Sandra (which was directly after the one relied upon by the insurance company in the policy document) did provide cover for baggage left in an unattended motor vehicle between 9am and 9pm, when in a locked boot, separate from the passenger compartment, for those vehicles with a boot.

Having considered these two exclusion clauses together, the Ombudsman was of the view that the wording of these exclusion clauses created a confusing situation making it nearly impossible for a policyholder to understand whether or not they will be covered.

The Ombudsman referred to Chapter 4 of the Central Bank of Ireland's Consumer Protection Code 2012 which provides 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".*

The Ombudsman took the view that the information in the two exclusions in the insurance policy, when read together, was unclear, and was not in line with the requirements of the Consumer Protection Code 2012.

Accordingly, the Ombudsman upheld the complaint and directed the travel insurance company to admit the couple's claim, applying the applicable cover limits, and to also make an additional compensatory payment to Mark and Sandra in the sum of €500 within a specified period.

# Travel Insurance

**Decision Reference:**
**2021-0405**

Read the full decision

## Cruise impacted by COVID-19 restrictions

Bethany and Luke purchased a travel insurance policy which commenced in October 2018. This policy was used to cover a 77-day trip that commenced in January 2020.

As part of their trip, Bethany and Luke boarded a cruise in February 2020, which was scheduled to make a number of stops. However, due to COVID-19 restrictions, the cruise itinerary changed a number of times during the course of the cruise.

On 14 March 2020, the captain announced that decisions made by national authorities had significantly affected the planned itinerary. As a result, alternative plans for the cruise were put in place. The captain gave passengers the option to stay on board or to disembark the cruise at a particular location, and that the cruise company would cover the cost of the repatriation flights if passengers chose to disembark.

A few days later, the captain made a further announcement, informing all passengers that new COVID-19 restrictions had been announced, which meant that the trip had been curtailed and no passenger or crew could disembark at the suggested location. Consequently, all crew and staff had to remain on board the cruise until its final destination, in April 2020.

Bethany and Luke submitted a claim to the insurance company for reimbursement relating to the 33 days during which they said they were quarantined on board. They said that their trip was 'curtailed', due to COVID-19 restrictions. Bethany and Luke claimed that the cruise was curtailed for 33 days, given that the cruise did not make the stops scheduled in the cruise itinerary. Bethany and Luke also claimed that they were not allowed to socialise and were essentially in quarantine for 33 days due to COVID-19 measures that the cruise company had to implement.

The insurer was of the view that Bethany and Luke's claim fell outside the policy's terms and conditions, and it declined Bethany and Luke's claim. Bethany and Luke subsequently made a complaint to the FSPO.

The Ombudsman was of the view that it was reasonable for the insurance company to determine that Bethany and Luke's claim fell outside the scope of the insurance policy. The Ombudsman noted that the captain of the cruise had described the trip as having been *"curtailed"*, but referred to the definition of "*curtailment*" contained in the insurance policy and noted that the insurance policy clearly sets out a limited number of reasons for curtailment which would be covered by the insurance policy.

The Ombudsman noted that while it was disappointing that the definitions within Bethany and Luke's policy did not include a definition of "*quarantine*", the Ombudsman was satisfied that in this instance there was no evidence to suggest that Bethany and Luke were required to stay in strict isolation within their cabin, in order to prevent the spread of COVID-19. Rather, it appeared that Bethany and Luke were confined to the cruise ship and were unable to disembark, owing to the unwillingness of the intended disembarkation ports to accept passengers from the cruise. The Ombudsman noted that while this undoubtedly reduced Bethany and Luke's enjoyment of the trip, the insurance policy offered no cover for such loss of enjoyment.

The Ombudsman did not uphold the complaint.

# Travel Insurance

**Decision Reference: 2021-0115**

Read the full decision

## Trip cut short due to COVID-19 outbreak

Sebastian purchased a travel insurance policy on 17 February 2020, with cover for one year beginning on 28 February. He travelled abroad and was due to return home to Ireland on 28 March 2020. Due to the outbreak of COVID-19, the Department of Foreign Affairs released a statement advising all Irish citizens to return home. As a result, Sebastian cut his trip short and returned to Ireland on 19 March 2020.

When Sebastian returned to Ireland, he submitted a claim seeking to recover the cost of unused accommodation, and additional travel expenses, as a result of curtailing his trip (a total of more than €1,000). The insurance company declined to accept Sebastian's claim and as a result, he made a complaint to the FSPO.

The Ombudsman considered the submissions from Sebastian and from the insurance company. The insurer argued that under the "*cutting your trip short*" section of Sebastian's policy, he was insured against specified events but the circumstances leading to his claim did not come within those specified events.

The Ombudsman acknowledged that Sebastian was not suggesting that his circumstances fell under any of the specified events outlined in the "*cutting your trip short*" section of his policy. Rather, he contended that his claim would have been successful if it fell within the "cancellation" provisions of the policy. In considering the cancellation provisions of the policy the Ombudsman noted that it provided that cover would be available if the cancellation of the trip was necessary and unavoidable.

The Ombudsman also referred to the Department of Foreign Affairs' statement which asked Irish people to "*avoid non-essential travel*" to Sebastian's trip destination, after he had already arrived in the country.

In considering the various provisions of the insurance policy and in particular, the definition of "*Period of Cover*", the Ombudsman was satisfied that Sebastian had cut his trip short and had not "cancelled" the trip.

The Ombudsman noted that if Sebastian's trip had not yet begun, he would have been entitled to make a claim under the cancellation provisions of the policy. However, because he had already departed on his trip, that entitlement ceased.

The Ombudsman acknowledged that the timing for Sebastian was unfortunate when he had very wisely elected to follow Government advice. The Ombudsman accepted however that the insurance company was entitled to decline cover for his claim, because the specific circumstances of his claim were not covered by the provisions of his travel insurance policy.

The Ombudsman did not uphold the complaint.

# Travel Insurance

**Decision Reference: 2019-0099**

Read the full decision

## Poor customer service after injury abroad

Susan held a travel insurance policy. While on holiday abroad with her family in 2017, Susan sustained an injury which required medical attention. Susan was advised to attend a hospital and as a result, her husband contacted her insurance company to clarify what hospital she was insured to attend. Susan was subsequently diagnosed with having a fractured coccyx, as well as tissue damage.

Susan complained to the Ombudsman that her insurance company displayed very poor customer service as it:

- failed to communicate with her (by not answering phone calls or responding to emails);
- failed to provide comprehensive or consistent customer service;
- failed to put in place procedures to deal with her after her injuries were sustained;
- failed to communicate those procedures;
- acted negligently causing her stress and uncertainty;
- failed to carry out a full investigation into her complaints;
- failed to communicate the outcome of any such investigation;
- issued a letter of response which Susan argued did not reflect what happened and
- failed to provide the service that it had claimed to provide.

Susan sought financial compensation for the losses incurred, including for the inconvenience and unnecessary stress suffered. This amounted to a total sum of €4,000.

The insurance company acknowledged that its performance should have been better, that its communication had been confusing and that it could have responded much sooner than it did. Various settlement offers were made by the insurer. However, in August 2018, the insurer made an increased offer of €3,475 (of which €475 had already been paid as a gesture of goodwill, given Susan's poor experience). The insurer said that this offer covered the cost of Susan's flights and the additional cost of accommodation to which it might have been exposed, had Susan stayed abroad until she was deemed medically fit to travel, as well as an additional sum as a further gesture of goodwill.

The Ombudsman concluded that the insurance company's compensation offer, including the sum offered as a gesture of goodwill, did not adequately reflect the consequences of its failings in the service provided to Susan, during a period when she found herself abroad with a significant injury, and ultimately found herself having to make the decision to fly home in very unsuitable conditions, because of the lack of response from the insurer. The Ombudsman was satisfied that the conflicting and incorrect information provided by the insurer caused significant anxiety and very considerable inconvenience to Susan.

The Ombudsman also concluded that there was a failure to address Susan's concerns and queries which were clearly expressed on multiple occasions and through multiple platforms. The Ombudsman was satisfied that the insurance company had excessively delayed in seeking a copy of Susan's medical reports, including her MRI results, in coming to a determination as regards her fitness to fly and in communicating with her in this regard. The Ombudsman concluded that this all amounted to significant maladministration, poor communication and poor customer service.

The Ombudsman upheld the complaint and directed the insurance company to make a compensatory payment of €5,000 to Susan, separate and distinct from any goodwill payment already paid by the insurer in relation to out of pocket expenses and the cost of cancelled tours.

# Travel Insurance

**Decision Reference: 2018-0081**

Read the full decision

## Policy holder missed original flight by 5 minutes due to rental car not starting

Liam held a travel insurance policy. In March 2017, Liam missed a flight from Germany to Ireland as his rental car would not start when he went to leave for the airport. Liam had to purchase a replacement flight and made a claim for the price of the new flight under his travel insurance policy. Liam was dissatisfied when the insurance company declined his claim, and he made a complaint to the FSPO.

The insurance company submitted that its claims department received a call from Liam in July 2017, regarding his missed flight in March 2017. It stated that Liam had informed it that he had missed the flight due to his rental car not starting and although he was able to resolve the issue himself in 20 minutes, he did not have sufficient time to clear security and make it to the gate before the flight closed and departed. Liam only missed his flight by 5 minutes.

The insurance company argued that, as Liam had missed his flight as a result of a delay of 20 minutes only, it was entitled to form the view that he did not allow sufficient time for any delays that might arise, when travelling to the airport.

The insurance company relied on the section titled "*Missed Departure - Section 7*" of the policy in support of its decision to decline Liam's claim. This section provided cover for the costs of extra accommodation and transport that an insured had to pay, as a result of either the transport not running to its timetable or where the vehicle an insured is travelling in has an accident or breaks down. The section explicitly excluded cover for (i) delay as a result of breakdowns, unless the insured person gets "*confirmation of the delay from the authority who went to the accident or breakdown (if this applies) affecting the vehicle*" in which they were travelling or (ii) where an insured person did not allow time in their travel plans for delays which are expected.

The insurance company also queried why the matter had not been reported to the car rental company and noted that Liam had no proof to support that there was a fault with the vehicle.

The Ombudsman noted that the insurance company had not disputed Liam's assertions when first dealing with his claim, that he (1) rectified the problem with the car himself; (2) it took 20 minutes for him to do so; (3) the time at which he arrived at the airport; or (4) that Liam missed his flight by 5 minutes only.

The Ombudsman further addressed the interpretation of relevant wording contained in the policy. The insurance company argued that Liam had failed to allow sufficient time to account for "*possible delays*". The Ombudsman noted that the insurance company's reference to "possible delays" did not reflect the wording of the policy. The policy requires an insured person to allow sufficient time for "*delays which are expected*" as opposed to "*possible delays*". The Ombudsman took the view that there is a significant distinction between the two and was satisfied that, whereas the breakdown of the hire car could be categorised as a possible delay, there is no evidence to support the proposition that it was a delay that should have been expected. Therefore, the Ombudsman was satisfied that this exclusion, based on the precise wording of the policy, should not have been applied.

The Ombudsman also addressed the insurance company's reference to the period of time generally recommended by airlines to passengers, to allow for check-in and security. The Ombudsman noted that although it may very well be a sensible matter to include in a travel insurance policy, the policy in this instance, did not stipulate any specific time period which insured individuals should allow.

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# Travel Insurance

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Finally, the Ombudsman looked at the insurance company's argument that it was entitled to decline Liam's claim due to his failure to satisfy the following requirement:

> "*[To] get confirmation of the delay from the authority who went to the accident or breakdown (if this applies) affecting the vehicle you were travelling in*"

The insurance company argued that the qualifying words "(*if this applies*)" refer to the reason for the delay "*and not to whether a third party attended the vehicle*". In essence, the insurance company was of the view that the words in question operate simply as an indicator that one of the two grounds of cover will require verification, depending on which is applicable.

The Ombudsman did not agree with the insurance company's interpretation of these words and was satisfied that the plain meaning of the exclusion is that vouching documents from an authority would be required only if an authority went to the breakdown.

The Ombudsman concluded that it was clear that, had Liam not been delayed by 20 minutes, he would not have missed his flight, which he ultimately only missed by 5 minutes. In light of this, the Ombudsman was satisfied that Liam's claim was covered.

The Ombudsman concluded that the insurance company had not established valid grounds for declining Liam's claim. The Ombudsman upheld Liam's complaint and directed the insurance company to admit the claim for assessment in the usual way.

# Travel Insurance

**Decision Reference: 2018-0155**

Read the full decision

## Flight cancelled due to air traffic control strike

Seamus took out a travel insurance policy for a trip from Ireland to France. His return flight from France to Ireland in June 2016 was cancelled as a result of an air traffic control strike in France on that date. Seamus booked an alternative flight home from France to Ireland for the following day. He submitted a claim under his travel insurance policy for the cost of this alternative flight home.

Seamus' claim was rejected by the insurance company on the basis that he had prior knowledge of the possible disruption of his travel plans, due to air traffic control disputes in France. Seamus disputed this, stating that he had no such knowledge and neither did the airline in question, which had a fully booked flight from France to Ireland on the date of the original flight.

Seamus was dissatisfied with the rejection by the insurance company and complained to the FSPO.

Seamus noted that the insurance company made reference to a number of media websites which had announcements about scheduled air travel disruptions affecting flights from France on the date in question, in advance of the dates Seamus booked his trip and purchased his travel insurance. Seamus submitted that he was not informed of these notifications until after he had submitted his claim to the insurance company. Seamus further submitted that it is unreasonable of the insurance company to assume he had prior notice of possible disruption to his flights.

The insurance company submitted that Seamus' travel insurance policy contained an exclusion of cover for any claim for additional travel expenses incurred in returning home, arising from one of the contingencies listed in the policy booklet (including "strike" and "industrial action"), if the contingency in question had already started or been forecast before the trip was booked or the insurance was purchased, whichever was the later.

The insurance company argued that the expected strike action received extensive coverage in the media across Europe at the time and it referred to a number of media sources. The insurance company expressed regret if Seamus was not aware of the scheduled strikes prior to booking his flights or purchasing his policy, but stated that the exclusion applied regardless of Seamus' knowledge.

The Ombudsman noted that the insurance company's submissions made reference to strike action being "*announced*" rather than "*forecast*", as provided for in the policy. The Ombudsman observed that neither word, "*announced*" or "*forecast*", appeared to be defined in the policy and questioned what the insurance company relies on to establish if a strike has been "forecast". Given the potential for this claim to deny a policyholder the right to make a successful claim in certain circumstances, the Ombudsman was of the view that greater clarity is required in relation to what constitutes whether a strike is "*forecast*".

The Ombudsman considered the insurance company's submissions regarding media coverage in May and early June 2016 of air traffic control strikes that were scheduled to take place in France on a number of dates in May and June 2016.

The Ombudsman concluded that even if Seamus had given careful consideration to the content of all of these articles, he would have had difficulty knowing whether or not his particular flight would be cancelled on the date in question.

The Ombudsman accepted Seamus' submission that he was unaware of the strike action. He noted that the insurance company stated that the exclusion applies, irrespective of Seamus' knowledge.

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# Travel Insurance

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The Ombudsman further noted that the exclusion that the insurance company relied on in declining Seamus' claim made no reference to any requirement of knowledge on the part of the insured, but simply required that the contingency "*had already started or been forecast*" before the trip was booked or the insurance policy was purchased, whichever was the later. In circumstances where "*forecast*" was not defined as it relates to strike action, the Ombudsman considered this to be an unreasonable requirement.

The Ombudsman noted that, in circumstances where the insurance company did not define what it meant by "forecast" and had then gone on to use the word "announced" in its place, it was unreasonable to decline the claim in question.

The Ombudsman referred specifically to Section 60 (2) (c) of the Financial Services and Pensions Ombudsman Act 2017 which permits a complaint to be upheld even though the conduct complained of was in accordance with a law, established practice or regulatory standard, if that law, practice or standard is unreasonable, unjust, oppressive or improperly discriminatory in its application to the person who made the complaint.

The Ombudsman held that the conduct of the insurance company in declining this claim was unreasonable. Accordingly, the Ombudsman upheld the complaint and directed the insurance company to admit the claim in the sum of €606.80.

# Travel Insurance

**Decision Reference: 2018-0174**

Read the full decision

## Policy did not provide cover for claims arising from anxiety

Emma and Ross booked a holiday in Italy and were due to travel in September 2016. They purchased a travel insurance policy for this trip in January 2016. Emma visited her doctor in early September complaining of pain. Following this visit, Emma and Ross decided to cancel their trip to Italy. The next day Emma and Ross submitted a claim with the insurance company seeking a refund of their holiday costs.

Based on the information provided by Emma's doctor, the insurance company rejected the claim as the policy terms and conditions specifically excluded claims arising directly or indirectly from anxiety. Emma and Ross were dissatisfied with this as they claim the cancellation was due to pain Emma was suffering and made a complaint to the FSPO.

Emma submitted that her condition of anxiety was directly caused by her pain, which began earlier that summer. She was advised in August that she had arthritis. She further submitted that, after little improvement, she attended her doctor in early September 2016, feeling concerned about her condition and the forthcoming holiday. She also submitted that she had been absent from work since early September 2016. Emma and Ross complained that the insurance company wrongly or unfairly declined their travel insurance claim.

The insurance company said that Emma and Ross had cancelled their holiday due to medical advice received from Emma's doctor, who had specified "anxiety" as the main condition, on the medical claim form completed. The insurance company further submitted that according to Emma's doctor, Emma had attended her doctor for anxiety in early September, after which the doctor advised her to cancel the upcoming holiday.

The insurance company relied on a general exclusion contained in the policy which provided that the insurance company would not pay for claims arising directly or indirectly from stress, anxiety, depression or any other medical or nervous disorder.

The Ombudsman was satisfied that based on the medical evidence it had received, it was reasonable for the insurance company to conclude that the reason for the cancellation of the holiday was due to Emma's diagnosis of anxiety.

While Emma could explain her anxiety as being due to her severe back pain, the Ombudsman concluded that the reason for the cancellation of the holiday was confirmed by her doctor to be her anxiety. The Ombudsman noted that the policy specifically excluded claims arising from anxiety.

The Ombudsman did not uphold the complaint.

# Travel Insurance

**Decision Reference: 2018-0213**

Read the full decision

## Travel insurer sought contribution to cost of claim from policy holders' home insurer

Louise and Thomas purchased an annual multi-trip travel insurance policy in March 2016. While the couple were in Spain in September 2016, their car was broken into. A number of items were stolen out of the car and as a result, Louise and Thomas made a claim under their travel insurance policy.

Initially, the travel insurance company declined to cover any of the claim on the basis that there was no sign of a forced entry to the car. Louise and Thomas appealed this decision and ultimately it was agreed to settle the claim with the travel insurance company.

Louise and Thomas received a letter from their home insurance company some weeks after they had settled the claim with the travel insurance company. The letter explained that it had received a claim form arising out of Louise and Thomas' claim under their travel insurance policy and it transpired that the home insurance company had paid the travel insurance company for certain items that the travel insurance company had declined to pay Louise and Thomas when settling the claim.

Louise and Thomas complained to the FSPO that the travel insurance company failed to handle their claim appropriately.

The travel insurance company rejected any wrongdoing and stated that it was entitled under the terms and conditions of the policy to approach Louise and Thomas' home insurance company to seek a contribution for the claim.

The Ombudsman reviewed a copy of the relevant terms and conditions of the policy and in particular the part titled "*General Conditions Applying to All Sections*" which provided that the company was entitled to take over the policyholder's rights in the defence or settlement of a non-medical claim, or to take proceedings in their name for their own benefit, against another party and the company would have full discretion in such matters. The section went on to explain that this was to enable the company "*to recover any costs they have incurred from any third party who may have liability for the costs.*"

The Ombudsman considered correspondence between Louise and Thomas and the home insurance company, where the home insurance company explained that there was dual insurance in place under both the travel insurance policy and the home insurance policy, which meant that there was a legal obligation on both insurance companies to pay the claim. It explained that the travel insurance company paid Louise and Thomas the amount that was ultimately settled and then sent a request to the home insurance company to contribute towards this.

The home insurance company stated that Louise and Thomas had the benefit of more cover, under their home insurance policy. It accepted that it had miscalculated the amount due to the travel insurance company and stated that the error was on its part and not the part of the travel insurance company. It invited the couple to proceed with a claim under their home insurance policy, however, Louise and Thomas declined to do so. The home insurance company also confirmed that the travel contribution claim had no effect on their home insurance policy or their no claims discount, going forward.

The Ombudsman was not satisfied that it was made clear to Louise and Thomas that the travel insurance company would seek to recoup the cost of any claim from the couple's home insurance policy. The Ombudsman made clear that the company's entitlement to take over the rights of the insured in the defence or settlement of a claim was not in question.

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# Travel Insurance

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However, in the Ombudsman's view, it was quite a stretch to extend this entitlement to making a claim on the couple's home insurance policy, without either clearly outlining this in detail in the policy conditions or notifying the couple of its intention to make the claim.

The Ombudsman noted that while Louise and Thomas' home insurance policy was not affected, there was no guarantee that the couple would not be prejudiced in the future if they decided to change their home insurance provider, as they would be required to inform any potential insurer that there had been a claim or event on their home insurance.

Because of the unclear wording in the policy terms and conditions and the travel insurance company's failure to inform Louise and Thomas that it would seek to recover part of the claim from their home insurance policy, the Ombudsman upheld the complaint. The Ombudsman directed that the sum of €1,000 be paid to the couple in compensation for the inconvenience caused to them.

The Ombudsman also confirmed that the decision would be drawn to the attention of the Central Bank of Ireland so that it may consider if any action was merited, in relation to information provided to policyholders regarding the "*Travel Contribution Formula*".

# Travel Insurance

**Decision Reference: 2019-0281**

Read the full decision

## Illness prevented couple from embarking on cruise

Damien and Astrid held travel insurance and in October 2017, they travelled to the US and were due to depart from there, on a cruise. However, prior to embarking on the cruise, Damien became unwell and, based on the advice of a retired nurse in the US, the couple immediately returned to Ireland where Damien attended his GP. The GP in turn advised Damien not to go on the cruise. As a result, Damien and Astrid cancelled their cruise and made a claim under their insurance policy for compensation for the price of the cruise, namely €6,204. The insurance company declined the claim on the basis that Damien had failed to comply with the terms and conditions of his insurance policy. Damien and Astrid made a complaint to the FSPO.

The couple submitted that they were entitled to a refund of the basic cost of their holiday. Damien argued that it appeared he was refused his claim because he did not inform the insurer of his intended claim until after he had returned to Ireland and consulted his GP. Damien argued that, given the medical advice he received from a retired nurse in the US, he had made the right medical decision in returning to Ireland rather than seeking medical care in the US.

Damien stated that the final response letter received from his insurer suggested that he was symptom free for 5 days prior to the departure of the cruise. However, Damien argued that this was not the case and that he was symptom free for 4 days prior to departure. He noted that the insurance company offered the couple the sum of €500 in its final response letter by way of settlement, which the couple did not accept.

The insurance company submitted that the couple did not comply with the terms of their insurance policy, which require customers to contact the insurer in relation to medical issues before travelling home or cancelling trips. The insurer further argued that based on the information it received, it was difficult to determine whether the couple had acted reasonably, as there was no evidence to demonstrate that the couple had mitigated their loss by travelling home to seek medical attention in Ireland. The insurer also relied on the fact that Damien was symptom free for a number of days prior to the cruise departing. The insurer pointed out that a disinclination to travel was not covered by the policy. Any subsequent treatment required by Damien for his symptoms was deemed by the insurance company to be irrelevant to the appeals process.

The Ombudsman considered the insurer's argument that Damien and Astrid ought to have contacted the emergency medical numbers for the US, provided in its policy documents before travelling home. The Ombudsman took the view that it was not reasonable for the insurer to seek to rely on this aspect of the policy to refuse the claim, as these numbers were set out more for information purposes, than as a contractual requirement. Given the supporting medical documentation provided by Damien, the Ombudsman concluded that there was sufficient evidence to indicate that it was reasonable for Damien to cancel or curtail the trip.

The Ombudsman considered the requirement in the policy that an insured person, at all times, should act as if they were not insured. The Ombudsman was of the view that the couple had complied with this requirement, given that the couple could not be sure of the medical costs they would have incurred in the US, the Ombudsman accepted that they had sought to reduce that risk.

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# Travel Insurance

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The Ombudsman noted that Damien's GP had stated that Damien's condition was more nuanced and complex than just being free of symptoms, by the date of departure of the cruise and the Ombudsman was of the view that the insurer had not adequately appreciated this point when assessing Damien's claim. Accordingly, the Ombudsman was satisfied that on the basis of the medical evidence, it was necessary for Damien and Astrid to cancel their cruise and that Damien had submitted sufficient documentation to the insurer to support his claim. Accordingly, the Ombudsman concluded that it was not reasonable for the insurer to decline Damien's claim.

However, the Ombudsman did not agree with Damien's complaint that the insurer had handled his complaint in an unreasonable or inappropriate manner and this part of the complaint was not upheld.

The Ombudsman substantially upheld the complaint and directed the insurer to pay the sum of €6,500 by way of compensation to the couple.

# Travel Insurance

**Decision Reference: 2019-0299**

Read the full decision

## Loss of baggage and ski equipment by airline

Aideen bought travel insurance in January 2016 and her policy included winter sports cover. In March 2016, Aideen went on a skiing holiday and her suitcase and its contents were lost by the airline. Her suitcase was never located and she was left without any clothes or skiing equipment, and as a result, she purchased replacement items at her own expense. In mid-April 2016, Aideen made a claim under her policy to the insurance company. Aideen felt that her insurer failed to assess her insurance claim fully, correctly and transparently and made a complaint to the FSPO.

Aideen submitted that the handling of her claim was frustrating and the compensation offer was unacceptable. In this regard, the insurance company advised Aideen in early June 2016, that her claim would be settled for €1,085.83. However, the settlement sums were changed on a number of occasions thereafter, to both higher and lesser amounts. Aideen argued that the insurance company dealt with her claim in an inconsistent manner and ignored her requests. She argued that this was unprofessional and confusing. Aideen felt that her insurer should compensate her for lost luggage and the cost of the replacement items that she purchased, which amounted to €2,684.71.

The insurance company indicated that Aideen was originally offered €200 for the baggage delay and that once evidence was furnished to confirm that her bag was irretrievably lost, it would then assess and pay the baggage claim, less the €200 paid for delayed baggage. The insurer indicated that various settlement offers were made. However, it also stated that Aideen's unwillingness to communicate via telephone led to delays, which led to issues not being dealt with as soon as they could have been. The insurer submitted that Aideen had refused to accept the claim settlement offer made in late October 2016, as she was dissatisfied with its decision to apply depreciation for age, wear and tear and the lack of receipts and not to provide cover for items not covered by the policy. The insurance company submitted that it adhered to the terms of Aideen's policy and provided a high level of service. It therefore argued that the settlement sum of €1,021.70 was final and correct, as well as fair and reasonable.

The Ombudsman took the view that the emails sent by the insurance company were unclear and inconsistent and that the administrative errors and customer service were unsatisfactory. The Ombudsman noted that the final claim settlement offer of €1,021.70 differed from a previous offer made by the insurer in mid-October 2016. With regard to the offer of €200, the Ombudsman highlighted that although this sum was referred to in various communications, it had never actually been paid to Aideen, and it was unclear why it was repeatedly referenced in correspondence on that basis. The Ombudsman also noted that it was unclear why the settlement offer changed on a number of occasions, or how the various settlement offers had been calculated. The Ombudsman was of the opinion that contrary to the insurance company's submissions, Aideen was very cooperative and that the information which she provided was of a high standard, while the service provided by the insurance company to her had certainly not been.

Having regard to the policy limits which applied to claims for lost baggage, the Ombudsman upheld the complaint and directed the insurer to honour the settlement figure which it offered in early November 2016 (i.e., €1,331.70) and to also make a compensatory payment of €750 to Aideen.

# Travel Insurance

**Decision Reference:**
**2020-0109**

Read the full decision

## Backpack stolen from overhead locker not kept "on policyholder's person"

Tara purchased travel insurance in April 2018 and the following month, she went on holiday abroad. During her flight, she placed her personal items in a backpack which she placed in the overhead locker in the cabin. However, on landing, Tara could not find her backpack and reported it stolen. Tara subsequently made a claim to her insurance company. Tara's claim was rejected on the grounds that (i) her personal possessions were not kept on her person and therefore were not covered by the policy and (ii) she could not show proof of ownership of the items in question. In light of the insurance company's response, Tara made a complaint to the Ombudsman.

Tara argued that the insurance company's decision to decline her claim was unfair and unreasonable. She said that the policy only extended cover if an insured person had their personal possessions on their person, but this was misleading, given that there was no definition of "one's person" in the policy itself, even though this allowed the insurance company to decline claims which should otherwise be valid. In addition, Tara submitted that she could not prove ownership of the items in her backpack (including a gift and old items) and that it was unfair to refuse evidence such as cash withdrawals. Tara argued that there were various service failings.

The insurance company argued that its policy does not cover personal possessions unless they are kept on the insured's person or locked in a secure location. The insurer submitted that its policy was clear and applied to Tara in circumstances where the personal items in question were not on her person during the flight. In addition, the insurer submitted that it attempts to be flexible and take into account individual circumstances, but that there is no obligation to exhaustively set out each scenario where the policy cover will not apply. Furthermore, the insurance company asserted that it could not accept cash withdrawals as evidence of ownership, as it could not verify whether the cash was used to purchase the items in question. In relation to the handling of Tara's complaint, the insurer accepted that there were some delays and customer service failings due to staff absences. A final response letter was sent to Tara in early August 2018.

The Ombudsman formed the opinion that the clauses in the insurance company's policy were potentially confusing and that if the insurance company had included a clear definition of "*on your person*" in its terms and conditions, it may have been clear to Tara that if she stowed her backpack in the overhead compartment, it may not be considered to be on her person, but it had not done so. The Ombudsman concluded that while there was no obligation to exhaustively set out all of the circumstances where a claim would be declined, a consumer may reasonably expect the most relevant circumstances to be included.

The Ombudsman accepted that it was reasonable for the insurance company to ask Tara to supply proof of ownership for items held in her backpack, but given the lack of definition of "*on your person*" in the policy, the Ombudsman concluded that it was unreasonable for the insurer to reject Tara's claim.

The Ombudsman partially upheld Tara's complaint and directed the insurance company to pay Tara €600 in compensation.

# Travel Insurance

**Decision Reference: 2020-0295**

Read the full decision

## Claim not covered due to symptoms before the policy was purchased

In March 2019, Chris and Sarah booked a holiday to the USA for early June 2019. They purchased travel insurance on 19 May 2019, and on the same day, Sarah attended her GP due to feeling unwell for the previous 12 hours and she was advised not to travel due to a pre-existing health condition she had. As a result, Chris and Sarah cancelled their flights with the airline a day before they were due to fly and the airline refunded the taxes relevant to the flights. The couple made a claim through their insurance company. However, the insurance company declined their claim under the insurance policy on the basis that Sarah had purchased the policy after the onset of symptoms and the knowledge of a pre-existing condition. Chris and Sarah made a complaint to the FSPO.

The couple explained that Sarah's symptoms, which were in existence for 12 hours before the policy was purchased in May 2019, were unrelated to their decision to cancel their holiday. In a letter from Sarah's consultant, it was stated that Sarah had various tests and was ultimately advised not to travel, but that she would not have known this when she booked her trip in March 2019. The couple argued that the insurance company wrongfully declined to indemnify them for losses relating to their cancelled flights. The couple wanted their insurer to refund the balance of their fares, following the refund of the relevant taxes from the airline.

The insurer said that in a letter received from Sarah's medical advisor, reference was made to a pre-existing medical condition, which resulted in the couple cancelling their flights. Following a request from the Ombudsman, a full investigation was carried out and the insurer indicated that its decision to refuse the claim was being maintained, based on the evidence relating to the pre-existing medical condition at the time when the insurance policy was purchased. In this regard, the insurer furnished a timeline of events which was considered by the Ombudsman.

The Ombudsman referred to the terms and conditions contained in the insurance policy and noted that the insurance company was entitled to decline the claim because Sarah was aware at the time of purchase of the policy, that she had symptoms which could reasonably be expected to give rise to a claim.

In light of the above, the Ombudsman accepted that it was reasonable for the insurance company to refuse to admit the claim for payment.

The Ombudsman did not uphold the complaint.

# Travel Insurance

**Decision Reference: 2020-0413**

Read the full decision

## Couple's claim after two thefts on the same day

In January 2019, Joe and Bridget travelled abroad to organise their daughter's wedding. Unfortunately, twice in the same day, Joe and Bridget had items of value stolen from them and as a result, the couple made a claim under their travel insurance policy.

The insurance company rejected certain aspects of the couple's claim and sought further information in respect of other aspects. Joe and Bridget were unhappy with how their claim was handled and with the insurer's final decision. As a result, the couple complained to the FSPO.

The couple submitted that their flights were booked by their daughter and her fiancé. After their arrival, their money (approximately €4,650), bags and personal belongings (including passports, earphones, jewellery, clothes, shoes, make-up and medication) were taken from the boot of their hire car. Unfortunately, later the very same day, Bridget's handbag was also taken from a hotel lobby. The couple reported these crimes to the local police and to their insurer. The couple advised that they had to purchase new emergency passports and incurred other expenditure following these events.

The insurance company said that the couple had claimed for theft of a bag and its contents from the boot of a hire car, theft of a bag from a hotel lobby, and loss of a mobile phone. The insurer submitted that it was unclear when, where or how the phone was lost or stolen. It explained that the couple's mobile phone and money were excluded from cover under the terms of their policy, as the policy did not cover items that were either in a car, left unattended, or out of the couple's line of sight in the hotel lobby. As a result, the insurer advised that it would not cover valuables which were left unattended, including €4,000 which was stolen from the boot of the rental car, the phone and headphones. With regard to the passports, the insurer agreed that they were covered, but that any other items in Bridget's handbag which was stolen from the lobby, were not covered.

The insurance company highlighted that it sought various supporting documents to allow it to progress the other elements of the claim relating to other personal possessions that had been taken. Although the couple provided a list of the stolen items and replacement values, they supplied no original receipts, which the insurance company stated was insufficient to satisfy the claim requirements. Joe and Bridget argued that the insurer had everything that was required.

Having considered the policy and the submissions received, the Ombudsman was satisfied that the couple were not entitled to expect reimbursement for items purchased or expenses incurred after the thefts, as only stolen items were covered by the policy. Regarding the items that were stolen, the Ombudsman accepted that it was clear from the policy that valuable items would not be covered if left in a motor vehicle. In addition, both valuables and cash were required to be on the individual's person, locked in a safe or safety deposit box, or locked in accommodation. As a result, the loss of items not stored in this manner, were not covered under the policy.

The Ombudsman accepted that it was reasonable for the insurer to seek additional documentation in support of the claim for cover in respect of the other personal possessions the couple were seeking payment for and that this information should be furnished to enable the insurer to progress the claim. Ultimately, the Ombudsman accepted that the insurance company did not act in a wrongful or unreasonable manner in refusing to admit the couple's claim, pending receipt of the documents required.

On that basis, the Ombudsman did not uphold the complaint.

# Travel Insurance

**Decision Reference: 2021-0028**

Read the full decision

## Medical issue deemed to have been a pre-existing condition

Jack and Jennifer's travel insurance policy commenced on 4 January 2019, with a cover period for one year. Jack and Jennifer paid an additional premium to extend the policy to cover the duration of a holiday they had planned from June until August of that year. Before the trip, Jennifer experienced persistent back pain. Initially, Jennifer thought this back pain stemmed from a sports injury that occurred in August 2018. Jennifer's doctor recommended physiotherapy and painkillers.

Jennifer was subsequently diagnosed with a spinal cord condition and underwent surgery. Because Jennifer was unfit to travel, Jack and Jennifer cancelled their holiday and claimed cancellation expenses amounting to a total of €6,168.82 from the insurance company.

The insurance company declined Jack and Jennifer's claim stating that it was not unreasonable to assume that a simple back pain should be considered a medical condition, which should be declared on a travel insurance policy. Jack and Jennifer believed that the insurance company's refusal of the claim was unreasonable, as Jennifer was unaware of the extent of her condition at the time of purchasing the policy.

Jack and Jennifer argued that the insurance company's policy booklet provided that a policy holder did not need to contact the insurance company if they had "*myalgia*", which was defined in the Collins Dictionary as "*pain muscle or muscle group*".

The insurance company submitted that Jennifer's medical condition was not covered by the policy because, even though the specific condition had not been diagnosed, Jennifer was aware of her unresolved symptoms, on the date when the policy was purchased. The insurance company also submitted that, under the policy, Jack and Jennifer were obliged to disclose details of any medical condition for which they were taking prescribed medication or waiting to receive treatment, within the last 2 years. The insurance company also noted that Jack and Jennifer would not be covered for any claims arising directly or indirectly from the medical condition, unless it was agreed in writing that the medical condition would be covered by the policy. The insurance company advised that if Jennifer had notified it that she had back pain and was being treated but had no diagnosis, she would have been advised that nothing directly or indirectly related to the back pain would be considered for cover under the policy.

The insurance company acknowledged Jack and Jennifer's position, together with the impact of the eventual diagnosis and on that basis made a formal offer of €3,084.41 which represented 50% of the value of Jack and Jennifer's claim. Jack and Jennifer declined this offer but indicated that they would be willing to accept 90% of the total amount claimed.

The Ombudsman accepted Jack and Jennifer's position that they were unaware of the severity of Jennifer's medical condition at the time they purchased the policy. However, at that time, Jennifer had been attending her doctor and physiotherapist for a condition that had existed for a period of more than four months and the pain was not improving. The Ombudsman took the view that it was clear that although Jennifer's condition was not diagnosed, she had a medical condition which she was aware of and for which she was receiving on-going treatment. While the Ombudsman understood Jack and Jennifer's distress, the Ombudsman accepted that the insurance company was not obliged to admit Jack and Jennifer's claim under their travel insurance policy.

The Ombudsman did not uphold Jack and Jennifer's complaint but welcomed the insurance company's offer of €3,084.41 (representing 50% of the value of Jack and Jennifer's claim), noting that this offer was still available to Jack and Jennifer to accept.

# Travel Insurance

**Decision Reference: 2021-0101**

Read the full decision

## Rejection of claim for treatment arising from pre-existing condition

Emily held a travel insurance policy, which began on 12 August 2019. In October 2019, Emily fell ill while abroad and was admitted to hospital, where she was advised to undergo certain treatments and investigations. The results from Emily's scans showed that Emily required various medical treatments.

Emily's hospital bill came to a total of GBP £17,750. Emily paid GBP £9,500 of this bill, leaving a balance of GBP £8,250 outstanding. Emily submitted a claim for her medical expenses, under her travel insurance policy, but the insurer rejected her claim.

The insurance company advised that Emily's claim was not covered under her policy because the treatment she underwent abroad was for a pre-existing medical condition. The insurance company also advised that travel insurance policies do not cover every situation, and that the policy cover was subject to limitations.

The Ombudsman noted that neither Emily, nor Emily's partner contacted the insurance company, before seeking medical treatment abroad. It was only at the end of Emily's hospital stay that Emily's partner contacted the insurance company. The insurance company then obtained reports from the hospital abroad and from Emily's doctor. The Ombudsman acknowledged that in a report dated 25 October 2019, Emily's doctor ticked "yes" alongside boxes, to indicate that Emily had a history of cardiac disease, pulmonary disease and endocrine disease. Emily's doctor also confirmed that Emily was aware of these conditions. The Ombudsman also noted that a repeat-medication list from Emily's doctor in November contained a list of medications used for her treatment.

The Ombudsman referred to the terms of the travel insurance policy which provided cover against certain specified events which were set out. The Ombudsman noted that the policy cover was subject to conditions, restrictions and exclusions. Therefore, for a valid claim to arise, it would have to be shown that one of the events specified under the policy resulted in the claim being submitted, and that such event was not subject to any condition, restriction or exclusion that applied to the policy.

The Ombudsman acknowledged that although the policy placed an onus on Emily or Emily's partner to contact the insurance company before undergoing treatment abroad, the insurance company did not seek to rely on this clause.

The Ombudsman was satisfied that the treatment which Emily underwent whilst abroad, arose from her pre-existing medical conditions, none of which were listed as acceptable medical conditions within the insurance policy. The Ombudsman sympathised with Emily in relation to her life-threatening illness whilst abroad, but accepted that the insurance company was entitled to reject Emily's claim because none of the pre-existing medical conditions identified by Emily's doctor were included in the list of acceptable medical conditions within the policy.

The Ombudsman did not uphold the complaint.

# Travel Insurance

**Decision Reference: 2021-0180**

Read the full decision

## Holiday cancellation not covered by travel insurance policy

Brian's travel insurance cover was purchased through his digital banking platform and the premium was paid monthly.

In December 2019, Brian was injured in an accident abroad. Following this, Brian submitted a claim to the insurance company for expenses in relation to private hospital costs and his travel home. This claim amounted to a total of €882.29. The insurance company settled this claim under the "*emergency overseas medical assistance and expenses*" section of Brian's travel insurance policy.

In January 2020, Brian went for an x-ray which revealed that his injury had not healed. As a result, Brian was unable to go on a holiday he had planned for the end of that month. Brian managed to reschedule flights for the first leg of his holiday at no extra cost, but the rescheduling of the second flight cost him €268. Brian also suffered a loss of €51.44 when he cancelled a non-refundable overnight stay in a hotel.

Brian submitted a second claim for these expenses, which amounted to €319.44. However, the insurer declined this claim, saying that he had no cover for the cancellation of a holiday.

In reaching his decision, the Ombudsman reviewed the insurer's "*Insurance Product Information Document*" which set out what was insured under the policy. The Ombudsman noted that "*Emergency Overseas Medical Assistance and Expenses*", "*Delayed Departure*" and "*Delayed Baggage*" were covered.

Brian contended that his additional loss was recoverable under the "*Delayed Departure*" category because his holiday in January was "*delayed*". The Ombudsman reviewed the provisions under the "*Delayed Departure*" heading, which provided that a person was entitled to recover benefit under the policy

"*…if the departure of the Public Transport on which you are booked to travel, according to Your travel itinerary, is delayed by at least 4 hours.*"

The Ombudsman was satisfied that Brian had not booked public transport which delayed him from going on his holiday in late January 2020.

The Ombudsman acknowledged that the cancelled holiday was disappointing for Brian but accepted that Brian's loss was not covered, as it did not fall under "*Emergency Overseas Medical Assistance and Expenses*", "*Delayed Departure*" or "*Delayed Baggage*" categories of cover available to him. The Ombudsman also noted that even if Brian had originally included these items in his first claim, they would not have been recoverable at that time, as they did not fall within the three categories of cover specified in the policy. The Ombudsman pointed out that like all insurance policies, travel insurance policies do not cover every possible situation.

The Ombudsman did not uphold the complaint.

# Travel Insurance

**Decision Reference:**
**2021-0290**

Read the full decision

## Claim for Permanent Total Disablement benefit after injury abroad led to surgery

In June 2016, Lily was on holiday abroad when she suffered a fracture to her shoulder and notified the insurance company of her injury. Lily was due to undergo emergency surgery on her shoulder on 4 July 2016, however the insurance company subsequently arranged for her to fly home on 5 July 2016, so that she could seek treatment in Ireland instead.

Lily arrived home on 6 July 2016 and on 7 July, she attended the first hospital, where conservative management of her injury was advised. She sought a second opinion and was referred to a consultant orthopaedic surgeon at a different hospital. On this consultant's advice, Lily underwent two surgeries, one in August 2016 and the other in April 2017.

It was Lily's belief that if she had undergone surgery abroad on 4 July as originally planned, she would have recovered sooner and/or better from her injury. To support this, Lily submitted an undated letter from the consultant orthopaedic surgeon stating that the surgery was difficult given the delay from the time of the fracture, and that in an ideal situation, the fracture to her shoulder would have been preferably treated within the first two weeks of presentation. The consultant went on to say that it would be difficult to say with certainty that this would have altered the outcome in such fractures.

In May 2018, Lily sent a claim form to the insurance company, advising in her cover letter that she wished to apply for Permanent Total Disablement benefit, in the amount of €40,000. The definition of "*Permanent Total Disablement*" was considered by the insurer and it declined Lily's claim on the basis that the medical evidence concluded that her condition had improved post-surgery, and the medical file did not support her argument that she was medically unfit to undertake work of any kind. Lily argued that as part of her job as a nurse she was required to lift people, perform CPR and manual duties, which was not possible with a weak arm and limited reaching capacity. Lily contended that as she had suffered financially as a result of being unemployed for 2 years and 8 months, financial compensation would suffice.

In assessing Lily's claim, the insurer referred to the "*Medical and Other Expenses incurred abroad*" section of the policy, which noted that the insurance company reserved the right to arrange for Lily's relocation to Ireland at any time during the trip, in compliance with the opinion of a medical professional. The insurer submitted that a second doctor at the treating facility abroad, had assessed Lily on 4 July 2016 and completed a "*Fit to Fly Certificate*" confirming that she was fit to travel without a medical escort.

In response to Lily's belief that if she had undergone the surgery abroad on 4 July 2016 she may have recovered sooner and/or better from her injury, the insurance company submitted that these comments were purely speculative, and that there was no medical evidence to support this. The insurer also said that, upon reviewing the medical reports received from the hospital when Lily returned to Ireland, it was clear that while surgery was eventually required, it was not urgent. The insurer submitted that it was guided at all stages by medical advice when arranging Lily's return to Ireland, and that efforts to get Lily home were made in absolute good faith.

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# Travel Insurance

**Continued from page 31**

In assessing Lily's claim, the insurance company focused on the definition of "Permanent Total Disablement" under the travel insurance policy which was defined as follows:-

> "Disablement which entirely prevents the Insured Person from attending to business or occupation of any and every kind for at least 12 months and at the end of that time being beyond the hope of improvement."

Documentation submitted by Lily accepted that she could return to work in another field or for lighter duties, but she was reluctant to do so because of her age and the complications of another underlying medical condition. While the insurance company acknowledged that Lily's ability to work as a nurse was temporarily limited, and that she may never return to nursing in the same way as before, in order to qualify for the Permanent Total Disablement benefit, it must have been medically evident that Lily would never return to work in any capacity, as a result of her injury. As a result, the insurer decided that Lily's injury did not meet the policy definition of Permanent Total Disablement.

In reaching his final decision, the Ombudsman reviewed the totality of the medical evidence and took the view that it was reasonable for the insurer to conclude, based on medical evidence received, that the recommended surgery was not urgent and that it was medically safe for Lily to fly home to seek medical treatment in Ireland.

The Ombudsman noted that Lily's insurance policy, like all insurance policies, did not cover every situation and was subject to terms, conditions and exclusions. The Ombudsman referred to the Definitions section of Lily's policy and concluded that it was reasonable for the insurance company to conclude that the medical evidence received did not support Lily's claim that she was medically unfit to undertake work of any and every kind, and that it was reasonable for the insurance company to stand over its decision to decline the claim.

The Ombudsman did not uphold Lily's complaint.

# Travel Insurance

**Decision Reference:**
**2021-0393**

Read the full decision

## Cost of replacement flights and expenses not covered after original flight cancelled by airline

Conor held a travel insurance policy, from 11 July 2018. Both Conor's wife, Chloe and their son were also insured under the policy.

On 12 July 2018, the family went on holiday. They were due to return home to Ireland on a flight scheduled for 27 July 2018. However, due to a mechanical fault, the airline cancelled the flight. Conor and Chloe were subsequently advised that the next available flight to Ireland, was four days later.

Conor advised that it was not possible to extend the holiday for an additional four days, due to work commitments. Ultimately, Conor and Chloe had no option but to book overnight accommodation and to seek an alternative flight for the following day.

In September 2019, Conor submitted a "*Delay/ missed departure claim form*" to the insurance company, seeking to recover the amount of €2,378.16 in respect of the cost incurred for new flights, accommodation and taxi and train. The insurance company assessed Conor's claim under Section 2 of his policy which dealt with "*Travel Delay*" and offered the sum of €285.00 in full settlement of the claim.

Conor was not happy with the assessment and believed that the flight that was due to depart on 27 July was cancelled, and not delayed. Conor was of the view that the insurance company should have assessed his claim under Section 1 of the policy, which dealt with "*Cancellation, Curtailment [and] Rearrangement*". This section provided cover of up to €3,000.

The insurance company submitted that Conor and Chloe may have assumed that because their flight was cancelled, Section 1 of the policy should apply. The insurance company explained that Section 1 was for a cancelled holiday, not for a cancelled flight.

Section 2 provided cover to a policy holder if there was a delay for "*at least 12 hours on the outbound or return journey…*" and although their flight had been cancelled, this resulted in the family's return home from their holiday being delayed, rather than the cancellation of their holiday itself.

The insurance company also said that "*Holiday*" was defined in the policy as a "*trip devoted entirely to pleasure, rest, or relaxation, where travel begins and ends in Ireland*", and as a result, Section 1 would only apply in circumstances where the whole holiday was cancelled, curtailed or rearranged.

In addition, the insurance company submitted that the reason it did not provide cover for additional accommodation, travel, replacement flights, etc. was because these costs were the responsibility of the airline itself, under Regulation (EC) No. 261/2004 of the European Parliament and of the Council of 11 February 2004. The insurance company noted that this was detailed in the cancellation notification Conor received from the airline. The insurer believed that Conor and Chloe ultimately misunderstood what the airline was offering.

The Ombudsman noted that like all insurance policies, Conor's travel insurance policy did not provide cover for every possible situation, and that it was subject to its terms, conditions and limitations.

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# Travel Insurance

**Continued from page 33**

The Ombudsman reviewed the provisions under Conor's policy, with particular focus on the wording of Sections 1 and 2. With regard to Section 1, the Ombudsman was satisfied that for this section of the policy to operate, the entire holiday was required to have been cancelled, cut short or rearranged, and that such travel and accommodation costs incurred as a result of the cancellation, curtailment or rearrangement could not be recovered from any other source.

The Ombudsman also referred to the definition of "*Holiday*" under the policy documentation and noted that it was clear that Conor's holiday remained in place until Conor had returned to Ireland. The Ombudsman therefore accepted that the insurance company was correct to maintain that Conor and Chloe could not recover the claimed expenses under the insurance policy.

However, the Ombudsman was of the opinion that it would be a lot clearer for policy holders if the wording under Section 1 specified that the cancellation referred to, was the cancellation of an entire holiday. The Ombudsman referred to the insurance company's obligations under the Central Bank of Ireland's Consumer Protection Code 2012, to ensure that all information it provided to a consumer is clear, accurate, up to date and written in plain English.

The Ombudsman was satisfied that the wording of the policy caused confusion and inconvenience to Conor and Chloe and took the view that the complaint should be partially upheld. The Ombudsman directed the insurance company to make a compensatory payment to Conor and Chloe in the amount of €1,500 in recognition of the poor and confusing wording in the policy, and also recommended that the insurer review its wording under Section 1 of the policy to consider if the position regarding cover, could be made clearer to policyholders.

# Travel Insurance

**Decision Reference:**
**2018-0096**

Read the full decision

## Evidence of symptoms before policy purchased

Sharon took out an annual multi-trip travel insurance policy on 9 March 2016. Sharon was 16 at the time and was due to accompany her aunt on a holiday to the United States later in March 2016. This holiday had been booked since September 2015.

On 11 March 2016, Sharon's aunt was admitted to hospital where she was diagnosed with a medical condition and was advised against travelling during the period in which she had been due to go on holiday. Due to her aunt's diagnosis, Sharon had to cancel her trip and made a claim under the policy for the cost of her trip. The insurance company declined Sharon's claim on the basis that her aunt's symptoms pre-existed the purchase of the policy.

Sharon was dissatisfied with this and complained to the FSPO and sought to be compensated for the cost of her trip.

The insurance company argued that while Sharon's aunt was diagnosed on 11 March 2016, the symptoms giving rise to the diagnosis were in existence the day before the purchase of the policy on 9 March 2016. Accordingly, the insurance company stated that the claim was excluded under the part of the policy entitled "*Exclusions that apply if a Close Relative or Travelling Companion has Medical Conditions*". The insurance company further relied on the part of the policy entitled "*Cancellation or Curtailment Charges*" which provided that payment for irrecoverable unused travel and accommodation costs, together with any reasonable additional travel expenses, will only be paid if the cancellation of the trip is necessary and unavoidable as a result of certain events occurring after payment of policy premium and incurring within the period of insurance.

The Ombudsman considered the relevant travel insurance policy documents. The Ombudsman noted the date on which the policy was purchased and the dates on which Sharon's aunt had subsequently been treated by her GP and physiotherapist. The Ombudsman also reviewed the relevant medical notes. The Ombudsman concluded that it was clear that Sharon's aunt experienced some symptoms the day before the policy was purchased, which she associated with some prior history of pain. The Ombudsman was of the view that this indicated an awareness by Sharon's aunt that she was suffering from "*a disease, illness or injury*" (as referred to in the policy).

Taking the relevant terms and conditions of the policy into consideration, the Ombudsman was satisfied that it was clear that any claim arising from a medical condition, which a close relative or travelling companion is aware of, but for which they have not had a diagnosis, would not be covered by the insurance policy and therefore the insurance company was entitled to decline the claim.

For these reasons, the Ombudsman did not uphold this complaint.

# 3 Steps to making a complaint about a financial service provider or pension provider

**Watch our video**
'How to make a complaint to the FSPO'

## 1

### Contact your financial service provider or pension provider and make your complaint formally.

You should speak or write to the person you usually deal with, or ask for the complaints manager to make a complaint.

Before bringing your complaint to the FSPO, you must give your provider a chance to sort out the problem.

### What information should you give them?

- **Make it very clear that you are making a complaint.**
- **Explain your complaint.**
- **Suggest how the provider should put it right.**

**Before making a complaint to the FSPO, you must give your provider a chance to sort out the problem.**

However, if you think you may be approaching the time limit for making a complaint to us, please contact us.

## 2

### Be patient and persistent

**The provider should deal with your complaint through its complaint handling process.** The provider may take up to 40 working days to deal with your complaint.

**When you complain to the provider be persistent.** If nothing happens, call the provider to check on the progress of your complaint.

**The provider should fully investigate your complaint,** in accordance with its internal dispute resolution process. This is known as IDR.

At the end of IDR, the provider will let you know its position regarding your complaint, so that either:

- The provider issues a final response letter and you are satisfied with the resolution of your complaint.
- The provider issues a final response letter and you are not satisfied with the resolution of your complaint.

## 3

### Contact the FSPO

If you are not satisfied after receiving your final response letter, you may contact the FSPO. To progress your complaint, we will need:

**A** **A fully completed complaint form**

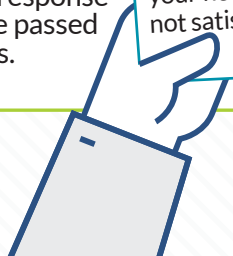
&

**B** **A copy of your final response letter.**

If you are having difficulty getting the final response and 40 days have passed please contact us.

**A final response letter**

should set out what the provider has done to investigate your complaint through its internal dispute resolution process. It should advise you to contact the FSPO as your next step, if you are not satisfied.



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