Ombudsman Decision
CIFO Reference Number: 16-001312
Complainant: [The complainant]
Respondent: [Company X]

It is the policy of the Channel Islands Financial Ombudsman (CIFO) not to name or identify complainants in any published documents. Any copy of this decision made available in any way to any person other than the complainant or the respondent must not include the identity of the complainant or any information that might reveal their identity.[1]

A decision shall constitute an Ombudsman Determination under our law.

[The complainant] complained about the decision taken by [Company X] to decline a claim he made under a medical insurance policy for expenses relating to a diagnosis of colon cancer.

Background

On 3 May 2015, [the complainant] completed an application form for a medical insurance policy with [Company X]. The policy started in June 2015; however, on 11 May 2015, [the complainant] visited his doctor regarding changes in his bowel habits. The doctor noted that [the complainant] had been [overseas] for the previous 20 months and that he would be travelling [overseas] shortly. The medical notes from this appointment record that:

> "*For Bt and to review with the results. ? due to diff food ? needs ref* [sic]."

This appears to suggest that the cause of the change in [the complainant's] bowel habits could have been due to different foods he was consuming, but the doctor's diagnosis was equivocal.

In September 2015, [the complainant] attended his doctor [overseas]. When this doctor asked [the complainant] about the length of time for which he had noticed blood in his stool, [the complainant] estimated that it may have been six months. The doctor referred [the complainant] for a colonoscopy and further assessment and he attended a hospital [overseas] for the same. Following the results of the colonoscopy on 11 October 2015, [the complainant] was diagnosed with colon cancer.

[1] Financial Services Ombudsman (Jersey) Law 2014 Article 16(11) and Financial Services Ombudsman (Bailiwick of Guernsey) Law 2014 Section 16(10)

[The complainant] asked [Company X] for reimbursement of his medical fees, but they declined [the complainant's] claim because he had not informed them that symptoms had been present for six months.

[The complainant's]] formal complaint to [Company X] was not upheld and he subsequently referred the complaint to CIFO.

As a fair and reasonable resolution to his complaint, [the complainant] sought a settlement of the expenses already incurred, which amounted to approximately £14,500.

The case handler upheld the complaint. He considered that a change in bowel habits for the six months prior to May 2015 was not sufficient evidence for [Company X] to reject [the complainant's] claim on the grounds that symptoms of cancer were present at the time of inception. In addition, the case handler concluded on the balance of probabilities that blood was not present in [the complainant's] stools prior to inception of the policy.

Subsequent submissions

[Company X] did not agree with the case handler's conclusions. [Company X] did not dispute that [the complainant] did not know that he had cancer or blood in his stools at the time the application was made on 3 May 2015, but the insurer considered that [the complainant] had symptoms of a change in bowel habits for six months prior to 11 May 2015 and he did not disclose this to [Company X].

[Company X] suggested that it would have expected [the complainant] to notify it of any changes during the delay to the policy start date but and also that the application would be completed honestly. [Company X] found that the details of the medical note from the doctor indicated that [the complainant's] bowel movements had changed for the previous 6 months from going once a day to three times a day. According to [Company X], this would mean that when the application form was completed [the complainant] had knowledge of the bowel changes, but this was not disclosed.

Finally, [Company X] explained that the treatment was not covered because the policy did not cover pre-existing conditions.

[The complainant] informed CIFO that he did not have any medical appointments prior to May 2015 regarding the symptoms he subsequently experienced. [The complainant] also explained that he had blood tests shortly after his medical appointment on 11 May 2015 but these returned normal results, and that he had blood tests and fecal occult blood tests ("FOBTs") in September 2015 [overseas].

Findings

I agree with the conclusions of the case handler.

I consider that [the complainant] was only estimating the length of time he had known blood was present in his stool when he visited the doctor [overseas] in September 2015. This is because there was no reference to this symptom in the notes of his previous appointment in May 2015. It would not, therefore, be reasonable to suggest that the symptoms of cancer existed before [the complainant] applied for the policy in May 2015.

I acknowledge [Company X's] view that the change in bowel habits for six months leading up to the application in May 2015 means that a condition was pre-existing and would exclude cover; however, the record made by the doctor on 11 May 2015 suggests that the change in [the complainant's] bowel habits may have been due to different foods. In addition, the doctor did not see fit to refer [the complainant] for further tests. He also records that [the complainant] "*came for review*" and was receiving annual check-ups. When the above is taken into account, a change in bowel habits in itself does not, in my view, confirm that [the complainant] had cancer at the time of his 11 May 2015 appointment. An increase in bowel movements from once to three times per day is too generic a symptom to suggest that it relates to a future diagnosis of cancer and it would be unreasonable for [Company X] to exclude cover on the basis that there was a pre-existing condition.

[Company X] has advised that the policy rules in place at the time of inception specified as follows:

> "*Where there is a* ***delay between your application and the initial start date of your policy****, we* ***<u>may</u> send you a statement of facts and ask you to confirm if the details are still valid****. If we send you such a statement and the details have changed, but you have not informed us, we may treat this as a misrepresentation, which could affect coverage under your policy or payment of claims*".

When CIFO asked [Company X] for a response to the complaint, [Company X] initially provided CIFO with an up-to-date policy guide, rather than the above provision that was sent to [the complainant] at the point of sale.

[The complainant] completed and signed his insurance application on 3 May 2015. On 11 May 2015 he went to the doctor. The policy started on 15 June 2015. There was a delay of approximately six weeks in implementing the policy. I consider, therefore, that the above provision applies and the obligation was on [Company X] to send [the complainant] a

statement of facts if it wanted to know whether any of his circumstances had changed. Given that [Company X] did not send such a statement, [the complainant] was under no obligation to provide the insurer with any updated information after his visit to the doctor on 11 May 2015.

Because the above policy exclusion does not apply, I am of the view that it would not be reasonable for [Company X] to decline [the complainant's] claim under the policy in this instance.

Medical expenses

I recognise that a number of expenses have been incurred and [the complainant] advised CIFO of these; however, the *Customer Guide* produced by [Company X] specifies the payments which are covered under the policy:

> "*Cancer care*
>
> ***We** will pay for **active** and **evidence-based treatment** received for, or related to **cancer**, including chemotherapy, radiotherapy, oncology, **diagnostic tests** and drugs whether the **beneficiary** is staying in a **hospital** overnight or receiving **treatment** as a **daypatient** or **outpatient**.*"

Based on the above, it would be reasonable for me to recommend that only expenses incurred as a direct result of treatment should be recoverable.

Final decision

My final decision is that I uphold this complaint.

[Company X] should pay [the complainant] £11,255.94 for expenses incurred as a result of his treatment for cancer.

[Company X] should also pay [the complainant] a further £400 for distress and inconvenience caused to him through the pursuit of his claim.

The total amount payable to [the complainant] by [Company X] is therefore £11,655.94.

[The complainant] must confirm whether he accepts this determination either by email to ombudsman@ci-fo.org or letter to Channel Islands Financial Ombudsman, PO Box 114, Jersey, Channel Islands, JE4 9QG, by **20 August 2018**. The determination will become binding on [the complainant] and [Company X] if it is accepted by this date. If we do not

receive an email or letter by the deadline, the determination is not binding. At this point [the complainant] would be free to pursue his legal rights through other means.

If there are any particular circumstances which prevent [the complainant] confirming his acceptance before the deadline of **20 August 2018**, he should contact me with details. I may be able to take these into account, after inviting views from [Company X], and in these circumstances the determination may become binding after the deadline. I will advise both parties of the status of the determination once the deadline has passed.

Please note there is no appeal against a binding determination, and neither party may begin or continue legal proceedings in respect of the subject matter of a binding determination.

Douglas Melville
Principal Ombudsman and Chief Executive

Date: _____20th July 2018_____