**Ombudsman Decision**
**CIFO Reference Number: 25-000261**
**Complainant: Mr H**
**Respondent: Cigna Global Insurance Company Limited**

The complainant, who I will refer to as Mr H, complains that, in summary, Cigna Global Insurance Company Limited unfairly declined a claim and added a disproportionate exclusion to his health insurance policy.

## Background

Mr H applied for a policy with Cigna in September 2024, which excluded all pre-existing medical conditions. Mr H completed a medical questionnaire as part of the application in which he was asked about previous and current health conditions, but he did not disclose any.

On 9 December 2024 Cigna received a claim, on Mr H's behalf, from a residential rehabilitation facility, which I will refer to as Provider A. The claim is related to pre-authorisation for inpatient/residential treatment for anxiety, stress, and burnout.

Cigna sought clarification from Provider A as to the date Mr H's symptoms started. Provider A referred Cigna to their Opinion Report dated 10 December 2024 which noted *"Patient reports stress over the last 6 months"*.

Cigna sought further clarification and Provider A responded on 17 December, which included: "*Throughout the assessments, the onset of the symptoms has happened many times over the last 2 years and came on and off due to various factors. The first time there was similar stress (including anxiety and depression) was at the end of 2022. There was increased stress over the*

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

*last 6 months and led to this episode that deteriorated this year which has pushed the client to reach out to us. There were a few episodes over the years and the onset of each one has been unclear but could be identified as above."*

Based on this report, Cigna concluded that Mr H's symptoms were present before the policy began. As such, Cigna declined the claim and added an exclusion to the policy for *"MENTAL HEALTH CONDITIONS, any psychiatric or mental health disorder and any complications."*

Mr H did not agree with Cigna's conclusion and requested an appeal. Cigna confirmed he would need to provide a *"Medical report with the accurate information from the treating doctor which should be typed on clinic letterhead, signed by the doctor and submitted in a non-editable format (e.g. PDF)."*

Mr H couldn't obtain an amended report from Provider A and gave Cigna a report dated 27 February from Dr M, a Consultant Psychiatrist, which stated following:

> *"I am writing to confirm that I have provided treatment for Mr H, in relation to diagnosed alcohol use disorder.*
>
> *He has not been diagnosed with any other Axis I DSM diagnosis, namely Major Depressive Disorder or Generalised Anxiety Disorder.*
>
> *He has to my knowledge never been prescribed antidepressant or anxiolytic medication."*

Cigna did not change its decision.

Mr H's states Cigna have relied on a fraudulent report from Provider A, disregarded his report from Dr M and added a disproportionate exclusion.

The Adjudicator did not recommend upholding the complaint explaining that it was fair and reasonable for Cigna to rely on the contemporaneous report from Provider A. She explained the role of CIFO to consider whether Cigna's decision was fair and reasonable based on the information available, and the report from Dr M had not provided sufficient information to outweigh the report and medical history from Provider A.

Mr H disagreed and asked for an Ombudsman to review the complaint for a final decision.

## Subsequent Submissions

Mr H asked that an Ombudsman review the validity and fairness of Cigna's decision to impose a lifetime exclusion for mental health conditions, highlighting significant flaws in evidence and procedure. He argues that medical testimony and procedural standards were ignored, leading to an unjust and disproportionate outcome. In summary he raised the following:

> **Ignored definitive medical evidence:** The analysis fails to address a psychiatrist's report confirming no diagnosis of mental health disorders or related medication, directly contradicting Cigna's exclusion basis.
>
> **Reliance on invalid and financially motivated evidence:** Cigna accepted a psychiatric diagnosis from a provider with no direct patient assessment, based on unqualified staff input, constituting professional misconduct and influenced by financial incentives.
>
> **Procedural breaches and disproportionate penalties:** Despite acknowledging potential fabrication and offering fraud review, Cigna finalised its decision without proper investigation, imposing an excessive lifetime exclusion unrelated to any confirmed diagnosis.
>
> **Legal and regulatory violations:** The process violated natural justice principles, failed in the utmost good faith obligations, contradicted regulatory standards, and risks setting harmful precedents by allowing unverified, non-clinical evidence to override professional medical opinions.

The complaint has been referred to me for a final decision.

## Findings

I have considered all available evidence and arguments to decide what is, in my opinion, fair and reasonable in the individual circumstances of this complaint. Having done so, I find that I have come to the same overall conclusions as the adjudicator did, for much the same reasons.

While Mr H has provided a significant amount of information and submissions, I do not intend to answer every single point in the same way he has submitted them. I do not intend to be discourteous but rather my approach reflects our informal role as an alternative dispute resolution

service. I will focus on the main points I consider to be relevant to the complaint. And where information is missing or incomplete, I make my findings based on what I consider to be more likely than not.

The principal issue I need to decide is whether Cigna acted fairly and reasonably based on the information it received to decline the claim and add an exclusion to the policy.

As part of the application process Cigna asked Mr H to provide information about pre-existing health conditions including diagnoses, symptoms, treatment and known or suspected issues. He did not disclose any and maintains that he has never had anything of relevance about his mental health and has gone as far as to say that the medical report(s) Cigna has relied on is a fraud.

I place little weight on what Mr H has said about 'fraud' because Provider A was his chosen provider. The report dated 10 December 2024 confirmed that Provider A had assessed him that same day and a recommendation was made to be admitted for inpatient treatment for 'occupational burnout and generalized anxiety disorder'.

The report notes Mr H had been experiencing stress over the previous 6 months. Cigna reached out to Provider A for additional information about his medical history, particularly the date of onset of symptoms, previous hospitalisations or treatment and past medical history. Provider A's response detailed depression, anxiety, stress, and burnout over the previous 2 years. Furthermore, knowing Cigna was seeking further information, Mr H advised Cigna that he did not have a regular GP as he had not required any treatment for some time. And he referred to GPs not being able to provide a report as they did not know him.

Although Mr H says Provider A's report was factually incorrect, that he did not have a doctor-patient relationship with the provider, and the report was based on a telephone conversation with a counsellor who lacks medical qualifications, he raised no issue at the time. He was willing to accept the report's content for treatment to be authorised, but it became an issue when Cigna declined the claim.

Cigna copied Mr H in the emails to Provider A, so he could see both the information requests and responses, but he did not question the information provided regarding his medical history. His assertion is also contrary to his email to Cigna on 13 December 2024 following a request for additional

medical information, where he said, *"I already submitted to a clinical evaluation by [Provider A] about this admission and understand they wrote a report".*

Provider A was an 'in-network' facility for Cigna, had a recognised international accreditation along with a license from the local health ministry. As such, it is reasonable that Cigna accepted the report from Provider A and assessed Mr H's claim based on the content, which showed he had pre-existing mental health issues prior to taking out the policy.

When a medical report is provided by a specialist in support of a claim, I find it reasonable for an insurer to consider the content to be a reliable account of what was said and diagnosed, unless the contrary is evidenced. In appealing Cigna's initial decision, Mr H provided a short medical report, which confirmed he had not been diagnosed by that doctor with a 'Major Depressive Disorder or Generalised Anxiety Disorder'. The report is so brief and absent of detail that its probative weight in my opinion is weak. I also note that while Mr H advised Cigna he did not have a regular GP, he received treatment for alcohol misuse in 2021. It is reasonable to infer that there will be some related notes about the circumstances that led to treatment, details of the treatment itself and accompanying details around Mr H's circumstances at that time. I find it unlikely that medical records do not exist, rather Cigna has not been given information that may (or may not) assist Mr H's stated position about his mental health. As such, I am satisfied that Cigna's decision was made based on relevant information, having weighed it fairly and applied the relevant policy terms and conditions.

There is no dispute that the policy terms exclude cover for pre-existing conditions, and I am satisfied that the evidence presented to Cigna demonstrated, on balance, that Mr H had undisclosed pre-existing mental health conditions. There is no equivalent law in Guernsey to the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). But I consider this Act a relevant consideration in reaching a determination that is fair and reasonable in the circumstances of Mr H's complaint.

CIDRA requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract. If a consumer fails to do so, the insurer has certain remedies, provided the misrepresentation is what CIDRA describes as a qualifying misrepresentation. For it to be a qualifying misrepresentation, the insurer must show it would have offered the policy on differing terms – or not at all

– if the consumer had not made the misrepresentation. And the types of 'qualifying misrepresentations' are careless and deliberate or reckless.

Cigna has provided confidential underwriting evidence, which shows that if Mr H had disclosed details of his prior anxiety, stress and burnout, an exclusion regarding mental health conditions would have been added to the policy.

Based on the evidence presented, Mr H had been suffering mental health issues for some time before he bought the policy yet did not disclose them. As such, I am satisfied that a reasonable consumer with that knowledge should have disclosed the history in response to the questions asked by Cigna. I am satisfied there has been a 'qualifying misrepresentation', and Cigna proceeded to apply the exclusion it would have if the correct information had been provided. I am satisfied this is fair and reasonable in the individual circumstances of this complaint.

Mr H considers the 'lifetime' nature of the exclusion is unfair. How an insurer determines the length of time an exclusion is applicable is a matter of its commercial discretion and judgment. Given the policy rules specifically exclude treatment for pre-existing conditions, or any condition or symptom related to a pre-existing condition, the lifetime applicability seems in keeping with the policy rules. As such, I do not find the lifetime applicability unfair.

## Final Decision

My final decision is that I do not uphold this complaint.

**Sean Hamilton**
**Ombudsman**

Date: 2 February 2026