DRN-3561769

The complaint

Ms D complains that CIGNA Life Insurance Company of Europe SA-NV ("CIGNA") unfairly cancelled her policy.

What happened

Ms D held an international medical insurance policy with CIGNA. In April 2020 she said she noticed irregularities with some of her bills from a particular healthcare provider, so contacted CIGNA and asked it to halt processing her claims while she looked into the matter.

CIGNA paid those claims towards the end of April 2020, but in May 2020 told Ms D her policy had been randomly selected for an internal audit. Ms D told CIGNA she'd previously contacted it to explain she was concerned about irregular bills. And in June 2020 she asked CIGNA to put an alert on her account because she'd identified irregular bills from another healthcare provider too.

CIGNA requested details of all the claims Ms D thought were impacted. Ms D collated that information and explained she thought there was over €7,500 still outstanding in unpaid genuine claims, but more than €2,200 that had been overpaid in relation to irregular bills.

In October 2020 CIGNA made the decision to terminate Ms D's policy and said it had done so because of the presence of fraudulent claims.

Ms D complained and said she'd previously been a victim of identity theft and CIGNA should have done more to work with her to resolve the issue rather than terminating her policy. Ms D said she'd continued to undergo treatment and accrue medical bills before being told of the termination. And when CIGNA did tell her of it its letter contained someone else's details which only added to her identity theft concerns. Ms D also said claims data had been deleted from her account and the genuine medical bills that had been submitted prior to the policy termination remained unpaid.

CIGNA said it'd terminated Ms D's policy correctly. It said it had initiated the audit before she'd flagged any concerns to it and claims on the policy had been found to be fraudulent. It said it hadn't found any evidence of someone else accessing or compromising Ms D's account, and Ms D had received the overpayments herself. CIGNA did accept that someone else's details were on its termination letter, but it said that was a mistake and not a result of identity theft.

Unhappy with CIGNA's actions Ms D referred her complaint to this service.

Our investigator said it wasn't disputed that some of the claims were fraudulent, but they said the policy explained a policyholder would have needed to make a fraudulent claim both knowingly and with intent and CIGNA hadn't demonstrated that had happened here. As they didn't think CIGNA had done enough to show it'd acted fairly and reasonably, our investigator recommended it paid the unpaid genuine claims (less the overpayment from the fraudulent ones) with interest and reinstate the policy should Ms D want that policy again.

Ms D accepted those recommendations, but CIGNA did not. CIGNA said Ms D now had a new policy with it and claims were being processed under that cover as normal. It also said Ms D hadn't returned the overpayments, the fraud wasn't reported to the police, and the claims were made via a member portal which had no evidence of being accessed without Ms D's login details.

For reference, Ms D went on to cancel the new policy she'd taken out with CIGNA. That policy is now the subject of a different complaint being considered under separate reference.

What I've decided – and why

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

Having done so I too will be upholding Ms D's complaint for largely the same reason as the investigator before me.

The presence of discrepant claims and Ms D being in receipt of an overpayment isn't in dispute here. What remains in dispute is whether CIGNA has done enough to demonstrate that the presence of those claims invoked the policy's fraud terms.

Looking at the policy's terms and conditions I can see Ms D's cover is subject to the following general exclusion:

"*We will not pay a claim which we have reasonable grounds to suppose has been made fraudulently. Please see clause 16 for further details.*"

The terms and conditions also set out the specific fraud term as being:

"*Any beneficiary who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals, for the purposes of misleading, information which has been asked for, commits a fraudulent insurance act, which is a crime*."

So, for me to conclude CIGNA had acted fairly and reasonably it would need to demonstrate that Ms D had submitted fraudulent claims knowingly and with intent to defraud. For the reasons given below I don't think it did:

- I won't recite the full timeline of events here as I think they are now well known by both parties, but Ms D appears to have alerted CIGNA to potentially fraudulent claims on her policy first and before it decided to undertake an internal audit.

- Ms D appears to have tried to work with CIGNA to identity the cause of the discrepancies with her account too. She asked it to allow her some time to gather further information about the claims she suspected were fraudulent before it terminated her policy. And she provided it with the information asked of her.

- While I accept Ms D may not have reported the fraud she suspected to the police I don't think that's evidence of her submitting fraudulent claims knowingly and with intent to defraud. Ms D had shared her concerns with CIGNA, and she'd tried to work with it to identify what had happened too.

- Ms D has remained consistent about her concerns and has provided evidence which suggests she has previously been the victim of identity theft/fraud as stated.

- CIGNA says it found no evidence of someone accessing Ms D's online portal without login details. I understand why CIGNA would have been concerned by that but I must bear in mind the wording of the relevant policy terms here. I don't think it automatically follows that a lack of evidence to demonstrate someone logging in without Ms D's login details evidences Ms D having acted knowingly and with intend to defraud.

- Ms D did not return the overpayments identified at the time to CIGNA. But she did identify the amount she thought she had been overpaid and she did appear to be willing to work with CIGNA to identify the inconsistencies at the time. Given the actions CIGNA took following its audit and the matter subsequently becoming the subject of a complaint, I don't think Ms D not returning the overpayment at the time is evidence of her acting knowingly and with intent to defraud either.

I would like to reassure CIGNA that I do understand why it was concerned by the activity on Ms D's policy and decided to take the action it did. But the policy terms set out that Ms D would need to have acted knowingly and with intent to defraud. And without more I'm not persuaded CIGNA has been able to demonstrate that is what has happened on this occasion. So I'm unable to agree it acted reasonably and I too think it needs to take steps to put things right.

Putting things right

To put things right I think CIGNA should:

- Reinstate Ms D's policy.

- Pay the outstanding genuine claims that were made through the policy (less any overpayment from the fraudulent ones and subject to the remaining terms of the policy) plus 8% simple interest.

My final decision

My final decision is that I uphold this complaint. CIGNA Life Insurance Company of Europe SA-NV should put things right in the way I have set out above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms D to accept or reject my decision before 19 October 2022.

Jade Alexander
Ombudsman