DRN-4644211

The complaint

Mr and Mrs W are unhappy that CIGNA Life Insurance Company of Europe SA-NV declined a claim and placed an exclusion on their private medical insurance policy.

What happened

Mr and Mrs W have a private medical insurance policy which they took out in 2018. In 2023 they claimed for an MRI scan for Mrs W's back. CIGNA reviewed the claim and placed an exclusion on the policy relating to Mrs W's back. Mr and Mrs W were unhappy as they said that the policy had been in force for five years and they had accurately declared their pre-existing medical conditions when taking the policy out. They also complained about other customer service related issues.

CIGNA looked into what happened and upheld Mr and Mrs W's complaint in relation to customer service. They offered them $300 in compensation but maintained the decision to apply the exclusion was fair based on the available medical evidence. CIGNA said Mr and Mrs W hadn't asked a question about their medical history correctly. They concluded that it was a qualifying misrepresentation which entitled it to apply an exclusion to the policy and decline the claim. Unhappy, Mr and Mrs W complained to the Financial Ombudsman Service. Their complaint focused on the application of the exclusion to the policy and the cost of the premiums they were paying.

Our investigator looked into what happened and didn't uphold the complaint. He thought CIGNA had fairly applied the exclusion. He also explained that the insurer was entitled to set the price of the policy and it covered healthcare costs in countries where the cost of healthcare was more expensive as well as countries where the cost of healthcare was cheaper.

Mr and Mrs W didn't agree and asked an ombudsman to review their complaint. They said that the only resolution now possible was for CIGNA to treat the policy as if it had never existed and return all the premiums from inception. They expressed concern that the investigator had referred to a misrepresentation having been made and reiterated that they did not misrepresent anything. So, the complaint was referred to me to make a decision.

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.

At the outset I acknowledge that I've summarised this complaint in far less detail than Mr and Mrs W have, and in my own words. I won't respond to every single point made. No discourtesy is intended by this. Instead, I've focussed on what I think are the key issues here.

The rules that govern our service allow me to do this as we are an informal dispute resolution service. If there's something I've not mentioned, it isn't because I've overlooked it.

I haven't. I'm satisfied I don't need to comment on every individual point to be able to fulfil my statutory remit.

The policy terms and conditions

The policy terms and conditions say there is no cover for:

> Treatment for:
>
> a) a pre-existing condition; or
>
> b) any condition or symptoms which result from, or are related to, a pre-existing condition.

A pre-existing condition is defined as:

> 'any disease, illness or injury, or symptoms present before the initial start date linked to such disease, illness or injury for which:
>
> - medical advice or treatment has been sought or received; or
> - the beneficiary knew about and did not seek medical advice or treatment.

The policy terms also say:

> 'If we determine on reasonable grounds that you deliberately or recklessly provided us with false or misleading information, it could adversely affect this policy and any claim.
>
> For example, we may:
>
> - treat this policy as if it had never existed, refuse to pay all claims and return the premium paid. We will only do this if we provide you with insurance cover which we would not otherwise have offered;
>
> - amend the terms of your insurance. We may apply these amended terms as if they were already in place if a claim has been adversely impacted by your carelessness.'

Was it fair for CIGNA to decline the claim?

During their review of the claim Mrs W provided evidence that she'd visited a Doctor in 2016. An MRI had been completed and the results said:

> L3-4: Evaluation of L3-4 reveals evidence for spinal stenosis. there is about 6mm combination of broad-based disc protrusion bulge complex. There is also hypertrophic arthropathy. There is probably some degree of hypoplasia of the pedicles. Overall there is severe spinal stenosis…

Mrs W claimed on the policy for the MRI in 2023 as she was referred for 'lumber spinal stenosis with neurogenic claudication'. The referral also states that Mrs W was referred for, 'further assessment and treatment for her lumbar spine stenosis'.

Mrs W had been diagnosed with severe spinal stenosis in 2016. So, I don't think it was unreasonable for CIGNA to conclude that Mrs W had a pre-existing condition when she took out the policy in 2018.

I appreciate that Mr and Mrs W are unhappy that they were not told about the case being sent to another team for a more detailed review of Mrs W's medical history. They feel that this was done covertly. I don't think CIGNA acted unreasonably by referring the claim for further review. On the basis of the medical evidence provided I think it was reasonable for them to want to explore whether Mrs W had a pre-existing condition and whether it was linked to the current claim. That's standard industry practice and I don't think that CIGNA acted unreasonably. CIGNA acknowledged that there were issues with communication and customer service in their final response letter but I don't think the decision to review the claim in more detail was unfair and unreasonable.

Did CIGNA fairly apply the exclusion to the policy?

The relevant law in this case is The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). This requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract (a policy). The standard of care is that of a reasonable consumer.

And if a consumer fails to do this, 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 has to show it would have offered the policy on different terms or not at all if the consumer hadn't made the misrepresentation.

CIDRA sets out a number of considerations for deciding whether the consumer failed to take reasonable care. And the remedy available to the insurer under CIDRA depends on whether the qualifying misrepresentation was deliberate or reckless, or careless.

CIGNA thinks Mr and Mrs W failed to take reasonable care not to make a misrepresentation when they answered questions about Mrs W's previous medical history. They included the following questions:

> Q1 Has any applicant been diagnosed with or had treatment for Cancer or Tumour; Heart Condition; Stoke, Brain or Neurological Disorders; Diabetes; Hepatitis or any Musculo-skeletal condition?

The answer to this question was, 'Yes' and high blood pressure was disclosed.

> Q5 Does anyone have any illness, condition or symptom not already mentioned?
>
> Please include details of any known or suspected issues whether or not medical advice has been sought or a diagnosis reached.

The answer to this question was 'No'.

I don't think Mr and Mrs W took reasonable care when answering these questions as they didn't disclose Mrs W's MRI scan and diagnosis in 2016.

CIGNA has provided evidence that if Mrs W had disclosed the condition she was diagnosed with in 2016 during the application process they'd have applied a general exclusion to the policy for lower back conditions. This means I'm satisfied that Mr and Mrs W's misrepresentation was a qualifying one.

CIGNA has considered Mrs W's case on the basis that the misrepresentation was careless. I agree it was careless rather than deliberate or reckless. As I'm satisfied that it was a careless misrepresentation I've looked at the actions CIGNA can take in accordance with CIDRA.

CIDRA says that CIGNA are entitled to add the relevant exclusion from the point of misrepresentation and then assess any claim in line with this exclusion. That's also set out in the policy terms which say CIGNA has the right to amend the terms of the insurance and apply those amended terms as if they were already in place if a claim has been adversely impacted by Mrs W's carelessness. Taking all of the above into account I think the fair and reasonable outcome to this complaint is that CIGNA have acted fairly by adding the exclusion.

I've taken into account whether CIGNA should refund Mrs W's premiums for the policy which she's paid since 2018. It's not in line with the remedies set out in CIDRA and I don't think that's fair and reasonable in the circumstances of this case. Mr and Mrs W have had the benefit of cover during the relevant time the policy has been in force and CIGNA have carried the risk of Mr and Mrs W making a claim. In CIGNA's final response letter, they referred to a few successful claims on the policy. So, this further persuades me that Mr and Mrs W have benefitted from the cover and it wouldn't be fair for them to receive a refund of the premiums.

The policy premiums

Mr and Mrs W have also complained about the cost of their premiums compared to the cost of healthcare in the country where they are currently living.

It's a commercial decision for CIGNA what price they want to charge for cover. And Mr and Mrs W's policy is an expatriate policy which covers them for healthcare worldwide, excluding the USA. Given the scope of cover I think it's reasonable to conclude that Mr and Mrs W are paying for a specialist insurance policy which factors in the cost of healthcare in various countries. So, I'm not persuaded by Mr and Mrs W's representations on this point.

My final decision

CIGNA Life Insurance Company of Europe SA-NV has already made an offer to pay $300 to settle the complaint and I think this offer is fair in all the circumstances.

So, my decision is that CIGNA Life Insurance Company of Europe SA-NV should pay Mr and Mrs W $300**.**

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr and Mrs W to accept or reject my decision before 15 April 2024.

Anna Wilshaw
Ombudsman