DRN-5241261

The complaint

Mrs D complains that CIGNA Life Insurance Company of Europe SA-NV has turned down a claim she made on a private medical insurance policy.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the key events.

Mrs D took out a personal private medical insurance policy in October 2023, which was underwritten by CIGNA.

In April 2024, a claim was made on the policy by a medical provider because Mrs D needed to undergo surgery for a prolapse. A Guarantee of Payment (GoP) was issued by CIGNA to cover the costs of the surgery. However, it was later clarified by the provider that Mrs D wasn't undergoing surgery at that point, she simply needed a scan. So CIGNA issued a new GoP for the scan and told the provider to disregard the surgical GoP.

Subsequently, on 13 May 2024, another provider asked CIGNA to issue a GoP to cover the prolapse surgery Mrs D needed. CIGNA asked for medical evidence so it could assess whether or not the surgery would be covered.

Based on the medical evidence report provided by the treating doctor (who I'll call Dr G), it seemed that Mrs D had been experiencing symptoms of urinary incontinence for around one year. This was about eight months before Mrs D took out the policy. So CIGNA thought Mrs D ought to have told it about her symptoms when she applied for the contract. It said that if she'd done so, it would have applied exclusions to her policy for both urinary incontinence and for prolapse. It concluded she'd made a qualifying misrepresentation under relevant law and added exclusions to Mrs D's policy. And therefore, it turned down Mrs D's claim.

Mrs D was unhappy with CIGNA's decision. She provided updated medical evidence from Dr G which said that in fact, her symptoms had only begun after the policy had begun and that the reference to one year was a clerical mistake.

But CIGNA maintained its stance because it didn't think there was a sufficient justification for the change in dates. So Mrs D asked us to look into her complaint.

Our investigator didn't think it had been unfair for CIGNA to place more weight on the first medical report to conclude that Mrs D had made a qualifying misrepresentation under relevant law and to apply exclusions to the policy. She also thought it had been fair for CIGNA to rely on the exclusion for urinary incontinence to turn down Mrs D's claim.

Mrs D disagreed. In late 2024, she underwent surgery with another doctor, Dr B. And she provided us with new medical evidence from Dr B which she felt supported her position.

The complaint's been passed to me to decide.

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, whilst I'm sorry to disappoint Mrs D, I don't think CIGNA has treated her unfairly and I'll explain why.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, amongst other relevant considerations, such as industry principles, the law, the policy terms and the available evidence, to decide whether I think CIGNA treated Mrs D fairly.

First, I must make it clear that within this decision, I'll only be considering the medical evidence which was available to CIGNA when it assessed this claim and issued its final response to Mrs D's complaint. I appreciate she's now undergone the surgery she needed under the care of Dr B and she's sent us new medical evidence provided by Dr B. But it isn't clear to me that CIGNA has had a chance to consider and comment on Dr B's evidence or to decide whether it alters its understanding of Mrs D's claim. So it wouldn't be appropriate for me to take into account Dr B's evidence as part of this decision.

Did CIGNA guarantee to cover Mrs D's treatment?

Mrs D says that CIGNA agreed to cover her surgery in April 2024. So it seems she considers it's bound to agree to pay the costs of her treatment. I've considered this point carefully.

It's clear that in April 2024, a medical provider asked CIGNA for pre-authorisation for Mrs D to undergo surgery for prolapse. CIGNA issued a GoP. However, Mrs D *didn't* undergo surgery at this point. Instead, the provider asked for a GoP for an MRI, which CIGNA went on to issue. CIGNA told the provider to 'tear-up' the surgical GoP.

So I don't think I could reasonably find that Mrs D still had a valid GoP for the costs of surgery in May 2024. And it seems that the May 2024 request for a GoP came from a different provider entirely. So I don't think it would be fair for me to direct CIGNA to pay a claim based on a GoP it had told a provider to disregard about a month before Mrs D's actual scheduled surgery. Nor is it clear that CIGNA had all of the medical evidence it needed to make a full claims decision until after the GoP was requested in May 2024.

Therefore, I'm not persuaded that Mrs D did have an existing, valid pre-authorisation for surgery when she came to claim in May 2024. This means I'm not telling CIGNA to pay the claim based on the GoP it originally gave in April 2024.

Has CIGNA handled the claim fairly?

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

When Mrs D took out the policy in October 2023, she was asked information about herself and about her medical history. CIGNA used this information to decide whether or not to insure Mrs D and if so, on what terms. CIGNA says that Mrs D didn't correctly answer the questions she was asked during the policy application. This means the principles set out in CIDRA are relevant. So I think it's fair and reasonable to apply these principles to the circumstances of Mrs D's claim.

CIGNA thinks Mrs D failed to take reasonable care not to make a misrepresentation when she took out the policy. So I've considered whether I think this was a fair conclusion for CIGNA to reach.

First, when considering whether a consumer has taken reasonable care, I need to consider how clear and specific the questions asked by the insurer were. CIGNA has provided us with a copy of the medical history questions Mrs D answered, on which it based its assessment of the risk. Mrs D was asked about:

'Q10 Urinary or reproductive disorders e.g. urinary tract infections, kidney problems, fibroids, painful, irregular or heavy periods, fertility problems, polycystic ovarian syndrome, endometriosis, testicular or prostate problems.'

CIGNA's records show that Mrs D answered 'no' to this question. In my view, this question was asked in a clear and understandable way and ought to have prompted a reasonable consumer to realise what information CIGNA wanted to know. CIGNA considers Mrs D answered this question inaccurately, so I've next looked at the available medical evidence to decide whether I think this was a fair conclusion for CIGNA to draw.

When CIGNA was considering whether or not to issue a GoP for Mrs D's surgery in May 2024, it asked her treating doctor to provide a report.

A report dated 15 May 2024 was issued by Dr G. This said that Mrs D had symptoms of a prolapse. The report referred to the date of diagnosis and said: *'Symptoms progression: 1 year with progressive worsening.'*

Based on Dr G's report, CIGNA concluded that Mrs D had answered its questions incorrectly and it turned down the claim.

Subsequently, Dr G provided new reports, dated 20 and 21 May 2024. The 20 May report said:

'Onset in January 2024 with progression of symptoms and progressive worsening…

The following is a medical report with rectification regarding the onset of symptoms in January 2024.'

The 21 May 2024 report said:

'(Mrs D) complains of…prolapse associated with urinary incontinence, with the onset of symptoms between January and February 2024.

I request rectification regarding any dates wrongly filled in reports prior so as not to cause any doubt as to the onset of symptoms; must be disregarded and only the information in this report should be followed; in order to not bring any harm to the patient due to delay in the

release of her procedure.'

Dr G added that surgery was indicated for prolapse and urinary incontinence.

An undated report from a Dr S was also provided, which stated that Mrs D had significant stress urinary incontinence and prolapse and had done so for around three months. Dr S said surgery had been planned for 15 May 2024.

In August 2024, Dr G provided a further letter in support of Mrs D's claim. They said:

'During this consultation, the patient reported symptoms of prolapse and urinary incontinence, which began in January 2024…These symptoms were confirmed through physical and gynaecological examinations.

Please note that the mention of 2023 was a simple clerical error. The correct date has been updated to 2024, as evidenced by my attached medical records and previously signed and stamped reports.'

Based on the content of Dr G's initial report of 15 May 2024, I don't think it was unfair for CIGNA to conclude that Mrs D had been experiencing symptoms for around a year and from before the policy began.

Dr G has since provided additional information which indicates that the reference to Mrs D experiencing symptoms was down to a clerical error. I've carefully considered this point. On the one hand, Dr G has now indicated that Mrs D's symptoms began after the policy started. But CIGNA doesn't think Dr G has given a sufficient explanation as to the reason for any clerical error and that the date of symptom onset they first recorded is likely to be the date Mrs D gave Dr G at their first consultation. I've taken Dr S' report into account but this isn't dated and it isn't sufficiently clear to me that it pre-dates CIGNA's decision to turn down the claim.

This is a very finely balanced decision to make and I've weighed-up the evidence very carefully. But overall, I don't think CIGNA's position here is unreasonable. I don't think it's unfair for it, based on the evidence it has, to conclude that the first report Dr G completed is likely to set out accurately the details of their discussions with Mrs D about her symptoms and when they began. And that evidence indicates that Mrs D had experienced worsening symptoms of a prolapse and urinary incontinence before she took out the policy. While Dr G says the reference to '2023' was an error, the 15 May 2024 didn't refer to 2023 – it referred to 'one year'.

I'm also mindful that CIGNA has been provided with very little further medical evidence which could help it assess the likely start date of Mrs D's symptoms. For example, it doesn't appear to have been sent copies of Mrs D's doctor's records setting out her medical history. And it isn't clear how, why or when she came to be referred to hospital for testing into her symptoms. In the absence of such evidence, CIGNA is necessarily reliant on the contemporaneous evidence from the time.

On balance, I don't find CIGNA acted unreasonably when it relied on Dr G's initial report to conclude that Mrs D hadn't accurately answered its question. This means I think it was fair for CIGNA to consider that Mrs D had made a misrepresentation.

So I now need to think about whether CIGNA has shown Mrs D's misrepresentation was a qualifying one. It's provided me with confidential underwriting evidence which shows that had Mrs D told it about her symptoms of urinary incontinence, it would have delayed offering Mrs D a policy until she had a diagnosis. This means it wouldn't have offered Mrs D a policy at all

when it did. However, it's shown us that it took the decision to add exclusions to Mrs D's policy instead, for prolapse and urinary incontinence.

This means I think CIGNA has shown Mrs D made a qualifying misrepresentation under CIDRA. And so I think it's reasonable for CIGNA to apply the relevant remedy available to it under the Act.

CIDRA says that in cases of careless misrepresentation, an insurer may rewrite the policy as if it had all of the information it wanted to know from the start. If it would still have offered cover, but applied different terms, then it can retrospectively add those terms to the contract from the start. In this case, given the underwriting evidence shows CIGNA would likely have declined to offer Mrs D cover until her urinary symptoms had been investigated, it *could* have chosen to cancel Mrs D's policy from the start and refund her premiums. It would have been entitled to do so under the relevant law.

But it didn't do so. Instead, it applied exclusions for prolapse and urinary incontinence, as it said Mrs D was experiencing symptoms of both conditions when she applied for the policy. CIGNA has shown it would have applied exclusions for both conditions. The exclusions for prolapse and for urinary incontinence also excluded claims for any associated or related conditions or symptoms and complications.

I accept Mrs D couldn't have declared a prolapse at the time of sale, as it appears she hadn't had a formal diagnosis of that condition. But it seems that she did have clear symptoms of urinary incontinence. And I'm satisfied CIGNA's demonstrated that if it had waited until Mrs D had a diagnosis for the cause of the incontinence, it would've excluded cover for prolapse too.

In my view, CIGNA has taken a more generous approach to Mrs D's misrepresentation than it could have done under the law. Based on the medical evidence it has, I don't think it was unfair for it to apply exclusions for both conditions in the specific circumstances of this complaint. CIGNA has concluded that even if the prolapse exclusion hadn't been applied, it was clearly linked to Mrs D's symptoms of urinary incontinence – and was most likely the cause of it. So it seems to me CIGNA has shown that the prolapse would be an associated or related condition in any event and therefore excluded by the policy terms.

Summary

It's clear Mrs D has been through a very difficult time and I'm sorry to disappoint her. But overall, I don't think CIGNA has handled her claim unfairly. So based on the evidence it has, I don't think it acted unfairly when it turned down this claim.

I appreciate Mrs D may wish to provide CIGNA with further medical evidence in support of her claim. It's open to her to do so and I'd expect CIGNA to review that evidence in line with its regulatory obligations. If Mrs D is unhappy with any further assessment of her claim, she may be able to bring a new complaint to us about that issue alone.

My final decision

For the reasons I've given above, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs D to accept or reject my decision before 10 March 2025.

Lisa Barham
Ombudsman