Before the Arbiter for Financial Services

Case No. 043/2019

SE & FE ('the Complainants')

vs

Axeria Insurance Ltd. (C 55905)

('the Service Provider'/'the Insurer')

Hearing of the 22 June 2020

The Arbiter,

Having seen the complaint whereby the complainant submits that he had received a communication from Axeria Insurance Ltd that they were withdrawing from the UK private medical insurance market and will no longer cover him for treatment from the termination of his current insurance cover, that is, from the 23 May 2019.

He also submitted that the insurer had informed him that they will no longer compensate for claims submitted under his policy even if the claim was submitted when the policy was in force.

The complainant reiterates that it is not fair for the insurer to act in this manner since they continued to accept the premium till the end date.

Since he was diagnosed during the cover period, he should be compensated for treatment even if the treatment happens after the expiry date of the policy.

He could only do the operation later on in the year due to work commitments. He also states that he did not submit a formal complaint form.

He pretends that the insurer should cover the costs for all treatment (within the policy limits) for his shoulder injury that might include surgery expected to take place at the end of the year and the treatment is estimated in the region of £7,000 to £10,000 depending on what the surgery entails.

Having seen the reply of the service provider which states that:

Axeria Insurance Ltd had decided to withdraw from the UK Private Medical Insurance Market and were no longer offering this type of cover. As a consequence, they did not renew the complainant's policy after the expiry date of his policy.

In line with the Policy terms and conditions (page 19), Axeria Insurance Ltd cannot pay for any treatment which takes place after the expiry date of the policy. Accordingly, on page 19, the Policy terms and conditions state:

'This policy provides benefit for treatment incurred during the policy period only. In the event that this policy is not renewed, we will cease paying for expenses incurred after the expiry date.'

This is in line with UK insurance practice.

The service provider did not collect any premium from the complainant following the expiry of his policy.

The Arbiter has to decide the complaint by reference to what, in his opinion, is fair, equitable and reasonable in the particular circumstances and substantive merits of the case.[1]

The issue that the Arbiter has to decide is whether the risk covered by the policy occurred during the cover period and whether the complainant is entitled to be paid for treatment which takes place after the expiry date of the policy.

The complainant is arguing that since he suffered pain in his shoulder during the duration of the insurance cover, he is entitled to be compensated even if the treatment connected with his injury is carried out after the policy has expired.

[1] Chapter 555 of the Laws of Malta, Art. 19(3)(b)

He insists that at the time he suffered the injury he was covered by the policy and treatment could only be received at a later date due to work commitments.

The insurer argues that since the treatment would be given after the expiry date of the policy, the complainant is not entitled to receive compensation for that treatment.

The Arbiter notes that the insurer is not refusing to compensate the complainant because a formal claim was not lodged or because the claim notification was not made in time but, simply, because the treatment would have been received after the expiration date of the policy.

One of the problems that the Arbiter is facing in deciding this complaint is the lack of detailed information submitted by the complainant and the service provider. The complainant does not give a detailed picture of what exactly happened to him and how he got injured; and the date of the incident. However, the insurer did not raise these issues presumably because, as soon as the complainant lodged the informal claim, it was immediately rejected by quoting page 19 of the policy document, which is also being quoted in this case.

However, the Arbiter has a different view to that submitted by the insurer. When reading the policy, the Arbiter notes that page 19 of the policy document states a little bit more than the part selected by the insurer.

In fact, the relevant part provides the following:

'*We shall not terminate your policy unless you fail to pay your premium when due or in the event of fraud or non-disclosure, or we decide to discontinue the policy.* ***Rights to benefits relating to a time prior to the date of termination are unaffected.***[2]

This policy provides benefit for treatment incurred during the policy period only. In the event that this policy is not renewed, we will cease paying for expenses incurred after the expiry date.'

The insurer was very much selective in the quoting of the policy document. The first paragraph was omitted.

[2] Emphasis by the Arbiter

The Arbiter has to interpret the policy in a fair manner which is also the duty of insurance companies to abide by the principles of fairness, reasonableness and equity in interpreting policy documents. Once the premium is paid and the claim falls within the terms and conditions of the policy, a claim should, as much as is reasonably possible, be honoured.

The policy document provides two different scenarios on page 19.

The first scenario is when the risk covered materialises during the period of insurance, that is, prior to the expiration date of the policy. In that case, the policy is clear that claims are to be honoured even if the policy is not renewed:

'Rights to benefits *relating to a time prior to the date of termination are unaffected'.*

The second scenario contemplates a situation which relates completely to the time when the policy has already expired and not renewed. In this instance, it is fair for the insurer not to pay for a risk which was not covered because there was no policy in place and for which the insured had not paid any premium.

The first scenario applies to this case. The policy expired on the 23 May 2019. Although the exact date of the shoulder injury has not been submitted, from evidence supplied by the complainant, there is no doubt that the injury took place during the period covered by the policy. The complainant submitted a medical certificate by Mr Richard Hartley[3] dated 15 March 2019, which signifies that the injury sustained by the complainant must have taken place before that date. This falls within the period of insurance since the policy expired after the 23 May 2019.

From the wording of the policy document, this scenario is specifically covered when the policy document states:[4]

'*Rights to* ***benefits*** *relating to a time prior to the date of termination are unaffected'.*

[3] Pages 10 and 11 of the proceedings

[4] Page 19 of the policy document, page 68 of the proceedings

The insurer cannot refute the claim by quoting the subsequent part of the policy document because, as explained earlier in this decision, the second scenario applies to **risks** which materialise after the policy has expired.

The benefit being claimed by the complainant is the direct result of the injury he sustained whilst he was validly insured.

The law stipulates that the Arbiter has to decide the case with reference to what, in his opinion, is fair, equitable and reasonable in the particular circumstances of the case.[5]

The Arbiter deems the conduct of the service provider to be unfair and unreasonable when it summarily declined the informal complaint, and for the above-stated reasons, the Arbiter is upholding the complaint as follows.

By way of remedy, the Arbiter directs the complainant to file a formal claim form with the insurer in accordance with the terms and conditions of the policy.

On its part, the insurer should deal with the merits of the claim also in accordance with the same terms and conditions of the policy and consider that a benefit deriving from an incident which took place before the expiration of the policy is covered by the policy and the insured be compensated.

Without prejudice to any rights the complainant might have after the processing of his formal complaint.

Each party is to bear its own costs of these proceedings.

Dr Reno Borg
Arbiter for Financial Services

[5] Chapter 555 of the Laws of Malta, Art. 19(3)(b).