Disclosure of material facts; utmost good faith; ex-gratia payment; pre-existing medical condition; questions in a proposal form; Cap. 555, Art. 19(3)(b)

Before the Arbiter for Financial Services

Case Number 161/2018

PS (the complainant/the insured)

vs

Laferla Insurance Agency Ltd (C-14529)

(the service provider/the insurer)

Hearing of the 9 July 2019

The Arbiter,

Having seen the complaint which states that the complainant was insured with the insurer from July 2016.

In January 2018, he asked the insurer to pay him for the medical expenses he incurred for an initial check-up with the doctor, a surgical operation and a post-operative check-up.

In April 2018, the insurance paid for the operation but they refused to pay for the check-ups, although they were an integral part of the surgical operation.

Also, Laferla Insurance has changed the terms of the insurance, imposing restrictions. It was emphasised that this was done during the period of insurance.

The complainant is asking the Arbiter to order the insurer to pay him €155.85 for the initial check-up and €576.81 for the post-operative check-up.

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

Mr PS was very clearly informed by the service provider what product he was purchasing, and the level of cover offered by his health insurance product. Mr PS consciously chose to take out a health insurance policy which offers cover for In-Patient and Day-Case Treatment only, with no cover for any form of Out-Patient treatment.

The definitions of 'Treatment', 'In-Patient Treatment', 'Day-Case Treatment', and 'Out-Patient Treatment' as per the insurance policy document are as follows:

- 'Treatment' – 'Any Medically necessary surgical or medical procedure, consultation, test or investigation to cure or actively and substantially relieve an Acute Medical Condition and must be carried out or controlled by a Specialist.'
- 'In-Patient Treatment' – 'This is where the Beneficiary is admitted to Hospital for treatment which is medically necessary, has signed an admission form; undergone a surgical procedure which is medically necessary and stayed in Hospital for one or more nights.'
- 'Day-Case Treatment' – 'This is where the Beneficiary is admitted to hospital as a registered Day-Case patient and has signed an admission form, occupied a bed or undergone a surgical procedure which is medically necessary but not stayed overnight.'
- 'Out-Patient Treatment' – 'Treatment received from a Specialist or under the control of a Specialist at a Hospital, Specialist's consulting room or other place approved by us where the Beneficiary does not go in for day-case or in-patient treatment.'

Tests and investigations done prior to a surgery are considered 'Out-Patient Treatment' in the case where a patient is not admitted as an In-Patient or Day-Case Patient when the tests are actually being carried out, as was the case with Mr PS.

Furthermore, Mr PS failed to inform the service provider of a pre-existing medical condition when purchasing the policy. This condition would have been specifically excluded from his cover as it was pre-existing. Details of this medical

condition transpired from medical reports which were sent to the service provider together with the claim in question.

It turned out that the costs which he claimed related to the afore-mentioned pre-existing medical condition. In view of this, technically, **none** of the costs claimed should have been covered by his policy as per exclusion number '2' in the insurance policy which states that the service provider cannot pay claims for pre-existing medical conditions. This general exclusion is written in virtually all health insurance policies worldwide, specifically, to catch out cases where a client fails to inform the underwriters of an existing medical condition which would otherwise be expressly excluded.

With regards to his claim regarding Laferla changing the terms of his insurance, this also stems from the pre-existing medical condition. Had Mr PS informed the service provider of his pre-existing condition in his application, as is his legal obligation to do, Laferla would have immediately included a specific exclusion on his cover for that condition, and informed him of such exclusion before he even purchased the insurance policy (which would have given him the option not to purchase the insurance policy, if he was not happy with the exclusion). Once the service provider learned of this pre-existing condition, it imposed this exclusion retroactively which is standard practice.

The service provider had clearly advised Mr PS, as the Office of the Arbiter for Financial Services may see from the documents which have already been presented to it, that a commercial decision was made to pay part of the costs claimed purely on an *ex-gratia* basis, which the service provider had absolutely no obligation to do. Therefore, in the service provider's opinion, Mr PS has no right to carry on with this complaint which it sees as being superfluous.

The service provider hopes that the explanation assists in the better understanding of this case. The service provider states that they have already exchanged countless correspondence with their client to try to explain to their client that his complaint is completely unfounded, and that they feel that they are spending an unnecessary amount of time re-explaining themselves.

Having seen all the documents filed by the parties,

Considers

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

The complainant requested the insurer to pay him the amounts of €155.85 for the '*initial check-up'* and €576.81 for '*the post-operative check-up'*.

The insurer refutes the claim on various grounds, namely:

1. That the complainant chose to take up a policy that covered only in-patient and day-case treatment with no cover for out-patient treatment;

2. The complainant had failed to inform the insurer of a pre-existing medical condition when purchasing the policy. Exclusion number 2 states that the insurance cannot pay claims for pre-existing medical conditions before the lapse of five years since coverage;

3. The altering of the terms of the policy also stemmed from the pre-existing medical condition of the insured. Had the insured informed them of the pre-existing medical condition, they would have included a specific exclusion on his cover for that condition and informed him of that exclusion even before purchasing the policy. As soon as they learned of the pre-existing condition, they imposed this exclusion retroactively which is standard practice.

4. They paid the complainant part of the costs claimed on an *ex-gratia* basis which they had no obligation to do.

The Arbiter appointed Professor Emanuel Farrugia, a medical expert, to report whether there was a pre-existing medical condition.

The medical expert reported:[2]

'*When Mr PS took out his insurance policy aged in his late sixties, it seems that he omitted to disclose his significant past eye problems which included cataract extraction and anterior vitrectomy in the right eye (January 2011), and left retinal surgery (done 30 years previous in Russia). In his telephone testimony on*

[1] Cap. 555, Art. 19(3)(b)
[2] *A fol.* 68

the 5th November 2018, Mr PS refers to a question he was asked regarding any medical procedure in the previous 5 years before enrolment, to which he correctly answered in the negative. Nonetheless, Mr PS should have disclosed this pre-existing medical condition (and others, if present), on the assumption that it was a must in the said policy documentation to state all pre-existing medical conditions.'

Pre-Existing Medical Conditions - the Juridical Context

The Maltese Courts have on various occasions dealt with the question of the disclosure of pre-existing medical conditions. For instance, in the Court Judgement delivered in the case of ***Ambrose Mackay et vs Citadel Insurance p.l.c.*** **decided on the 18 May 2016, the Court of Appeal** held that a contract of insurance is one based on the utmost good faith of both parties and it is a risk for the insurer that issues the policy and, therefore, it is expected that the insured should inform the insurance about any material fact that could impinge on the risk insured.

The Court of Appeal quotes the English case **'*Rozanes v. Bowen, 1928*'** as follows**:**

"'It has been for centuries in England the law in connection with insurance of all sorts, that as the underwriter knows nothing and the man who comes to him to ask him to ensure knows everything, it is the duty of the assured, the man who desires to have a policy, to make a full disclosure to the underwriters, without being asked, of all the material circumstances. That is expressed by saying that it is a contract of the utmost good faith'.

Then, in the case ***Greenhill v. Federal Insurance Co Ltd, 1927***,[3] it was also stated:

'Now, insurance is a contract of the utmost good faith, and it is of the gravest importance to commerce that the position should be observed. The underwriter knows nothing of the particular circumstances of the voyage to be insured. The assured knows a great deal, and it is the duty of the assured to inform the underwriter of everything that he has not taken as knowing, so that the contract may be entered with an equal footing.'

[3] As quoted by the Court

However, in accordance with EEC Council Directive of 1977, it was suggested that it would be sufficient for the insured to answer correctly the questions being asked by the insurer without the need to add further."[4]

Therefore, the existence of a pre-existing medical condition is a material fact that should be disclosed by the insured prior to the purchase of the policy. The Court added that the insured should respond correctly to all the questions asked in the proposal form and inform the insurer about all the material facts that are relevant to the insurer.

The medical expert concluded that the complainant '*seems that he omitted to disclose his significant past eye problems which included cataract extraction and anterior vitrectomy in the right eye (January 2011) … Nonetheless Mr PS should have disclosed this pre-existing medical condition (and others if present), on the assumption that it was a must in the said policy documentation to state all pre-existing medical conditions'.*

The Arbiter accepts the conclusions of the medical expert and agrees with the service provider that relevant pre-existing medical conditions should have been disclosed to the insurer.

On the strength of Section 6 - Exclusions, 2, of the policy,[5] the insured could only be reimbursed for '*Pre-Existing Medical Conditions, however, will be covered after five years continuous insurance cover with us provided that during the five-year period the Beneficiary has not:*

- *consulted any doctor for treatment or advice (including check-ups); or*
- *taken any medication (including drugs, etc.) for that Pre-Existing Medical Condition.'*

The complainant had only been insured for less than two years (July 2016 - January 2018) and, therefore, he did not qualify for the five-year period as indicated in the policy. As already emphasized in this decision, any material fact and pre-existing medical condition should have been mentioned to the insurer

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[4] Part of the Court's judgement has been translated by the Arbiter from Maltese to English to enable the complainant to understand the quote.

[5] *A fol.* 59

as an obligation of the basic principle of utmost good faith which is the basis of any insurance contract.

The service provider explained that although it was not obliged under the policy:

'*We decided to pay the in-patient part of his claim as an 'ex gratia' payment even though the condition was pre-existing and technically it should not have been covered. We did this purely as a sign of good will and good intention which unfortunately was not appreciated by the client.'*[6]

The Arbiter is of the moral conviction that the insurer has acted fairly, equitably and reasonably with the complainant and, for the reasons mentioned in this decision, the complaint is being rejected.

The expenses of these proceedings are to be paid by the complainant.

Dr Reno Borg
Arbiter for Financial Services

[6] *A fol.* 48