

Case ASF 184/2025

GB

(‘Complainant’)

vs

**Atlas Healthcare Insurance
Agency Limited**

(C 32603)

(‘Service Provider’/‘Atlas’)

Sitting of 21 November 2025

The Arbiter,

Having seen the complaint, whereby the Complainant disputes the Service Provider’s unjust rejection of a medical claim related to a breast module.

Basically, the case revolves on the interpretation which applies to exclusion of pre-existing conditions in the policy cover.

The membership handbook on page 6 states:

‘Our position on pre-existing medical conditions’¹

Private healthcare insurance is designed primarily to provide cover for new medical problems arising after joining. Depending on your underwriting terms, pre-existing medical conditions may be excluded. However, certain conditions which are unlikely to recur may be covered.

¹ Page (p.) 18

For us to determine whether treatment of a condition will be eligible for benefit, each member must, if required by us, have completed a full medical declaration in detail, when first applying for any level of cover. Upon completion of a full medical history declaration your membership statement will clearly show the medical condition(s) for which you are not covered for treatment. We may ask for a medical report, at your own cost, to clarify the status of any medical condition.

No treatment of any pre-existing conditions, whether chronic or not, will be eligible for benefit at any time if the condition has not been declared to us on the member's original application form and we have agreed in writing to cover for the condition or we have agreed in writing that there was no need to declare it. Refer also to paragraph 3.23 pre-existing conditions and paragraph 7.2 Our options if you break the terms of this policy.'

Para 3.23 on page 12 of same handbook states:

'pre-existing conditions

- i. treatment of any medical condition which the member already had when he or she joined and/or which the subscriber should have told us about but did not tell us at all or did not tell us everything unless we had agreed otherwise in writing that there was no need for you to tell us. This includes any physical defect or medical condition or symptoms whether or not being treated and any previous medical condition which recurs or which the member should reasonably have known about even if he or she has not consulted a medical practitioner.*

Please note that if you joined us on a Medical History Disregarded (MHD) basis, this exclusion will not apply.²

The application form filled by Complainant to subscribe to the medical policy has these clauses:

² P. 24

‘6. Medical History Declaration

Please note (i) no liability will be accepted for any medical condition which originated before the date of enrolment or which was foreseeable at the time of application unless such medical condition has been declared to and accepted by Atlas (ii) Failure to notify Atlas Healthcare of a medical condition may result in your policy being invalidated. If you are in any doubt, you must disclose the medical condition. Full and complete details must be given in respect of each person to be covered.

	You (Y/N)	Spouse/ Partner (Y/N)	Child 1 (Y/N)
a Present physical defects or medical conditions	N	N	N
b Consultation with specialists or hospital admittance/s in the last 5 years	N	N	N
c Consultations with a family doctor in the last 2 years	N	N	N
d Routine checks within the last 5 years (e.g. mammograms, smear tests, etc.)	N	N	N
e Are you or any applicant aware that you are or may be pregnant at the time of making this application?	N	N	N

If you have answered yes to any of the above, please give full details including names of medical conditions, relevant dates, treatment received including drugs, present state of health and foreseeable need for further treatment.³

The Complaint⁴

The Complainant stated:

‘I am filing a complaint against Atlas Healthcare Insurance regarding the unjust rejection of my medical claim related to a breast nodule.

At the time, I enrolled in the insurance policy, the nodule was not of clinical concern and did not require any treatment. Medical reports I submitted clearly confirm this, including a letter from a specialist indicating that the monitoring started later, only as a precaution, after a sudden growth occurred. Despite this, Atlas denied my claim, incorrectly stating that I was undergoing monthly checks before joining, which is not true and is not supported by any documentation.

³ P. 90

⁴ p. 1 – 6 and documents attached p. 7 - 77

Additionally, Atlas failed to respond to my follow-up emails within the required 15-working-day period. I sent multiple messages without receiving any reply. I only received a repeated refusal after calling their office several times, which is against MFSA complaint-handling rules.

I believe this situation constitutes an unfair application of policy terms and improper handling of a legitimate medical claim.

Atlas Healthcare has let me down in two ways:

- 1. They unfairly applied a policy exclusion by claiming that my breast nodule was a pre-existing condition requiring monitoring before the policy started. However, all medical evidence provided confirms that the nodule was not clinically significant at the time of enrolment and that monitoring only began after an unexpected and sudden change in size. Their decision to reject my claim is therefore based on incorrect assumptions and not supported by the medical documents submitted.*
- 2. They failed to handle my complaint in accordance with regulatory standards. I submitted a formal request for review and sent several follow-up emails, none of which were acknowledged or answered within the 15-working-day timeframe required by MFSA rules. I had to call multiple times before finally receiving a repeated denial. This shows a lack of proper internal complaint handling and customer care.*

These actions caused unnecessary stress, delayed access to reimbursement, and reflect poor professional conduct by a regulated insurance provider.⁵

In support of her claim, she submitted:

- 1. Certificate dated 27.03.2025 from Malta Lab recommending ultrasound guided core biopsy.⁶*

⁵ P. 2 - 3

⁶ P. 67

2. Certificate dated 07.04.2025 from same Malta lab reconfirming biopsy recommendation to be followed, if necessary, by surgical removal of the nodule.⁷
3. Receipt for payment for €620 by Malta lab.⁸
4. Certificate dated 14.04.2025 issued by Italian Medico Chirurgico Dr Giuseppe Grasso confirming that his 2022 examination of Complainant resulted in ultrasound characteristics compatible with a BIRADS 2 classification which required no further investigations.⁹
5. Certificate dated 18.06.2025 issued by same Dr Grasso stating that, in his opinion, the patient need not have declared his 2022 finding in her medical declaration on application to membership of the health scheme.¹⁰

By way of remedy, she is requesting the Arbiter to order Atlas to settle her claim for €620.

The Reply

In their reply of 09 September 2025, the Service Provider stated:

‘I’m writing to address the various issues brought forward by (the Complainant) in her above referenced complaint. I’m summarising her complaints:

- 1. (The Complainant) is disputing that her condition is pre-existing application to insure with Atlas*
- 2. Atlas stated that she needed monthly checks and that is why we declined her claim*
- 3. Atlas failed to respond to emails within the required 15 working day complaint handling period.*

Our answers follow:

- 1. **Dispute that the condition is pre-existing.** Please refer to my final response to (the Complainant) on behalf of Atlas (attached full detail and attachments, and page 8 of complaint), in which I explained in detail why,*

⁷ P. 69

⁸ P. 52

⁹ P. 73

¹⁰ P. 75

according to our policy wording, the condition is definitely pre-existing. This was even confirmed by Dr Andre Gatt on 27 March 2025 and 7 April (page 67 of complaint and 7 April report attached) clearly stating that the breast nodule in question is the same one identified in 2022, before her health insurance application date of 22 August 2024. This is more fully explained in my final response to (the Complainant) and I invite you to go through our reasoning which is fully explained in the response. In addition, there is a clear issue of non-disclosure which could even invalidate (the Complainant's) policy, however, we have not gone down that road. Again, this is fully explained in my final response to (the Complainant).

2. ***Atlas rejected (the Complainant's) claim based on the fact that she needed monthly checks.*** *This is not the case. My colleagues and I searched thoroughly through the correspondence and did not find any claim repudiation based on this. There is a mention in a report from Dr Giuseppe Grasso dated 1 October 2022 (translation attached) where he recommended monthly self-checks, but this is not material to this case – current medical advice is that all women should self-check their breasts for changes on a monthly basis and this is not an indication or recommendation that is material to this case. I can only conclude that this was a misunderstanding between Atlas and (the Complainant) and would like to confirm that our repudiation was based on the reasons I gave in my final reply to (the Complainant) and nothing else.*
3. ***Atlas failed to respond to emails within the required 15 working day complaint handling period.*** *Atlas received (the Complainant's) complaint on 27 May 2025 and responded on 18 June. This is unfortunately 16 working days. We apologise for this 1 day delay. There was quite extensive correspondence between Atlas and (the Complainant) (page 54 of complaint onwards) and I can only think that (the Complainant) may have the day of her formal complaint to be an earlier date than the email she sent to Nicolette Vella dated 27 May. We apologise if this was the case, but we took the previous correspondence to be normal claims processing correspondence. In fact, (the Complainant) wrote to me on 6 June formally*

*(page 7 of complaint) and at that point we had already been working on the complaint for some time.*¹¹

In their final reply of 18 June 2025 to the Complainant, referred to in their reply to OAFS, Service Provider had stated:

'I'm writing in my capacity as Atlas's Complaints Officer, and I have gone through your case in detail, taking into consideration all the facts. My role is to be impartial and examine your policy wording and the evidence you have presented to decide whether we have been fair in our assessment of your claim.

...

Medical Issues

- *In February 2019 and in October 2022, tests showed some anomalies, and the specialist diagnosed "bilateral fibrocystic mastopathy with some microcysts, ... a benign condition," classified as BIRADS 2. It is important here to note that a benign condition is still a condition.*
- *In your consultation with Dr Andre Gatt on 27 March this year, there had been some developments. The ultrasound report states the following:*
 - *"Comparison is made with a previous outside ultrasound report dated 01/10/2022."*
 - *"Comparison with previous scans shows that the newly palpable right lateral breast nodule corresponds to significant enlargement of a pre-existing nodule, now measuring 20mm in diameter (previously 11mm)."*

This report clearly states that the condition observed is the same as the one found to be present in 2019 and 2022, with changes being that the nodules had undergone "significant enlargement".

I am of the opinion that we have been fair in our assessment of your claim. I understand how disappointing this will be in your situation, and completely empathise, but I hope you understand our position that our claim assessment is

¹¹ P. 83 - 84

*based on a contract between you and us and to be fair to all our members, we must interpret and apply the policy the same way for all.*¹²

Hearing

A hearing¹³ held on 29 October 2025 resulted in parties reiterating their respective positions and relying on the Arbiter's adjudication to decide if the claim was or was not irregularly refused.

Analysis and recommendations

A contract of insurance is a contract where the parties are obliged to act in utmost good faith.

Insurers must address claims fairly without adopting an obstructive stance, seeking minute issues to avoid the claim. The insured must disclose faithfully all information demanded of them at the enrolment stage to ensure that the insurer has a fair view of the risk they are being requested to shoulder.

A pre-existing medical condition is an illness or injury that claimants had before their policy began.

Some insurance policies are individually underwritten and in such cases the insurer would

- ask questions about applicant's health
- oblige applicant to declare their medical history.

This is often called 'medical screening' required to enable the insurer to price correctly the risk they are being asked to assume.

Whether a condition is covered – and whether it will cost more – depends on the insurer's underwriting criteria for the specific policy.

We often hear from consumers who tell us that they:

¹² P. 85 - 87

¹³ P. 126 - 130

- weren't aware of the exclusion or warranty relating to pre-existing medical condition
- didn't understand the pre-existing medical condition exclusion and what it meant in practice
- weren't sure what, if anything, they needed to declare
- felt the policy was mis-sold
- felt their insurer wrongly rejected their claim.

To help us consider a complaint fairly and in reaching a decision, we consider:

- **the policy's terms and conditions** – we will look at what your insurer asked you about your health when you took out, amended or renewed your policy, and if you've been mis-sold a policy.
- **exclusions for pre-existing medical conditions** – If your insurer did not ask you anything about your health and there was no medical screening, we'll consider whether it was fair for them to use an exclusion in your policy.
- **misrepresentation and non-disclosure** – If there were a medical screening, we will check you gave the insurance company all the relevant information. If you did not, we will consider if you have deliberately misrepresented information or made a mistake.
- **change in health** – if an insurer turns down a claim because of a condition that came after the policy began or was renewed and had no medical history at inception of the policy we often decide in favour of complainant as this would not be a pre-existent condition.

In this particular case, we feel that the Insurer asked questions which were incorrectly answered by the Complainant leading to mispricing of the risk or the inclusion of risks which would have been excluded if the Complainant had answered correctly.

We take into consideration that the policy application was dated 22 August 2024, and the claim was made in April 2025. There is no evidence of the change of condition from the 2022 report all happened in the period between policy inception and the claim event.

However, irrespectively, the Complainant was obliged to give full details of her medical history as requested in paragraph 6 of the policy application form.

The Complainant answered with a straight 'N' (NO) to questions of consultations with specialists and routine checks in the last 5 years and certainly did not follow the instruction to disclose with full details even if in doubt.

Decision

The Arbiter is required to determine and adjudge a complaint by reference to what, in his opinion, is fair, equitable and reasonable in the particular circumstances and substantive merits of the case.¹⁴

This case unequivocally pertains to the misrepresentation of material facts. Material facts constitute a fundamental principle of insurance, which facts are those upon which the insurer bases the decision to accept or reject the risk presented, and, if accepted, under what terms.

The application form, which was signed by the complainant at the initial stage, explicitly states that no liability shall be accepted for any medical condition that was foreseeable at the time of application. Had the complainant been truthful during the application process by providing evidence that the 'matter' was benign, Atlas might have considered extending coverage, even if subject to certain conditions, such as an increased premium.

It is essential to note that the requirement for continuous monitoring leads to the reasoning that the potential for this breast module to result in a more severe condition was never completely ruled out. Therefore, this was undoubtedly a medical issue or condition that was foreseeable at the time of application.

The Arbiter shall refrain from evaluating whether the misrepresentation by the complainant was intentional or not. However, the consequences of such misrepresentation or nondisclosure were explicitly delineated in the same application form.

¹⁴ Article 19(3)(b) of Chapter 555 of the Laws of Malta.

For reasons explained above, the complaint is being dismissed, and each party is required to carry their own costs of these proceedings.

Alfred Mifsud

Arbiter for Financial Services

Information Note related to the Arbiter's decision

Right of Appeal

The Arbiter's Decision is legally binding on the parties, subject only to the right of an appeal regulated by article 27 of the Arbiter for Financial Services Act (Cap. 555) ('the Act') to the Court of Appeal (Inferior Jurisdiction), not later than twenty (20) days from the date of notification of the Decision or, in the event of a request for clarification or correction of the Decision requested in terms of article 26(4) of the Act, from the date of notification of such interpretation or clarification or correction as provided for under article 27(3) of the Act.

Any requests for clarification of the award or requests to correct any errors in computation or clerical or typographical or similar errors requested in terms of article 26(4) of the Act, are to be filed with the Arbiter, with a copy to the other party, within fifteen (15) days from notification of the Decision in terms of the said article.

In accordance with established practice, the Arbiter's Decision will be uploaded on the OAFS website on expiration of the period for appeal. Personal details of the Complainant(s) will be anonymised in terms of article 11(1)(f) of the Act