Before the Arbiter for Financial Services

Case ASF 052/2026

YW

('Complainant')

vs

Starr Europe Insurance Limited

(C 85380)

('Service Provider' or 'SEIL')

Sitting of 17 July 2026

The Arbiter,

Having seen the complaint[1] of 03 February 2026, whereby the Complainant seeks compensation amounting to €2,320 related to compensation for stolen luggage and a further €4,456.08 related to cancellation of trip resulting from assault and injury.

These were claims covered by a travel policy issued by Voyager Insurance No. 00X445XX52 covering a holiday trip scheduled for 25 July 2024 till 18 August 2024 bought online on 17 July 2024 for a premium of €92.81.

Policy showed residence of the insured as Germany and a destination including Europe, Channel Islands, Canary Islands, Isle of Man and Iceland.[2]

In the application for cover, the insured answered NO to a question:

[1] Pages (P.) 1 - 6 and attachments p. 7 - 87
[2] P. 55 - 66

> *"In the last 2 years have you or anyone insured under this policy : Suffered from or received medical advice (including routine checkups, investigations, treatment or prescribed medication) for any disease, illness, injury or psychological condition?"*

Complainant declared that on 26 July 2024 at 23:00, when he was in Amsterdam, he was the victim of an assault and robbery as a result of which:

- he sustained physical injuries and was transported to hospital for medical treatment;
- his luggage and personal belongings were stolen.

A report was filed with the Police at 12:30 of the 27 July 2024, where it was reported that:

> *"I hereby report that I have been the victim of a street robbery. I was not given the opportunity to give my belongings voluntarily, they were taken from me. I am making this complaint for insurance purposes ... I was in my vehicle parked on Van Beuningenstraat near house number 10C in Amsterdam. I saw two men walking towards me and heard one of them asking for a cigarette. Subsequently everything went very quickly. I know I was hit several times in my face and against my head. I know that I was struck against my chest and as a result I fell to the ground. I lost consciousness …".*[3]

He presented a hospital report showing that at 23:35 he was examined in a hospital and examination by CT scan showed no post-traumatic abnormalities and was immediately discharged with pain relief medicine and advice to rest[4].

After the event, he returned to his home in Germany and on 30 July 2024 was examined by his doctor who declared him unfit for work or travel for 10 days.[5] Accordingly, he had to cancel his holiday plans.

On 24 September 2024, he submitted two claims under the policy as follows:

[3] P. 72
[4] P. 84 - 87
[5] P. 79

1. Compensation for stolen luggage and personal items for €2,500;
2. Compensation for trip cancellation for €4,456.08.

The first claim was referenced STARR/104836 and was approved for settlement for an amount of €2,320.[6] In the settlement details. he asked for payment to be made to the account of a third party who during the course of the complaint process was helping Complainant as a translator.

SEIL maintain that the payment was bounced back to them because of some technical issue with incorrect beneficiary details and by the time they were investigating the second claim for cancellation of travel, they started harbouring doubts on the genuineness of both claims. Accordingly, they withheld the payment of even the first claim pending further investigations.

In fact, SEIL appointed a private investigator to examine the claims and on 06 August 2025, he was interviewed by the private investigator where he was assisted by a translator.

He maintains that although he gave all necessary information demanded of him, the claims have not been settled and, accordingly, he requests the Arbiter to order their proper settlement without further delay.

Reply of Service Provider

In their reply of 20 February 2026, SEIL stated:

"*As Complainant will be aware, a request was made by SEIL for him to undertake a further in-depth interview, post-initial notification, to confirm all aspects of the alleged assault and injury that reportedly took place In Amsterdam on 26 July 2024 - this was requested in order to validate all information provided by him, with the hope of being able to honour the claim.*

As a result of that interview, a further assessment was undertaken regarding the information that was provided, and the key findings are below:

Three differing accounts were provided of the incident to the Police, the Claims Handling Team, and the External Investigating Agents - imperatively, there were significant variations in the circumstances including parties involved in taking

[6] P. 154

(Complainant) to hospital, as well as destination locations of which (Complainant) was heading to.

(Complainant) confirmed that he had not submitted any previous claims under his insurance with SEIL, however, upon review, it was established that he had submitted two additional claims under references STARR/104XXX and STARR/104XXX.

In order for an insurer to pay a claim, circumstances must be validated and assurance must be provided to be able to satisfy any questions that may arise. Due to the differing accounts and information that were given, it resulted in SEIL not being able to accurately obtain a clear picture of the circumstances that gave rise to the alleged incident. Additionally, in answering that (Complainant) had not made any previous claims with SEIL, and for it then to be established that there had been two previous cases, both of which were reported to have occurred in 2024, and therefore the same year as the alleged assault he is claiming for under STARR/104XXX, it is not unreasonable to question why the two additional incidents were not spoken of when asked directly.

Additionally, I must also draw the Arbiter's attention to Points 4 and 16 of the General Conditions of (Complainant) Policy Wording that state:

Point 4: you must advise the claims handlers of any possible claim as soon as possible. You must supply them with full details of all the circumstances and any other information and documents we may require.

Point 16: if you or anyone acting on your behalf makes any claim knowing it to be false or fraudulent in any way then this insurance shall become void, premiums non-refundable and all claims shall be forfeited

As advised, we cannot validate the circumstances of this claim based on the information that has been provided, and furthermore, (Complainant) directly confirmed that he had not submitted any previous claims to SEIL.

I understand that this is not the outcome that (Complainant) would have hoped for, however, based on the above, and previous correspondence, SEIL is not able

to further consider this claim for payment and our decision to not uphold the related complaint remains".[7]

It is to be noted that reference to non-declaration of claim STARR 104952 is irrelevant as this is the reference number of the second claim being refused in this complaint.[8]

Accordingly, the reference to non-declaration of a prior claim rests on claim STARR/104XXX. This referred to a claim by same Complainant on a similar travel policy settled for €2,880.61 following medical expenses for falling off a scooter while in Switzerland.[9]

Hearing

At the hearing held on 28 April 2026, the Complainant largely repeated his complaint as already documented and explained above.

On cross-examination, he stated:

"It is said that when completing the online application on the 17th of July, I was asked whether I have ever submitted any previous claims under my insurance, and I answered, no.

Asked whether this is correct, I say, yes.

It is said that at the time I completed the application in July 2024, I was already aware of a claim with reference 104193 with regard to an incident in March 2024 in Switzerland, where I fell off a scooter.

Asked whether this is correct, I say, yes, I was.

It is said that, therefore, when I stated on the 17th of July 2024 that I had never submitted any previous claims under insurance, that was not true.

I say I knew that I had another claim.

It is said that the claim was settled by Starr for the amount of £2,880.61.

[7] P. 90
[8] P. 156 showing claim ending 952 was merged into claim ending 836
[9] P. 99

I say that I do not remember the amount.

I say, yes, I remember that it was settled, that it was paid.

It is said that from the facts of my complaint, it seems that I travelled from Germany to Amsterdam on the 25th of July.

I say, yes, it's correct.

And that my accommodation in Spain was booked from the 27th of July to the 18th of August.

I say that I don't remember everything offhand. I say that there is everything in the email. I am not in a position to remember every date of everything. So, I will not answer such questions because I have to go back and check the exact dates. These questions regarding dates could be verified by going back to my statement. There is everything in there.

So, I don't remember.

Asked whether I remember having a rented vehicle for that one night I stayed in Amsterdam, the night I was mugged, I say, no, I did not have a car.

It is said that on page 72 of my police report, I say that I was in my vehicle parked on Van Burgenstadt near a house.

Asked whether or not I had a vehicle, I say, no, I did not have a vehicle but I got a taxi to go to the hospital.

It is said that before the incident happened, I said that I did not have a car but in my police report I said that when the incident happened, the street robbery, I was in a car, in my vehicle parked on a road near a house number 10c in Amsterdam.

Asked whether or not I had a vehicle at the time of the alleged mugging, I say I did not have any cars.

It is said that once I received a reply from Starr (which was sent by email), I or whoever submitted an additional report. In that report, I say that whatever the investigator. appointed by the insurer whom I met and had an interview with, was saying was incorrect because I was asked not to bring documents with me and I couldn't remember. (page 150)

It is said that in this report, I said that the investigator recorded what I told him and that I told him that the police report and medical records should be relied

on. And I say that the information written in the report is incorrect. However, I am asked whether it is not the case (page 16) that when I was invited to meet the investigator, I was asked to prepare any relevant details that might assist me in the evaluation of my claim.

I say I am sorry but I forgot everything.

Asked why I did not take the documents or anything which I needed to take with me when I met the private investigator of the insurance, I say that the investigator did not ask me about the documents.

Asked whether I am claiming that the investigator got the information wrong, and asked whether, when I was with the investigator, I checked the information that I was giving him with any documents or with my phone or with any data which I had on me to verify what I was saying to the investigator, I say that the investigator did not ask me about the documents. The investigator asked me, 'What is it?' and I answered, 'I will send it to you by email.' He took a photo of me and a photo of my ID and he asked me some questions, and the rest of the conversation was about everything in Germany.

I am referred to the medical report I submitted dated 30 July 2024 by Dr Youssef Hamdan.

Asked whether I know Dr. Youssef Hamdan personally, I say, yes, he is a doctor.

Asked whether he was recommended to me by someone, I say Dr. Hamdan speaks Arabic so many of my friends and I go to him because Dr Hamdan understands our complaints better than other doctors in Germany.

It is said that in his report, he said that I was unfit to travel for a period of 10 days, and yet, according to the hospital report, I was discharged on the same day of the incident and I left Amsterdam on the 27th, on the day after the incident. I say that I was unfit to travel by aeroplane.

I am referred to the terms and conditions of my travel insurance. And that is the Voyager Plus Travel Insurance points.

Asked whether I am aware of the fact that Clause 16 of the terms and conditions of the policy states as follows:

'If you or anyone acting on your behalf makes any claim knowing it to be false or fraudulent in any way, then the insurance will not cover claims' and asked why I am expecting that the insurance pays this claim when there is enough

evidence that I made declarations which are to be false or fraudulent, I say that I do not know why the insurance company denied this claim. They have evidence, they have the police report, they have the medical report.

Asked whether I am denying that my claim is based on false and fraudulent statements, I say I deny."[10]

A second hearing was held on 04 June 2025, for the evidence of the Service Provider where Mr Dennis Xuereb, Compliance Officer, stated that the claims were rejected on the basis of investigation and inconsistencies found in the claim.

He added:

"I would like to refer to page 62 of the initial set of documents that were submitted by the OAFS. We see the statement of facts, and I refer to question 2 under that particular questionnaire which is the online questionnaire that the Complainant had filled prior to purchasing this cover asking,

'Did you sustain any losses in relation to disease, illness, or bodily injury?'

to which the Complainant also declared 'No' when, in fact, in March 2024, the Complainant sustained an injury by falling from a scooter, and that was settled under claim Starr 104XXX.

Something that stood out was the fact that the payment, (page 6 of the Cancellation Policy), with regard to the banking details of the beneficiary, the Complainant indicated XXXXXX XXXXX as the beneficiary. And this is a different party, not the policyholder. So, we were a bit confused as to why the funds would have been transferred to someone who is not party to the contract.

So, yes, this is another inconsistency.

Regarding the medical certificate attached to the claim form, where it says that you need the practitioner's signature (page 5 and 6 of this claim form), this was completely omitted.

In Starr's reply to the complaint, I made reference to Article 16 of the Terms and Conditions which state that a claim may be rejected if the claimant knowingly makes a false claim; that the claim becomes void and Starr would not be able to proceed with the claim.

[10] P. 159 - 162

Clause 16 under the general conditions of the policy details that false or fraudulent acts would render the policy void, and no premiums or claims would be paid. And this led us to believe so, since we had seen so many inconsistencies with respect to the versions provided by the claimant and, also, that he reported different times of the incidence to the police, to the Claims Team and, also, to our independent investigators.

The details and the events, who took him to hospital, they all differed. There were so many differing facts on his part. Not to mention the misrepresentation of facts at the inception of the policy when he did not declare the claims even though there was a specific question asking whether he had sustained or had any claims with respect to bodily injury in the last two years, and only a few months before inception of this cover, he had already undergone medical treatment that was settled by a fall off a scooter. Also, at claim stage, he also provided various inconsistencies.

Apart from all this, even when you see that the Complainant purchased waiver of excess, both for any other section of the policy, as well as for Gadget insurance, and these specific sections were being claimed under."[11]

The Arbiter enquired what would have happened if at the enrolment stage Complainant had disclosed the injury of March 2024 which was settled by a claim that was not even mentioned in the current claim in spite of a specific request for such declaration.

The Arbiter also enquired if at the enrolment stage, the underwriting system can discover any previous claim even without disclosure or whether such discovery is only discovered through investigation following a claim.

On 11 June 2026, the following declaration was received in reply:

"***I, Dennis Xuereb (ID No. …), in representation of Starr Europe Insurance Limited solemnly declare and confirm the following:***

The insurer underwrites the risk on the basis of the information provided by the prospective insured, who is required to answer all questions truthfully to the best of their knowledge and in utmost good faith.

[11] P. 174 - 175

Based on the responses received, the insurer may raise further questions, undertake additional assessments, and apply the underwriting measures deemed appropriate to evaluate the risk.

Given the nature of Travel Insurance, which is a high volume, low premium product, the insurer's systems do not provide access to the prospective insured's past insurance history at the point of application. Despite this, question 21 on page 6 of the claim form is clear and had the Insured answered truthfully, they would have been required to provide details which would have been considered at the time of the relevant claim.

In addition, had the complainant answered question No. 2 of the questionnaire (found on page 62 of the complaint form) honestly, the insurer would have conducted further enquiries and undertaken additional underwriting considerations as deemed appropriate."[12]

Final Submissions

In his final submissions, Complainant repeated his case and, in addition, argued:

1. Non-disclosure of previous injury and claim resulted from a proper understanding of *'this type of service'* in the application text which a non-English speaking consumer has difficulty to understand.

2. Document reference p. 99 of the process shows that contrary to what SEIL stated, they make discovery of a previous claim at the claim stage.

3. No evidence of bad faith has been provided. He argued that his answers, even if not accurate, did not create prejudice to the Service Provider and the vital facts and supporting documentation remain unchallenged and have not been disproved.

Final Submissions by Service Provider

In their final submissions,[13] SEIL asserted that they have no obligation to meet the claims based on three main grounds:

[12] P. 179
[13] P. 193 - 197

1. Breach of doctrine uberrimae fidei (utmost good faith) by material non-disclosure of prior claim.

   They quote several case laws supporting that utmost good faith is the basis on an insurance contract

2. False representation at claim stage

   They refer to false declaration denying existence of a prior claim and the nomination of a third party as recipient of the claim payment. They also make reference to an unsigned medical certificate lodged with the claim form.

3. Substantial inconsistencies in Complainant's own accounts, making reference to passport, destination and manner of transport to hospital apart from whether he was or was not in a car when he was assaulted.

Consideration and analysis

The Arbiter,

Having seen the statements made and evidence given by the Complainant,

Having seen the reply and evidence of the Service Provider,

Considers

That while there are circumstances that raise genuine suspicions on the veracity and honesty of this claim, the basic deciding factor is whether at the application stage, the Complainant made false declarations which, had the truth had been properly disclosed, the Underwriters would have taken a different view of the risk either by refusing it or by accepting it under different conditions.

The Arbiter accepts that the negative reply in question 2 (p. 62), already quoted above, was a substantial false declaration which breaches the principle of utmost good faith that underpins insurance contracts.

Added to this, that even in the claim form (p. 166) in question 21, no disclosure was made of a prior claim just 4 months earlier on a policy with similar characteristics (well defined by the clause 'this type of insurance') gives further support to the argument about lack of good faith on the part of the Complainant in bringing this claim.

There are other circumstances which raise questions on the validity of the claim even if on their own they may not provide conclusive evidence:

a. Why was settlement of the claim indicated to a third party and not to Complainant's own account?

   The third party happens to be the translator who was helping Complainant in the process and seems to be a very interested party in this claim.

   Any suggestion that Complainant had no bank account raises questions as to how he paid for this cover and how he paid the expenses claimed for.

b. Host of Airbnb accommodation (which is the major part of the claim for cancellation) bears same surname as the 'interested' translator.[14]

c. All excesses were removed from the insurance cover even for personal items.

d. Confusion as to whether or not at the time of the incident in Amsterdam, Complainant was in a car, as reported to the police, or he was on his own without a car.

The above circumstances, even if on their own are not conclusive, add support to the evident lack of utmost good faith declarations in the application for online cover.

It is quite indicative that the injury for which a claim was made in March 2024 was not mentioned at all neither at the application nor at the claim stage.

Decision

For reasons explained above, the Arbiter does not uphold this complaint as it fails on the basic insurance principle of utmost good faith by the insured and is further surrounded by other circumstances which raise serious doubts on the genuineness of this claim.

[14] P. 40

This case is being dismissed, and each party is to bear its own costs of the proceedings.

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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. Personal details of the Complainant(s) will be anonymised in terms of article 11(1)(f) of the Act.