

Before the Arbiter for Financial Services

Case ASF 059/2026

OM

(‘Complainant’)

vs

**Steadfast Insurance Partners Limited
formerly Cowen Insurance Company Limited**

(C 55905)

(‘Service Provider’ or ‘SIPL’)

Sitting of 20 October 2026

The Arbiter,

Having seen the complaint¹ of 13 February 2026, whereby the Complainant seeks compensation amounting to €82,239.92 in respect of medical expenses incurred while travelling under cover of a travel policy issued by Service Provider.

Complainant issued on 20 March 2025 a travel policy No. 6X02 XX34 XX00 under a Revolut Scheme which policy was administered by Cover Genius Europe B.V. (XCOVER) and underwritten by SIPL.

The Complainant claims that on 22 November 2025, he was involved in a serious traffic accident in Bali, Indonesia, resulting in severe traumatic brain injuries requiring immediate emergency hospitalisation and neurosurgery. He has remained in a coma and has required prolonged inpatient care, intensive treatment and further necessary medical brain surgery.

¹ Pages (P.) 1 – 10 and attachments p. 11 - 115

On 23 November 2025, the medical assistance team of SIPL contacted the family who cooperated fully and promptly, providing all requested medical records, reports and supporting documentation. By 5 December 2025, all documentation requested by the insurer and its medical assistance partners had been fully submitted. Despite this, no guarantee of payment, interim emergency support or formal written coverage position was issued. Instead, the family was informally informed of a claim rejection via Whatsapp², without a formal written decision or explanation and without any interim emergency assistance.

Due to the absence of a formal decision and the ongoing medical emergency related to the claim on the travel policy Bali-Thailand-Bali, the claim was formally lodged on the insurer's online portal on 9 December 2025.

This submission was initially handled by the insurer's local partner, PT Asuransi Dayin Mitra Tbk, and was rejected on 15 December 2025³ on the basis that the insured's travel route was Bali-Thailand-Bali between 2 to 8 November 2025, while the accident occurred in Bali on 22 November 2025.

This position was communicated without interim assistance and without a consolidated or final coverage determination from the insurer. Communication remained delayed, fragmented and inconsistent while the insured remained in critical condition. In this regard, the accusation seems addressed to SIPL who seemed to be underwriters or arrangers⁴ alongside PT Asuransi Dayin Mitra Tbk, whose reply was prompt and clear.

As a result of such inaction, the treating hospital demanded payment, initiated discharge discussions due to non-payment, and the family was forced to exhaust all available funds, seek external financial assistance and arrange transfers to public hospitals under severe financial pressures.

The insurer issued its formal final written response rejecting the claim only on 2 February 2026, more than 8 weeks after all the documentation had been submitted, during which time the insured remained in a coma and without effective insurance support. The rejection relied on a strict interpretation of trip duration and return-to-home requirements, raising concerns as to how a policy

² P. 190

³ P. 21

⁴ P. 189

marketed as providing “*worldwide emergency medical coverage*” reasonably applies to policyholders who travel frequently or reside internationally. Regardless of coverage interpretation, the absence of any interim emergency assistance during the investigation, combined with delayed decision-making, resulted in foreseeable and severe harm during a life-threatening medical emergency.

By way of a summary, it is being claimed that the financial services provider let the Complainant down by failing to act fairly, promptly and proportionately during a foreseeable and ongoing medical emergency, particularly due to:

- Failure to provide timely emergency assistance, despite early notification on 23 November 2025 and full compliance with documentation requests by 5 December 2025;
- Failure to issue a guarantee of payment or any interim emergency financial measure to the treating hospital;
- Reliance on informal communication (Whatsapp) to convey rejection without issuing a formal written decision;
- Prolonged delay of more than 8 weeks before issuing a final written response during a life-threatening situation;
- Lack of a clear, consistent coverage position communicated at an early stage;
- Fragmented handling across multiple entities, resulting in inconsistent grounds for rejection as well as
- Administrative handling that exposed the insured to risk of discharge, forced hospital transfer and compelled the family to self-fund costs reasonably expected to be covered under an emergency medical policy.

Finally, it is being claimed that even where coverage is disputed, insurers remain under an obligation to handle emergency claims with due care, urgency and regard for foreseeable harm. The absence of any interim measures or conditional support during a coma-level medical emergency falls below reasonable standards of care for emergency medical travel insurance and directly caused severe financial distress and medical risk.

Reply of Service Provider

SIPL replied⁵ on 9 March 2026 stating:

“

Following a thorough review of the claim and the applicable policy terms, we regret to confirm that we are unable to offer coverage in this case.

Under the terms and conditions of the policy, trips purchased using the Revolut Premium Plan are covered for a maximum duration of 30 days.

The policy defines a trip as “the period spent away from your home on pre-booked personal travel for up to 30 days. Travel must be scheduled to start and end at your primary residence. A trip starts (departure date) when you leave your regular place of residence (primary residence) to either travel to a destination”.

The insured’s country of residence is Romania. Accordingly, the trip is considered to have commenced when the insured departed from Romania.

Based on the documentation provided, the insured left Romania on 23 February 2025. The loss for which this claim was lodged is reported to be 22 November 2025. As such, based on the information provided, the loss occurred well beyond the 30-day coverage period specified in the policy.

In this case, we also need to refer to the general exclusions of the policy, wherein it is stated that you are not covered: “for trips exceeding 30 days”.

In view of the above, and in accordance with the policy terms, we therefore regret that we are unable to provide coverage for this claim.”

Submissions made by the Complainant’s wife

By means of an email dated 14 May 2026, the Complainant’s wife, LAD, further submitted that the Complainant was at the time *“in a state of confusion, able to respond only in single words, and remains under active neurological monitoring following two major brain surgeries. His treating neurosurgeon, documents encephalomalacia affecting both frontal lobes and the brainstem.*

⁵ P. 120 - 121 and attachments p. 122 - 148

While my husband shows some minimal awareness, he is clearly unable to give coherent sworn testimony or respond meaningfully to cross-examination in his current condition. This is not a temporary situation – the medical report indicates ongoing deterioration requiring potential further surgery.”

She, therefore, requested the Arbiter’s guidance as to whether, as co-insured under the same policy and present throughout all relevant events, she could pursue this complaint with the Complainant’s sister, ES, speaking on behalf of both.

Decree dated 22 May 2026

By means of a decree dated 22 May 2026, and after an informal meeting held with the parties to understand “*prima facie*” the position of both sides and explore any possibility to conduct a formal hearing process, the parties were invited to consider negotiating in good faith a settlement on an *ex gratia* basis taking into consideration the tragic circumstances of the case.

It was decreed that “*Failure to be informed of such a voluntary settlement by end July 2026, will lead to holding formal hearings and giving special permission for the Complainant to be represented, given that the particular circumstances of the accident do not seem to have a bearing on the arguments of either side*⁶.”

Reply of the Service Provider

By means of an email dated 8 June 2026⁷, SIPL replied by stating that:

“Having carefully reviewed the Decree and the matters discussed, Steadfast’s position remains unchanged, as a number of material issues remain unresolved and insufficiently supported by the evidence available to us.

⁶ P. 152 - 154

⁷ P. 155 - 156

We therefore wish to reiterate the principal issues that remain in dispute:

1. Trip Duration

The policy provides cover for trips of a maximum duration of 30 days. Based on the information available to us, the Complainant departed Romania in February 2025 and remained outside his country of residence thereafter. The medical incident occurred on 22 November 2025, well beyond the maximum trip duration permitted under the policy.

2. Residence Eligibility

Information provided during the claim assessment indicated that the Complainant may have changed his residence to Dubai. During the discussions held, the position regarding the Complainant's residency status remained unclear and no supporting evidence was provided to address this point.

3. Booking.com Cover

The separate Booking.com travel insurance cover related solely to the Bali–Thailand–Bali journey undertaken between 2 November 2025 and 8 November 2025 and had terminated prior to the incident giving rise to this claim.

4. Coverage Expectations

Whilst the Complainant continued to subscribe to Revolut Premium, Steadfast's position remains that insurance benefits are subject to the policy terms, conditions and eligibility requirements, and that payment of a subscription does not in itself create entitlement to cover where policy conditions are not satisfied.

Whilst Steadfast acknowledges the unfortunate circumstances surrounding the Complainant's medical condition, it maintains its position that the claim falls outside the scope of cover provided under the policy for the reasons outlined above.

In light of the material factual and legal issues that remain in dispute, including the application of the policy's trip duration limitation, eligibility requirements and residency provisions, Steadfast respectfully request that the

matter proceed in accordance with the Arbiter's procedures so that these issues may be formally determined.

Hearing

At the hearing held on 23 July 2026⁸, it was noted that the Complainant's medical condition remained largely unchanged. Therefore, the Arbiter observed that, though not ideal, he would have to rely on the exchanges made during the previous informal meeting and the submissions made by SIPL in its email of 8 July 2026, in arriving at a decision. It was accepted that the medical problem which arose from the incident and the events of the incident itself are not under contestation and the dispute rather revolved on whether the consequences of the incident are covered by the insurance policy.

The Complainant emphasised that since her husband paid the monthly subscription since the beginning when he bought the Premium Plan, they were expecting this incident to be covered. It was also noted that there is no interpretation of what 'residence' is and queried what happens if the product is targeted for digital nomads, frequent travellers, which is exactly what her husband is. She also observed that there were a lot of typos in the policy wording and the terms and conditions of the policy regarding the 30-day period, as now presented, differ from when the policy was taken out via Revolut. She affirmed that the policy is ambiguous and leaves room for interpretation. In such a case, the benefit of the doubt should be given to the policyholder.

She also referred to the manner in which the case was handled, considering that it was an emergency, with the final response being given two months later.

The Service Provider maintained that their position regarding the 30-day limit remains unchanged. They affirmed that the policy was clear and there was no ambiguity and that it was made available for review from the day the Complainant started paying. The fact that one of the conditions for the policy to be operative is that the insured must be an EU or EEA resident and that on the date of the loss, the insured was not an EU or EEA resident was reiterated.

⁸ P. 157 - 159

Also, the words “Trip” as well as “Home Country” are clearly defined in the policy in order to establish applicability of the 30-day period.

Decree dated 6 August 2026

Further to the hearing, the Complainant put forward a request by email dated 23 July 2026⁹, to submit further written submissions on the point raised during the hearing relating to the ambiguity of the policy. This request was acceded to by the Arbiter by means of a decree dated 6 August 2026¹⁰, which set as a deadline for such submissions 16 August 2026, with the deadline of end August 2026 being provided to SIPL to provide its counter-submissions. These submissions¹¹ and counter-submissions¹² were duly presented by the stipulated deadline and taken into cognizance for the purposes of this decision.

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

This case involves two conflicting opinions on the interpretation of the applicability or otherwise of a travel insurance policy.

The main issues under contestation relate to the interpretation of the 30-day period stipulated in the policy, the residence eligibility criteria and the ambiguity or otherwise of the policy as a whole.

The terms and conditions of the policy provide as follows” *When Am I Protected? You’re protected for trips, which start and end at your home, for up to 30 days*¹³”

⁹ P. 160

¹⁰ P. 161

¹¹ p. 162 - 206

¹² P. 207 - 210

¹³ P. 67 and 130

“Home” is in turn defined as *“your primary place of residence”*¹⁴. The fact that the insured must be a resident of the EU/EEA for the policy to be upheld is not under dispute.

On the other hand, *“Trip”* is defined as *“the period spent away from your home on pre-booked personal travel for up to 30 days”*. Travel must be scheduled to start and end at your primary residence. A trip starts (departure date) when you leave your regular place of residence (primary residence) to either travel to a destination:

- *Worldwide (except for travel to countries sanctioned countries).*
- *More than 100 kms away from your home.*
- *That includes an overnight stay outside of your city/town with a commercial provider such as a hotel or hostel.*

*A trip ends when you return home to your regular place of residence*¹⁵.”

The Arbiter is obliged to judge the complaint by reference to what is fair, equitable and reasonable in the particular circumstances and substantive merits of the case.¹⁶

The above-captioned definitions revolve around the concept of *“primary place of residence”*. This term is not defined in the policy itself, and it could arguably mean, within the context of the circumstances of the current case, either Romania or UAE. This could give rise to uncertainty for policy holders. However, the Complainant allegedly moved to reside in the UAE in February 2025 whereas the accident subject-matter of this case took place in November 2025. Therefore, the fact that the maximum 30-day period elapsed from the time when the Complainant left, either his home in Romania or the UAE, cannot be disputed.

It is uncontested by the parties that the policy holder must be a resident of the EU/EEA. Though, clearly the Complainant still holds a Romanian ID Card which would make him a *prima facie* resident of the EU, it is undisputed that at the time of the accident and when the policy claim was triggered, he was not residing

¹⁴ P. 80 and 143

¹⁵ P. 82 and 145

¹⁶ Article 19(3)(b) of CAP. 555 of the Laws of Malta.

therein. Residency normally requires presence of 183 days or more in any calendar year and it is clear that this was not the case with the Complainant.

For the above reasons, it can be concluded that the medical expenses arising from the accident fall outside coverage by the insurance policy taken out by the Complainant.

Nonetheless, the Arbiter also notes that it is undisputed that there was a significant lapse of time between 5 December 2025, when it is claimed that the Service Provider had all the documentation requested to process the claim, and the point in time on 2 February 2026 when the formal decision signifying the insurer's refusal to provide cover was issued. Given the grave and urgent circumstances of this case, a gap of more than 8 weeks to determine the claim is considered unjustified and prejudicial to the interests of the insured.

Though it is understandable that it is necessary for the insurer to understand the circumstances before issuing a refusal decision, cognizance must also be taken of the pressure that the Complainant's family was under in an emergency as the one they encountered. In such cases, it is understandably of paramount importance for the Complainant's family to assess the best possible care within the limits of their financial capabilities.

A Whatsapp message dated 5 December 2025 by MedConTeam Revolut Romania,¹⁷ which is not the underwriter, and which has no final authority to interpret the policy, clearly is not the best mode to obtain certainty as to the coverage or otherwise of the medical costs to be incurred, especially at such a sensitive time as the Complainant and his family were going through. It is only on the basis of a final decision by the insurer that the Complainant's family could decide on the best course of action within their financial means. **This possibly led them to take a financial decision under the expectation of full or partial coverage under the policy, which decision they possibly would not have taken had the final and official refusal decision been provided in a more timely manner.**

The Arbiter considers that for a substantial length of time, and particularly in view of certain terms in the policy which could arguably lend themselves to

¹⁷ P. 190

interpretation, there was an element of legitimate expectation by the Complainant's family that the medical expenses incurred would be covered by the policy. In their final submission, SIPL seem to admit that their handling of this claim fell below expected standards and insist that:

"Any issues concerning the administration or communication of the claim should also be distinguished from the coverage question. Such matters do not, in themselves, create insurance cover where the contractual requirements have not been satisfied¹⁸."

Decision

For the reasons explained above, the Arbiter rejects the Complainant's claim for the recovery of medical expenses as well as for the repatriation costs mentioned subsequently in his submissions sent by email dated 16 August 2026. The fact that for Bali–Thailand–Bali journey undertaken between 2 November 2025 and 8 November 2025, Complainant issued a separate travel policy indicates awareness that the Travel Policy under which he is now claiming was not offering open coverage as he expects in his complaint.

However, considering that:

- (i) in terms of Article 19 (3) (c) of the Arbiter for Financial Services Act (Cap. 555 of the Laws of Malta), the Arbiter is required to consider the consumer's reasonable and legitimate expectations in arriving at his decision;
- (ii) it may be concluded that there was some element of reasonable and legitimate expectation on the part of the Complainant that the expenses being incurred would be partially or fully covered by the policy, arising from the unduly long period taken by the Service Provider to provide a final official decision signifying its total refusal of claim under the policy;

in terms of Article 26(3)(c)(iv) of CAP. 555 of the Laws of Malta, the Arbiter orders the Service Provider to pay Complainant the sum of €5,000.00 (five thousand euro), by way of compensation to the Complainant. Calculation of such compensation is not scientific and, generally, the Arbiter adopts a best

¹⁸ P. 210

judgement approach as normally followed by the principle of *arbitrio boni viri* where the amount is established *ex aequo et bono*.

Each party is to bear its own costs of the 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. Personal details of the Complainant(s) will be anonymised in terms of article 11(1)(f) of the Act.