

SC

(‘Complainant’)

Vs

Stellantis Life Insurance Europe Limited

(C 68966)

(‘Service Provider’ or ‘SLIEL’)

Sitting of 20 October 2026

Having seen the **Complaint**¹ regarding the Service Provider’s denial to settle a claim on an insurance policy which covered lease payments on her car during a period of incapacity between 26 September 2025 and 03 April 2026. The claim regards 6 monthly instalments of €221.72 each for a total of €1,330.32.

Complainant explained that she presented medical certificates confirming a case of depression, which has also been shown to involve physical symptoms (obesity and hearing loss). These circumstances led to a prolonged period of illness during which she was unable to work.

She challenges SLIEL’s denial decision, claiming it was based solely on the diagnosis of depression and disregarded additional physical issues which are covered by the policy.

She insists that SLIEL is obliged to meet her claim for €1,330.32 and requests the Arbiter to find them responsible for such payment.

¹ Pages 1 – 6 and attachments p. 7 - 83

Having seen the **Reply**² of the Service Provider wherein they state:

‘This insurance policy contains exclusions. The analysis carried out by our medical department, based on the documents provided and the information given during the claim assessment, indicates that the Temporary Disability results directly from the following exclusion:

- *Illnesses resulting from a **psychiatric condition or an anxiety-depressive syndrome** that do not present measurable organic symptoms enabling a diagnosis.*

This information is stated in your policy (Article 7 – Exclusions). The application of these terms and exclusions results in the rejection of the claim for coverage submitted with your finance contract.

*According to the information received, the **confirmed condition is “depression”** (as indicated in the Medical Report dated 09/02/2026 by Dr. D. Möller), and also the **physical symptoms are a consequence of the depression**. In accordance with the general terms and conditions of the insurance, this condition is not covered, as **depression falls within the above-mentioned exclusion**. Consequently, Stellantis Life Insurance Europe Ltd must confirm the refusal of coverage.³*

Hearing

A hearing was held on 09 September 2026 where the Complainant failed to attend whereas SLIEL was duly represented.

Complainant had requested the Arbiter to decide the case without holding a hearing as she felt that all evidence had been provided by both parties and she had difficulty communicating verbally in English and taking time off work⁴.

The Arbiter offered to reschedule the hearing⁵ to give her time to be accompanied by a translator of her choice, but Complainant failed to reply.

² P. 87 – 88 and attachments p. 89 - 100

³ P. 87

⁴ P. 102 - 104

⁵ P. 106

At the hearing, SLIEL's representative opted not to insist on cross-examination of the evidence submitted by Complainant⁶. By way of supporting their own evidence, SLIEL submitted:

1. Copy of the Exclusions referred to in their reply i.e. *"Illnesses resulting from a psychiatric condition or an anxiety-depressive syndrome that do not present measurable organic symptoms enabling a diagnosis"*⁷.
2. Copy of medical advice⁸, contributing to the claim being declined, as it certifies as its conclusion:

'On the basis of the available medical documents, [Complainant's] incapacity for work is primarily caused by a recurrent depressive disorder, with a current severe episode without psychotic symptoms.

The reported sleep disturbance, fatigue, physical exhaustion, deterioration in general condition and reduced resilience are compatible with, and form part of, the depressive disorder. They do not constitute evidence of a separate measurable organic disease causing the incapacity for work.

The hearing loss and grade I obesity are recorded as secondary diagnoses, but the submitted documents do not identify them as the determining cause of the incapacity for work.

From a medical perspective, the additional documents therefore provide no new evidence allowing the incapacity for work to be separated from the psychiatric principal diagnosis or attributed to an independent organic disorder.

The final interpretation and application of the contractual exclusion remain matters for the insurer. From a medical-technical perspective, however, the established cause of the incapacity for work is consistent with the exclusion in Article

⁶ P. 107 - 108

⁷ P. 87 (English); p. 119 (French)

⁸ P. 113 - 116

7 concerning psychiatric or anxiety-depressive disorders without an independently demonstrated organic substrate.⁹

Analysis and considerations

As Complainant had requested to close the case on the basis of evidence submitted in her complaint and she has not offered any reply to the evidence provided by SLIEL during and subsequent to the hearing, the Arbiter is obliged to make his decision based on available evidence.

The Arbiter decides by reference to what, in his opinion, is fair, equitable and reasonable in the particular circumstances of the case, as provided in Article 19(3)(b) of CAP. 555 of the Laws of Malta.

SLIEL's medical opinion confirms that the cause of the illness being separate and independent from the specific policy exclusion **a psychiatric condition or an anxiety-depressive syndrome**, has not been proven.

The Arbiter considers that such opinion is much stronger than the medical certificate supporting the Complainant's claim that **hearing loss and obesity** were independent (as against consequential) causes of her inability to work during the period of illness.

Whilst the Arbiter is not an authority on medical issues, he can understand that obesity and hearing loss *per se* do not provide a justification for extended absence from work.

Decision

For the reasons explained above, this complaint is hereby dismissed and parties are ordered to carry their own costs of the procedure.

Alfred Mifsud
Arbiter for Financial Services

⁹ P. 116

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.