Before the Arbiter for Financial Services

Case ASF 237/2026

RS

('Complainant')

Vs

GasanMamo Insurance Limited

(Reg. No C 3143)

('Service Provider' or 'GM')

Sitting of 06 November 2026

The Complaint[1]

Having seen the complaint filed on 29 July 2026 whereby Complainant (age 19 years at the time of the event) challenges the Service Provider's decision to refuse settlement of her claim for €662.11 being a bill issued by Mater Dei Hospital[2] (MDH) related to services provided[3] on 19 November 2025 as covered by MDH Case summary[4].

She explained that:

"*My health insurance policy with GasanMamo Insurance commenced on 12 September 2025.*

On 18 November 2025, I experienced acute abdominal pain and heavy vaginal bleeding and attended the emergency department of Mater Dei Hospital. The situation was treated as an urgent medical case and medical assessment

[1] Page (p.) 1 - 7 and attached documents p. 8 - 189
[2] P. 15
[33] P. 17 -24
[4] P. 25 - 26

confirmed a pregnancy complication. The event required immediate medical evaluation and treatment.

I submitted a claim to GasanMamo Insurance for the medical expenses incurred during this emergency admission.

On 26 December 2025, the insurer requested additional medical information, including clarification regarding a previous right salpingectomy that took place in September 2024 following an ectopic pregnancy. I provided the requested medical documentation and clarification.

The insurer subsequently rejected my claim on two grounds:

That pregnancy and childbirth complications are only covered if the insured has been continuously insured for at least 12 months.

That I failed to disclose a previous ectopic pregnancy and salpingectomy when completing the proposal form at policy inception.

Regarding the prior surgery, the ectopic pregnancy occurred in September 2024 and was treated with emergency surgery. The condition was resolved and no ongoing treatment or follow-up was required at the time I applied for insurance. When completing the proposal form, I answered all the questions to the best of my understanding and without any intention to omit relevant medical information.

The medical event giving rise to this claim was an unexpected and acute emergency requiring immediate medical attention.[5]"

By way of resolution, she requests the Arbiter to order GM to meet her claim and pay her the amount of €662.11.

Reply[6] of Service Provider

In their elaborate and extensively documented reply, they maintain that on 2 February 2026, the claim was declined on two separate grounds:

[5] P. 3
[6] P. 195 - 199 and attachments p. 200 - 327

- *"The applicable 12-month eligibility requirement for pregnancy and childbirth complications had not been satisfied.*
- *Material medical and surgical history had not been disclosed at policy inception."*[7]

They refer to a request of 09 February 2026 by Complainant to consider an *ex gratia* payment but GM refused the request and maintained their position to decline the claim for the reasons stated[8].

On 26 March 2026, Complainant made a further request for the decision to be reconsidered, and GM replied in final terms that the claim is declined on the basis that:

- "*The negative answers on the proposal form did not disclose the previous ectopic pregnancy and right salpingectomy.*
- *The information was material and, had it been declared, specific underwriting terms would have been applied.*
- *The 12-month requirement for pregnancy-related complications had not been satisfied because the policy commenced on 12 September 2025 and the admission occurred on 18 November 2025.*
- *The request for an ex gratia payment had been considered but no discretionary settlement would be offered.*
- *No payment would be made under the policy or on an ex gratia basis*."[9]

GM concluded that at the date of the treatment, Complainant had not completed the continuous 12-month period required for the listed pregnancy and childbirth complications.

Separately, the disclosed medical documentation confirmed a previous ectopic pregnancy and right salpingectomy before policy inception, which had not been declared on the fully medically underwritten proposal form.

[7] P. 198
[8] *Ibid*.
[9] P. 198 - 199

The request for an *ex gratia* settlement was also considered and declined[10].

Hearing

A hearing was held on 29 September 2026[11].

Complainant stated:

> ***"My complaint concerns the rejection of my medical claim arising from acute medical emergency on 18 November 2025. GasanMamo declined the claim mainly because of the 12-month waiting period for pregnancy-related complications. And because they say I failed to disclose my previous ectopic pregnancy when I took the policy.***
>
> ***My position is that the medical event of 18 November 2025 was an acute and unforeseen emergency. I did not seek treatment as a routine pregnancy consultation. And, also, the previous ectopic pregnancy that occurred in September of 2024 had been treated by surgery and was resolved. I'm asking for the consideration of the actual circumstance of November of last year as emergency and not like a routine pregnancy consultation.***
>
> ***The Arbiter explains that the issue regarding this case is not whether the intervention of November 2025 was an emergency or not because there is not any dispute on that. The issue is whether it was covered by the insurance policy.***
>
> ***In their reply, the Service Provider explained that there are two reasons why they are saying that the Complainant is not covered. But the most important reason is basically that the Complainant failed to disclose the previous surgery related to the same issue which had occurred just a year before.***
>
> ***The Arbiter asks the Complainant why she did not disclose this surgery of 2024.***
>
> ***The Complainant replies:***
>
> ***I understand GasanMamo's position. My previous ectopic pregnancy occurred approximately one year before I took the insurance with them.***

[10] P. 199
[11] P. 328 - 331

And the treatment was an emergency and had been completed. Also, I did not receive any treatment for that surgery.

Asked why I did not declare this in the Prosposal Form, I say that at the time I completed the Proposal Form, I understood that the ectopic pregnancy of September had been treated and resolved. The emergency, the surgery had been completed and I did not receive any treatment. So, I understand that this was resolved and that I did not have anything to disclose in this context.

I am referred to a letter which I received in reply from the insurance, from Ms Donna Micallef Briggs, which says:

'In relation to your request for an ex gratia payment, we would like to explain …'

It is said that, normally, people who ask for an ex gratia payment are people who know that they are not covered.

Asked why I asked for an ex gratia payment, I say that after GasanMamo declined my claim, I made a formal request for an ex gratia consideration. And I asked them to consider the matter as an exceptional payment without accepting their reason for rejecting the claim.

The Service Provider's representative has no questions for the Complainant. [12]***"***

Donna Micallef Briggs gave evidence on the part of GM, stating:

"[Complainant] is actually confirming here her non-disclosures relating to the ectopic pregnancy and the surgery that followed which she was required to declare because we specifically have a question, "If you had any pregnancy complications." So, I cannot see why there was any misunderstanding there.

I say that the questions relating to pregnancy and surgery are not time related, so these had to be declared on the Proposal Form. However, she had declared all the questions as 'No', that there were not any issues. But, besides the fact that there were these non-disclosures as well, there is the policy condition that specifically states that we do not cover

[1212] P. 328 - 329

pregnancy and childbirth complications except a specific number of complications, one of them being miscarriage ectopic pregnancy. However, the policy specifically stipulates that one has to be insured for a continuous 12 months, in which case even if there was no history of pre-existing, she is still not entitled to claim because she only had been insured just two months prior to the incident happening as the policy was incepted on the 12th of September of 2025 and she was hospitalised on the 18th of November of 2025.

So, based on the policy term and conditions on its own, the claim was obviously not covered on those bases either.

The Complainant has no questions for the representative of the Service Provider[13]***.***"

Final Submissions

Complainant submitted:

"I want to say that again, I understand GasanMamo's position regarding the 12- month period, but my concern is that they have treated the event simply as a pregnancy-related claim. But the incident that happened on 18 November 2025, was a cured medical emergency. I started to feel bad. I started to feel heavy abdominal pain, and I had a lot of vaginal bleeding. For that reason, I went to the hospital emergency, and they declared this as an emergency.

The is why I am asking the Arbiter to consider the circumstance as an emergency and not as a routine pregnancy consultation because that was the only time that I went to the hospital for an emergency. Actually, if I hadn't felt so bad that day, I wouldn't have gone there. But, as I said before, it was an emergency and the hospital regarded this as an emergency.[14]***"***

Service Provider submitted:

"I say that the actual document, the case summary of the hospital, specifically states that she was admitted to Mater Dei Hospital in the

[13] P. 330
[14] *Ibid*.

EPU, which is the Early Pregnancy Unit, and she was treated specifically for this pregnancy complication.

I am not denying that it was an emergency. No, not at all. In fact, the complications that we cover in the policy would all be emergency situations, not routine cases. So we are not debating that[15].”

Analysis and Considerations

The Arbiter will decide the Complaint by reference to what, in his opinion, is fair, equitable and reasonable in the particular circumstances and substantive merits of the case.[16]

The Arbiter has to decide whether GM had good reasons to deny the claim for the reasons explained above, i.e., that the Complainant had not declared a material event in her medical history on the proposal form, and that irrespectively, the policy had a waiting period of 12 months before such event as claimed for would become operative under the policy.

It is an established principle that insurance contracts require utmost good faith on behalf of both sides especially in full and honest disclosures by the insured to enable the insurer to decide whether to accept the risk and to price it appropriately.

There is ample evidence that Complainant failed to abide by the principle of utmost good faith when in her proposal form, she answered ‘NO’ to all questions exploring her medical history[17]. Investigations effected post claim disclosed serious undeclared medical events[18].

Furthermore, insurance policy exclusion No. 31[19] clearly defines the waiting period of 12 months applicable for claims related to pregnancy and childbirth complications.

Furthermore, the fact that Complainant has sought an *ex gratia* settlement is indicative of her understanding to her claim not being covered by the policy.

[15] P. 331
[16] Cap. 555, Art. 19(3)(b)
[17] P. 249
[18] P. 200 appendix G (p. 262 – 298), p. 25 - 26 MDH Case Summary
[19] P. 221

The Arbiter has no competence to decree *ex gratia* settlements.

Decision

For reasons above explained, the Arbiter is hereby dismissing this complaint and orders parties to carry their own expenses 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. Personal details of the Complainant(s) will be anonymised in terms of article 11(1)(f) of the Act.