Before the Arbiter for Financial Services

Case No. 048/2019

OH

(the complainant)

vs

Axeria Insurance Ltd (C-55905)

(the service provider/the insurer)

Sitting of 1 February 2021

The Arbiter,

Having seen the complaint[1] whereby the complainant submits that:

OH and HH had a continued healthcare policy for over 30 years covering a limited number of employees and family members.

During that time, they changed insurers many times acting on the advice of their brokers, currently, Caprica Healthcare.

The complainant further stated that the insurance cover was always on a continuous '*like-for-like basis'* subject to full disclosure of medical conditions. A member of the family, HHH, had a surgical procedure in 2016 to improve his shoulder strength and enable him to continue playing sports including rugby. This was known to the insurer who paid for part of that claim. There has been a recurrence of the original complaint which now requires surgery to allow him to continue with his sporting aspirations.

[1] *A Fol*. 4, 7-9

His medical condition has been confirmed by doctors and surgeons who have treated him.

The insurer is using every excuse to avoid this claim including suggesting that his current condition was caused by a single incident during a rugby match in 2018 which is simply not true.

HHH is also depressed having to cope with his studies at the University and by the fact that he cannot play active sports and uncertain as to whether he can participate in sports activities again.

By way of compensation, the complainant is requesting the payment of £183 for consultation; £200 for transport expenses to travel from Leeds to Bridgen and the expenses of the surgery which are not known yet. The complainant is also asking for compensation (which has not been specified) for HHH's depression due to the fear that he may not be able to continue to participate in the sport activities which are a big part of his life.

The service provider responded that:

Under the historical Private Medical Insurance Policies held, HHH was insured for any injuries sustained from rugby activity. However, in terms of the contract of insurance which applied since when the Private Medical Insurance policy was underwritten by Axeria Insurance Ltd in July 2018, any injuries arising from rugby were clearly excluded.

The Private Medical Insurance plan was placed by April UK from 15 July 2016 to 14 July 2017; with BUPA from 15 July 2017 to 4 July 2018; and then back to April UK (and insured by Axeria Insurance Ltd) from 15 July 2018 to 14 July 2019. HHH did not break his insurance cover through this three-year period. However, he was insured by different insurance companies and different terms and conditions applied in each case.

Upon re-contacting April UK in 2018, HHH subscribed to Axeria Insurance Limited's terms and conditions which clearly excluded injuries arising from rugby activity. Notwithstanding the fact that there was no breakage of cover from HHH, the claim arose due to a rugby injury and, according to the terms and conditions in place with Axeria Insurance Limited, this claim cannot be covered.

The service provider also notes that the complainant is disputing the fact that the original injury was caused by rugby activity despite clear evidence to the contrary according to the consultant's medical reports.

For the above-stated reasons the claim should be refused.

The Arbiter has to decide the case **by reference to what in his opinion is fair, equitable and reasonable in the particular circumstances of the case.**[2]

The basic issues that have to be decided by the Arbiter are the following:

The complainant's main arguments:

The complaint has been lodged by OH who is the insured's (HHH's) father acting on the authorisation of his son. The service provider has not raised any issue on this fact.

The complainant states that the claim should not have been rejected because:

1. He had a continued policy cover and cover was never broken, but over the years changed different insurance companies on the advice of their broker. Nonetheless, each new cover was made on a '*like-for-like'* basis.

2. The new exclusions (namely that rugby activity was no longer covered when the insured re-joined Axeria in July 2018) did not apply to him, firstly, because he was covered on a *'like-for-like'* basis as in previous years and, secondly, because he had a feeble shoulder and the claim was not the result of rugby activity but was the result of a continued condition.

On its part, the service provider insists that:

1. Although HHH was 'historically' insured for rugby activity, when the insured joined Axeria in July 2018, rugby activity was excluded in the policy. In spite of the fact that there was no insurance break from 2016 to 2018, the insured was covered by different companies and terms and conditions of the policies varied from one company to the other.

[2] CAP 555 of the Laws of Malta, Art. 19(3)(b)

2. The claim arose due to a rugby injury and according to the terms and conditions in place with Axeria Insurance Limited, this claim cannot be covered.

The issues that the Arbiter has to decide are:

1. **whether the medical condition complained of and for which the claim has been lodged was caused due to rugby activity and,**

2. **whether rugby activity was effectively insured by the service provider when the complainant joined Axeria in July 2018.**

On the question of participation in rugby by HHH, the complainant states that HHH had a surgical procedure in 2016 to improve his shoulder strength and enable him to continue participating in sports including playing rugby. This was known to April UK who paid part of the claim at that time. There has been a recurrence of the original complaint which now requires additional surgery to allow him to continue with his sporting aspirations.

In the complaint form,[3] the complainant denies that HHH sustained a new injury when playing a rugby match in 2018 which the insurance says is the subject of the present claim.

When the Arbiter examined the exchange of emails between the complainant and the service provider, he discovered that in an email dated 18 April 2019 (12.46) the complainant explained that:

'*In 2018 whilst training and playing rugby, it became clear that the procedure had not worked, and HHH would require further surgery if he wanted to continue playing'.*[4]

Moreover, the complainant argues that participation in rugby was allowed by previous policies and, since their re-joining with April in July was on '*a like-for-like basis'*, he should still be covered for '*playing rugby'.*

[3] *A Fol.* 4
[4] *A Fol.* 55

This was a response to the service provider's letter sent to the complainant on the 16 April 2019,[5] where *inter alia* the service provider explained that:

'*On a clinic letter from Mr Keshav Singhal on 20 July 2015, he states the issue "started about 6 months ago when he had a rugby tackle and severely externally rotated his right shoulder". A further letter dated 25 January 2016 states "He had been doing very well following his shoulder rehabilitation but had a severe rugby tackle a month or so ago, in which he felt his shoulder probably came out. This was fairly similar to his original injury which he had in early 2015". There are subsequent reports on his GP history of a dislocation in September 2018 caused "during a rugby tackle".'*[6]

The above medical history was not disputed by the complainant in his email replies but always insisted that since his policy was a continuing policy on a like-for-like basis, rugby should have not been excluded by the policy. As explained above, the complainant confirmed that his son had participated '*in training and playing football'* in 2018 but insists that his son's condition was a recurring one dating back to 2015.

The Arbiter has to reach his conclusions in a fair, equitable and reasonable way. From the narration of facts by both parties, the Arbiter has no doubt that, unfortunately, HHH, who is a passionate rugby player, has had an injury in 2015 from which he had never fully recovered. This is stated in the various medical reports submitted but there is also no doubt that his condition was again aggravated when he participated in rugby in 2018. The complainant himself admitted that HHH took part in rugby training and also played rugby. GP history confirmed a dislocation in September 2018 caused '*during a rugby tackle'.*[7]

The medical certificates filed by the complainant issued by Anthony Martin[8] and Dan Henderson[9] do not categorically exclude the incident of 2018 but simply state that HHH had a recurring condition dating back to 2015 and did not heal completely.

[5] *A Fol.* 58-59
[6] *A Fol.* 59
[7] *Ibid.*
[8] *A Fol*. 48
[9] *A Fol.* 49

Anthony Martin states that '*Subsequent symptoms he experienced in his shoulder in 2018 are consistent with again instability/dislocation of his shoulder*.' He mentions that recurrence of this *'familiar'* condition is due to a recurrence of the original injury but does not exclude that HHH's participation in rugby training and playing in 2018 did not aggravate what had been damaged in 2016. The reference letter by Dan Henderson does not make any reference to any incident because it is simply a referral highlighting the best remedy to cure Mr HHH's condition '*to allow him to get back to full contact play'.*[10]

What the Arbiter can make of these facts is that it is true that the first dislocation took place in 2015, but the insured continued to play rugby, including in September 2018 and, unfortunately, on some occasions his participation in rugby triggered again his unfortunate condition. Dan Henderson's reference letter is directed towards a solution to the problem so that the insured would have a better hope of participating in rugby without incurring further damage.

Therefore, the Arbiter reasonably concludes that the present claim also relates to the participation of the insured in rugby playing in September 2018 and therefore related to rugby.

The Arbiter has now to decide whether the insured could insist that since his son had been covered for participation in rugby activity in previous policy covers, and since he joined Axeria in 2018 on a '*like-for-like basis'*, the exclusion of rugby from the policy in 2018 should apply.

The Arbiter examined thoroughly the policy document[11] and he discovered that it is true that under the heading '*What is not covered?',* one of the exclusions is '*treatment arising from participation in hazardous pursuits … rugby'.*[12]

However, on the same page of the policy under '*Underwriting choices'* and the sub-heading '*Continued Personal Medical Exclusions (CPME)',*[13] the policyholder is given the opportunity to transfer '***your** private medical insurance cover over to **us** on **your** renewal date. Your cover will stay on the same individual*

[10] *A Fol*. 49
[11] *A Fol.* 78 The policy document
[12] Pg. 12 of the policy *a Fol. 89*
[13] *Ibid.*

underwriting terms that were applied by the previous insurer, providing that continuous cover is maintained.

*This means that **we** will continue to provide cover for all **medical conditions** that were covered under **your** previous **policy**. However, any medical exclusions or restrictions that were imposed on your private medical insurance cover by **your** previous insurer will also continue under your cover with **us.** Please note: if **you** are transferring on a CPME basis **we** reserve the right to exclude additional symptoms or conditions according to the information provided in the declaration'.*[14]

An exclusion in a policy document is not a condition precedent or a warranty. Rather, these clauses define the boundaries of the risk to be insured by setting out what will not be covered under the contract of insurance. While insuring clauses are often broadly worded for simplicity, exclusion clauses are often used as a tool to narrow the scope of coverage provided.

The purpose of an exclusion clause is to define, from the outset, the specific risks which will not be covered by insurers in any event under the policy.

The Arbiter has to decide the case on the merits of the facts of that particular case. In this case, the policy is clear that had the complainant chosen to underwrite his policy in a normal manner, the exclusion of rugby would have applied.

However, in the case under consideration, the exclusion clauses relating to '*what is not covered*' have to be read in conjunction with the section of the policy titled '*underwriting choices'*. Under this section, if a policyholder chooses to transfer his/her existing policy to the service provider (Axeria) on the renewal date, the cover will stay on the same underwriting terms that were applied **by the previous insurer**.

This is further explained explicitly in the same policy that '*we will continue to provide cover for **medical conditions** that were covered under **your** previous **policy'**.*

[14] *Ibid.*

The only limitation is that medical exclusions imposed by the previous insurer would also apply to the policyholder that joins Axeria.

It is clear that the purpose of the advantages offered to the insured under the section '*underwriting choices'* is a commercial one namely that of attracting new business by enticing policyholders who are insured with other service providers to switch to Axeria. The Arbiter finds nothing wrong with this in a competitive market. However, in offering these advantages to new policyholders, the service provider was limiting the application of the relevant exclusion clause for the first year of cover.[15]

The complainant explained that:

'When we do change policy, and we did a few times for our health insurance, my belief was that it was always on a monitorial basis and the cover that we had previously was always the same cover that we took on'.[16]

The section of the policy titled '*underwriting choices'* confirms the complainant's position that he was only joining the service provider on condition that:

'*Your cover will stay on the same individual underwriting terms that were applied by the previous insurer providing that continuous cover is maintained.'*

The service provider does not contest the '*continuous cover'* of the complainant. Whilst the service provider promised to cover the complainant on the same terms and conditions that the complainant had with the previous insurer, (as an incentive to take him on board), it is now invoking the new conditions which, although applied to other policyholders, they did not apply to the complainant because he was exempted from the application of the new exclusions by the service provider itself.

The service provider did not prove that the complainant was not covered for rugby by the previous insurer and since the complainant was taken on board on the same conditions of the previous insurer, the complainant was covered for rugby participation.

[15] If the policy is for a period of one year which is the normality in these kind of policies
[16] *A Fol*. 73

The policy cover was conditional, as it was onboarding the complainant on the same conditions he had with the previous insurer. This contractual condition needs to be respected.

Therefore, the accident happening in September 2018 was covered by the policy. Apart from the wording of the policy which, as has already been stated, covered the complainant's son, the Arbiter is obliged to decide the case on the basis of fairness, equity and reasonableness in the particular circumstances of each case.[17]

On the basis of fairness, equity and reasonableness, and the wording of the policy as explained above in this decision, the Arbiter believes that what was promised to the complainant, namely, that he would be insured on the same basis and conditions of the previous insurer, should be respected and applied and, therefore, the new exclusion eliminating rugby activity did not apply to the complainant.

For the above-stated reasons, the Arbiter is accepting the complaint in so far as it is compatible with this decision.

Compensation

The complainant asks the Arbiter to order the service provider to pay him the sum of £183 for consultations, £200 for transport costs connected with the medical procedure and the cost of the surgery which is not known yet.

Therefore, in virtue of Article 26(3)(c)(iv) of Chapter 555 of the Laws of Malta, the Arbiter orders Axeria Insurance Ltd to pay the complainant the sum of £383 as described above, together with the payment of the cost of the surgery, merits of this claim, in accordance with any policy limit on the cost of the surgery.

The complainant also asked the Arbiter to award compensation for the 'depression' of HHH. The Arbiter cannot accede to this request because no sufficient medical proof has been provided to the Arbiter to conclude that, first

[17] Cap. 555 of the Laws of Malta, Article 19(3)(b)

of all, HHH is indeed suffering from depression and, secondly, to determine that the cause of the depression can be specifically attributed to any misconduct of the service provider. No such proof has been provided and, therefore, the Arbiter cannot accede to such request.

Since the Arbiter has partially upheld the complaint, each party is to bear its own costs of these proceedings.

Dr Reno Borg
Arbiter for Financial Services