Before the Arbiter for Financial Services

Case No. 078/2020

JK

(the Complainant)

vs

Laferla Insurance Agency Ltd. (C14529)/

MAPFRE Middlesea p.l.c (C5553)

(the service provider/the Insurer

respectively)

Hearing of the 3 May 2021

The Arbiter,

Having seen the complaint whereby the complainant submitted that for approximately six weeks, he had stomach issues, continued diarrhoea, blood in his stool, constipation and acid reflux, which were all very horrific. He went to St. James Hospital and was advised to do some blood tests which, however, were inconclusive. A colonoscopy was then suggested.

The complainant stated that he claimed on the insurance for both the blood tests and the colonoscopy, but he admits that for the former test he was not insured.

He was informed by the insurer that diarrhoea was an existing condition, and so, they refused to pay for the colonoscopy.

The complainant insists that diarrhoea is a symptom of millions of illnesses and being sent for a colonoscopy to find out more about what was causing it (after inconclusive blood tests) does not mean that it was an existing condition.

He claimed to have been let down in the following ways: immediate and rude rejection of his claim and constant changes in the rationale as to why the claims were not being settled.

Therefore, since in the complainant's opinion diarrhoea was not a pre-existing medical condition, he insists that the insurer should pay him the sum of €935.

Having seen the service provider's reply[1] which states that:

They refuted the claim due to the complainant's condition being pre-existing, i.e. the underlying condition was present before the client took out his insurance policy.

At the time of application, the complainant had already been experiencing symptoms being caused by an underlying medical condition, even though the underlying condition was not yet diagnosed. Notwithstanding this, the complainant chose to respond negatively to the following direct questions on his health insurance proposal form:

- Have you consulted with a General Practitioner and been provided with prescription drugs or medication within the last five years?
- Have you consulted with a specialist in the last five years with an actual or suspected medical condition?
- Is there any known or foreseeable need for you to consult a doctor or any other health professional for any reason?

The complainant had already consulted a specialist to discuss his symptoms and he also performed some blood tests to try to diagnose the underlying condition causing the symptoms.

[1] *A fol.* 27

To make matters worse, just one day before applying for his insurance policy, the complainant received a quote for a '*colonoscopy'* which was recommended in order to investigate further the cause of his symptoms and diagnose the underlying medical condition causing such symptoms.

The service provider further submits that the insurance policy, which is available publicly on their website, and was made available to the complainant when purchasing the policy, clearly defines a *'pre-existing medical condition'* as follows:

QUOTE

32. PRE-EXISTING MEDICAL CONDITION

Any Medical Condition for which:

the Beneficiary has received medication, advice, diagnostic tests or treatment; or the Beneficiary has experienced symptoms or should have reasonably known about;

whether the condition has been diagnosed or not before the Beneficiary joined the Policy.

UNQOUTE

The service provider states that the complainant, bound by the principle of utmost good faith, should have disclosed all material facts truthfully on his application form.

The fact that the complainant consciously chose to give false replies to direct questions in his application form is a solid ground for the insurer to void his insurance policy, an option which the insurer did not pursue.

Reply by MAPFRE Middlesea p.l.c.[2]

By means of a 'note' received by the OAFS on the 28 August 2020, MAPFRE Middlesea p.l.c. (MAPFRE) declared that it agrees with the reply filed by Laferla Insurance Agency Ltd.

[2] *A fol.* 29

The insurance company confirms that the policy was issued by MAPFRE but '*managed'* by Laferla Insurance Agency Ltd and the complainant is a client of Laferla Insurance Agency Ltd.

MAPFRE also declared that it is authorising Laferla Insurance Agency to '*act in these proceedings'*.

MAPFRE submitted that it should be declared non-suited and that it should not be a party to these proceedings.

Preliminary Decision

MAPFRE Middlesea p.l.c. has raised the plea that it should be declared non-suited because the complainant was not a '*direct'* client of MAPFRE. However, at the same time, it confirms that the policy in question was issued by itself and that Laferla Insurance Agency '*managed'* the policy.

The Arbiter cannot accept the plea raised by MAPFRE to be non-suited because, as admitted by itself, the policy was issued by MAPFRE and, therefore, a contractual relationship existed between the complainant and MAPFRE. It is the underwriter who has to answer to claims in relation to a policy issued by the underwriter and not the broker or the agent.

The broker or the agent would only answer if, for instance, the complainant raises an issue regarding the misconduct or the negligence of the broker/agent during the sale of the policy, or if they do not adhere to the general obligations resulting from the contractual relationship between the customer and the broker/agent.

A claim for the payment of compensation regarding a claim under a policy should be directed to the underwriter.

For the above-stated reasons, this plea is being rejected.

The Merits of the Case

The Arbiter shall determine and adjudge the complaint by reference to what, in his opinion, is fair, equitable and reasonable in the particular circumstances and substantive merits of the case.[3]

The Complainant's Version

The complainant testified that in March 2020, he joined a new company and, as part of a package, he was offered an insurance cover with the insurer. After filling all the details requested from him, he was provided with the insurance certificate.

He stated that completely coincidentally, after joining the new company, he experienced several stomach issues; he was scared and went to St James Hospital, where blood tests were taken which did not yield any negative result.

He declared in his testimony that:

"My fault is, and I did this unknowingly (I shouldn't have and I apologise very profusely), that I claimed for the blood tests and as I was not insured with Mr Laferla at that time, this claim was rightly rejected."[4]

The complainant stated that considering the blood tests were clear, his consultant wanted to have a colonoscopy and to take biopsies from the intestines to rule out stomach cancer. Following the colonoscopy, he filled out the paperwork according to the insurer's claims' procedure. He was then informed by the insurance company that his claim would not be accepted because he had an existing condition which he failed to report.

The complainant insisted that:

"The case is purely based around whether or not one can deem diarrhoea being an existing condition. It is not a condition. It is a symptom of something that wasn't conditioned or proven to be related to the condition."[5]

When asked to confirm the date on which he experienced diarrhoea and blood in the stool, he stated that he could not remember.

[3] Chapter 555, Article 19(3)(b)
[4] *A fol.* 30
[5] *A fol.* 31

With regards to the fact that he filled in the insurance proposal form on 19 June, and by the 18 June, he had already enquired with St James Hospital about the colonoscopy to further investigate the symptoms, he stated that the colonoscopy took place following blood tests being inconclusive. He also insisted that he is in no way claiming something which is not fair.

The Service Provider's Version

MAPFRE Middlesea p.l.c. did not submit any evidence because it rested its case on the reply filed by Laferla Insurance Agency Ltd. On its part, the service provider submitted a string of documents[6] to prove that the complainant had a pre-existing medical condition for which he was already doing tests even before the inception date of the policy.

Further Considerations

The main issue regarding this complaint is whether the complainant had symptoms of/or any pre-existing medical condition before the inception date of the policy.

Timeline of Events

To establish the facts of the case and the actual date of their occurrence, the Arbiter has composed the following timeline.

- *March 2020* – The complainant stated[7] that in March 2020, he joined a new company and, as part of a package, he was provided with an insurance cover by the insurer.
- *11 June 2020* – Expiration date of health policy with GasanMamo Insurance;[8]
- *11 June 2020* – Date of first visit to a doctor for this condition; specialist recommended blood tests and colonoscopy;[9]

[6] *A fol*. 32 *et seq*
[7] *A fol.* 30
[8] *A fol.* 36 - As declared in the proposal form
[9] *A fol.* 40; *A fol.* 43- – As indicated in the claim form

- *11 June 2020* – Blood tests were carried out;[10]
- *18 June 2020* – Quote for colonoscopy issued;[11]
- *19 June 2020* – Date proposal form completed;[12]
- *22 June 2020* – Date of Policy Schedule;
- *24 June 2020* – Receipt for payment of fees for laboratory services carried out at St James Hospital;[13]
- *1 July 2020* – Invoice/receipt re colonoscopy and related fees,[14] and date of colonoscopy report;[15]
- *1 July 2020* – Claim Form completed.[16]

The service provider submitted two copies[17] of the claim forms submitted by the complainant, both dated 1 July 2020. One crucial section in these claim forms related to the reason for seeking medical advice and the description of symptoms, which section had to be completed by the complainant himself, being the patient.

Under this section, the complainant stated that the reason for seeking medical advice was *"Continued abdominal pain, discomfort, and diarrhoea,"*[18] and *"Colonoscopy + Biopsy as a result of consultation."*[19]

On both claim forms, the '*Date of first visit to any doctor for this condition'* was declared by the complainant to be 11 June 2020.

The Arbiter notes that *ex admissis* the complainant stated that **before** the inception date of the policy, he had already visited a doctor, blood tests had already been carried out, and a quotation for the colonoscopy had been issued.

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[10] *A fol*. 44
[11] *A fol.* 48
[12] *A fol.* 35 – *fol.* 39
[13] *A fol.* 44
[14] *A fol.* 45
[15] *A fol.* 47
[16] *A fol.* 40 - *fol.* 43
[17] *Ibid.*
[18] *A fol.* 40
[19] *A fol.* 42

As mentioned in the timeline above, the complainant visited the doctor on the ***11 June 2020*** **and, on the same day, blood tests were carried out. On the *18 June 2020,* a quote for colonoscopy was issued.[20] The next day, on *19 June 2020*,** the proposal form was completed, and the policy schedule was issued on the 22 June 2020.[21]

This means that the colonoscopy had already been ordered before the policy inception date and the complainant's assertion that this was a coincidence cannot be accepted by the Arbiter.

In the Arbiter's opinion, the complainant already had the symptoms of the medical condition complained of prior to the policy's inception date and the colonoscopy was ordered before the date of the proposal form and before the issue of the policy's schedule.

Although the medical condition complained of had not yet been diagnosed, pending the result of the colonoscopy, the complainant was already suffering from the medical condition prior to the contract of insurance completed with the service provider at a later date. This leads to the conclusion that the complainant was not yet insured at the time he experienced the condition.

The policy clearly states that the insured had the duty to inform the insurer of all the material facts regarding any medical condition in the proposal form.

When answering direct questions on the same proposal form in this regard, the complainant did not disclose material facts regarding the medical condition. Section 5 of the proposal form refers to '*Medical History and Other Information'*, where it is made amply clear that the complainant should disclose all known and suspected medical conditions.

Under this section, the complainant was required to answer with a "Yes" or "No" to various questions, two of which were specifically the following:

"Have you or any dependents consulted with a specialist in the last five years with an actual or suspected medical condition?

[20] *A fol.* 48
[21] *A fol*. 35 – *fol*. 39

Is there any known or foreseeable need for you or any dependents to consult a doctor or any other health professional for any reason?"[22]

The complainant ticked "No" for both questions, and this, despite the fact that a day before, he had visited a doctor and blood tests were carried out. A day before filling the proposal form he was given a quote for a colonoscopy.[23]

The Arbiter notes that the questions asked in the proposal form were indeed very generic and the timeframe spanning a period of five years is, in the Arbiter's opinion, too extensive. This can lead to the avoidance of even the most legitimate claims if the insurer takes shelter under this very wide umbrella.

However, this is not an excuse for the complainant not to mention important material facts which had occurred only **a few days before** filling the proposal form.

The Arbiter would have sympathised with a complainant forgetting to mention a visit to a doctor five years before the filing of a proposal form, because it is reasonably expected that the ordinary person might forget what happened five years before. However, in the case under examination, it cannot be reasonably argued that the insured could have forgotten a very recent visit to a medical professional who had even suggested blood tests and a colonoscopy.

In the complaint form, the complainant also declared that

"I had for some weeks (approx. 6) stomach issues. Continued diarrhoea, blood in my stool, constipation, acid reflux, all very horrific …"[24]

This also implies that, at the time of completing the proposal form, there was already *"a known or foreseeable need … to consult a doctor or any other health professional …"*.[25]

Let alone that consultations and blood tests had had already taken place.

[22] *A fol.* 36
[23] *A fol.* 48
[24] *A fol.* 4
[25] *A fol.* 36

Evidently, the complainant did not answer the questions in the proposal form correctly and honestly, leading to the misrepresentation of material facts.

The Proposal Form, specifically, Section 5, clearly states that:

"It is important to note that we shall not accept liability for a medical condition which arose prior to the proposal date unless such a condition is declared, and which MAPFRE Middlesea plc did not exclude. Failure to notify MAPFRE Middlesea plc of any suspected medical condition may result in the policy being voided."[26]

Moreover, the policy document, which is the basis of the contract, specifically excludes pre-existing medical conditions, which are defined as:

"Any medical condition for which:

- *The Beneficiary has received medication, advice, diagnostic tests or treatment; or*
- *The Beneficiary has experienced symptoms or should have reasonably known about;*

Whether the condition has been diagnosed or not before the Beneficiary joined the Policy."[27]

At the time of completing the proposal form, the complainant had already experienced symptoms and received advice in this regard, whilst diagnostic tests had also been carried out on the same day.[28] According to the policy, this was a pre-existing medical condition and, therefore, excluded by the same policy.

Although, as submitted by the service provider, it did not void the policy on grounds of misrepresentation of material facts, the Arbiter still feels that the complainant failed in his duties of disclosure of material facts and failed in his underlying obligation of utmost good faith.

[26] *A fol.* 36
[27] *The Laferla Healthplans – Health Insurance Policy* accessed on 14/04/2021 from https://www.laferla.com.mt/wp-content/uploads/Laferla-Health-Insurance-Policy-LHP-POL-2018.pdf)
[28] *A fol.* 44

For all the reasons stated above in this decision, the Arbiter decides that the insurer had every right to repudiate the claim and the Arbiter is rejecting the complaint.

The expenses of this procedure are to be borne by the complainant.

Dr Reno Borg
Arbiter for Financial Services