An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0034
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Rejection of claim - non-disclosure & voiding
Outcome:	Substantially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint relates to a claim for benefit under a Whole of Life Policy. The Policy was taken out in 1992. Following contact by a representative of the Company, a Policy Alteration application was made in 2003, so as to include Critical Illness and Hospital Cash Cover.

The First Complainant made a claim for critical illness benefit in 2015, which was turned down by the Company on the basis that there was a non-disclosure of material facts in the 2003 Policy Alteration application.

The complaint is that the Company incorrectly and unreasonably voided the Policy Alteration cover and refused to provide the benefits under the policy.

The Complainants' Case

The Complainants dispute that there was a non-disclosure entitling the Company to void the Policy Alteration Cover. The Complainants want the Company to reinstate full critical illness and hospital cash cover with effect from March 2003, and deal with the original critical illness and hospital cash claim. The Complainants state that they want the Company to make full payment of the claim benefits as they feel that this is a legitimate claim and should be admitted and paid in full with accrued interest from the date the claim was originally made.

The Provider's Case

The Company states that a Critical Illness Claim Form was received from the First Complainant on the 16th February 2015. The Company's positon is that during assessment of this claim significant non-disclosure was discovered which rendered the amendment to cover for the First Complainant from May 2003 as void.

It is the Company's position that if the Company had been aware of the First Complainant's full medical history at the time of this amendment to their policy further information and tests would have been sought before offering cover. The Company states that as it was not given an opportunity to fully assess the medical history at the time it had no option but to make the amendment null and void from commencement.

Evidence

Application Form completed in 1992

"The following questions are to be answered by the Life (Lives) to be assured. Please answer all questions carefully giving full details where appropriate. If more space is required, please use and attach a separate sheet of paper. If you are in doubt as to whether certain facts are material, such facts should be disclosed.

"(ii) do you consume alcohol?" **"Yes"** was answered by the First Complainant.

"If "Yes", weekly average consumption" **"10pts Guinness"** was answered by the First Complainant.

"Declaration
I/We declare that to the best of my/our knowledge and belief the above statements (including any statement written down at my/our dictation), together with any made or to be made to the Company's medical examiner and signed by me / us are true and complete and that they shall form the basis of the Contract with the Company".

2003 Alteration Form

Health Questionnaire and other Information

"The following questions are to be answered by the Lives to be assured. Please complete relevant sections carefully giving full details where appropriate. If more space is required, please use and attach a separate sheet of paper. If you are in doubt as to whether certain facts are material, such facts should be disclosed.
..
2(a) Do you consume alcohol? If "Yes", weekly average consumption"

Answer for First Complainant was **"(1) 8 units week"**

"3 Are you currently

/Cont'd…

(a) Suffering from any physical defect, illness or is there any ailment from which you tend to suffer?"

"No" was selected for the First Complainant

(b) "Under medical observation or taking prescribed drugs, medicines or tablets?"

"No" was selected for the First Complainant

"4. Have you ever

(a) suffered from any mental or physical illness or injury requiring medical, psychiatric or any other form of treatment or advice?"

"No" was selected for the First Complainant

"(d) undergone any special investigations, blood or laboratory tests?"

"No" was selected for the First Complainant

"7. Is there any other information relating to health, habits or otherwise which should be disclosed to the Company?"

"No" was selected for the First Complainant

"Health Questionnaire (continued)

9. Have you ever suffered from or had treatment for:

(a) Disease of the Heart or Circulatory System?"

"No" was selected for the First Complainant

"(d) undergone any special investigations, blood or laboratory tests?"

"No" was selected for the First Complainant

"(j) Any physical or Mental complaint or injury not mentioned above?"

"No" was selected for the First Complainant

"Declaration

1. *I/We have read through all the questions in this Policy Alteration Form and declare that to the best of my/our knowledge and belief all the information and statements (including any statement written down at my/our dictation) together with any made or to be made to [the Company's] medical examiner and signed by me/us are true and complete and that they shall form the basis of the alteration to the Contract with*

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[the Company]. I/We declare that if I/we am/are applying for Non-Smoker Rates that I/we do not intend to consume tobacco at any time in the future.

2. *..*
3. *I/We understand that if a material fact is not disclosed in this Proposal then the Policy Alteration issued may be of no effect. (A material fact is one which is likely to affect the [the Company's] assessment or acceptance of your Proposal. If you are in doubt as to whether a fact is material or not, you are, in your own interest, advised to disclose it)".*

This proposal was signed by the Complainants and dated 4 March 2003.

Life Plan Provisions

"2.4 Other Changes in Benefits and Premiums
In addition to Provisions 2.3 (a) and 2.3 (b) you may elect to vary the Premium or Protection Benefits at any time. Any variation will be subject to such terms and limits as we may apply at that time. This may include a requirement that satisfactory evidence of the good health of the Life Assured is produced.
…
General

(a) The Policy, the Application Form, any written statements by you or the Life Assured in respect of the Application, any medical information in respect of the Life Assured and any endorsement attached to the Policy when issued will be the entire contract between you and us. It is therefore very important that you answer all questions correctly and disclose all material facts when applying for the Policy".

Correspondence

2 March 1992 – Clarification from Company representative to Company on the First Complainant's alcohol consumption

"[First Complainant] tells me he drinks 2-3 pints per night maybe three nights per week and that some weeks he might only go out to pub one night in the week. But taking social events, birthdays, Christmas etc into account we agreed a figure of 10 pints on average".

18 December 2014 – HSE to consultant interventional cardiologist

"This gentleman has severe aortic stenosis, and a very poor chamber behind it. Ordinarily one would consider a stress study followed by aortic valve replacement and single vessel grafting, but clearly if he remains a committed alcoholic, then I think this could be a challenging undertaking".

22 December 2014 – HSE

"Primary Diagnosis: Non-ischemic cardiomyopathy (likely alcohol related)

Secondary Diagnoses

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Excess C2H5OH (60 units per week)"

3 February 2015 – Hospital Cash Claim Form completed by the First Complainant's doctor

"Reason for hospitalisation (if injury, please state circumstances surrounding same)"

'Decompensated heart failure'

"*Date of onset of symptoms:"* **'30/06/14'**

"Has the claimant ever suffered from this or any related illness in the past? If so, please give full details" **'No'**

24 February 2015 Specialist Medical Report (From First Complainant's medical specialist in response to the Company's questions)

"On what date did the patient first become aware of any symptoms of the condition specified or any related condition? **"Nov'14"**
..
'Never Smoked'

"Is the Cardiomyopathy related to alcohol or drug misuse?"

"alcohol is a contributor to cardiomyopathy but aortic stenosis is the dominant element".

18 March 2015 – Medical Certificate completed by the First Complainant's GP

"When did your patient first become aware of this condition or any symptoms leading to it?" **'17/06/14'**

"Has your patient suffered any previous episodes of this condition, or any related condition? If so, please give full details including dates" **'No'**

23 March 2015 – the Company to the First Complainant's GP

"From the above report we note that [the First Complainant's] diagnosed of cardiomyopathy is alcohol related. Please advise a detailed history [the First Complainant's] alcohol consumption, what date did he commence drinking in excess and what advice was given. Please provide LFT's that you may have on file".

2 April 2015 – HSE

"This gentleman was discussed at our cardiothoracic conference, back in January, he had severe aortic stenosis, with impaired left ventricular function, and as such is at high risk, I would be grateful if you could keep this in mind, and try and expedite his surgery"

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9 April 2015 – First Complainant's GP to the Company

"LFTs which I enclose are all normal. Patient drank about 30 pints per week over the years. I advised him to desist on 3/10/14".

30th April 2015 – First Complainant's GP to the Company

"On review of my notes [the First Complainant] underwent an ECG on the 16/03/2000 he was found to be in sinus rhythm and to have a pulse rate of 100 beats per minute and I prescribed a beta blocker for I month (from my interpretation of my notes cannot find actual ECG report). Chest x-ray on the 11/04/2000 showed lung fields clear. Copy enclosed All bloods were normal copies enclosed from the 06/04/00. …
According to my notes he attended on the 16/03/00 and for bloods on 6/04/00 and did not attend again till 06/11/08. No bloods were taken from April 2000 to 2010 copy of ECG enclosed dated the 06/11/08. A chest x-ray was also carried out on the 17/11/08 which was normal copy enclosed".

28 May 2015 – Underwriter's "Null & Void Instruction"

"Requirement to Effect the Removal of an Historic Endorsement Effective Today – Effective Date 6 May 2003

1. *Claims Underwriting*
   (a) Decision due to non disclosure He endorsed in May 2003 re Life 1 is to be cancelled, all benefits apart from LC to be removed from Life 1
   All days paid in for life 1 to be refunded.
   Client reduced his LC in 2003 but this to be as what it was before … Please I dec accordingly"

24 June 2015 – The Complainant's GP to the Company

"[The Complainant] answered truthfully in his opinion 'No' [to questions set out on Policy Alteration Form 4/3/03]. I consider this an honest answer, as he had not had any special investigations or hospitalisations. I would consider chest x-ray ECG and blood test as regular routine investigations in a GP setting.

In the consultation on the 16/03/00 [the First Complainant] complained of recurrent colds with green phlegm often up to six times per year. He had a stuffy nose and was often catarrah. He was a non-smoker. He felt tired all the time. He had nausea and catarrh. Examination was unremarkable. There was a ?clicking sound of the mitral valve. I noticed some tachycardia 100bpm. My provisional diagnosis was of allergic rhinitis with recurrent upper respiratory infections. I did an ECG which confirmed normal sinus rhythm with pulse of 100bpm. His full blood count was normal. His fasting blood sugar was normal. His biochemistry including liver function test were normal. Thyroid function tests were normal ruling out hyperthyroidism. His chest x-ray was normal. I treated his allergic rhinitis and commenced him on a beta-blocker for one month.

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I saw him again on the 15/12/00 with a foreign body in the eye which I removed under local anaesthetic. There was no comment between us on the previous consultation as he was keeping well.

In conclusion:
I would be of the opinion that [the First Complainant] was truthful in his answer that he had no medical problems on the 4/3/03 as he was not on any medication & had not seen a doctor for well over two years".

17 June 2015 - the Company's claim decision

"To assist in the completion of our assessment we requested a medical report from [the First Complainant's] GP, Dr H. We noted on reviewing this report that there was non disclosure of material facts on your Policy Alteration Form dated 4th March 2003 (copy enclosed). We were advised that [the First Complainant] had a history of tachycardia in 2000 which required investigations and treatment for same.
The following question on the Policy Alteration Form dated 4th March 2003 should have been answered Yes:

"3.Section A

Q4 Have you ever
(a) Suffered from any mental or physical illness or injury requiring medical, psychiatric or any other form of treatment or advice?

d) undergone any special investigations, blood or laboratory tests?

Q9 Have you ever suffered from or had treatment for:

(j) Any physical or Mental complaint or injury not mentioned above?

Had these material medical facts been disclosed on the Policy Alteration Form we would have requested medical reports in 2003. As we were not given the opportunity to assess same we have no option but to cancel the endorsement that applied in 2003 for Life 1, [the First Complainant]
..
As Critical Illness and Hospital Cash benefits have been removed, I regret to advise that no payment will be made for the Critical Illness and Hospital Cash Claims that [the First Complainant] submitted"

13 July 2015 – the Company confirmed its previous decision

"After this review I am of the opinion that there was a clear breach of the duty of disclosure of material facts – Utmost Good Faith – and the appeal is not valid".

<u>Communication re Company's Claim Review</u>

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"We have receive in a CI claim for our client claiming under cardiomyopathy. Before we finalise our decision on this claim I note there was slight non disclosure on PAF in 2003 when he added CI to this policy"

Critical Illness Benefit Claim Form

"What Critical Illness are you claiming under?" ***"Severe aortic stenosis, atrial fibrillation, cardio myopathy with congest .. Cardiac failure"***

"Date condition diagnosed" **29/12/14**

"Date symptoms first commenced" **17/6/14**

"When did you first attend a doctor for this condition?" **17/6/2014**

13 May 2016 – the Complainants' representative to this office
"you will see .. that Alcohol was a contributor to Cardiomyopathy but Aortic Stenosis is the dominant element. I have had this reviewed and it has been confirmed that there is no relationship between Alcohol and Aortic Stenosis".
Critical Illness Claim Definition

"The unequivocal diagnosis by a consultant cardiologist of cardiomyopathy resulting in permanent impaired ventricular function and permanent marked limitation of physical activity with the life assured unable to progress beyond stage two or a treadmill test using the standard Bruce Protocol. Acute myocarditis is excluded unless there is subsequent development of cardiomyopathy as above. Cardiomyopathy directly related to alcohol or drug misuse is excluded".

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainants were given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

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A Preliminary Decision was issued to the parties on 26th February 2018 outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

A Submission dated 15th March 2018 from the Company, was received by the Financial Services and Pensions Ombudsman after the issue of a Preliminary Decision to the parties. This submission was exchanged with the Complainants and an opportunity was made available for any additional observations arising from the said additional submission. No additional submission was made by the Complainants. I have considered the contents of the Company's additional submission for the purpose of setting out this, my Final Decision.

The issue for investigation and adjudication is whether the Company correctly and reasonably assessed the First Complainant's claim for benefit under the Policy.

It is important to point out that I am not making a medical assessment. Rather I am examining if the decision of the Company was reasonable based on the medical and other evidence available to the Company when it declined to deal with the claim.

The Company states that this policy commenced in March 1992. Amendments to add Critical Illness, Hospital Cash and Accidental Injury for both lives assured were made in May 2003.

The First Complainant submitted a Critical Illness claim form in February 2015, which was almost 12 years after the cover was applied for by the Complainants. The Company states that during assessment of the claim significant non-disclosure was discovered and the amendment from 2003 was made void for the First Complainant only.

The Complainant's feel they disclosed all medical information and the amendment should not be made void.

The Complainants signed their initial application form on the 17th January 1992.

The policy was issued on the 4th March 1992.

The Complainants signed to add Critical Illness, Hospital Cash and Accidental Injury Benefits for both lives assured on the 4th March 2003.

The Complainant's signed a Letter of Acceptance on the 1st May 2003 and their amendment was issued on the 2nd May 2003.

The Company states that a Critical Illness Claim Form was received from the First Complainant on the 16th February 2015. The Company's positon is that during assessment of this claim *significant non-disclosure* was discovered which rendered the amendment to cover for the First Complainant from May 2003 as void. However, I note that on 13th July

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2015 a Company representative classified the non disclosure as: ***"slight non disclosure on PAF in 2003"***

It is the Company's position that if the Company had been aware of the First Complainant's full medical history at the time of this amendment to their policy further information and tests would have been sought before offering cover. The Company states that as it was not given an opportunity to fully assess the medical history at the time it had no option but to make the amendment null and void from commencement.

The policy commenced on 4th March 1992. The complaint relates to cover that was in place following the amendment that was done to the policy effective from 6th May 2003.

The Company states that the criteria that were considered in relation to a need to obtain medical evidence were:

(a) Response to the questions asked on the application form which apart from a response to alcohol consumption levels were all answered "No" from the First Complainant.
(b) Has the proposed Sum Assured crossed over the Company's non- medical limits?

The Company says that in 2003 the Non-medical limits for someone of the First Complainant's age were €190,001 for Life Cover and €160,000 for Critical illness.

The Company advise that the associate that completed the amendment to the policy in May 2003 left the company in April 2005.

Life Plan Provisions

The original Life Plan Provisions from 1992. Point 10 (d) states:

"The Policy, The Application for The Policy, any statements or medical information and any other written or oral statement by the life assured or by the person applying for the policy or by any person concerned with the policy and any endorsement attached to the Policy when issued shall constitute the entire contract between the parties to the policy".

Life Plan Provisions 2.11 (General) (a) (from the Revised Life Plan Provisions from 2003) states:

"The Policy, the Application Form, any written statements by you or the Life Assured in respect of the Application, any medical information in respect of the Life Assured and any endorsement attached to the policy when issued will be the entire contract between you and us. It is therefore very important that you answer all questions correctly and disclose all material facts when applying for the Policy".

The Complainants signed the declaration on their Policy alteration Form on the 4th March 2003.

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The declaration states:

"I/we have read through all the questions in this Policy Alteration Form and declare that to the best of my knowledge and belief all the information and statements (including any statements written down at my/our dictation) together with any made or to be made to [the Provider's] medical examiner and signed by me/us are true and complete and that they shall form the basis of the alteration to the Contract with [the Company]. I/we declare that if I/we aware applying for Non-smoker rates that I/we do not intend to consume tobacco at any time in the future".

It is the Company's position that in not advising the Company of pertinent material facts by the First Complainant whether deliberate or not, the opportunity was not given for the Company's underwriters to assess the risk presented under his application. The Company states that had it been made aware of the full medical history through a correct response to the application form questions terms as issued in May 2003 cover would not have been given to the First Complainant. The Company says that the medical evidence highlighted that the First Complainant had presented to his GPs medical practice with a history of being Tired all the Time (TATT) on the 16th March 2000 and a series of colds.

At this attendance it was noted that the Complainant was suffering from tachycardia (a fast heart beat) which required investigations and treatment for same. An ECG and chest x-ray were also to be carried out. The Company states that the First Complainant's GP cannot provide the ECG Report from that time. The Company submits that in the context of this finding of tachycardia the First Complainant was prescribed a beta-blocker which is a treatment for tachycardia and has to be viewed only in this context. I note the First Complainant in correspondence has intimated that the beta-blocker was prescribed for allergic rhinitis. The Company says however that based on the note of 30th April 2015 the First Complainant's GP has advised that a beta-blocker was prescribed only in the context of the finding of tachycardia. The Company states that the First Complainant was also referred for a chest x-ray which would have to be carried out in a hospital setting and was carried out a month later.

The Company submit that in addition there were findings of a click/heart sound at the time of this GP visit in 2000. It is the Company's position that it was therefore not given the opportunity which its underwriters would have taken to obtain a report from the First Complainant's GP and get its own investigations carried out to ascertain with what risks the Complainant presented.

The Company advise that the applicable Level of Critical illness cover at the time of the claim was €64,696.22. The Company states that it did not receive a Hospital Cash Claim from the First Complainant so it cannot calculate what the benefit amount would be based on the information received to date. The Company states that notwithstanding the issues in relation to the non-disclosures at outset it would also make representation in relation to the following:

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- The First Complainant's claim was submitted under the Policy Definition of Cardiomyopathy which is as follows:

> *"The unequivocal diagnosis by a consultant cardiologist of cardiomyopathy resulting in permanent impaired ventricular function and permanent marked limitation of physical activity with the life assured unable to progress beyond stage two of a treadmill test using the standard Bruce Protocol. Acute myocarditis is excluded unless there is subsequent development of cardiomyopathy as above. Cardiomyopathy directly related to alcohol or drug misuse is excluded".*

The Company's position is that the medical evidence received from the First Complainant's Consultant Cardiologist indicated that the First Complainant had/has an alcoholic cardiomyopathy which would be excluded for payment under the above definition. The Company states that it did not fully investigate whether the definition would have otherwise applied viz a viz permanent limitation of physical activity as it noted the non-disclosure which meant that terms would not have been offered and ceased processing the claim.

The Company states that, separately in submission made to the Ombudsman by the Complainants, it has been advised that the First Complainant has undergone open heart surgery to replace an aortic valve and as there is no alcohol related exclusion applicable the First Complainant asserts that he would be entitled to claim under this Policy definition.

The Company's comments in relation this are as follows —

1. The Company says that the occurrence of this surgery and validation of same in accordance with the Policy criteria has not taken place as claim assessment ceased after receiving the medical evidence that highlighted the non-disclosure and resulted in the voidance of cover.

2. The Company says that even if it was accepted by the Company that cover should not have been voided, it is the Company's contention that, had there been full and proper disclosure of the attendance at his GP on the 16th March 2000, the finding of a "Clicking sound of the mitral valve" from an underwriting viewpoint is quite significant.

The Company states that assuming contemporaneous further investigation results were available then in a best case scenario (test results showed no adverse findings whatsoever) an underwriter's decision would have been to exclude Heart Valve surgery from Critical Illness Benefit. The Company submit that in a scenario where adverse findings were discovered then Critical Illness may have been declined altogether.

It is the Company's position that accordingly the First Complainant does not fulfil any of the policy criteria for a valid Critical Illness Benefit claim.

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The Company states that it refunded all charges paid by the First Complainant for Critical Illness Benefit upon the discovery of non-disclosure even though this would not have been a contractual obligation.

The Complainants' response submission dated 29th August 2016

The Complainants states that in February 2003 they were contacted by a representative of the Company and it was discussed and agreed to add critical illness benefit of €40,000 indexing and hospital cash benefit of €100 per day indexing to the existing policy.

The Complainants say that the Company representative asked questions and completed a policy alteration form containing medical questions for both Complainants on 4th March 2003 which was signed by both of them.

In December 2014, the First Complainant, was diagnosed with severe Aortic Stenosis, Atrial fibrillation, cardiomyopathy with congestive cardiac failure. The Complainants state that they are satisfied beyond a reasonable doubt that the First Complainant had a genuine critical illness claim under the following policy conditions:

"a. Cardiomyopathy which is being denied by [the Company] as there view is that it was Alcohol related.

b. Heart Valve Surgery. [the First Complainant] has had open heart surgery to replace an aortic heart valve which [the Company] is more than aware of from the medical information they gathered from the relevant Doctors/Consultants. [The Company] have not taken this into account and this I understand from both medical and legal advice is a claim that has to be admitted on the basis that it is not alcohol related and this is supported in evidence by Dr O - Cardiac Consultant who stated quite clearly that the cause of the Cardiomyopathy is from Severe Aortic Stenosis and that while Alcohol is a contributor to Cardiomyopathy, Aortic Stenosis is the dominant element. This is recorded on [the Company's] own review of the claim ... This has been discussed with medical underwriter with other Insurance companies and the view on Aortic Stenosis is clear in that Alcohol is not a contributor to Aortic Stenosis. The fact that [the First Complainant] has had open heart surgery to correct this issue is covered under the policy conditions as a stated claimable benefit. It is accepted that the policy has an alcohol related exclusion in the general exclusions Section 4.1(b) but in the case of Aortic Stenosis and the heart surgery claim this cannot be relevant as there is no relationship between Alcohol and Aortic Stenosis. If this statement is put to [the Company's] medical underwriters, it is certain that they would agree with this".

In relation to the Company's position that there was non-disclosure, the First Complainant has the following to say on this issue.

The question on the application form was as follows:

"(a). Suffered from any mental or physical illness or injury requiring medical. Psychiatric or any other form of treatment advice.

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(b) undergone any special investigations, blood or laboratory tests

Question 9: Have you ever suffered from or had any treatment for

(j) Any physical or mental complaint or injury not mention above".

The Complainants state that when asked these questions by the representative they believe that the First Complainant truthfully and honestly answered 'No' to them as the last time he was at a Doctor was 16th March 2000 in which he complained of recurrent colds and stuffy nose. It is argued that the GP carried out what would be regarded as routine tests that the First Complainant says that he honestly did not recall.

The Complainants submit that it is quite normal for people to forget about tests that were carried out by a GP especially when there are no issues arising that are of a serious nature. The Complainants say that the doctor treated the First Complainant for an allergic Rhinitis and was put on a tablet which he understands now was a beta-blocker, but that this was only for one month and then discontinued. The First Complainant's next visit to his GP was in December 2000 for a foreign body that got into his eye.

It is the Complainants' position that on 4th March 2003 when the application form, to add on critical illness and hospital cash was completed, the First Complainant had no medical problems and he was not on any medication and had not been with his GP for over 2 years. The Complainants says that on this basis it would be reasonable for any person to not remember when and what tests were carried out especially when there was no issues arising as a result of the last visit. The Complainants state that their GP, has verified all of the above and he has confirmed to the Company in a letter dated 24th June 2015 that he did answer all medical questions truthfully when asked as the First Complainant had no special investigations or hospitalisations and he would know him quite well due to the length of time he has been his GP.

The Complainants submit that it is their understanding that the Company is trying to avoid paying a legitimate critical illness claim by voiding the cover from inception by claiming a non-disclosure of material facts which is disputed given that the First Complainant answered the medical questions honestly and truthfully at the time when the Company's representative completed the form.

The Complainants state that they are surprised that the Company has basically said that both the First Complainant and the GP were untruthful. The Complainants state that the GP knows the First Complainant better than any person and he can and has said with certainty that the First Complainant was telling the truth. The Complainants state that the Company would have been able to see that as well if it availed of the opportunity to ask the question directly to the First Complainant face to face, but says it appears easier for the Company to adopt the current position. The Complainants submit that a number of Doctors and medical underwriters when contacted were asked if they considered requesting x-rays and ECG's as

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normal and they all agreed that this was normally carried out but more so to discount possible issues that basic viewing of a person's body could not provide. The Complainants question how the Company can state that it was not normal, is questionable at the very least.

The Complainants state that it is fair to state that the Company knows that it will have to pay out on this claim if not for Cardiomyopathy then it would have to do so for Heart Surgery benefit, which the Complainants say cannot be disputed. The Complainants position is that the issue of non-disclosure is not an issue as the doctrine of Utmost Good Faith and honesty has been in play at all times by the First Complainant.

The Complainants say that at the date of the claim the First Complainant was covered for a critical illness sum assured of €68,414 and a hospital cash benefit of €171.05 per day.

The Complainants want the Company to reinstate full critical illness and hospital cash cover with effect from March 2003 and admit the original critical illness and hospital cash claim. The Complainants state that the want the Company to make full payment of the claim benefits as they feel that this is a legitimate claim and should be admitted and paid in full with accrued interest from the date the claim was originally made.

Analysis

I must assess whether there was a full disclosure to the Company of the First Complainant's health history. In this regard, I am mindful of the decision in *Chariot Inns Ltd v Assicurazioni Generali spa [1981] IR* 199 wherein the Supreme Court stated that the test for materiality is:

> "*...a matter or circumstance which would reasonably influence the judgment of a prudent insurer in deciding whether he would take the risk, and if so, in determining the premium which he would demand. The standard by which materiality is to be determined is objective and not subjective.*"

I am further mindful of the well accepted principle that a contract of insurance is a *"contract of utmost good faith on both sides"* and I note the dicta of Mr Justice Barrett in *Earls -v- The Financial Services Ombudsman & Anor [2015] IEHC 536* in relation to this duty wherein he outlined that;

> *"The duty of utmost good faith requires a genuine effort to achieve accuracy using all available sources; to require disclosure of all material facts which are known to an insured may well require an impossible level of performance"*

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With regard to this office's assessment of whether the fact that was not disclosed was a material fact, the High Court in Earls (cited above) decided that this office should not proceed on the basis that if a material fact was not disclosed then, *ipso facto*, there has been a breach of the duty of disclosure. Rather in the Court's opinion, this may not always be the case, as the duty arising for an insured in this regard, is to exercise a *"genuine effort to achieve accuracy using all reasonably available sources"* and on the facts of the case in Earls it was noted the proposer's *"memory and experience"* in the characterisation of the event was relevant.

Consequently, it is evident that the test for materiality is an objective one and the proposer is required to disclose every matter which a reasonable person would consider to be material to the risk against which indemnity is being sought.

Furthermore, I note this general duty may be limited in particular circumstances by reference to the form of questions asked in the proposal form. Consequently, I must consider whether the particular questions that were asked of the Insured on the Application Form had limited that general duty.

In this regard, it is recognised by Finlay CJ in *Kelleher v Irish Life Assurance Company [1993] 3 IR 393* Finlay CJ that the test is as follows:

> *"whether a reasonable man reading the proposal form would conclude that information over and above it which is in issue was not required"*

Consequently, the question at issue is also to be assessed by reference to the reasonable person / prudent proposer.

Having examined the documentation in relation to the policy that gives rise to this complaint, I accept that, a **"material fact"** was defined and the consequence of a non-disclosure of a material fact was also set out, that is: *the Policy Alteration issued may be of no effect*.

The obligation placed on the Insured was to answer questions on the application form fully (whether via a Company representative or otherwise) and it was specifically set out on the application form that if in doubt whether a fact was material, such facts were to be disclosed. The Insureds declared by their signature on the Alteration application that they had read the Policy Alteration Form and to the best of their knowledge and belief all the information and statements signed by them were true and complete.

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I accept that there was a failure by the Complainants to disclose in 2003 his visit/s to his GP of March / April 2000, and the medical reasons for same. Likewise, I accept that the subsequent hospital visit for blood tests and chest x-ray were matters that a Company would wish to know of. However, I consider that the Company (a) should not have voided the alteration cover of 2003 and (b) should not have completely refused to deal with the claim/s that arose. In coming to these conclusions I have had regard to (i) the materiality of the non-disclosure and (ii) I have taken into account what a reasonable person would consider material, in the following analysis:

- The First Complainant's GP has stated that he considered that the chest x-ray ECG and blood tests were regular routine investigations in a GP setting. Therefore, I believe it was not unreasonable of the Complainants to take a similar view.

- The First Complainant's ECG and blood tests of March / April 2000 were carried out by the First Complainant's GP in his own practice and not in a hospital setting, but noting that the chest x-ray would have been carried out in a hospital. However, the chest x-ray was noted to be clear.

- The GP's account of the Complainant's visit in March / April 2000 is as follows:

  "In the consultation on the 16/03/00 [the First Complainant] complained of recurrent colds with green phlegm often up to six times per year. He had a stuffy nose and was often catarrah. He was a non-smoker. He felt tired all the time. He had nausea and catarrh. ***Examination was unremarkable****. There was a ?clicking sound of the mitral valve. I noticed some tachycardia 100bpm.* ***My provisional diagnosis was of allergic rhinitis with recurrent upper respiratory infections.*** *I did an ECG which confirmed normal sinus rhythm with pulse of 100bpm. His full blood count was normal. His fasting blood sugar was normal. His biochemistry including liver function test were normal. Thyroid function tests were normal ruling out hyperthyroidism. His chest x-ray was normal. I treated his allergic rhinitis and commenced him on a beta-blocker for one month".* [my emphasis]

- There were no additional hospital or consultant referrals between 2000 and 2003.

- There is no evidence of what the GP actually advised the First Complainant regarding what the conclusions / findings were following his examination in March / April 2000, other than as set out in the GP's evidence that his provisional diagnosis of the First Complainant was of ***allergic rhinitis with recurrent upper respiratory infections*** and that he had treated him for same and commenced him on a beta-blocker. The evidence does not show that the Complainant was made aware of the GP hearing **a *clicking sound of the mitral valve*** or that what the First Complainant was experiencing was medically described as ***some tachycardia 100bpm*** or that there was any indication of their being anything more sinister amiss with his health, other than having ***allergic rhinitis with recurrent upper respiratory infections*** with the

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accompanying symptoms. This of course does not discount that the doctor may have thought that there was something more sinister.

I have also taken into account the Provider's position is that the prescribing of a beta-blocker was for the tachycardia infections, not rhinitis. However, it is not unreasonable to assume, if this is the correct position, that the Complainant was not aware of this, for the following reasons:

- There was no long-term medication prescribed.

- The First Complainant's next visit with the GP was on 15/12/2000 with a foreign body in his eye which was removed under local anaesthetic. The GP confirmed that there was no comment between them at this time of the previous consultation as the First Complainant was keeping well.

- The First Complainant appears to have had no medical issues requiring a visit to his GP after the visits in 2000 up to the date of the Complainants signing of the Policy Alteration Form in 2003.

- The Complainants position is that the Alteration of the policy resulted from a direct contact from the Company's representative, and it was the representative that asked the questions and completed the application. The Company has not denied that this is how the Alteration of the policy arose in 2003.

- The GP's opinion on the First Complainant's disclosure is also noted, as follows:

  "I would be of the opinion that [the First Complainant] was truthful in his answer that he had no medical problems on the 4/3/03 as he was not on any medication & had not seen a doctor for well over two years".

In the *Earls* case (quoted above) it was noted that the proposer's *"memory and experience"* in the characterisation of the event was relevant. The *Earls* case also posited a consideration of whether the Insured exercised a genuine effort to achieve accuracy using all reasonable available sources. It would appear to me that the Complainant did exercise a genuine effort to achieve accuracy for the following reasons.

The First Complainant states that the last time he was at a Doctor was 16th March 2000 in which he complained of recurrent colds and stuffy nose.

It is the First Complainant's evidence that the GP carried out what would be regarded as routine tests which the First Complainant says that ***he honestly did not recall***.

I accept that not recalling matters does not equate to fulfilling the duty to disclose material facts. However, where no underlying health issues were diagnosed / discovered, following the medical examinations, I consider that the Complainants may reasonably have thought that such matters were not material and that they achieved accuracy in their answers.

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Indeed, as previously noted, on 13th July 2015 a Company representative classified the non disclosure as: ***"slight non disclosure on PAF in 2003"***

As regards the policy exclusion for benefit where Cardiomyopathy is directly related to alcohol or drug misuse, and the Company's reliance on same when assessing eligibility for the policy benefit, I note the following:

The Company's position is that the medical evidence received from the First Complainant's Consultant Cardiologist indicated that the First Complainant had/has an alcoholic cardiomyopathy. This would be excluded for payment under the policy definition. The Company states that it did not fully investigate whether the definition would have otherwise applied viz a viz permanent limitation of physical activity as it noted the non-disclosure which meant that terms would not have been offered and ceased processing the claim.

I am not satisfied that 'alcoholic cardiomyopathy' was given as a diagnosis for the First Complainant or that the First Complainant's Cardiomyopathy was stated by the treating doctors to be *directly related to alcohol*.

The Primary Diagnosis was stated to be: *"Non-ischemic cardiomyopathy (**likely** alcohol related)".*

In the Specialist Medical Report dated 24 February 2015, the Company had asked: *"Is the Cardiomyopathy related to alcohol or drug misuse?"* The answer given by the Specialist was that:

"alcohol is a contributor to cardiomyopathy but aortic stenosis is the dominant element".

It is the Company's position that "Directly related" means that there has to be a connection between the cardiomyopathy and alcohol abuse. It is noted that the Company did not use this meaning or the phrase "Directly related" when questioning the Medical Specialist. It is also noted that this meaning was not specifically set out in the policy provisions. A general response was given by the Medical Specialist to the Company's query and does not appear to be specific to the Complainant's condition.

Therefore, it is my opinion that the exclusionary element of ***directly related to alcohol*** has not been conclusively evidenced by the Company.

Section 60(2)(c) of the Financial Services and Pensions Ombudsman Act 2017 (from which the Financial Services and Pensions Ombudsman derives jurisdiction) prescribes that:-

"(2) A complaint may be found to be upheld, substantially upheld or partially upheld only on one or more of the following grounds:

(c) although the conduct complained of was in accordance with a law or an established practice or regulatory standard, the law, practice or standard is, or may be, unreasonable, unjust, oppressive or improperly discriminatory in its application to the complainant; .."

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Having regard to all the circumstances of the complaint and the respective responsibilities of both the Complainants and the Company in relation to the policy, and in order to do justice between the parties, I consider that the Company should (i) put the policy cover back in force (ii) assess the claims (without applying the alcohol exclusion in the claim assessment) and (iii) where the First Complainant meets, in all other respects, the policy criteria for benefit, pay 50% of the benefit. An adjustment of the benefit payable can be made to take account of any premium already refunded to the Complainants, and for any outstanding premiums on the policy.

Finally, in relation to the Company's positon that: *"the FSPO did not give any consideration to submissions made by [the Company], and therefore [the Company] was not treated fairly"*, I reject this contention.

As Financial Services and Pensions Ombudsman I am an independent officer with the remit to resolve complaints about the conduct of regulated financial service and pension providers through mediation and where necessary by investigation and adjudication. At all times, including, in the adjudication of this complaint, I undertake this responsibility in a fair and impartial manner.

At every stage of the investigation and adjudication of this complaint, both the Complainants and the Company were afforded the equal opportunity to state their positions in their submissions and to have same considered by this office, and those submissions and evidence have been considered by me in arriving at my Decision. In addition, the parties were provided with my Preliminary Decision and were given the opportunity to make further submissions pointing out errors of law or significant additional points of fact, for my further consideration, before a Legally Binding Decision, appealable only to the High Court, is made by me.

As with all complaints, I have taken a balanced view of this complaint, and in doing so, I considered both the Complainants' position, and the Provider's position, equally. In coming to my decision on the matter, I have endeavored to deal with all the points raised by the Complainants and the Company.

Having considered the matter at length, I take the view that in light of the circumstances surrounding the GP visits in 2000 and the subsequent claims for the benefit under the policy, the Company's approach in voiding the cover and not assessing the claim was unreasonable and that this complaint should be substantially upheld. I consider that given the overall circumstances of the situation the Complainants found themselves in, the strict application of the policy conditions sought to be relied upon by the Company, was unduly harsh and unjust.

Consequently, in order to do justice between the parties, it is my Legally Binding Decision that the complaint against the Company is substantially upheld, and I direct that the claim is to be assessed on the basis of where the claim meets the policy criteria, in all other

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respects, that 50% of the policy benefit is to be paid (with the required adjustment for any payments made to the Complainants in respect of premiums, and for any outstanding premiums on the policy).

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is substantially upheld on the grounds prescribed in ***Section 60(2)(c).***

- Pursuant to ***Section 60(4)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct that the Respondent Provider complete the assessment of the claim and pay benefit as directed above.

- Pursuant to ***Section 60(8)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** the Respondent Provider is now required, not later than 14 days after the expiry of six weeks from the date of this Decision to notify this office in writing of the action taken or proposed to be taken in consequence of the said direction/s outlined above.

The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

29th March 2018

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that—

(a) ensures that—

(i) a complainant shall not be identified by name, address or otherwise,

(ii) a provider shall not be identified by name or address,

and

(b) in accordance with the Data Protection Acts 1988 and 2003.