An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0051
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Rejection of claim - non-disclosure Rejection of claim - fit to return to work
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant's claim for continuing income protection was declined by the Insurer upon review. The Complainant appealed this decision and, in the course of the consideration of this appeal, the Insurer concluded that the Complainant had failed to disclose certain material facts at inception. Arising from this, the Insurer cancelled the Complainant's cover.

The Complainant is that the Insurer has failed to continue making payments on foot of the income protection scheme. The Complainant seeks a direction that her insurance be reinstated and that the monthly payments be restarted, to include back pay.

The Complainant's Case

The Complainant was a member of the Insurer's income protection scheme which she joined by completing a written application form on the 16th of March 2010 followed by a telephone interview on the 30th of March 2010. The Complainant submitted a claim in September 2013 on the scheme having become unwell. The Insurer initially accepted this claim, relying upon a report of [Dr G] which agreed that the Complainant had become "*totally disabled*" (as per the terms of the policy) and unable to work as result of her illness. Accordingly, the Insurer made payments to the Complainant from January 2014 (backdated to September 2013).

In April 2015, the Complainant was recommended for health retirement and she communicated this to the Insurer. Thereafter, the Insurer sought an updated report from its medical expert as to whether the Complainant remained eligible for cover. To this end, the Complainant attended with Dr G in June 2015.

The resultant medical opinion concluded that the Complainant was no longer "*totally disabled*" and thus no longer eligible and, on foot of this, the Insurer wrote to the Complainant in July 2015 proposing to terminate payments as and from October 2015.

The Complainant appealed this determination, providing her own supportive expert medical opinion. In the course of considering this appeal, the Insurer concluded that the Complainant had, at the time of inception of the policy, failed to disclose material facts. This alleged non-disclosure related to an alleged failure on the part of the Complainant to disclose, in both her written and oral application, that she was taking prescription medication (sleeping tablets) and an alleged failure to disclose symptoms and treatment arising from a road traffic accident in September 2000 including treatment for symptoms of anxiety and depression. On foot of this alleged non-disclosure, the Insurer cancelled the Complainant's policy with the result that it no longer considered it necessary to determine the Complainant's appeal of the decision of July 2015.

The Complainant submitted a letter of the 19th of August 2016 with her complaint form to this office. This letter addresses the alleged non-disclosure points by pointing out that, to the best of the Complainant's recollection, she had referred to the sleeping medication in the telephone interview at the application stage and that, arising from this disclosure, "*my answer was a no to taking any other medications or treatment in the last 12 months*". The Complainant also highlighted the fact that she had referred to the sleeping medication on her initial claim form in September 2013 and relied on this as evidence that she was not seeking to conceal the matter.

The letter of the 19th of August 2016 provided as follows:

> *To my knowledge, at this time during this telephone medical questionnaire I mentioned the use of the sleeping medication Zopiclone, which had been prescribed to me from approximately 2002. This was the second reason mentioned for cancelling my Income Continuance Cover because* [the Insurer] *stated that I said no to taking medication on my original application. As my use of the Zopiclone had been discussed on this telephone medical questionnaire, my answer was a no to taking other medications or treatments in the last 12 months.*

With regard to the issues surrounding the road traffic accident, the Complainant stated that she was prescribed anxiety medication "*for a couple of weeks*" only or for "*approximately three weeks*" and that "*the anxiety did not last more than 3 weeks*". The Complainant further maintained that the telephone questionnaire asked for medical details relating to the "*previous 5 years*" only which would not have required her to disclose details of the road traffic accident which had occurred 10 years earlier.

In conclusion, the Complainant comments that her "*claim was paid out until* [she] *had reason to disclose to* [the Insurer] *that* [she] *was forced due to illness to retire from work at age 57 on medical advice*".

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Following the initial complaint form to this office, the Complainant made a number of additional submissions.

In those submissions, the Complainant appears to accept that she may not have disclosed details relating to the sleeping medication (as she had initially thought she had) but she emphasises that same was entirely unintentional, a position she maintains is supported by the fact that she disclosed the sleeping medication on her claim form in September 2013 and in the telephone interview following the submission of the claim form.

The Provider's Case

The Insurer relies on the terms of the scheme which require the disclosure of all material facts, failing which, the Insurer will be at liberty to cancel the cover. The Insurer maintains that the Complainant failed to disclose material facts at the application stage. In this regard, the Insurer has noted that the Complainant's General Practitioner's records include several references, in August and September 2009, to sleeping tablets and to an addiction to same. In addition, the Insurer states that the Complainant's General Practitioner confirmed that the Complainant was prescribed Seroxat for anxiety and depression between March 1999 and March 2001 at which point her prescription was changed to Prozac. Reference is also made to a road traffic accident which the Complainant suffered in 2000 and to subsequent treatment for "*significant symptoms*" "*up to at least November 2011*"

The Insurer states that its underwriters have reviewed this information and have stated that "*had the information been disclosed at the time, a prudent underwriter would have postponed* [the] *application for cover initially, and subsequently declined upon re-applying*". In its submission to this office, the Insurer is more unequivocal in stating that if the information had been disclosed, the underwriters "*would not have been in a position to offer cover and her application would have been declined at the time*".

The Insurer states that it is satisfied that it was entitled to cancel the cover.

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 Complainant was 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

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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.

A Preliminary Decision was issued to the parties on 1 May 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.

In the absence of additional submissions from the parties, the final determination of this office is set out below.

This complaint addresses two separate decisions by the Insurer. In the first instance, the Complainant takes issue with the Insurer's decision to cease payments to her on the basis that she no longer qualified/qualifies as "*totally disabled*" pursuant to the income protection scheme. The Complainant also takes issue with the Insurer's subsequent decision to cancel her cover under the scheme. I will consider the cancellation decision first and, in the event that I come to a decision favouring the Complainant on this point, I will go on to consider the rejection of the claim.

Before embarking on the substantive aspect of this decision, it will be useful to set out a chronology of developments. It will also be helpful to reproduce certain evidential matters including passages from the various formats of the application for cover made in this complaint as well as the relevant terms from the policy.

Chronology

Sept 2000	Road traffic accident
2002/2003	Complainant purchased over-the counter sleeping medication when on holiday in Tenerife. Upon her return home, she was provided a prescription for same which she takes on a nightly basis.
Aug/Sep 2009	Records in the Complainant's GP notes referring to addiction to sleeping medication and the necessity to wean the Complainant off same
16/03/2010	Complainant completes application form for enrolment in the income protection scheme and posts same to the Insurer
30/03/2010	Letter from the Insurer providing a report of the Complainant's interview of the same date with [the medical underwriters] in relation to the application to join the scheme.

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14/04/2010	Letter from the Complainant's broker confirming that she has been accepted into the income protection scheme with effect from 1 12/04/2010
10/05/2010 has from	Further letter from Complainant's broker confirming that she been accepted into the income protection scheme with effect 06/05/2010
18/09/2010 Complainant's underwriters in relation Complainant on	Letter from the Insurer providing a report of the interview of the same date with the medical to her claim. Report subsequently signed by the 23/09/2013 and furnished to the Insurer.
27/08/2013	Claim Form submitted by the Complainant
08/11/2013 *work*"	Report of Dr G certifying the Complainant as "*totally unfit for* and confirming that the Complainant "*meets the definition of disability*".
Jan 2014	Commencement of payments (backdated to September 2013)
12/04/2014 work on disabled'.	Report of Dr G certifying the Complainant as fit to return to a part time basis and as no longer to be classified as 'totally
15/04/2015 that the application for	Letter from Dr O'C to the Complainant's employer advising Complainant "*is likely to be incapable of regular and effective service*" "*due to an ongoing condition that is likely to be permanent*". The letter goes on to recommend that the health retirement be accepted.
01/07/2015 work	Report of Dr G certifying the Complainant as fit to return to and as no longer to be classified as 'totally disabled'.
22/07/2015 that	Letter from the Insurer notifying the cessation of payments relying on the medical report of Dr G to the effect the Complainant was not "*totally disabled*"
01/10/2015	Cessation of payments
16/11/2015	Report of Dr R recommending further investigations
04/01/2016 cancelling the on the *medical*	Final Response Letter from the Insurer (misdated 2015) declining the Complainant's appeal and, additionally, Complainant's cover. This latter action was said to be taken basis of the Complainant's failure "*to disclose* [her] *full history to us at the application stage"* which is

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described as a letter makes as follows:

"*significant non-disclosure of material facts*". The reference to two instances of alleged non-disclosure

i) A failure to disclose an addiction to sleeping tablets as referenced in the Complainant's GP records of August and September 2009;

ii) A failure to disclose injuries sustained and treatment received as a result of a road traffic accident in September 2000 and relating to treatment up until November 2001 including treatment for anxiety and depression;

The Final Response Letter does not re-engage on the issue as to whether the Complainant was totally disabled other than to the note that the Complainant had submitted "*supportive medical evidence*" and that the Complainant had undergone an independent medical examination conducted by Dr R.

Paper Application Form

As part of her application, the Complainant completed a hard copy application form dated the 16th of March 2010. This form included the following passage set out in italics in the original:

> ***Warning****- Telling [the Insurer] about Material Facts – Failure to disclose all material facts on the application form and/or during the Medi-Phone call could render your contract void. A material fact is one that an insurer wold regard as likely to influence the assessment and acceptance of the proposal for insurance. If you are in doubt as to whether certain facts are material, such fact should be disclosed. If you do not, or if any of the answers you give to the questions are not true and complete, [the Insurer] could treat your membership of the plan as void. If this happens you will not be covered under the plan and in these circumstances your claim will not be paid.*

The application form included the following two questions to which the Complainant indicated answers of 'No':

> *Are you currently taking prescribed drugs, medicines, tablets or other treatment or have you done so in the last year (colds, influenza or respiratory tract infections may be ignored)?*
>
> *Have you ever had any symptoms of, or suffered from any of the following: Depression, stress, anxiety, nervous breakdown or any other mental or behaviour disorder?*

The application form also included a 'Declaration' section which is signed by the Complainant. This section included the following:

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I also declare that the statements overleaf (including any statements written down at my dictation) are TRUE and COMPLETE. I understand that failure to disclose a material fact may constitute grounds for rejection of a claim.

Phone Recording

I have been provided with a recording of the Complainant's telephone interview with a medical professional on behalf of the Insurer on the 30th of March 2010. This interview is expressly said to be for the purposes of ratifying the insurance policy provided to the Complainant and it is also expressly stated that the interview forms part of the Complainant's application. The interview included the following exchanges:

Agent: *All the questions must be answered fully and honestly. I have to advise you that you should tell us anything that may be relevant to your application and if you're not sure whether any fact is relevant, you should tell us anyway.*

If you mislead us, fail to disclose all relevant information, then this may result in alteration, cancellation of your contract and may invalidate future claims. As it's unlikely that [the Insurer] *will contact your GP about this information, therefore please ensure that you answer all the questions as fully as possible. So, I just have to ask whether you fully understand and agree to this?*

Complainant: *Sure, no problem.*

…

Agent: *Have you ever had stress, anxiety or low mood that persisted for more than three weeks at a time or for which you sought medical advice or counselling?*

Complainant: *No.*

Agent: *Have you ever had depression or any other psychiatric illness?*

Complainant: *No.*

…

Agent: *Are you currently unwell or do you have any physical defect or condition that's not already mentioned?*

Complainant: *No.*

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Agent: *In the last 12 months have you taken or been advised to take any types of prescribed medication or treatment including tablets, creams, inhalers or sprays?*

Complainant: *No.*

There is no reference at any point in this interview of 19 minutes and 47 seconds duration by the Complainant to the taking of prescription medication or sleeping tablets.

Policy Terms and Conditions

The policy document provides as follows:

> ***Failure to disclose Material Facts*** *– If an any time, there shall be or have been on the part of the any Insured Person any failure to disclose Material Facts in connection with the commencement or continuation of cover under this Policy or in connection with any claim under the policy, then*
>
> *(i) The Company shall have the right to cancel the Policy in respect of that Insured Person with immediate effect*
> *(ii) The Company shall be entitled to the repayment of any benefit paid in respect of that Insured Person and*
> *(iii) No further benefit shall be payable in respect of that Insured Person and*
> (iv) *No amount of Premium which has been paid to the Company shall be refunded in whole or in part*

The policy document defines a 'material fact' as follows:

> *Material Fact means any fact which a reasonable insurer would regard as likely to influence the assessment and acceptance of an application for insurance. If in doubt as to whether some piece of information is relevant the Company should be informed.*

Analysis

The Insurer has sought to rely on material non-disclosures as the basis for declining cover. I accept, on the basis of the terms and conditions set out in the Policy Document and on the basis of the various warnings in the application procedures, including during the above telephone conversation, that this is a course of action that is open to the Insurer if it can establish that there were indeed non-disclosures of material facts. The alleged material non-disclosures relate to the history of taking prescription sleeping medication, to the symptoms

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and treatment relating to a road traffic accident in 2000, and to the diagnosis of and treatment of stress, anxiety and/or depression.

It is accepted that the Complainant was taking prescription medication for sleeping for a prolonged period prior to her application to join the income protection scheme. Indeed, the medical evidence provided by the Insurer includes a number of entries from the Complainant's GP records relating to this matter in the period of 6-7 months prior to the Complainant's application to join the scheme.

These entries include a reference made on 25/09/2009 to being "*Addicted to sleepers*" and they also record that the Complainant had been taking the medication for "*4 years*" [06/08/2009]. The Complainant's letter of the 19th of August 2016 states that the medication was prescribed since "*approximately 2002*".

It also appears to be accepted that the Complainant omitted any reference to this medication in both her written application form and in the subsequent telephone interview.

It is clear that the Complainant was asked two questions (one in the written application and one in the phone application) specifically addressing the issue as to whether she was taking prescription drugs/medication. Both of these questions sought clarity as to whether prescription medication was being taken at the time or whether it had been taken in the past 12 months. In the Complainant's case, she was taking the medication at the time (as well as for the preceding 12 months) notwithstanding which she answered the questions in the negative.

The Complainant has pointed to her claim form submitted in September 2013 wherein the medication *was* disclosed as proof of the contention that she did not intend to conceal the matter. I have no difficulty accepting this submission however, unfortunately from the point of view of the Complainant, the question I must consider is whether the information was or was not disclosed at the time of inception of the policy and whether, if it was not disclosed, it amounted to a 'material fact'. Having examined the evidence I accept that the detail relating to the sleeping medication was not disclosed at the relevant time. I will return to the question as to whether this information constituted a material fact.

The Insurer also relies on an alleged non-disclosure surrounding a road traffic accident in September 2000 and treatment provided in or around that time including treatment for anxiety, stress and depression. I am of the view that there has been a certain amount of conflation of these two matters arising from the fact that a reference to the psychological matters was made in a medico-legal report generated for the purposes of litigation regarding the road traffic accident. I am not of the view that the issues relating to the road traffic accident itself, and any physical injuries arising therefrom, are relevant. However, diagnosis of, and treatment for, psychological illnesses may well be relevant.

The Complainant's GP's practice records include a handwritten document which contains an entry dated 26/03/2001 recording that the Complainant was taking Seroxat (an antidepressant medication) "*for past 2 years since breakup of marriage*". The records also include a medico-legal report dated the 26th of November 2001 produced by the

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Complainant's GP at the request of her solicitors in the context of a personal injuries action arising from a road traffic accident. This report includes the doctor's view that he "*was of the impression that she was significantly depressed*". The report continues to note that "*more recently I have diagnosed her with depression*", a diagnosis which is described as "*clinical depression*" later in the document. Under the heading of 'Past Medical History', the report notes that the Complainant "*has been separated from her husband for a few years now and has suffered from anxiety and depression and was taking Seroxat 20mg, po, daily for this*." The report further states that, in respect of treatment, the Complainant had been taking Seroxat but that this had recently been changed to Prozac. It is unclear when this treatment ceased.

In light of the foregoing, and given the Complainant's negative answers to the questions referring to 'anxiety' and 'depression' in the paper application form and in the course of the telephone interview, I accept that the Complainant failed to disclose the fact that she had suffered from anxiety that persisted for more than 3 weeks and for which she sought medical advice. The evidence does not support the Complainant's submission that "*the anxiety did not last more than 3 weeks*" or that she was prescribed anxiety medication "*for a couple of weeks*" only.

The Complainant appears to accept this position in her letter of the 15th of December 2017. In any event, I note that the relevant question on the paper application form, in contrast to the question asked in the telephone interview, did not include any limitation by reference to the length of time that the symptoms of anxiety and/or depression lasted. I also accept that the Complainant failed to disclose that she had been diagnosed as suffering from depression.

The Complainant's submission that the telephone questionnaire asked for medical details relating to the "*previous 5 years*" only is not borne out by the recording of the call. There is a 12-month limitation in respect of the prescription medication question but no limitation in respect of the other questions.

I must now turn to the question whether these non-disclosures related to 'material facts'. The definition of a material fact as set out in the policy document is comprehensive and correct. A material fact is one which would have influenced a reasonable insurer had it been disclosed. Accordingly, it is not sufficient merely to establish that the particular insurer or underwriter involved would have declined cover, it is also necessary to show that such a course of action would have been reasonable, or that a reasonable insurer would have been influenced by the information had it been disclosed.

The Insurer has provided email correspondence passing between its claims assessor and the underwriter wherein the underwriter is asked what it might have done had the relevant information been disclosed at inception. The response from the underwriter of 17/12/2015 states as follows:

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> *"I think we would have postponed the cover initially in 04/2010. But the clients health did not improve following a postponement period and I have declined the cover overall."*

Whilst this response is not entirely clear, I understand it to mean that, ultimately, the underwriter would not have accepted the Complainant into the scheme. More importantly, I accept that a reasonable insurer would have been influenced by the information which was not disclosed had it been aware of it. In the context of an application to join an income protection scheme, a recent history of long-term addiction to prescription medication would certainly, in my view, represent a material consideration.

Equally, a history of diagnosis of, and treatment for, depression and anxiety would also represent a material consideration which would be likely to influence the decision whether to accept or decline the application.

The diagnosis is referenced in the medico-legal report wherein the treatment is documented as having been provided up to November 2001 at least (and having begun some considerable time before that), some 9 years before the application to join the scheme. I am nonetheless satisfied that a reasonable insurer would have been influenced by this and indeed, contrary to the Complainant's submission, it should be noted that the questions during the application process dealing with the question of diagnosis of depression did not incorporate any time limit.

In light of the entirety of the foregoing, I accept that the Insurer was entitled to cancel the Complainant's membership of the scheme.

In those circumstances, I do not need to consider any issue as to the Complainant's qualification as "*totally disabled*". I note that the Insurer has stated that it does not propose to seek the return of any payments made to-date and that it would be happy to refund any premiums paid by the Complainant into this plan and, in the unfortunate circumstances of this complaint, and on the basis that this offer remains available to the Complainant, I do not intend to uphold this complaint.

Conclusion

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

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.

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GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

31 May 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.