An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0057
Sector:	Insurance
Product / Service:	Life
Conduct(s) complained of:	Rejection of claim - non-disclosure
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant and her late husband incepted a Guaranteed Term Protection policy with the Company, effective from 1 September 2015, which provided him with life cover in the sum of €75,000. The Complainant's late husband died on [redacted]. The Company declined the ensuing death benefit claim due, it said, to the nondisclosure of material facts and refunded the Complainant all premiums paid since the inception of the policy.

The Complainant's Case

The Complainant and her late husband met with a Financial Advisor who called to their home in May 2015, during which they discussed which Provider to renew their life insurance with. The Complainant herself elected to keep her cover with a different provider but she says that her husband was advised to take out life insurance with the Company and he completed the Guaranteed Term Protection application on 6 May 2015. The policy was ultimately incepted on a joint ownership basis, with the first life only assured.

The Complainant states that in mid-July she, her husband and their two children took a holiday and they stayed in a holiday home. During this time she states that her husband

> "[redacted]. *He did canoeing and archery also. We returned home on the 17th July and getting out of the car, he got a pain in his back. Naturally, as anyone would assume, he thought he had pulled a muscle from both the*

> *uncomfortable furniture and the horse play. He took no more than a paracetamol and deep heat to sort out the pain"*.

The Complainant then states that

> *"for some reason in the delay in the process of the policy,* [the Company] *requested another declaration of health.* [Our Financial Advisor] *called to our home again and* [my husband] *signed this declaration on the 4th August 2015.* [My husband] *had not intended to seek medical advice or treatment for this* [back] *pain, as he assumed it was just a pulled muscle. He signed this form honestly and in utmost good faith"*.

The Complainant states that

> *"Over the following week, the paracetamol was not as effective, and only at this time did* [my husband] *decide to see our GP…His main complaint was the pain in his back, and he mentioned too that he had indigestion, which he normally would just take Gaviscon for.* [My husband] *felt that since he was in the surgery with the back pain, why not mention the indigestion. This consultation was at* [redacted]. *He decided to send* [my husband] *for a gastroscopy…and that his back pain was just a pulled muscle and gave him pain killers and something stronger for the indigestion. At no stage did* [the GP] *suspect anything serious"*.

The Complainant's late husband's pain did not improve and he was admitted to hospital on [redacted]. Following numerous tests and keyhole surgery, he was advised on 14 January 2016 that he had *"small cell carcinoma"* and was discharged from hospital with a date for chemotherapy to be forwarded. Later, on [redacted], he took ill and was admitted to Hospital, where they managed his pain and he commenced chemotherapy. He was advised on [redacted] that he had terminal cancer. He took ill again on [redacted] and died the following day, [redacted] with the Death Certificate detailing the cause of death as *"Stage IV Metastatic Oesophageal Cancer"*. The Complainant notified the Company of her late husband's death by telephone on [redacted].

The Company wrote to the Complainant on 4 May 2016 advising that it was declining the claim for death benefit in respect of her late husband and was cancelling the policy from inception due to the non-disclosure of material facts. The Complainant states that *"at no stage did* [her husband] *ever think he was seriously ill or was he dishonest in his declaration of health"* and questions *"If someone had sore throat and chest infection, would they disclose it on a health form, (only to find out later on they have throat cancer) after all, the majority of people assume these "little" niggles are just that – "niggles""*. The Complainant states that *"this life policy was signed honestly and in good faith. This policy was bought in the event of* [my husband]*'s death and would provide security for my* [redacted] *and our future"*. The Complainant considers that the Company decision to decline the claim is *"grossly unfair"* and seeks for it to admit the claim into payment.

The Complainant's complaint is that the Company wrongly or unfairly declined the death benefit claim made in respect of her late husband.

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The Provider's Case

Company records indicate that the Complainant and her late husband incepted a Guaranteed Term Protection policy with the Company, effective from 1 September 2015, which provided him with life cover in the sum of €75,000.

The Company notes that the Complainant's late husband completed the policy application on 5 May 2015, which was then forwarded by his Financial Advisor to the Company on 8 May 2015. The Company confirmed to the Financial Advisor on 12 May 2015 that this application had been accepted at standard rates, with confirmation of the risk commencement date as the only remaining outstanding requirement. The Company notes that no further communication was received until August 2015, at which stage it was necessary for the Complainant's late husband to complete a Declaration of Health due to the length of time that had elapsed between his signing the original application form and the request to commence cover. The Complainant's late husband completed and signed a Declaration of Health on 4 August 2015 and the policy was issued to him on 13 August 2015, with a commencement date of 1 September 2015.

The Complainant notified the Company of her late husband's death on [redacted] by telephone on 7 March 2016. The Death Certificate dated [redacted] records the cause of death as *"Stage IV Metastatic Oesophageal Cancer"*.

The medical evidence received during the course of the assessment of the ensuing death benefit claim confirmed that the Complainant's late husband had attended his GP on 3 June 2015 with a skin lesion on his right temple that had increased in size, particularly over the previous number of weeks. The GP noted this to be suspicious looking and referred the Complainant's late husband for urgent Specialist assessment as to query possible malignant melanoma. The Complainant's late husband was seen by a Consultant Surgeon at [redacted] Hospital on 11 August 2015, as which stage the skin lesion had fallen off. Nonetheless, the Company notes that the Consultant Surgeon referred the Complainant's late husband onward to a Consultant Dermatologist.

Furthermore, the Company notes that the Complainant's late husband attended his GP on 11 August 2015 with a history of gastro-intestinal epigastric pain with associated back pain that had been present at that time for the last few weeks. The GP prescribed medication and referred the Complainant's late husband to [redacted] Hospital for gastroscopy and further investigation.

Having considered the medical evidence before it, the Company wrote to the Complainant on 4 May 2016 advising that it was declining the claim for death benefit in respect of her late husband and was cancelling the policy from inception due to non-disclosure of material facts. This letter stated, as follows:

> *"The policy was issued on August 13th 2015.*
>
> *The medical evidence received during the assessment of this claim confirms that the deceased had been suffering a change in health between the date of*

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> *the original application* [6 May 2015] *and the date he signed the Declaration of Health* [4 August 2015]*, and furthermore had attended a doctor between the date of signing the Declaration of Health and the policy being issued. The medical records received confirm the deceased attended his GP on August 11th 2015 with gastro-intestinal abdominal pain and associated back pain for the last few weeks. The GP subsequently referred him for a gastroscopy on August 11th to* [redacted] *Hospital. In addition a letter from* [redacted] *Hospital confirmed the history as presentation with mid back pain starting in July 2015 which progressed in intensity and with time, affected the abdomen as well".*

The Company submits that under a contract of insurance, there is a duty on the part of the person seeking insurance to disclose all material facts which he or she is aware of. The Company is satisfied that the medical history was clearly within the Complainant's late husband's knowledge and should have been disclosed to the Company prior to the policy issuing, but was not and consequently, the Company was not afforded the opportunity to fully assess the risk.

The Company notes that if the deceased had disclosed that he had been suffering from abdominal pain with associated back pain and had been referred for investigations by way of a gastroscopy before the policy issue date of 13 August 2015, the proposal of insurance would have been postponed until he had undergone all the required tests and a diagnosis had been made. When the results were received, the Company would have been in a position to confirm a decision on the cover. In light of the subsequent diagnosis, that is, oesophageal adenocarcinoma, the Company states that it would not have allowed cover on this policy. In this regard, in its correspondence dated 18 September 2017, the Company states that *"if* [it] *had been given full and accurate information in relation to all aspects of the health and medical history of the deceased the policy would not have been accepted to issue at that time. This is because there was in fact a very significant change in the health of the life insured"*.

The Company states that the Complainant's late husband had an ongoing duty to disclose all material facts and changes in health up until the commencement of the policy. This ongoing duty of disclosure was clearly highlighted on Proposal Form he completed on 6 May 2015, the acceptance letter the Company issued on 12 May 2015 and on the Declaration of Health he completed on 4 August 2015. The Company is satisfied that a clear definition of a material fact was clearly explained in the relevant documentation.

In addition, the Company also wrote to the Complainant and her late husband's Financial Broker, who subsequently advised the Company by way of correspondence dated 4 October 2017, as follows:

> *"(1) I entered the information on the proposal form as* [the Complainant's late husband] *answered each question.*
> *(2) The application was completed face to face in* [his] *home.*

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(3) On completion, I handed the application form to [the Complainant's late husband] *and, at my request, he read through his answers to all the questions on the application form.*
(4) A copy of the application was not given to [him]
(5) No additional notes were taken in relation to the questions on the application form, but [the Complainant's late husband] *completed a Cyst/Growth/Mole Questionnaire at the time of the application form (6th of May 2015).*
[He] *also completed a Declaration of Health on the 4th of August 2015.*
I posted the Declaration of Health to [the Complainant's late husband] *on the 30th of July 2015.*
[He] *entered the answers to the questions on the Declaration of Health and I received the completed form from* [him] *by post on the 6th of August 2015.*
(6) The importance of disclosing all material facts and the consequences of not doing so was explained to [the Complainant's late husband] *before he answered any question on the application form.*
(7) There were no additional notes at the point of sale".

Accordingly, the Company declined the death benefit claim and cancelled the policy. It refunded to the Complainant by way of cheque on 13 May 2016 all premiums paid since the inception of the policy. The Company is satisfied that in declining the death benefit claim and cancelling the policy that it acted in accordance with the terms and conditions of the policy.

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 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 23 April 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

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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.

The complaint at hand is, in essence, that the Company wrongly or unfairly declined the death benefit claim made in respect of the Complainant's late husband. In this regard, the Complainant and her late husband incepted a Guaranteed Term Protection policy with the Company, effective from 1 September 2015, which provided him with life cover in the sum of €75,000. The Complainant's late husband died on [redacted]. The Company declined the ensuing death benefit claim on the basis of the nondisclosure of material facts and refunded the Complainant all premiums paid since the inception of the policy.

The Complainant states that *"at no stage did* [her husband] *ever think he was seriously ill or was he dishonest in his declaration of health"* and that *"this life policy was signed honestly and in good faith. This policy was bought in the event of* [my husband]*'s death and would provide security for my* [redacted] *and our future"*. In addition, the Complainant states in her correspondence to the Company dated 26 November 2016, *"*[My husband] *signed these documents honestly and in good faith. He never associated the back pain he had with having a very serious illness…*[he] *assumed he had pulled a muscle, that was all. He never imagined for one moment it was anything more serious than that"*. The Complainant considers that the Company decision to decline the claim is *"grossly unfair"* and seeks for it to admit the claim into payment.

I note from the documentation before me that the Complainant's late husband completed the Guaranteed Term Protection policy application on 6 May 2015.

In completing Part F on this Proposal Form, '*Health Statement and Other Information'*, the only question which the Complainant answered *"Yes"* to was, as follows:

> *"11. In the last 5 years, have you suffered from or received treatment, advice or had investigations for any of the following:*
>
> *(i) Lump, growth, cyst, mole or freckle that has bled, changed shape, colour or size or become painful?"*

In the column provided for details, the following handwritten note is inserted:

> *"May 2012.*
> *Mole on upper back*
> *(see Questionnaire)"*

In this regard, the Complainant completed and signed a Cyst/Mole/Growth Questionnaire, wherein he advised that the mole had been the size of a 1c coin on his upper back, that he first went to his doctor about the mole in May 2012, that it had been removed for biopsy at

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[redacted] Hospital that same month with no further treatment. The Complainant signed this form on 6 May 2015.

The Complainant and her late husband's Financial Advisor submitted the application to the Company, which replied to the Financial Advisor on 12 May 2015, as follows:

> *"We are pleased to advise that the above proposal is receiving our attention and the current position is as follows:*
>
> *The first life assured has been accepted at standard rates.*
>
> *Risk Commencement Date.*
>
> *On receipt of the above we shall be pleased to give the proposal our further attention.*
>
> *Please note that your client(s) has a duty to disclose any material facts which come to light between the date the proposal form is signed and the date the policy is issued. Failure to do so may result in any subsequent claim being refused."*

The policy did not become effective at that time as the Company did not receive notification of a risk commencement date as requested in its correspondence of 12 May 2015. I note that the Company submits that no further communication was received in this regard until August 2015, at which stage it was necessary for the Complainant's late husband to complete a Declaration of Health due to the length of time that had elapsed between signing the original application form, and the request to commence cover.

The Complainant's late husband therefore completed and signed the Declaration of Health on 4 August 2015, the first page of which included the following:

> *"**DECLARATION OF HEALTH***
>
> ***1st Life Insured*** [the Complainant's late husband]
>
> ***Date of Original Application to* [the Company]:** [6/5/2015]
>
> ***Important Notes***
>
> ***Please disclose all Material Facts. A Material Fact is any fact about your health, smoking or drinking habits, occupation, pastimes or policies with any other insurance companies that an insurer would regard as likely to influence the assessment and acceptance of an application for cover. If you are in any doubt about whether a fact is material you should disclose full details. Failure to disclose all material facts could mean that we do not pay your claim and cancel all cover under this policy.***
> ***You must advise* [the Company] *of any changes to your health, occupation, pastimes or residency since signing this form and up to the date your policy starts or is reinstated.***

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[my underlining for emphasis]

Since the date of the above application have you:

1. (a) Suffered from any illness or injury?

(b) Been referred to or consulted a GP, specialist, hospital doctor or surgeon?

(c) Been referred to or attended a hospital or clinic?

(d) Received any medical advice, treatment or course of pills or tablets?

(e) Any condition or symptoms for which you intend seeking medical advice or treatment in the future*"*

The Complainant's late husband answered *"**No**"* to all these questions.

The second page of this Declaration of Health included the following:

*"**Declaration by life (lives) insured***

Please read the Declaration below carefully before signing this form. If you do not fully understand any part of this form, or if you have any doubt about the meaning of any of the questions in this form or any part of the Declaration you should not sign the Declaration until all your queries have been clarified to your satisfaction.

I declare that I have read the entire Declaration of Health form after it was fully completed and that I am satisfied that all the answers and statements in this form are true and complete(included those completed by my Financial Advisor). I agree that this declaration shall be incorporated with and form part of the original application.

I understand that I must disclose all Material Facts*. I understand that if I fail to disclose all material facts or provide* [the Company] *with full and accurate information about any aspects of my health, smoking or drinking habits, occupation, pastimes or insurance policies with other insurance companies that any subsequent claim may be rejected. If you are in any doubt about whether a fact is material you should disclose full details.*

I understand that I must advise [the Company] *immediately of any material facts or any changes in my health between the date I sign this declaration and the date my policy starts …*

I confirm that I have read and fully understand all parts of the above declaration and the consequences of my failure to provide full, correct and accurate information*"*.

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I note that the Complainant signed beneath this Declaration on **4 August 2015** and the Company issued the policy on 13 August 2015, with a commencement date of 1 September 2015. As a result, I am satisfied that the Complainant's late husband was given clear notice that he had an ongoing duty to disclose all material facts and changes in health up until the policy commencement date of 1 September 2015.

The Complainant notified the Company of her late husband's death on [redacted] by telephone on 7 March 2016. The Death Certificate recorded the cause of death as *"Stage IV Metastatic Oesophageal Cancer"*. As part of its assessment of the ensuing death benefit claim, the Company requested, as is standard industry practice, the medical records of the deceased.

I note from the documentation before me that the Complainant's late husband had attended his GP on 3 June 2015. The GP records of that consultation detail the subjective symptoms as *"skin lesion on the R temple – however has increased in size in particular in the couple of weeks"*, the objective findings as *"skin there is a deeply pigmented mole on the R temple approx. 1 cm in diameter – slightly irregular base – somewhat suspicious looking in sun-exposed area"* and the plan of action as *"referral surgical FOR URGENT assessment"*.

In addition, I note that the Complainant's late husband was then seen by a Consultant Surgeon at [redacted] Hospital on [redacted], who advises in her correspondence dated 12 August 2015, *"He was referred to me by his GP because of a lesion on the right side of his face and was sent to me urgently as a query possible malignant melanoma"*.

I note that the Complainant's late husband failed to advise the Company in the Declaration of Health he completed on 4 August 2015 that he had attended his GP on 3 June 2015 in relation to a mole that had increased in size and that he had been referred onwards to a Consultant Surgeon on an urgent basis.

In this regard, he answered *"**No**"* in that Declaration of Health to the following question:

> *"**Since the date of the above application have you:***
>
> ***1. (a) Suffered from any illness or injury?***
> ***(b) Been referred to or consulted a GP, specialist, hospital doctor or surgeon?***
> ***(c) Been referred to or attended a hospital or clinic?***
> ***(d) Received any medical advice, treatment or course of pills or tablets?***
> ***(e) Any condition or symptoms for which you intend seeking medical advice or treatment in the future***"

As the documentary evidence before me indicates that he had attended his GP on 3 June 2015 in relation to a mole that had increased in size and that he had been referred onwards to a Consultant Surgeon, I am satisfied that the Complainant's late husband answered this question incorrectly. Given that on 6 May 2015, he had previously completed the additional Cyst/Mole/Growth Questionnaire, as part of his original policy application, and within that questionnaire he had advised of a previous mole in May 2012, I take the view that the

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Complainant's late husband had clear knowledge that the Company required details of such growths.

In any event, in signing the Declaration of Health on 4 August 2015 the Complainant's late husband declared

> *"I understand that I must advise* [the Company] *immediately of any material facts or any changes in my health between the date I sign this declaration and the date my policy starts"*.

It is clear however, that he did not notify the Company of developments when he attended his GP in June 2015, and was referred for urgent assessment.

In addition, I also note from the documentation before me that the Complainant's late husband attended his GP on 11 August 2015. The GP records of that consultation detail the subjective symptoms as *"gastro-intestinal abdominal pain epigastric – has been having back pain associated with it x last few weeks – eases with gaviscon"*, the objective findings as *"abdomen tenderness epigastric"* and the plan of action as *"referral for gastroscopy"*.

In signing the Declaration of Health on 4 August 2015, I am satisfied that the Complainant's late husband had clear notice that he had an ongoing duty to disclose all material facts and changes in health to the Company up until the policy commencement date of 1 September 2015. In this regard, the Complainant's late husband subsequently failed to advise the Company that he had attended his GP on 11 August 2015 and had been referred onwards for further investigation, prior to the commencement of the policy on 1 September 2015.

Insurance contracts are contracts of utmost good faith, wherein the failure to disclose information allows the Insurer to void the policy from the outset and refuse or cancel cover. Once nondisclosure takes place – whether innocent, deliberate or otherwise – the legal effect of that nondisclosure can operate harshly, and it entitles an Insurer to, amongst other things, refuse cover, as the Company has done in this instance.

As the Company was unaware of all of the Complainant's late husband's medical details, at the time when it agreed to incept the policy, I am satisfied that the policy came into being on the basis of a false premise.

This office is aware that the courts have long considered the issues surrounding non-disclosure of material facts. In *Aro Road and Land Vehicles Limited v Insurance Corporation of Ireland Limited* [1986] I.R. 403, the Court determined that representations made in the course of an insurance proposal form should be construed objectively, Henchy J said that

> *"… [a] person must answer to the best of his knowledge any question put to him in a proposal form."*

In *Coleman v New Ireland Assurance plc t/a Bank of Ireland Life* [2009] IEHC 273 Clarke J, held that a party could only be subject to having his policy of insurance voided because of the manner in which he answers a proposal form if he or she failed to answer "*such questions to the best of the party's ability and truthfully."*

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I am also cognisant of the views of the High Court in *Earls v The Financial Services Ombudsman [2014/506 MCA],* when it indicated that:

> *"The duty arising for an insured in this regard is to exercise a genuine effort to achieve accuracy using all reasonably available sources…."*

In my opinion, for the reasons outlined above, I am not satisfied that it would be reasonable to find that the Complainant's late husband answered the questions put to him in the application process, to the best of his ability.

Accordingly, I am satisfied that when the Company declined the death benefit claim in respect of her late husband, and cancelled the cover from the inception date, it was entitled to do so and its actions were in strict accordance with its terms and conditions of the insurance arrangement in place. Accordingly, whilst one must have every sympathy for the Complainant in respect of the position she has found herself in, I am of the opinion that, given the evidence made available by the parties, there is no reasonable basis upon which it would be appropriate to uphold this complaint.

Conclusion

My Decision is that this complaint is rejected, pursuant to ***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.

MARYROSE MCGOVERN
DIRECTOR OF ADJUDICATION AND LEGAL SERVICES

18 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.