Decision Ref:	2018-0078
Sector:	Insurance
Product / Service:	Mortgage Protection
Conduct(s) complained of:	Poor wording/ambiguity of policy Rejection of claim
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants, a husband and wife, incepted a mortgage repayment protection policy with the Company on 1 July 2006.

The Complainants' Case

The First Complainant was certified as unfit for work due to illness on 28 September 2015 with a diagnosis of multiple sclerosis and he submitted a claim to the Company. The Company accepted this claim and issued the First Complainant with twelve monthly benefit payments of €600 each from 28 October 2015 to 21 October 2016, totalling €7,200.

The First Complainant remained certified as unfit for work thereafter. As a result, the Second Complainant telephoned the Company on 10 March 2017 to ask if the First Complainant could claim again, however the Company advised that the First Complainant would need to return to work before claiming again for the same condition. In this regard, the First Complainant submits *"I cannot see anything in my policy that states I must return to work before I can make another claim…*[the Company] *are stating this is the case, even though it does not state this anywhere in my policy documents"*.

In addition, the First Complainant notes that the terms and conditions of the Complainants' policy provides that *"Periods of Accident/Illness arising from the same cause which are not separated by at least three calendar months shall be treated as being the same period of Accident/Illness"*. In this regard, the First Complainant submits that *"more than 3 months has elapsed since my last claim…I believe that I am entitled to claim again".*

As a result, the First Complainant emailed the Company on 21 March 2017, as follows:

> *"I claimed accident/illness on my policy for a period of 12 months last year. I am a MS sufferer and have…been unable to return to work.*
>
> *I have been advised by telephone last week that I am unable to claim for accident/ illness on my policy…as I have not returned to work. I asked for a copy of my policy showing where this is stated. I received* [this] *in the post today.*
>
> *I cannot see anything in my policy that states I must return to work before I can make another claim.*
>
> *More than 3 months has lapsed since my last claim…I believe that I am entitled to claim again"*.

The Company responded to the First Complainant by email the following day, 22 March 2017, as follows:

> *"Whilst I appreciate the policy does not specify a timescale for a return to work before another claim can be considered, the policy does state the monthly benefit (or pro-rata proportion thereof) will be paid thereafter for each complete month (or part thereof) that Accident/Illness continues, up to a maximum number of 12 monthly Benefit payments.*
>
> *Therefore, in order to consider a new claim, the person insured would need to have returned to work since the 21st October 2016, which is the date of final payment on the claim"*.

The First Complainant responded to the Company by email later that day on 22 March 2017, as follows:

> *"Not only is there no 'timescale for a return to work before another claim can be considered' specified in the policy there is no mention whatsoever of returning to work before another claim can be made.*
>
> *As I have pointed out in my original email the policy only states that 'periods of accident/illness arising from the same cause which are not separated by at least three calendar months shall be treated as being the same period of Accident/Illness'. Therefore as more than 3 calendar months have passed I can make a new claim"*.

In addition, I note that in their email to this Office dated 16 May 2018 the Complainants submit *"I still feel that* [the Company] *are trying to amend the terms and conditions of this policy. It does not state anywhere in the terms and conditions that I must return to work for a period of three months and* [the Company] *are unable to show us otherwise"*.

As a result, the Complainants seek for the Company *"to comply with the policy and not to make up new rules"* and admit a second claim in respect of the First Complainant's illness.

/Cont'd…

The Complainants' complaint is that the Company wrongly or unfairly administered the Complainants' mortgage repayment protection policy.

The Provider's Case

Company records indicate that the Complainants, a husband and wife, incepted a mortgage repayment protection policy with the Company on 1 July 2006. The First Complainant became certified as unfit for work due to illness on 28 September 2015 and submitted a claim to the Company. The Complainants' policy does not pay for the first 30 days of a claim. As a result, the Company admitted the First Complainant's claim into payment with a monthly benefit of €600 for the period 28 October 2015 to 21 October 2016, that is, 12 months, the maximum that can be claimed for any single claim. The Company wrote to the First Complainant on 21 October 2016 to advise that it had just paid the final payment in respect of his claim.

The Second Complainant telephoned the Company on 10 March 2017 to ask if the First Complainant could continue with his claim. The Company stated that the First Complainant would need to return to work before claiming again for the same condition. In addition, the Company also wrote to the First Complainant on 10 March 2017, as follows:

> *"Please find enclosed a copy of your policy terms and conditions. Please refer to section 2 Insurance Benefits, sub section a. This confirms the maximum benefit payable under a claim is 12 months and therefore you would need to return to work to make a further claim".*

The Company states that the First Complainant cannot submit a further claim in respect of his illness unless there has been a period of no less than 3 months since the end of his previous claim where he was able to work. In this regard, the First Complainant has been unable to work since September 2015 as he suffers with multiple sclerosis. The Company notes that there has been no separation of the cause, there has been no new event, and the First Complainant continues to suffer with the same illness, without reprieve, that he claimed for in September 2015 and has been continuously unable to work since. In this regard, the Company notes that the Complainants' policy is not a long term or critical illness insurance policy, but a short term protection policy.

The Company would consider a new claim for the same cause if there is a period of 3 months where the First Complainant is not considered to be unable to work because of his illness. The First Complainant would, for this period, need to be either working for 3 months or registered as unemployed with the Department for Social Protection for 3 months so as to demonstrate that he has not been unwell or suffering symptoms of his illness.

In addition, the Company understands that the First Complainant was made redundant on health grounds during the claim that ran from 28 October 2015 to 21 October 2016. In this regard, the Company cannot consider a redundancy claim as the First Complainant was already claiming benefit for illness for the same period and a policyholder cannot claim for redundancy and accident/illness benefit at the same time.

/Cont'd…

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.

A Preliminary Decision was issued to the parties 16 August 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.

The complaint at hand is, in essence, that the Company wrongly or unfairly administered the Complainants' mortgage repayment protection policy. In this regard, the First Complainant was certified as unfit for work due to illness on 28 September 2015 with a diagnosis of multiple sclerosis and he submitted a claim to the Company. The Company accepted this claim and issued the First Complainant with twelve monthly benefit payments of €600 each from 28 October 2015 to 21 October 2016. The First Complainant remained certified as unfit for work thereafter.

As a result, the Second Complainant telephoned the Company on 10 March 2017 to ask if the First Complainant could claim again, however the Company advised that the First Complainant would need to return to work before claiming again for the same condition. In this regard, the First Complainant submits *"I cannot see anything in my policy that states I must return to work before I can make another claim…*[the Company] *are stating this is the case, even though it does not state this anywhere in my policy documents"*.

In addition, the First Complainant notes that the terms and conditions of the Complainants' policy provides that *"Periods of Accident/Illness arising from the same cause which are not separated by at least three calendar months shall be treated as being the same period of*

/Cont'd…

Accident/Illness". In this regard, the First Complainant submits that *"more than 3 months has elapsed since my last claim…I believe that I am entitled to claim again".*

Mortgage repayment protection policies, like all insurance policies, do not provide cover for every eventuality; rather the cover will be subject to the terms, conditions, endorsements and exclusions set out in the policy documentation. In this regard, Section 1, 'DEFINITIONS', of the applicable Mortgage Repayment Protection Policy Wording states, as follows:

> *"**e. Accident/Illness***
>
> *"Accident/Illness" means temporary and total disablement from engaging in or giving attention to normal occupation or profession resulting from accidental bodily injury or sickness"*.

In addition, Section 2, 'INSURANCE BENEFITS', of this policy wording provides, as follows:

> *"**a. Accident/Illness Benefit***
>
> *If an Insured Borrower suffers Accident/Illness as defined above, the Insurer will pay to the Policyholder that proportion of the monthly benefit due to the Policyholder which the actual number of days of Accident/Illness bears to one calendar month. (For the purposes of this policy, "one calendar month" will be interpreted as 30 days.) The monthly benefit (or pro-rata proportion thereof) will be paid thereafter for each complete month (or part thereof) that Accident/Illness continues, up to a maximum number of 12 monthly Benefit payments.*
>
> *Accident/Illness Benefit will not be paid for the first 30 Days of Accident/Illness in respect of each and every claim.*
>
> *Accident/Illness Benefit will not be paid for any period of Accident/Illness after an Insured Borrower attains age 65, nor during any period for which Redundancy Benefit payments are payable under the Policy. Periods of Accident/Illness arising from the same cause which are not separated by at least three calendar months shall be treated as being the same period of Accident/Illness for the purposes of assessing the Monthly Accident/Illness Benefit."*

I accept that the Complainants' policy defines illness as *"temporary"* and that an illness claim is *"up to a maximum number of 12 monthly Benefit payments"*. I note that the Company wrote to the First Complainant on 28 October 2015 when it commenced payment of his claim and advised *"Provided that you continue to meet the terms and conditions of your policy, you can receive up to 12 payments"*. I accept that the First Complainant received from the Company twelve monthly benefit payments from 28 October 2015 to 21 October 2016, representing the maximum payment terms of a claim.

/Cont'd…

The First Complainant remained unfit to work thereafter and sought to submit by telephone a second claim on 10 March 2017 in respect of the same illness.

I note that the Company stated at that time that the First Complainant would need to return to work before claiming again and wrote to the First Complainant on 10 March 2017, as follows:

> *"Please find enclosed a copy of your policy terms and conditions. Please refer to section 2 Insurance Benefits, sub section a. This confirms the maximum benefit payable under a claim is 12 months and therefore you would need to return to work to make a further claim".*

However, the First Complainant submits *"I cannot see anything in my policy that states I must return to work before I can make another claim…*[the Company] *are stating this is the case, even though it does not state this anywhere in my policy documents"*. In addition, the First Complainant notes that the terms and conditions of the Complainants' policy provides that *"Periods of Accident/Illness arising from the same cause which are not separated by at least three calendar months shall be treated as being the same period of Accident/Illness"*.

In this regard, the First Complainant submits that *"more than 3 months has elapsed since my last claim…I believe that I am entitled to claim again".*

Whilst I accept the First Complainant's contention that the policy *"does not state anywhere in the terms and conditions that I must return to work for a period of three months"*, I accept that the terms and conditions of the policy must be read and interpreted as a whole.

The Complainants' policy defines an illness claim as being *"up to a maximum number of 12 monthly Benefit payments"* and the First Complainant received this maximum payment term in respect of his illness that commenced on 28 September 2015 when he was first certified as unfit for work. I therefore must accept that the First Complainant is not entitled to a second claim in respect of the same event, that is, he is not entitled to claim again in respect of the same ongoing and uninterrupted occurrence of his illness that commenced on 28 September 2015.

With regard to the policy provision, *"Periods of Accident/Illness arising from the same cause which are not separated by at least three calendar months shall be treated as being the same period of Accident/Illness for the purposes of assessing the Monthly Accident/Illness Benefit"*, the cause in this instance is the First Complainant's illness that commenced on 28 September 2015. As the First Complainant was still unfit for work in March 2017 from the same ongoing and uninterrupted occurrence of his illness that commenced on 28 September 2015, I accept that there was no separation (of three calendar months) in the cause (the illness).

As the First Complainant has, in this instance, received the *"maximum number of 12 monthly Benefit payments"* that constitutes an illness claim, he must cease to be certified as unfit for work for a three month period before any illness can give rise to a new claim. I accept that

/Cont'd…

it is in this context that the Company correctly advised the First Complainant that *"you would need to return to work to make a further claim"*.

For completeness, and in an attempt to explain the effect of this policy provision, although it has no direct bearing in this case, the policy provision in question, that is, *"Periods of Accident/Illness arising from the same cause which are not separated by at least three calendar months shall be treated as being the same period of Accident/Illness for the purposes of assessing the Monthly Accident/Illness Benefit"*, also provides that where a policyholder submits, for example, a claim for four months due to pneumonia, then returns to work but is two months later certified as unfit for work again due to pneumonia, the policy would consider this as a continuation of the previous claim as there is the same cause (pneumonia) and this cause is not separated by three calendar months and as such, it would assess that four months of the maximum twelve month claim term has already been exhausted, regardless that the policyholder was fit to return to work for two months in the interim.

Accordingly, I accept that in declining a second claim from the First Complainant in respect of his illness that commenced on 28 September 2015, the Company administered the Complainants' mortgage repayment protection policy in accordance with its terms and conditions. However, I have some concerns in relation to the presentation and communication of those terms and conditions which I will now address.

I will now deal with the manner in which the information in relation to the cover available under the policy is presented in the Policy Document which is titled "*Mortgage Protection Policy Wording*".

I believe this information could have been presented in a much simpler and clearer manner.

The Complainant is correct when he states that there is nothing in the Policy Document that states that he must return to work before he can make another claim.

In its Final Response Letter to the Complainant dated 13 March 2017, in response to this point, the Provider states:

> *"I appreciate the policy document was first written in 2006 for [third party financial provider] which was not updated when they were taken over by [another third party financial provider].*
>
> *However, as the claims administrators we will always try to interpret the policy terms in such a way as not to penalise a customer*".

In an e-mail to the Complainant on 22 March 2017 at 16:25, the Provider's Agent states:

> "*Whilst I appreciate the policy does not specify a timescale for a return to work before another claim can be considered, the policy does state the monthly benefit (or pro-rate proportion thereof) will be paid thereafter for each complete month (or part*

/Cont'd…

> *thereof) that Accident/Illness continues, up to a maximum number of 12 monthly Benefit payments.*
>
> *Therefore, in order to consider a new claim, the person insured would need to have returned to work* ***in some capacity****. I understand that you have not returned to work since the 21st October 2016, which is the date of final payment on the claim". [My emphasis].*

In its response to this Office dated 26 March 2018, the Provider states about the Complainant:

> "*He has not had a reprieve of his illness, for a period of at least 3 months, since September 2015. Given this no further claim can be made for this illness, unless he has a period of no less than 3 months, where he is able to work*".

It also states:

> "*we confirmed he would need to return to work before claiming again for the same condition and a letter was sent outlining same*".

On that same page, the Provider states:

> "*This is not a long term or critical illness insurance policy, but a short term protection policy. The definition confirms that the accident or illness giving rise to the claim should be temporary and it does therefore follow that chronic or degenerative conditions wouldn't be covered indefinitely*".

I find these statements contradictory and confusing.

On the one hand, the Provider is stating that if the Complainant returns to work for three months before claiming again for the same condition, throughout its communications with the Complainant it infers that if he were to return to work for three months, he could make a further claim.

On the other hand, it is stating "*this is not a long term or critical illness policy … and it does therefore follow that chronic or degenerative conditions wouldn't be covered indefinitely*".

While the Provider is stating that the Complainant could make a further claim if he returned to work for three months it is not at all clear to me if such a claim would succeed.

Overall I believe the manner in which the terms and conditions of the policy are set out is not at all clear and I think some of the correspondence from the Provider in relation to the Complainant's claim has not helped to clarify the matter.

In this regard, I note the Provider clarified that this is "*a short term protection policy*". However, this point was only made in the response to this Office. This is clearly a critical

/Cont'd…

piece of information that I believe should have been set out from the outset in the "Mortgage Protection Wording".

For the reasons set out above, while I do not uphold the substantive complaint, as I do not believe the terms and conditions entitled the Complainant to make a further claim without returning to work, I do partially uphold this complaint because of the poor and confusing presentation of the Policy conditions and ensuing correspondence. I direct that the Provider pay a sum of €3,000 in compensation to the Complainant.

Conclusion

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

Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainants in the sum of €3,000, to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants to the provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

/Cont'd…

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

19 September 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) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.