An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0099
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Rejection of claim - non-disclosure & voiding Mis-selling
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants incepted a Dual Life Flexible Whole of Life Protection Plan with the Company, hereafter 'the policy', with a commencement date of **15 May 2014**. This policy provided both of the Complainants with cover for life, accidental death, critical illness, hospital cash, personal accident and accidental injury. The First Complainant's cover was voided from the commencement date due to the non-disclosure of material facts that first came to light after he submitted a Hospital Cash claim to the Company in December 2015. The Second Complainant's cover has since lapsed.

The Complainants' Case

The First Complainant submitted a Hospital Cash claim to the Company in respect of his hospitalisation from 28 October 2015 to 4 November 2015. Dr [C.], his Consultant Cardiologist detailed the reason for this hospitalisation on the claim form as *"ACUTE MYOCARDIAL INFARCTION"*. Following its assessment of this claim, the Company wrote to the Complainants on 14 July 2016 to advise that as there had been the non-disclosure of material facts during the policy application, namely, that the First Complainant had failed to disclose his diagnosis of sleep apnoea and a referral to an ENT specialist, both in 2013, that the Company had no option but to cancel cover in respect of the First Complainant from the commencement date and it enclosed a cheque for €3,289.30 in respect of all premium paid in relation to his benefits since May 2014.

In this regard, the Complainants submit that *"in June 2012* [the First Complainant] *attended at Professor [G.], Consultant Physician at University Hospital Galway. He recommended that*

a sleep study be done…and this was subsequently undertaken in 2013. As a result of this sleep study, he was diagnosed with sleep apnoea. There is no medication for it".

In addition, in correspondence to the Company dated 26 July 2016, the Complainants state:

> *"It is true that* [the First Complainant] *did attend an ENT Specialist in October 2013 but this is information we did not conceal…We are advised by our Doctor that sleep apnoea cannot cause a blockage of the artery or lead to a heart condition and therefore, we believe that* [the Company] *are unfairly using this as a technicality to get out of making any payment on foot of the policy"*.

The Complainants applied for the policy during a sales meeting on **1 April 2014**, with two Company Agents in attendance. In this regard, the Complainants state that *"the proposal form was somewhat confusing to us, so the paperwork was filled out by a representative of* [the Company] *in our home in circumstances that was quite rushed. We did not have any time to review the document or study it in our own time and we felt pressurised but didn't think anything of it, at the time"*.

In addition, in an email to this office dated 4 December 2017, the Complainants state:

> *"There was a lot of info exchanged, the rep asked the questions and he ticked the boxes on the application form for the life assurance policies.*
>
> *This all happened at our kitchen table in our home in April 2014.* [The First Complainant] *had a very serious work related accident in Jan 2014 which we told them about. He was under a lot of stress and unfortunately had to get help from a psychiatrist. Looking back this was a bad time to discuss or take out policies.*
>
> *We would not have or deliberately leave any info out as we are very honest and upfront people"*.

The Complainants state that *"we were told we would qualify for up to €64,000 as per the critical illness cover for* [the First Complainant]*"* by one of the Agents in question and now seek for the Company to reinstate cover in respect of the First Complainant and admit his claim into payment. The Complainants consider that the Company *"are unfairly using the cancellation of* [the First Complainant]*'s Policy as a means of getting out of making any payment"*.

There are two elements to the Complainants' complaint. The first is that the Company wrongly or unfairly declined the First Complainant's claim and voided his cover from the commencement date. The second element of this complaint is that the Complainants were mis-sold their policy by two Company Agents on 1 April 2014 during a sales meeting in their home in circumstances that they considered *"rushed"* and *"pressurised"*.

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The Company's Case

Company records indicate that the Second Complainant telephoned the Company on 16 November 2014 to request a Hospital Cash claim form as the First Complainant had been hospitalised for almost two weeks due to the insertion of two stents. Given the reason for this hospitalisation, the Agent advised the Second Complainant to refer to the Policy Provisions as there may be a potential Critical Illness claim.

The Company received a Hospital Cash claim form from the First Complainant on 8 December 2014 in respect of his hospitalisation from 28 October 2015 to 4 November 2015. Dr [C.], his Consultant Cardiologist detailed the reason for this hospitalisation on the claim form as *"ACUTE MYOCARDIAL INFARCTION"*. The Company requested further information from the Complainant's GP on 8 December 2014 (received 16 December 2014), 17 December 2014 (received 21 December 2014), 23 December 2014 (received 8 April 2016) and 13 April 2016 (received 24 June 2016).

In this regard, the Company repeatedly sought the First Complainant's attendance records with his GP since 2009. Whilst he only submitted a Hospital Cash claim, the Company sought these records to help ascertain whether there was also a potential Critical Illness claim. The First Complainant's GP contacted the Company and advised that he considered the amount of information requested to be excessive. In addition, the Second Complainant telephoned the Company on a number of occasions for updates (16 December 2014, 18 December 2014, 25 January 2016, 3 February 2016 and 22 February 2016) and referred to the GP's comments about the amount of information sought. She was advised during these telephone calls by the various Agents that the information requested was necessary to fully assess the claim at hand. The Company notes that Second Complainant expressed dissatisfaction with the length of time it was taking to assess the claim but she did assist in contacting the First Complainant's GP to forward the requested information as the GP seemed reluctant to do so.

Following assessment of the medical records received on **24 June 2016**, the Company confirmed by way of correspondence dated **14 July 2016** that cover for the First Complainant was voided from commencement, due to the non-disclosure of material facts during the policy application. In this regard, the Company noted from the medical records received that the First Complainant had been diagnosed with sleep apnoea in 2013, which required his using a CPAP (Continuous Positive Airway Pressure) machine, and that he had been referred to an ENT specialist in October 2013 and underwent a tonsillectomy in January 2014. The Company states that it if had been made aware of this information at the time of application, it would have had an impact on any terms offered.

The Company notes that on the policy application the First Complainant answered the question:-

> *"Within the last 5 years have you - had or been advised to have any investigations or undergone tests or been referred to a specialist?"*

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with the answer *"No"*, when he should have answered *"Yes"* and should have provided details of his diagnosis of sleep apnoea and his referral to an ENT specialist, both in 2013.

In addition, whilst he answered the question:-

> *"Within the last 5 years have you - Suffered from any illness or condition that has required continuous medical treatment or prescribed medication for more than 4 weeks or requires you to attend for follow up or review?"*

with *"Yes"*, the First Complainant only provided details relating to his finger injury and did not disclose details of his diagnosis of sleep apnoea. Whilst the Complainants have confirmed that the First Complainant does not take medication for his sleep apnoea, the Company regards the use of a CPAP machine as a medical treatment that ought to have been noted on the policy application.

The Company is satisfied that had the First Complainant answered these questions correctly and fully, further underwriting would have been required and the policy would not have issued on the terms that it did, nor would cover have commenced on 15 May 2014.

The Company notes that in correspondence dated 26 July 2016 the Complainants state *"We are advised by our Doctor that sleep apnoea cannot cause a blockage of the artery or lead to a heart condition"* and they submit that the Company was unfair in its decision to decline the claim based on the diagnosis and non-disclosure of the First Complainant's sleep apnoea. However, the Company notes that the First Complainant did not fully and properly disclosure his medical history when applying for the Complainants' policy, as he was contractually obligated to do and which prevented the Company's underwriters from accurately assessing the risk presented by him. Had this history been disclosed, the policy would not have issued on the terms that it did. The medical records confirm that the First Complainant had sleep studies carried out in September 2013 and was subsequently diagnosed with the potentially serious condition of sleep apnoea and was receiving treatment with a CPAP machine at the time of applying for the policy. In addition, he was referred to an ENT specialist in October 2013 and underwent a tonsillectomy on 22 January 2014. The First Complainant was obliged to disclose all these material facts to the Company at the time of application.

The Company notes that the Complainants applied for the policy during a sales meeting on 1 April 2014, with two Company Agents in attendance. In this regard, the Complainants state that *"the proposal form was somewhat confusing to us, so the paperwork was filled out by a representative of* [the Company] *in our home in circumstances that was quite rushed. We did not have any time to review the document or study it in our own time and we felt pressurised but didn't think anything of it, at the time"*. The Company confirms that both of the Agents in question refute this.

In this regard, the First Agent provided the Company with a signed statement dated 10 August 2016 regarding the sale of the policy to the Complainants on 1 April 2014, which includes:-

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> *"I would be acquainted with both* [Complainants]
>
> *…the medical questions were asked of both* [Complainants] *the answers been recorded on the application form along with the associated paperwork. At no stage was the meeting rushed"*.

In addition, the Second Agent provided the Company with a separate signed statement dated 10 August 2016, which includes *"As* [the First Agent] *knew the clients quite well an amount of small talk ensued taking about 30 minutes…Following discussion regards premium and cover offered both* [the Complainants] *agreed to propose for a protection policy. The medical questions were then completed and at all times it was emphasised to both parties the importance of full disclosure of all material facts. All medical facts they conveyed to us were recorded on the application form. Both* [Complainants] *were very relaxed while conducting all of the above business and at no time did they convey or express an opinion that they felt stressed or rushed"*.

In addition, the Company notes that due to the nature of the product and the information required to complete the medical questionnaires in the policy application and to compare the benefits to the term policy that the Complainants held with a different provider at that time, the meeting would have taken a considerable period of time that would have allowed for the medical questions and their answers to be considered fully.

In this regard, the Company notes that the First Complainant disclosed details of his crushed finger whilst the Second Complainant disclosed details of high cholesterol and an under active thyroid, indicating that the Complainants were actively engaged in completing the policy application. Similarly, the Second Complainant signed her name on Page 2 of the application to note a change in one of her answers. In addition, both of the Complainants signed Section 7, 'Declaration', of the application, which included, as follows:

> *"11. I declare that, to the best of my knowledge and belief, the following are true and complete:*
> - *all the information and statements given by me as part of this application*
> - *any statements written by men or at my dictation and signed by me*
> - *any statements made or to made to* [the Company]*'s medical examiner and signed by me"*.

The Company notes that the policy application and the medical information disclosed therein was reviewed by its underwriters and a telephone call was made to the Second Complainant on 8 April 2014 in relation to the medical details that she had provided. Following this, a letter of acceptance issued on 11 April 2014 based on the medical details provided by the Complainants on the policy application and during this telephone call. Whilst the Complainants have stated in their complaint that *"we do not believe a meeting took place two weeks later"*, the Company notes that this Letter of Acceptance was signed by the Complainants on 15 April 2014 when one of its Agents met again with the Complainants at their home.

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This Letter of Acceptance excluded any claims relating to the First Complainant's right hand injury on Hospital Cash, Personal Accident and Accidental Injury benefits. This exclusion was based on medical information provided by the First Complainant and the Company submits that such an exclusion highlighted the importance of providing correct medical details on the application form. The Letter of Acceptance also invited the Complainants to ensure that they had disclosed all material facts and the Company notes that they did not take this opportunity to make further disclosures.

The Company issued the Complainants with all the policy documentation on **30 April 2014**. A copy of the policy application was enclosed and the Complainants' did not raise any query in relation to the accuracy of their responses therein. In addition, the Complainants were also provided with a 30 day cooling off period, during which they could cancel their policy for any reason and receive a full refund.

In conclusion, the Company is satisfied that it acted equitably and fairly towards the Complainants and it notes that it refunded to the First Complainant by cheque the sum of €3,289.30 in respect of all premiums paid in relation to his benefits, despite not being contractually obliged to do so. The First Complainant committed a clear breach of the principle of utmost good faith by failing to disclose material facts that were clearly known to him at the time of the policy application and the Company had no option but to void cover.

This decision did not alter the benefits for the Second Complainant, which remained at that time unchanged, although the policy has since lapsed.

Accordingly, the Company is satisfied that by cancelling the First Complainant's cover from the commencement date, due to the non-disclosure of material facts at the time of the policy application, that it administered the Complainants' policy in accordance with its terms and conditions.

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

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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 10 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.

Both parties have made a number of submissions since 10 May 2018, and following the consideration of all such additional observations from the parties, the final determination of this office is set out below.

The Complainants incepted a Dual Life Flexible Whole of Life Protection Plan with the Company, hereafter 'the policy', with a commencement date of **15 May 2014**. There are two elements to the complaint at hand. The first is that the Company wrongly or unfairly declined the First Complainant's claim and voided his cover from the commencement date. The second element of this complaint is that the Complainants were mis-sold their policy by two Company Agents on 1 April 2014 during a sales meeting in their home in circumstances that they considered *"rushed"* and *"pressurised"*.

With regard to the first element of this complaint, that is, that the Company wrongly or unfairly declined the First Complainant's claim and voided his cover from the commencement date, I note that the First Complainant submitted a Hospital Cash claim to the Company in respect of his hospitalisation from **28 October 2015** to **4 November 2015**. Dr [C.], his Consultant Cardiologist detailed the reason for this hospitalisation on the claim form as *"ACUTE MYOCARDIAL INFARCTION"*. Following its assessment of this claim, the Company wrote to the Complainants on 14 July 2016 to advise that as there had been the non-disclosure of material facts during the policy application, namely, that the First Complainant had failed to disclose his diagnosis of sleep apnoea and a referral to an ENT specialist, both in 2013, that the Company had no option but to cancel cover in respect of the First Complainant from the commencement date and it enclosed a cheque for €3,289.30 in respect of all premium paid in relation to his benefits since May 2014, as follows:

> *"To assist in the completion of our assessment, we requested a medical report from* [the First Complainant]*'s GP, Dr [N.]. We noted on reviewing this report that there was non disclosure of material facts on your proposal dated 1st April 2014…On this report Dr [N.] advised that* [the First Complainant] *was diagnosed with sleep apnoea in 2013 which required using CPAP and that he was referred to an ENT Specialist in October 2013 …*
>
> *As a consequence of this material non disclosure,* [the Company] *was not given the opportunity to fully assess* [the First Complainant's] *medical history. Had his history of sleep apnoea and a referral to an ENT specialist been disclosed this would have had an impact on any terms offered. We therefore have no option but to make*

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> *benefits for* [the First Complainant] *null and void from commencement date and all benefits for* [him] *have been cancelled …*
>
> *Enclosed please find a cheque for €3,289.30 in respect of all charges paid to date in relation to* [the First complainant]*'s benefits since May 2014"*.

In this regard, I note that the Complainants submit that *"in June 2012* [the First Complainant] *attended at Professor [G.], Consultant Physician at University Hospital Galway. He recommended that a sleep study be done…and this was subsequently undertaken in 2013. As a result of this sleep study, he was diagnosed with sleep apnoea. There is no medication for it"*. In addition, in correspondence to the Company dated 26 July 2016, the Complainants state, as follows:

> *"It is true that* [the First Complainant] *did attend an ENT Specialist in October 2013 but this is information we did not conceal…We are advised by our Doctor that sleep apnoea cannot cause a blockage of the artery or lead to a heart condition and therefore, we believe that* [the Company] *are unfairly using this as a technicality to get out of making any payment on foot of the policy"*.

I note that Section 5.1, '**Medical Details'**, of the Policy Application provides, as follows:

> *"**g) Within the last 5 years have you:***
>
> - *Had or been advised to have any investigations or undergone tests or been referred to a specialist?*

The First Complainant answered *"No"* to this question. I am, however, satisfied from the documentary evidence before me that it would have been correct for the First Complainant to have answered *"Yes"* to this question and to have then disclosed his diagnosis of sleep apnoea and his referral to an ENT specialist, both in 2013, and the tonsillectomy that he underwent on 22 January 2014.

In addition, this question further asked, as follows:

> *"**g) Within the last 5 years have you:** …*
>
> - *Suffered from any illness or condition that has required continuous medical treatment or prescribed medication for more than 4 weeks or requires you to attend for follow up or review?"*

The First Complainant answered *"Yes"* to this question and provided details, as follows:

> *"WORK ACCIDENT – CRUSHED FINGER – CURRENTLY ATTENDING SPECIALIST & OUT OF WORK – RESTRICTED MOVEMENT IN HAND (RIGHT) – STILL UNDER MEDICAL SUPERVISION WITH SPECIALIST"*.

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I am, however, satisfied from the documentary evidence before me that it would have been appropriate for the First Complainant to have also disclosed his diagnosis of sleep apnoea here. In this regard, whilst the Complainants have confirmed that the First Complainant does not take medication for his sleep apnoea, I am satisfied that it is reasonable for the Company to regard the use of a Continuous Positive Airway Pressure machine as a medical treatment that ought to have been disclosed on the policy application.

Section 7, 'Declaration', of the Policy Application then provides, as follows:

> *"**1.** I have read carefully through all the questions in this Application Form …*
>
> ***6.** I understand that I must disclose all Material Facts. (A Material Fact is one which is likely to affect* [the Company]*'s assessment or acceptance of your Proposal. If you are in doubt about whether a fact is material or not, you are, in your own interest, advised to disclose it).*
>
> ***7. I understand that if I fail to disclose all Material Facts or if I fail to provide* [the Company] *with full and accurate information about any aspects of my health…that this could result in any subsequent claim being declined and the Policy being cancelled from inception …***
>
> [Emphasis added]
>
> ***11.** I declare that, to the best of my knowledge and belief, the following are true and complete:*
>
> - *all the information and statements given by me as part of this application*
> - *any statements written by me or at my dictation and signed by me …*
>
> ***13.** I understand that all the information and statements as described in 11 above shall from the basis of the Contract with* [the Company] *...*
> ***18.** I understand that the Contract is subject to the Policy Provisions, and I hereby confirm that I have received a copy of these provisions …*
>
> ***Please ensure that you have read the Declaration carefully before signing**"*.

I note that the First Complainant signed directly below this statement on 1 April 2014, indicating that he had read the contents of this Declaration section carefully.

I am satisfied that the policy documentation completed by and provided to the Complainants provided clear notice of the importance of disclosing all material facts as well as the possible consequences of failing to do so.

For example, the Letter of Acceptance dated 11 April 2014 which the Complainants signed on 15 April 2014 provides, as follows:

> *"A Material Fact is any fact about your health, smoking or drinking habits, occupation, pastimes or policies with other insurance companies that an insurer*

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*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**".*

[Emphasis added]

In addition, I note that the Company wrote to the Complainants on 30 April 2014, as follows:

"Enclosed you will find your Policy Document folder which contains the following:

a) Policy Schedule including details of any Special Provisions that apply to your policy.
b) [Policy] *Provisions*
c) Important Notice
d) Your Benefit Guide

Please read these documents carefully to ensure you understand your policy and that it meets your requirements.

***A copy of your application form is also enclosed. You should review the information provided to ensure all questions have been answered correctly. If you would like to alter or clarify any information please contact us immediately as your policy has been issued based on the information provided**"*

[Emphasis added]

Furthermore, Section 2, '**General Conditions'**, of the enclosed Policy Provisions booklet provides at pg. 6, as follows:

*"**2.11 Further Conditions***

(a) The Policy, the Application Form, all written and oral 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 of the policy.

Failure to disclose all Material Facts could result in your claim being declined and the Policy being cancelled from inception".

In this regard, Section 1.2, 'Definitions', of this applicable Policy Provisions booklet provides at pg. 2, as follows:

*"**Material Fact***

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> *A Material Fact is one which is likely to affect* [the Company]*'s assessment or acceptance of your Proposal. If you are in doubt whether a fact is material or not, you are, in your own interest, advised to disclose it when applying for cover"*.

Insurance contracts are contracts of utmost good faith. For that reason, any failure to disclose material information to the Insurer, entitles the Insurer to subsequently 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, as 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 First Complainant'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."*

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 First Complainant answered the questions put to him in the application process, to the best of his ability. I take the view that the Company was entitled to form the opinion that there were details of the First Complainant's medical history which had not been disclosed, and which were material to its assessment of the risk. Both Complainants were present at the meeting when these questions were asked, but the information regarding the First Complainant's medical treatment for sleep apnoea was not disclosed to the Company.

The Complainants have, since the Preliminary Decision was issued to the parties on 10 May 2018, submitted a medical report dated 18 July 2014 from a Consultant Psychiatrist, Dr. N., arising from an examination on 9 July 2014. The report was prepared against the background of the Complainant's accident at work on 17 January 2014, and sets out the

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crush injuries he sustained to his right index finger in January 2014, and the treatment undergone in the 6 month period leading up to that report. I note that Dr. N. concludes the report by confirming a diagnosis of "*Post-Traumatic Stress Syndrome – Moderate*".

The Complainants have suggested, in that context, that when the proposal for cover was completed on 1 April 2014, "[First Complainant] *was just three months after a most serious accident and we feel that he was not in a position to properly deal with such matters."*

It is unclear in those circumstances why the Complainants went ahead with incepting the policy in question, if they believed that the First Complainant was unable to deal with the proposal procedure at that time, because of ongoing issues arising from his workplace accident. If they felt unable to proceed, it would have been open to them to postpone the proposal for the policy, until such time as the First Complainant felt capable of undergoing that process. They did not however, postpone the application for cover and instead the proposal proceeded in a way which gave rise to incomplete medical information being disclosed to the Company, upon which the Company then based its decision to offer cover to the Complainants, and the premium which would be payable in that regard. In that way, the policy came into being on the basis of incomplete information.

Accordingly, I am satisfied that when the Company declined the First Complainant's claim and cancelled his cover from the commencement date, it was entitled to do so and its actions were in strict accordance with the terms and conditions of the insurance arrangement in place.

With regard to the second element of this complaint, namely, that the Complainants were mis-sold their policy by two Company Agents on 1 April 2014 in circumstances that they considered *"rushed"* and *"pressurised"*, I note that the Complainants completed the policy application during a sales meeting in their home on 1 April 2014, with two Company Agents in attendance. The Complainants state that *"the proposal form was somewhat confusing to us, so the paperwork was filled out by a representative of* [the Company] *in our home in circumstances that was quite rushed. We did not have any time to review the document or study it in our own time and we felt pressurised but didn't think anything of it, at the time"*. In addition, in their email to this office dated 4 December 2017, the Complainants states, as follows:

> *"There was a lot of info exchanged, the rep asked the questions and he ticked the boxes on the application form for the life assurance policies.*
>
> *This all happened at our kitchen table in our home in April 2014.* [The First Complainant] *had a very serious work related accident in Jan 2014 which we told them about. He was under a lot of stress and unfortunately had to get help from a psychiatrist. Looking back this was a bad time to discuss or take out policies"*.

The Company has, however, advised that the Agents in question refute that the sales meeting with the Complainants on 1 April 2014 was rushed. It has provided signed statements from both of the Agents to that effect. In addition, the Company considers that due to the nature of the product and the information required to complete the medical

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questionnaires in the policy application and to compare the benefits to the term policy that the Complainants held with a different provider at that time, the meeting would have taken a considerable period of time that would have allowed for the medical questions and their answers to be considered fully. I note in that regard, that the documentation on file includes the "*Replacement Policy Comparison Quotation*", which was also signed by the Complainants on 1 April 2014.

Whilst it is not possible to precisely ascertain the pace and flow of this sales meeting, I do note that part of the Complainants' complaint in this regard is that *"We did not have any time to review the document or study it in our own time"*. In my opinion, however, the documentary evidence before me does not support this contention.

For example, the Company wrote to the Complainants on 30 April 2014, as follows:

> *"Enclosed you will find your Policy Document folder which contains the following:*
>
> *a) Policy Schedule including details of any Special Provisions that apply to your policy.*
> *b)* [Policy] *Provisions*
> *c) Important Notice*
> *d) Your Benefit Guide*
>
> ***Please read these documents carefully to ensure you understand your policy and that it meets your requirements***".
>
> [Emphasis added]

In this regard, I note that pg. 4 of the enclosed Important Notice provides, as follows:

> *"**Right of cancellation** …*
>
> *If after reading this notice and examining the policy documents you feel the benefits are not suitable for your particular needs, you may cancel this policy by returning the documents with a written instruction (signed and dated) to* [the Company] *within a period of 30 days from the date of the enclosed letter. On cancellation, all benefits will cease immediately and any premiums paid will be refunded in full"*.

As a result, I am satisfied that the Company clearly provided the Complainants with a 30 day cooling off period during which they were free to consider all of the enclosed policy documentation. If, having done so, the Complainants were not satisfied with their policy for whatever reason, it was open to them to cancel the policy within 30 days of the policy documentation issuing to them on 30 April 2014. I am satisfied that this provided the Complainants with two months from the sales meeting on 1 April 2014 to the expiry of the 30 day cooling off period (30 days after 30 April 2014) in which to review and their decision to purchase the policy in question and to cancel it if they so wanted.

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Finally, I note that the Complainants *"do not believe that a meeting took place two weeks later as referenced in the* [Company] *letter to us of the 25th August 2016. We are firmly of the view that everything was signed that day at our house"*, that is, 1 April 2014. I note that the Complainants' recollection of events is not borne out by the documentary evidence before me. In this regard, I note the handwritten note signed by both of the Complainants on 15 April 2014 advising *"We wish our first billing date to be the 15th of May 2014 and the 15th of each month there-after"*. In addition, I also note that the Complainants signed the Letter of Acceptance dated 11 April 2014 on 15 April 2014 and that one of the Agents has confirmed that he called to the Complainants' home on 15 April 2014 to obtain these signatures.

Accordingly, for the reasons outlined above, I take the view that the Company did not act wrongfully in its decision to void cover for the First Complainant, and that the evidence before me does not disclose any basis upon which it would be reasonable to uphold this complaint.

I am disappointed to note that the Complainants have suggested that this office shows an unfair bias in its determination of this complaint. They have suggested "*There were two* [Company] *agents present at the meeting in our home, there were also two of us present. And the fact that you believe them over us is showing an unfair bias".*

The determination of this complaint has been based upon the evidence available, including the medical evidence confirming the First Complainant's history of treatment in the period leading up to the proposal form. This objective evidence provides an independent and impartial confirmation that the medical details made available to the Company on 1 April 2014 were incomplete. It is also clear from the evidence that the Complainants were furnished with a copy of the completed proposal form in the Company's letter dated 30 April 2014, and were asked to review the information provided to ensure that all questions had been answered correctly. The Company invited the Complainants if they wished to alter or clarify any information to contact the Company immediately, as the policy had been issued based on the information which had been provided. The Complainants did not however, correct any such details on the completed proposal form, although it is now clear from the medical evidence available that the First Complainant's treatment for sleep apnoea had not been disclosed to the Company.

I am satisfied in those circumstances, that it is not appropriate to uphold the complaint.

/Cont'd…

Conclusion

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

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 INVESTIGATION, ADJUDICATION
AND LEGAL SERVICES

29 August 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.