An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0108
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Rejection of claim
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant became a member of a Group Income Protection Scheme on **2 May 2007**. The Grantees of this Scheme are a named Trade Union, the individual members of which can organise cover through the Grantees' Broker, which administers the policy. Premiums are paid by individual members by way of salary deduction. The Company was the Insurer of this Scheme from 1 July 2005, responsible for underwriting the applications for cover and assessing claims, until 2012.

The Complainant's Case

The Complainant initially ceased work on **11 April 2008.** She was placed on certified sick leave from **14 April 2008**.

The Complainant later submitted an income protection claim to the Company in **September 2008,** which it subsequently admitted into payment from **6 November 2008**, following the expiry of the deferred period provided for in the policy terms and conditions.

This claim remained in payment until **16 January 2017**, when the Complainant reached her 65th birthday, in accordance with the 2005 Policy Document.

However, the 2008 Policy Document, which came into effect from **1 July 2008**, allows for certain claims to be paid until age 67. The Complainant notes that (i) she submitted her claim to the Company in September 2008 and (ii) the claim did not commence payment

until 6 November 2008, both of which events took place after the 2008 Policy Document had come into effect on 1 July 2008. For those reasons, she believes that her claim should be assessed under the 2008 policy terms and conditions that came into effect on 1 July 2008, and thus the Company should continue to pay her income protection claim until her 67th birthday. The Company, however, has assessed the Complainant's claim under the 2005 Policy Document as it determined that the insured event, that is, the Complainant being placed on sick leave, took place on 14 April 2008.

The Complainant sets out her complaint, as follows:

"[The Company] *stopped paying me on my 65th birthday stating that since I finished work on 14th April 2008, my income protection was covered by the terms and conditions of the older scheme at the time, which stated that the normal retirement age was 65 for all members…and that the new scheme whereby claimants would be paid up until their 67th birthday came in in July 2008 …*

Since I did not receive benefits from [the Company] *until November 2008 and was paying premiums I believe…that I was then covered under their July 2008 policy document.*

Although sick, I always continued to see myself as 'working' for [my Employer] *and intended to go back working in my office as a [*occupation*] as soon as I could. I was available and helpful in the handover of clients during those months when paid fully by* [my Employer]. *Because of an unexpected need for further treatment I was not free to go back to the office until March 2010. I did go back with* [my Employer] *with the understanding I would have cover until my 67th birthday as in going back I knew I could continue to work until my 67th birthday. Unfortunately I was diagnosed with lung cancer (a new cancer) in September 2013 and left work in November 2013."*.

In addition, the Complainant submits, as follows:

"I see the core of this dispute as being [the Company]*'s definition of the 'insured event': Because they say the 'insured event' – the invasive breast cancer – occurred before the update of their policy in July 2008, I was not covered under the updated policy …*

The diagnosis of invasive breast cancer in April 2008 did not necessarily mean I would be claiming on my policy. I know a few people who although diagnosed with even very invasive fourth stage cancer did return to their work within a 6 month period…At one stage I believed I might do so myself …

The basis of my claim for cover under my policy was not an event that occurred in April 2008 but was based on an ongoing diagnosis and treatment which, by September 2008, resulted in the conclusion by myself and my medical team that I could not then return to work due to my condition [the Company] *has failed to address this point and continues to claim that my claim for cover related to what they describe as an "insured event" that occurred in April 2008. This is incorrect.*

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I still believe the deferred event is not related to the insured event but to the time the employer will pay an employer's salary. The [Income Protection] *scheme that I was part of states very clearly that "after 26 weeks of illness in any 12 month period, the…scheme pays you an income of 25% of the salary you were earning". Payment therefore may not be related to the date of any specific illness or diagnosis but to the amount of time out of work so it cannot be claimed by* [the Company] *as the basis for backdating the basis for my claim to April 2008 …*

Indeed, [the Company] *confirms my belief in my entitlement to the new benefits when it states in its last letter: "It is a fact that* [the Company] *were notified of* [the Complainant's] *claim after the changes were made to the policy and agreed with the Grantees and* [the Broker]*, however had we been notified of* [the Complainant's] *claim at the time the insured event occurred, 11 April 2008, we would have confirmed to her at that time that she was covered by the policy conditions in place at the time".*

[The Company] *was not informed, and could not have been informed, at that time because I was not sure I would be making a claim and neither was there any automatic entitlement to cover until* [the Company] *made their own medical assessment. Therefore,* [the Company's] *claim that I was not covered by the new policy is based on a series of assumptions that fall far wide of the facts of my case. I still hold that I was paying my premium over the period when the new policy came into force to ensure my cover would continue into the future when I would need to claim and not because, as* [the Company] *claims, that I was serving a deferred period"*.

The Complainant believes that the liability date in respect of her claim is at the end of the deferred period, which in her case was 6 November 2008 and therefore she takes the view that her income protection claim should come within the July 2008 policy document, *"since I did not receive benefits from* [the Company] *until November 2008 and was paying premiums"*.

In her email to this Office dated 17 November 2017, the Complainant submits *"The issue is about the so called insured event, the paying of premiums, the significance attached by* [the Company] *to the compliant with statutory requirement for deferred period. I disagree with their position on all these and continue to agree with* [the Broker] *who sold me the policy that liability began in September 2008 when the new conditions applied…This has been an extremely stressful experience for me, and it has effected significantly my income"*.

The Complainant seeks for the Company to reinstate payment of her income protection claim from 16 January 2017, when she reached her 65th birthday, onwards until 16 January 2019, when she reaches her 67th birthday.

The Complainant's complaint is that the Company wrongly or unfairly ceased payment of her income protection claim by incorrectly assessing her claim under the 2005 policy provisions.

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The Provider's Case

The Complainant became a member of a Group Income Protection Scheme on **2 May 2007**. The Grantees of this Scheme are a named Trade Union, the individual members of which can organise cover through the Grantees' Broker, which administers the policy. Premiums are paid by individual members by way of salary deduction. The Company was the Insurer of this Scheme from 1 July 2005, responsible for underwriting the applications for cover and assessing claims, until 2012.

The Company received an income protection claim from the Complainant on 11 September 2008 wherein she advised that she had *"invasive breast cancer"*. It also received a medical certificate from the Complainant's GP dated 8 September 2008, which noted the date the disability commenced as 11 April 2008 and the date treatment commenced as 12 April 2008.

The Complainant's Employer subsequently advised the Company that the Complainant ceased working on 11 April 2008 and was placed on certified sick leave from 14 April 2008. The Company was satisfied that the medical evidence received confirmed that the Complainant was unfit for work as a result of her medical condition and that she met the policy definition of disablement, as follows:

"Total disablement shall be deemed to exist where (a) the Insured Person is unable to carry out the duties pertaining to her normal occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted and (b) the Insured Person is not engaging in any other occupation for profit or reward or remuneration".

The Complainant's claim was admitted into payment from the expiry of the aggregate 26 week deferred period (182 days) provided for in the policy terms and conditions, that is, from 6 November 2008.

The initial benefit was 25% of the Complainant's pre-disability salary of €68,622 per annum, that is, €17,156 per annum / €1,429.37 per month. This benefit increased to 75% of her salary from 8 May 2009, that is, €51,467 per annum / €4,288.92 per month. When the Complainant notified the Company that she had begun receiving a Social Welfare benefit from 21 May 2009, the revised annual benefit was €40,843 per annum / €3,403.58 per month (75% of her salary less the Social Welfare benefit).

The Complainant returned to work on a two day week basis from 2 March 2010 and the Company paid a proportionate (partial) benefit amounting to €26,179 per annum / €2,181.59 per month.

The Complainant retired on ill health grounds on 22 November 2013. As her early retirement pension amounted to €7,104.82, the new benefit was €35,747 per annum / €2,978.92 per month. The benefit paid was escalated by the Consumer Price Index (to a maximum of 5%) on the payment date in December of each year. Claim payments ceased on 16 January 2017, when the Complainant reached her 65th birthday.

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The Company notes that the Complainant considers that her income protection claim ought to have remained in payment until 16 January 2019, when she reaches her 67th birthday.

The Company is satisfied that as the Complainant was placed on sick leave on 14 April 2008 that this is then the date that the insured event arose and that the resulting claim must be assessed under the policy terms and conditions in place at that time, that is, the Policy Document which took effect from 1 July 2005. This 2005 Policy Document contained an aggregate 26 week deferred period, meaning that any liability on the part of the Company would not commence until after such a deferred period was served. As a result, payment of the Complainant's claim commenced on 6 November 2008 and it remained in payment until 16 January 2017, when she reached 65 years of age. In this regard, the Normal Retirement Date, the ceasing age for claims, in the applicable 2005 Policy Document is age 65.
The Company notes that the Group Income Protection Scheme in question came up for review on 1 July 2008 and it engaged in discussions and correspondence with the Broker acting on behalf of the Grantee in the period before 1 July 2008 with a view to reaching an agreement for the cover to continue to placed with the Company. In this regard, the Company was successful in remaining as the Insurer of the Scheme. As part of this review, one of the agreed changes was to increase the Normal Retirement Date (ceasing age) to 67 for insured members who entered or re-entered the Public Sector after 1 April 2004. A new policy document was subsequently drafted to include this change and this 2008 Policy Document took effect from 1 July 2008.

The Complainant considers that while she did go leave work in April 2008, she did not approach either the Broker or her Employer until her Employer no longer paid her full salary, which was in November 2008. The Company notes that the Complainant completed her claim form on 8 September 2008, so she clearly approached the Broker in advance of that date. Regardless, the Company is satisfied that the Complainant's claim was to be assessed by the 2005 Policy Document which was applicable at that time the insured event arose, that is, when the Complainant was placed on sick leave on 14 April 2008, and not by the 2008 Policy Document that only came into effect on 1 July 2008, after the Complainant was already on sick leave since 14 April 2008; this happened during the deferred period of her claim.

In this regard, the Company is satisfied that the Complainant's claim cannot be governed by the 2008 Policy Document as its terms and conditions were only agreed with the Grantee and its Broker after the insured event arose and only took effect from 1 July 2008, after the Complainant had been absent from work for over two months. In addition, the Complainant considers that the liability date for her claim is at the end of the deferred period, that is, 6 November 2008. The Company agrees with this, but takes the view that there is a distinction between (i) the insured event arising and (ii) the liability of an insurer to pay a benefit out on the foot of this. The Company points out that

"The policy provides for a deferred period of 26 weeks to be served after the insured event occurs and a claim only become payable after the deferred period is served. The policy is clear in stating that a claim will only become payable after the expiry of the deferred

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period. By definition, therefore, the insured event must occur first, which in turn signals the start of the deferred period and, after the liability date occurs, a claim will become payable.

In this instance, as the insured event, which the Company says is the Complainant being placed on sick leave, occurred on 14 April 2008; the policy in place at that time was the 2005 Policy Document which contained the Normal Retirement Date (ceasing age) of 65 and not the later 2008 Policy Document, which came into effect after she was placed on sick leave and which contained the ceasing age of 67. The Company notes that the same rule applied to any other claims, including claims in payment, where the insured event had already occurred before the new changes were agreed and implemented.

The Company is satisfied that there is a distinction between the insured event, the requirement to serve a deferred period and the date of any liability. The Company agrees with the Broker that the liability date for any claims is the end of the deferred period and claims are always paid after a deferred period is served. However, the policy documents are very clear and in no way vague in relation to the matter of the ceasing age of claims. The 2005 Policy Document drafted with effect from 1 July 2005 is very clear in stating that the ceasing age for claims is age 65. The 2008 Policy Document drafted with effect from 1 July 2008 is very clear in stating that the ceasing age for claims is age 65 or where the insured person first took up employment in the Public Sector on or after 1 April 2004, is age 67.

The Complainant also notes that she continued to pay premiums after the insured event arose. In this regard, the Company is satisfied that it is standard procedure for an insured person to continue to pay premiums during a deferred period in order to keep their cover in place. Once the deferred period expires, there is no requirement to pay any further premiums if the claim is admitted. This is standard procedure in the case of all claims and potential claims for if a person returns to work after an insured event occurs but before the insurer has a liability at the end of the deferred period, it would be crucial that their premium payments continued during this period in order to ensure that cover remained in place for any future insured events.

The Complainant's claim remained in payment from 6 November 2008 until 16 January 2017. Whilst the amount of benefit changed during this period when the Complainant returned to work on a two day week basis, all payments were made in respect of the same insured event (illness) and thus under the same claim. In this regard, in order for the Complainant to be covered by any subsequent policy rules, her claim would have to have ceased entirely and a new claim would have to have been received where any new claim would then be governed the policy conditions in place at the time of that subsequent insured event.

The Company notes the Complainant's comments in relation to the fact that the Company was not notified of her claim until after the introduction of the 2008 Policy Document but it cannot agree that this implies that the Complainant's claim in question should be covered by these policy terms and conditions which took effect from 1 July 2008. The timing of the notification of any claim is not under the control of the Company and when claims are notified it is important that the Company applies the terms and conditions that

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were in place at the time the insured event occurred. As a result, the timing of the notification of a claim is not a determining factor in relation to the terms and conditions that apply but rather the timing of the insured event that is the key issue. The Company acknowledges that the Complainant was not in a position to inform it of the insured event earlier than she did, as it was her intention to return to work, however this does not alter the fact that the insured event occurred in April 2008.

The Company, in its letter to this Office dated 20 September 2017, recognised that the Complainant is dissatisfied with its position and given the particular circumstances of her case, it advised that it was prepared to make one final payment under her claim on an ex-gratia basis, amounting to six months' benefit gross, that is, €17,927.12 in full and final settlement of this matter, and it confirmed that this offer would remain open to the Complainant to accept. More recently, the parties have communicated further proposals/counter proposals, in open correspondence, but it did not prove possible for settlements terms to be agreed between them, so as to resolve the complaint, without the necessity of an adjudication.

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 23 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 any additional submissions from the parties, regarding the merits of the complaint, the final determination of this office is set out below.

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The complaint at hand is that the Company wrongly or unfairly ceased payment of the Complainant's income protection claim on her 65th birthday in January 2017. It is clear that the Company's decision to cease payments in 2017, stems from its position that when the Complainant sought to make her claim in September 2008, her benefits fell to be assessed pursuant to the 2005 policy document. Insofar as the claim was admitted by the Company, and payments were commenced in 2008 (pursuant to the 2005 policy document) and the complaint was made to the Financial Services Ombudsman, more than 8 years later, in mid-2017, I am satisfied that any aspect of the Complainant's grievance stemming from the Company's suggested error from 2008 onwards, until 2017, constitutes "*continuing conduct*" within the meaning of **Section 51(5)** of the ***Financial Services and Pensions Ombudsman Act 2017***.

I note that the Complainant initially ceased working on 11 April 2008 and was placed on certified sick leave from 14 April 2008. She later submitted an income protection claim to the Company in September 2008, which it subsequently admitted into payment from 6 November 2008, following the expiry of the aggregate 26 week deferred period (182 days) provided for in the policy terms and conditions. This claim remained in payment until 16 January 2017, in accordance with the 2005 Policy Document, as this was when the Complainant reached her 65th birthday.

However, the 2008 Policy Document, which came into effect from 1 July 2008, allows for certain claims to be paid until age 67. The Complainant believes that as (i) she submitted her claim to the Company in September 2008 and (ii) the claim did not commence payment until 6 November 2008, both of which events took place after the 2008 Policy Document came into effect on 1 July 2008, it is the 2008 policy document which is the correct set of policy terms and conditions that her claim should be assessed under, and thus the Company should continue to pay her income protection claim until her 67th birthday.

The Company, however, has assessed the Complainant's claim under the 2005 Policy Document as it determined that the insured event giving rise to the benefit payments, took place on 14 April 2008, when she was placed on certified sick leave.

The Complainant makes reference to a memo regarding the '**Salary Protection Scheme Rate Review**' dated 27 May 2008 which states that one of the new enhancements to the policy with effect from 1 July 2008 was *"Benefit payable until age 67 for those who have taken up employment in the Public Sector since 1st April 2004"*. The Company states that the Complainant cannot receive the benefit of this enhancement as this only came into effect after she was placed on sick leave on 14 April 2008. The Company says that "*this is the date that the event insured under the policy arose*". The Complainant, however, in her email to this Office on 8 November 2017 submits *"I continue to believe that the insured event occurred in September 2008",* when she submitted her claim.

The parties are agreed that the liability date for benefit payments, is the date from the end of the deferred period. They are also agreed that if the Complainant's claim fell to be paid pursuant to the 2008 policy document, she would be entitled to continue in receipt of

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benefits until she turns 67 in January 2019. What is at the centre of the parties' dispute however, is their differing opinions as to which policy document should govern the payment of the Complainant's claim; there has been considerable comment from both parties, in that context, as to what constitutes an "insured event", and when such an insured event occurred, for the purpose of the Complainant's claim.

The Company confirmed in a letter to this office dated 2 November 2017 that it agrees with the complainant that

"… just because an insured person is diagnosed with a particular medical condition, this does not automatically mean that an insured event has arisen. However, when an insured person is diagnosed with an illness and ceases working at the same time, and subsequently serves a full deferred period as required by the policy, then clearly an insured event has arisen in the circumstances…. Therefore, it is very clear that the insured event arose in April 2008…."

In my opinion however, the position in respect of any particular "insured event" is not "very clear". The Company's explanation of its position above, leaving aside any medical diagnosis, involves 2 separate elements, being (i) the cessation of work and (ii) the service of a full deferred period. The same letter from the Company says that

" *However, we do not agree that any person who was on sick leave in 1 July 2008 was automatically not covered by the new policy terms and conditions. For example, an insured person could have been absent with a minor ailment such as a cold or flu on 1 July 2008, however, this would not lead to an income protection claim and, therefore, the insured event would not arise in such circumstances. And the insured person could be covered for any future insured events upon their return to work. Obviously, such a person would be covered by the terms and conditions of the policy in place at the time the future insured event occurs*."

It is somewhat unclear to me why the Company maintains that in the Complainant's case, the "*insured event*" was the date upon which she commenced being absent from work due to illness, but in another suggested instance such as the example of where an insured person is totally disabled for a period owing to "*a minor ailment such as a cold or flu",* the date on which an insured person became absent from work, will <u>not</u> be the insured event, or in the Company's own words*, "the insured event would not arise in such circumstances".* On that suggested basis, it seems that whether or not an "insured event" has arisen will not be clear to either the insured person, or to the Company, on the date when that person first becomes absent from work (owing to total disablement within the meaning of the policy).

I note the Company's additional comments in its letter of 2 November 2017, that:

"We are happy to accept that [the Complainant] *was not in a position to inform us of the insured event at the time, as it was her intention to return to work, however, this does not alter the fact that the insured event occurred in April 2008 and* [the Company] *were*

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notified of this in September 2008, when it became clear to [the Complainant] *that she was unable to return to work and required the support of the income protection policy."*

Whilst it may well be that the Complainant notified the Company of her situation in September 2008, by completing a claim form, I am not convinced that an "insured event" thereby occurred, or that the Complainant's entitlements were in any way affected by the date upon which the claim form was submitted. I do not accept the Complainant's contention in that regard that an insured event occurred in September 2018, when she formed the opinion herself, in consultation with her medical advisors, that she would continue to be disabled beyond the deferred period, and she therefore submitted a claim in advance of the expiration of the deferred period, so that it would be processed in the intervening time.

In considering this aspect, I have examined the group policy terms and conditions of the **Salary Protection Scheme**. I also sought to examine the Company's contention, as outlined above, at the end of page 5, that

The policy is clear in stating that a claim will only become payable after the expiry of the deferred period. ***By definition, therefore, the insured event must occur first,*** *which in turn signals the start of the deferred period and, after the liability date occurs, a claim will become payable.*
[my emphasis]

I have examined the various definitions in the policy documents but I note that neither the 2005 policy document, nor the equivalent 2008 policy document, contains any definition or indeed any reference to an "*insured event*". In those circumstances, it is not at all surprising, that both parties have formed their own individual and differing opinions as to what constitutes the "insured event" giving rise to the benefit entitlement. It would seem from the policy documents that no such criterion is laid down. Rather, as indeed has been suggested by the Company, the entitlement to benefit involves 2 separate elements, being (i) the cessation of work owing to total disablement within the meaning of the policy, and (ii) the service of a full deferred period. I note that, for that reason, Provision 4 in both the 2005 policy and the 2008 policy, provides that:-

" 4. Duration of Payment *– Subject to Sub-Provision 7(iv), … the Benefit shall become payable from the expiry of the Deferred Period and continue throughout disablement up to whichever of the following shall first occur ….. "*

Other provisions set out within the group **Salary Protection Scheme** policy documents are also instructive, in forming an understanding as to how the cover is to operate. I note that the Schedule to each of the policy documents contains a definition of "**Deferred Period**" as follows: –

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2005 Policy Document

***"Deferred Period** means*

(a) in respect of an insured person who is of an officer grade

(i) The aggregate of the first 26 weeks of disablement in any 12 month period, in respect of the Benefit is as set out in 1(a) under the definition of Benefit

or

(ii) The aggregate of the first 52 weeks of disablement in any 4 year period in respect of the Benefit is as set out in 1(a) under the definition of Benefit.

and

(b) in respect of any other Insured Person, the aggregate of the first 13 weeks of disablement in any 12 month period.

2008 Policy Document

***"Deferred Period** means*

(a) in respect of an insured person who is a member of a superannuation scheme

(i) The aggregate of the first 26 weeks of disablement in any 12 month period of disablement

and

(ii) The aggregate of the first 365 days in any 4 year period of disablement

and

(b) in respect of any other Insured Person who is not *a member of a superannuation scheme, the first 13 consecutive weeks in each period of disablement*

In both instances the policy documents outline a deferred period, which prescribes an alternative definition of *"(a)"* or *"(b)", and* it seems from the evidence that the Complainant's deferred period fell to assessed under *"(a)".*

That definition at "(a)" then prescribes 2 different alternatives, the second of which at *"(ii)"* anticipates a deferred period being served over no less than 4 consecutive years, presumably to cover a situation where the insured person, suffers a number of individual

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periods of disablement, none of which in aggregate extend to a period of 26 weeks within one year, but which in aggregate extend to 52 weeks, within a 4 year period.

Within such a deferred period served, whether falling under (i) or (ii) above, an insured person could indeed have been absent with a minor ailment such as a cold or flu for eg. a period of 6 weeks, that period of disablement not in itself leading to an entitlement to benefit under the policy. The Company's position, in such circumstances is that an "*insured event would not arise in such circumstances, but the insured person could be covered for any future insured events upon their return to work*". The Company has contended that "*Obviously, such a person would be covered by the terms and conditions of the policy in place at the time the future insured event occurs*".

As outlined above however, the terms of the group policy do not refer to an "insured event". This is simply not a term which is anticipated by the policy. Whilst I accept the Company's position that entitlement to benefit involves 2 separate elements, being (i) the cessation of work owing to total disablement within the meaning of the policy and (ii) the service of a full deferred period, I don't accept that the policy requires the Company to identify an "insured event" for liability to arise. Having considered the matter at length, I am firmly of the opinion that it is the expiry of the Deferred Period, which governs the Company's liability, rather than the identification of any such suggested "insured event".

The Company has maintained its position from the outset. In its Final Response letter dated 12 July 2017, the Company advised, *inter alia*, that:-

"All income protection claims are governed by the terms and conditions of the policy which is in force at the date of the event giving rise to the claim. Any subsequent changes, only affect those who make claims after to (sic) the start of the new policy"

The Complainant has continuously pointed out that she made her claim after the new policy was put in place, but for the reasons outlined above, and in the absence of a provision in the policy which specifies that the date of making a claim is the relevant date governing liability, I do not believe that the vagaries of the particular date upon which a claim form is submitted, can govern the manner in which the Company's liability will arise.

Insofar as the Company maintains that all income protection claims are governed by the terms and conditions of the policy which is in force at the date of the event giving rise to the claim, neither can I see how such an understanding is borne out by the policy documents governing the parties' respective positions. The policy does not purport to identify the date of any such event/s, and indeed there may be a variety of such "events" (periods of total disablement which in aggregate ultimately lead to the deferred period standing fully served) occurring over a period of up to 48 months.

The entitlement to benefit will never become clear until that deferred period has been fully served (whether over an aggregate of 26 weeks within a 12 month period, or over an aggregate of 52 weeks served over 4 years) and the total disablement of the insured person then continues; this is the date upon which the Company's liability arises, and there is nothing in the policy provisions in my opinion which requires the Company to link

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that entitlement to benefit, to an "event", or to an "insured event". Rather, liability simply arises on a particular date when the deferred period has been fully served, as the policy document does not purport to distinguish situations where some portion of the deferred period has been served by the insured person, prior to the "Commencing Date" specified in the policy document.

I am satisfied in those circumstances, that the approach of the Company to the Complainant's claim, was incorrect. Given that the deferred period did not become fully served until November 2008, in my opinion the Complainant's claim then fell to be assessed pursuant to the policy document in place at that time, rather than pursuant to the previous 2005 policy.

For those reasons, I take the view that the Complainant's complaint must be upheld.

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is upheld on the grounds prescribed in ***Section 60(2)(e)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 rectify the conduct complained of by

- Issuing payment to the Complainant of the outstanding policy benefit payments due to her for the period since her 65th birthday, immediately, and at latest within a period of 35 days from today, and thereafter continuing such benefit payments as appropriate to the Complainant, pursuant to the 2008 policy conditions;

- Making such further payment as necessary to the Complainant, if any, in order to redress any loss that may have been caused to the Complainant by the Company not having paid those benefit payments at the time when they were payable to her, from January 2017 onwards, to date, to take account of any changes in the taxation regime, which may now disadvantage the Complainant in her receipt of those outstanding policy benefits.

- Making a further compensatory payment to the Complainant in the sum of €3,000, to an account of the Complainant's choosing, within a period of 35 days from the date when the Complainant nominates account details to the Provider. This payment is to take account of the fact that the Complainant has been out of pocket since January 2017, when her benefit payments were incorrectly ceased by the Company. Whilst I am satisfied that the Company acted in good faith in assessing the Complainant's claim, its incorrect approach and its misunderstanding of its obligations to the Complainant, have delayed her receipt of the benefits to which she was, and continues to be, entitled. I also direct that interest is to be paid by the

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Provider on the said compensatory payment of €3,000, 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.***

Finally, as indicated in the Preliminary Decision issued to the parties, I am conscious that in responding to this complaint, the Company advised this office that it noted that

… the same rule applied to any other claims, including claims in payment, where the insured event had already occurred before the new changes were agreed and implemented.

I must be cognisant in that regard however, of the views of the High Court in October 2007, in *Quinn Direct Insurance Limited v Financial Services Ombudsman [2007] IEHC 323.* The Court was clear in its statement regarding the powers of the Financial services Ombudsman at that time, that:

"… a direction in a finding of the respondent given under s. 57CI(4)(a) may only relate to conduct of the financial service provider specifically relating to the consumer who is the complainant or its consequences for that person. The authority given by this section does not extend to similar conduct of the financial service provider in relation to other consumers.
[my emphasis]

Whilst I believe that the Company should consider reviewing its claims history for the relevant period, so that any other insured person who may have been similarly affected by the Company's incorrect approach to claim assessment during the relevant period, can be identified as soon as possible by the Company, and the situation can be remedied, I do not however direct the Company to undertake such a review, as the directions in this decision issued pursuant to ***Section 60(4)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** can relate only to the position of the Complainant.

/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.

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION
AND LEGAL SERVICES

17 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.