An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0125
Sector:	Insurance
Product / Service:	Payment Protection
Conduct(s) complained of:	Claim handling delays or issues
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint concerns the refusal by the Provider to accept a claim on the Complainants' mortgage repayment cover policy.

The Complainants' Case

The Complainants are a husband and wife and hold a mortgage repayment cover policy with the Provider. The female Complainant suffered an injury which resulted in her being absent from work. While absent from work for that reason, she suffered a heart attack and required bypass surgery. Ultimately, she was forced to leave her employment and started receiving invalidity benefit.

The Complainants contacted the Provider with a view to making a claim under their policy. They were told that a claim could not be made in respect of the heart attack as the female Complainant was out of work at the time.

The Complainants contend that, as she did not claim while out injured, but rather only after suffering her heart attack, the requirement to return to work does not apply. They state that they are being penalised because she happened to have the misfortune of suffering the injury prior to developing a heart condition. They say they are not seeking to claim in respect of the injury, just the heart attack. They seek 12 months' mortgage protection payments.

The Provider's Case

The Provider states that a claim could only be made in respect of the injury if she was off work for 60 consecutive days.
It further states that a claim could not be made in respect of the heart attack because she had to return to work for a consecutive period of 30 days after her injury before being in a position to make a claim in respect of a different condition.

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 11 July 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.

On receipt of the Preliminary Decision, the Provider sought additional information from the Complainant to assist it in processing the claim. The Complainant provided the information requested which has been supplied to the Provider. These additional submissions related to the administration of the claim by the Provider and do not alter my decision.

My final determination is set out below.

The policy in this case provides disability benefit where a policyholder is certified unfit for work and remains out of work for a consecutive period of 60 days from certification. At that point, the policyholder is entitled to 2 monthly benefit payments. The monthly benefit payments continue for each consecutive 30 day period out of work up to a maximum of 12 payments for each claim.

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The Provider relies on the following clause in the policy:

> *"Further disability claims*
>
> *If you have made a disability claim which ends for whatever reason, you will not be able to make another disability claim until you have been in continuous work… for:*
>
> - *30 days if the disability is different; or*
>
> - *180 days if the disability is the same."*

The male Complainant called the Provider 10 days after his wife's heart attack to inquire about making a claim. While he gave details of the injury as well, it was clear from the phone record that he was primarily looking to make a claim in respect of the time out of work due to the heart attack. In spite of this, he was told that, if she was to make a claim *"it would need to be for the ankle"* and that, if she was to claim for the heart attack she must *"return to work in between claims"*.

I regard this as an improper use of the above extracted clause. The Complainants had not *"made a disability claim"* in respect of the injury. They rang up after the heart attack, seeking to make a claim. The Provider effectively treated that as a claim in respect of the injury, thereby barring a claim in respect of the heart attack.

Thus, the Complainants were penalised because she happened to be off work with an injury when she suffered her heart attack. There was only one claim.

For the clause extracted above to take effect, there clearly must have been two claims. If the Complainants had made a claim in respect of the injury, they would have been excluded from making a claim in respect of a heart attack until she had been back at work for 30 days. However, in this case there was no prior claim.

In the circumstances, I believe the Provider's reason for refusing the claim is invalid and unreasonable and for that reason I uphold the complaint and direct that the Provider admit the claim and make a compensatory payment of €500 to the Complainants in addition to the claim.

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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) (d), (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 process the claim made by the Complainants under the policy and make a compensatory payment to the Complainants in the sum of €500, 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.***

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

13 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.***