An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0132
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Rejection of claim - did not meet policy definition of disability
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant incepted a policy of Life Home Cover with the Provider, via his Broker, on 18 February 2008. The Plan in question had the following benefits: Life Cover of €140,000 and Accelerated Specified Illness Cover of €140,000. The Complainant was diagnosed with a condition, known as hard metal lung disease, in August 2014. The Complainant submitted a claim form to the Provider in January 2015. The Complainant's complaint is that the Provider has wrongfully and/or unreasonably refused to pay benefit arising from his claim.

The Complainant's Case

The Complainant suffers from a disease called "hard metal lung disease". The Complainant submits that this causes lung fibrosis and is a very debilitating disease.

The Complainant submits that when he received the claim form from the Provider it was partially filled in, claiming for Loss of Independence, which he was surprised by, as he understood this to be his responsibility, as it was he who was submitting the claim. He submits that as he was not claiming under Loss of Independence, his broker crossed it out on the form as he was applying for benefit in respect of a "lung disease."

The Complainant submits that the Provider nonetheless proceeded to assess the claim as *"loss of independence"*, before concluding that he did not fulfil the criteria for this.

The Complainant submits that he appealed this decision of the Provider. The Complainant submits that the provider subsequently assessed the claim under the definition of "*emphysema*", as a "*severe restrictive lung disease".* The Complainant notes that this is "*factually flawed*", as emphysema is an "*obstructive lung disease"* while pulmonary fibrosis is a "*restrictive lung disease*".

The Complainant submits that he believes that the Provider's policy is "*factually incorrect*" and that whilst the Provider says that if he was on a transplant list, then it would reassess the claim, but he says that this is "*farcical"* as the vast majority of fibrosis patients never achieve a listing and of those who are listed, only a minority secure a transplant. He submits that the mortality rate of those on the waiting list is approximately 50% and that therefore only a tiny minority of sufferers would ever be reimbursed for critical illness.

The Complainant submits that he is suffering from a terminal illness, and as a man in his thirties with a young family, he finds it difficult to cope with the restrictions to his life which his illness has wrought and that his wife's and family's lives have been dramatically changed by this diagnosis. The Complainant submits that the condition which he suffers, is considered by respiratory physicians as a diagnosis worse than cancer as it is a terminal, debilitating disease with no cure.

The Complainant has explained that prior to this "*unexpected and unwanted illness and subsequent diagnosis*", he was an active member of his local GAA team, a referee, and that had was working toward getting an articulated lorry license, to get back into the workforce, but that he is not physically fit to carry out any of the above anymore.

The Complainant submits that as he is unable to work due to his condition the bulk of any monies received into the household goes towards making mortgage repayments, with little remaining, for anything else. He has explained how his wife is in receipt of a carer's allowance from Social Welfare and that neither he, nor his wife, can seek employment, due to his condition.

The Complainant is seeking to have the Provider *"honour the policy they sold and cover the mortgage*", in the amount of approximately €107,000.

The Complainant has submitted that "*All professionals in the medical profession that I have dealt with since my diagnosis have advised me that this is a chronic, progressive and terminal disease, and the only hope of returning to full health is a lung transplant*."

The Complainant submits that his condition is one which should be considered as being eligible for benefit under the policy.

The Provider's Case

The Provider submits that, in December 2007, the Complainant applied for a Life Home Cover Plan, which plan was put in place on 18 February 2008. The Provider submits that the Plan had the following benefits: Life Cover of €140,000 and Accelerated Specified

Illness Cover of €140,000. The Provider submits that in accordance with the Policy conditions, this amount has since decreased to €118,210.

The Provider submits that there is no Income Protection Cover on this plan.

The Provider submits that, in order to qualify for payment, the claimant must fulfil the definition of one of the listed Specified Illness Cover illnesses. In this case it says that it assessed the Complainant's condition against the definition of Loss of Independence and Emphysema. It says that neither definition requires the claimant to be unable to work.

The Provider submits that on 02 February 2015, it received a Specified Illness Cover claim form in respect of Hard Metal Lung disease. It submits that this condition is not specifically covered and that it therefore assessed the claim against the Policy definition of Loss of Independence, which is:

(i) Permanent confinement to a wheelchair, or

(ii) Being permanently hospitalised or resident in a nursing home as a result of a medical impairment on the advice of a registered medical practitioner, or

(iii) Being permanently unable to fulfil three of the following activities unassisted by another person:

- *Walk 100 metres unaided*
- *Get into and out of a vehicle*
- *Put on or take off all necessary items of clothing*
- *Eat food that has already been prepared, using normal cutlery*
- *Wash yourself all over*
- *Claim stairs,*

or

(iv) Suffering from severe and permanent intellectual impairment which must

(a) Result from organic disease or trauma and

(b) Be measured by the use of recognised standardised tests and

The Provider submits that when assessing the medical reports furnished with the Specified Illness Cover claim form by the Complainant, together with the medical report provided by the Complainant's, G.P, it concentrated on point (iii) above, having, it submits, satisfied itself that his condition would not meet any other criteria outlined in the above definition, or any other illness covered by his plan.

The Provider submits that it also considered the illness against an industry standard definition of Emphysema which is:

"*Diagnosis of severe restrictive lung disease by a respiratory specialist who has been appointed as a consultant physician where there is shortness of breath at rest with markedly abnormal pulmonary function tests, the diagnosis being evidenced by all of the following:*

(i) Vital capacity being less than 50% of normal

(ii) FEVI (forced expiratory volume at one second) being less than 50% of normal; and

(iii) The need for continuous daily oxygen,

The Provider submits that, as the Complainant did not require continuous daily oxygen therapy, his condition would not fulfil the definition of Emphysema.

The Provider submits that on 23 February 2015 it declined the Complainant's Specified Illness Cover claim as it was of the opinion that the Complainant's condition was not covered under his Life Home Cover plan.

The Provider submits that following further representations from the Complainant's Broker, in June 2015, which included a letter from the Complainant's Consultant Respiratory Physician, it requested additional information from this Consultant.

The Provider submits that the Consultant's report was received on 06 August 2015, in which it was stated that the Complainant's vital capacity was 60% and FEVI was recorded at 55%.

Provider submits that therefore, the Complainant was not at that point sufficiently physically limited to fulfil the measured criteria as outlined in the definition of Emphysema. It says that it again concluded that the Complainant's condition would not fulfil the definition of Loss of Independence as his condition should not have prevented him being unable to carry out three of the six listed activities.

The Provider submits that it was for this reason that it was not in a position to alter its original decision to decline the Complainant's Specified Illness Cover claim and that it communicated this decision to him on 17 August 2015.

The Provider submits that as the Complainant's plan does not specifically cover Emphysema, it believes that confusion was caused by it advising the Complainant of the above definition, as he was not diagnosed with this condition and it is not listed in his terms and conditions.

The Provider has submitted that in understanding why it assessed the Complainant's condition against "*an industry definition of Emphysema*", that it is necessary to understand the background to the origins of "*Loss of Independence*" cover. It submits that historically, it provided cover for a small number of severity-based illnesses (meaning payable when the named condition reached a specified level of severity, not simply paid on diagnosis alone) under the heading "*Permanent and Total Disablement*" cover. It submits that this was an optional add-on to Specified Illness Cover. The Provider submits that in 1998, in an effort to clarify and simplify the Specified Illness Cover product, it replaced Permanent and Total Disablement cover, along with the severity-based illnesses it covered (Emphysema being one) with Loss of Independence cover.

The Provider submits that this change was made, as it was felt that if a claimant fulfilled the definition of one of the severity-based illnesses, they would fulfil the definition of Loss of Independence. However, it says that it was agreed that in the unlikely event that a

Specified Illness Cover claim fulfilled one of the historic severity-based definitions but failed under the Loss of Independence definition, it would admit the claim.

The Provider submits that it is aware that the Complainant was diagnosed with hard metal lung disease, which is a restrictive lung disease but that this specific condition is not covered under his Life Home Cover plan. It says that the only specific illness concerning lung function is Emphysema.

It submits that "*in an effort to treat the customer fairly andprovide equity*", it did try to apply the Complainant's pulmonary function to that function test but that his function had not deteriorated to that required to meet the definition of Emphysema. The Provider submits that it therefore concluded that it was not in a position to admit the claim under this definition.

The Provider submits that it has noted the Complainant's comments regarding the use of the word "*restrictive"* in the definition of Emphysema and says that it accepts that emphysema is an obstructive lung disease. The Provider submits, however, that once the specified criteria as outlined in this definition are met, it would admit a claim for payment.

The Provider submits that it has not obtained any medical evidence since August 2015 when the claim was last reviewed. It says that it is satisfied that declining the Complainant's Specified Illness Cover claim at that time was the correct course of action. However, it submits that if the Complainant's condition has deteriorated significantly over the intervening years, it would welcome the opportunity to reassess his Specified Illness Cover claim.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on 19 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.

In the absence of additional submissions from the parties, the final determination of this office is set out below.

In examining the conduct complained of, I believe that it may be useful to begin by setting out a chronology of events in relation to the Complainant's claim under his policy of insurance.

Timeline of Events

30 September 2014 - The Complainant's Insurance Broker emailed the Provider requesting a Specified Illness Cover claim form.

02 October 2014 - The Provider responded, requesting confirmation of which illness the claim was being made under.

02 October 2014 - The Insurance Broker responded by email, advising that "*the illness is known as hard metal lung disease*".

06 October 2014 - The Provider emailed the Broker to advise the specific illness being claimed for was not covered, and that therefore the Provider would only be in a position to assess the Complainant under the definition of Loss of Independence. The Provider attached a copy of the terms and conditions and asked the Broker to review the definition and discuss the matter with the Complainant.

14 January 2015 - The Complainant's Insurance Broker emailed the Provider again regarding the Complainant's medical condition, saying "*Further to your email dated 6th October 2014. I now wish to confirm client has informed us that his medical team has confirmed traces of lung fibrosis. Can he proceed to make a SI on his policy*"

14 January 2015 - The Provider replied to the email advising this medical condition is not covered under Specified Illness Cover, saying *"Lung fibrosis is not one of the conditions covered under Specified Illness Cover, so [the Complainant] would not be able to make a claim for this condition".*

15 January 2015 - The Provider received a letter from the Complainant regarding his condition, stating "*I have been diagnosed with Hard Metal Lung Disease. I now wish to claim under the above policy, would you please forward me a claims form to the above address."*

15 January 2015 - The Provider issued a Specified Illness Cover claim form to the Complainant.

30 January 2015 - The Complainant's Insurance Broker issued a completed Specified Illness Cover claim form and letters from the Complainant's medical attendants, confirming the diagnosis of hard metal lung disease, to the Provider.

03 February 2015 - The Provider wrote to the Complainant. It acknowledged the claim form and advised that it had requested additional information from the Complainant's G.P, *"in order to assess the claim further*".

03 February 2015 - The Provider issued a medical report form to the Complainant's G.P, for completion.

17 February 2015 - The Provider received a completed medical report and hospital correspondence from the Complainant's G.P.

23 February 2015 - The Provider issued a letter to the Complainant advising that the claim had been declined. It advised that it had assessed his condition against the plan definition of Loss of Independence, but that it did not consider the definition to have been met at that time.

30 June 2015 - The Provider received an email from the Complainant's Insurance Broker, together with a letter from the Complainant's Consultant Respiratory Physician, dated 18 June 2015 attached. The letter stated:

"[The Complainant] has been under the care of this Department in Hospital over the past number of years where he has biopsy proven hard metal lung disease which manifests itself as a diffuse interstitial disease causing lung fibrosis. This is caused by exposure to tungsten carbide and this has been proven by biopsy specimens. His condition remains stable but is not improving with medication. He will require long term medication for the remainder of his life and will suffer long term disability as a result of same. His pulmonary function tests are in the region of 50% of their normal value and this has not changed over the past number of years. Despite the use of appropriate medication this will not improve but hopefully will not deteriorate in the foreseeable future. We will be happy to provide further information regarding this condition with of course the consent of [the Complainant] if this is helpful to the decision making process".

07 July 2015 - The Provider acknowledged the email and confirmed that an update would follow.

09 July 2015 - The Provider issued a medical report to the Complainant's Consultant Respiratory Physician, to complete and it advised that *"in the event that we are satisfied that [the Complainant] has been diagnosed with Respiratory Failure of specified severity as defined, a lump sum amount will be payable.*" It asked the Consultant to provide details of

the Complainant's most recent pulmonary function tests, including "*FEV1 and vital capacity*" and confirmation of whether oxygen therapy was required on a daily basis.

10 July 2015 - The Provider sent an email to the Complainant's Insurance Broker to advise that additional information was requested from the Complainant's Consultant Respiratory Physician.

06 August 2015 - A completed medical report was received by the Provider from the Complainant's Consultant Respiratory Physician.

17 August 2015 - The Provider wrote to the Complainant, declining his claim. The letter stated that the Provider had assessed the Complainant's condition against the plan's definition of "*Loss of Independence*", which definition is as follows:

(i) Permanent confinement to a wheelchair, or

(ii) Being permanently hospitalised or resident in a nursing home as a result of a medical impairment on the advice of a registered medical practitioner, or

(iii) Being permanently unable to fulfil at least three of the following activities unassisted by another person:

- *Walk 100 metres*
- *Get into and out of a vehicle*
- *Put on or take off all necessary items of clothing*
- *Eat food that has already been prepared, using normal cutlery*
- *Wash yourself all over*
- *Climb stairs, or*

(iv) Suffering from severe and permanent intellectual impairment which must,

(a) Result from organic disease or trauma and

(b) Be measured by the use of recognised standardised tests and

(c) Have deteriorated to the extent that requires the need for continual supervision and assistance of another person

The letter went on to state that:

"*In order to meet the definition of Loss of Independence, the claimant must be either permanently confined to a wheelchair, permanently hospitalised or resident in a nursing home, permanently unable to fulfil three of the listed activities of daily living, or suffering from a severe and permanent intellectual impairment.*

Prof [name] does note in his report that [the Complainant] is limited in his ability to carry out the above activities of daily living. However he does not state that he is unable to fulfil three of the activities unassisted by another person and therefore our chief medical officer does not believe your current condition satisfies the criteria outlined in the above definition...

From previous medical information we have received we noted that possibility of a heart transplant had been discussed. If in the future you are placed on a transplant waiting list please contact us as we can assess your claim under the Major Organ Transplant definition.

Finally, your plan was also assessed under Emphysema 'The diagnosis of severe restrictive lung disease by a respiratory specialist who has been appointed as a consultant physician where there is shortness of breath at rest with markedly abnormal pulmonary function tests, the diagnosis being evidenced by all of the following:

i) Vital capacity being less than 50% of normal
ii) FEV1 being less than 50% of normal; and
iii) The need for continuous daily oxygen therapy.

In July your consultant noted your vital capacity reading was 60% and your FEV1 was 55% and there was no need for continuous daily oxygen. Unfortunately you do not meet the above definition. Should your condition continue to deteriorate further please contact us again and we would be happy to carry out a review of your claim again."

The Complainant is unhappy at how the Provider has assessed his claim.

Analysis

The Complainant has commented on the fact that when he received the claim form from the Provider, Q1 of Section B, "*Medical Details*" which asks the claimant to *"Please state the illness for which you are claiming*" was pre-filled in by the Provider as *"Loss of Independence".*

The Complainant has submitted that this was not the illness for which he was claiming. I note however that the illness in respect of which he was claiming is not one of the Specified Illnesses listed under the Plan, as giving rise to a payable benefit.

I have had regard to the "*Life Home Cover*" Mortgage Protection Policy terms and conditions. I note that that there is no Income Protection Cover provided for under this plan. I further particularly note the following provisions of the Policy:

Section 4 – Cover
4.1 the benefits provided for the proposer in relation to you under this master plan are shown in the certificate of membership. If a benefit type is not mentioned on the certificate of membership, we do not provide that benefit. We will pay a claim where a "benefit event" happens.

4.5 You are "diagnosed as having a terminal illness" if a medical specialist certifies and our Chief Medical Officer accepts, that it is highly likely that you will die from a worsening, incurable disease within 12 months.

4.6 You are "diagnosed as having a specified illness" if on a date after the start date and before cover ends, you have:

- *Had any surgery defined in a plan definition in this section; or*
- *Been diagnosed as having one of the illnesses or medical conditions referred to in a plan definition in this section.*

The Provider has confirmed that a one-off payment of €123,854 would have been paid, in the name of the Complainant, had it considered his condition to have been covered in August 2015 and that the plan in place, would then have ceased upon payment.

As noted above, the initial level of cover available to the Complainant under his Life Home Cover plan was €140,000, Life Cover and Accelerated Specified Illness Cover, of €140,000. The specific illnesses covered on this plan were as follows:

Alzheimer's disease
Benign brain tumour
Cancer
Cardiomyopathy
Coma
Coronary artery surgery
Heart attack
Heart valve surgery
HIV/AIDS from blood transfusion
HIV/AIDS from occupational injury
HIV/AIDS from physical assault
Kidney failure
Loss of hearing
Loss of independence
Loss of sight
Loss of speech
Loss of two or more limbs
Major organ transplant
Motor neurone disease
Multiple sclerosis
Paralysis of two or more limbs
Parkinson's disease
Severe burns
Stroke
Surgery to the aorta

In April 2010 the Provider added seven additional illnesses which qualified for full payment, and three illnesses that qualified for partial payment. These were:

<u>Full payment</u>
Bacterial meningitis
Creutzfeldt-Jacob disease
Dementia
Encephalitis
Liver failure
Systemic lupus erythematosus
Progressive supranuclear palsy

<u>Partial payment</u>
Ductal carcinoma in-situ - Breast
Loss of one limb
Surgical removal of one eye

The Provider submits that, when the Complainant submitted a Specified Illness Cover claim, that it assessed the claim comprehensively, giving full consideration to his condition along with the illnesses covered by his plan.

Having examined the Policy Terms and Conditions, I am satisfied that hard metal lung disease is not one of the specified illnesses covered under the Complainant's Life Home Cover Plan. This does not mean that it is not a very serious and debilitating disease. Having examined in detail the submissions furnished, I am aware of the significant impact that this diagnosis has had on the Complainant and upon his wife and family. Unfortunately it is nonetheless not one of the illnesses specified under the agreement which was entered into by the Complainant and the Provider, which would give rise to the payment of benefit under the Policy.

I would note in this regard that a policy of insurance is not all encompassing as regards the cover provided and when damage or loss occurs, the onus is on the policyholder to establish that the damage or loss in question was caused by an insured peril or in the words of the Policy in question, a "*benefit event*".

It appears that some degree of confusion may have arisen as to why the Provider proceeded to assess the Complainant's claim under the heading "*Loss of Independence*" and "*emphysema"*. I am satisfied however, upon review of all of the evidence furnished by each of the parties, and bearing in mind that the Provider is only obliged to "*pay a claim where a 'benefit event' happens"*, that the Provider assessed the Complainant's claim by having regard to those conditions for which the Complainant may have been able to prove an entitlement to benefit, in circumstances where hard metal lung disease is not one of the specified illnesses which would give rise to the payment of a benefit.

The letter which issued to the Complainant in August 2015, set out in some detail why the Complainant was not deemed, by the Provider, to meet the definition of Loss of Independence, or Emphysema. It also took into account that he may, in the future, be placed on a transplant waiting list and, in the event of same, advised him to contact it again as it could then assess his claim under the Major Organ Transplant definition.

I note the Complainant has submitted that his condition is "*a terminal illness with no cure*" and that "*it can't be fixed with a lung transplant I will always be treated as having lung fibrosis*". However, the definition under the Policy which must be met in order for a benefit to be payable is where a "*medical specialist certifies and our Chief Medical Officer accepts, that it is highly likely that you will die from a worsening, incurable disease within 12 months".* There is no evidence before me which suggests that this is the situation.

Overall, whilst I do have the greatest sympathy for the Complainant, I am satisfied that the Provider has acted reasonably, transparently and in accordance with its Policy Terms and Conditions, regarding its assessment of the Complainant's claim. As the evidence before me discloses no wrongdoing on the part of the Provider, there is no reasonable basis upon which I can be satisfied that it is appropriate to uphold this complaint.

I note that the Provider has indicated that if the Complainant wishes to submit new medical evidence it would reassess whether he would now more recently fulfil the definition of one of the listed Specified Illness Cover illnesses, and this is something which the Complainant may wish to consider. Whilst it is to be hoped that the Complainant's

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condition will not deteriorate, nevertheless should it do so and should the Complainant believe in the future that his condition meets the Policy criteria it will be open to him to apply for policy benefits at that time.

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

16 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.