An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0138
Sector:	Insurance
Product / Service:	Life
Conduct(s) complained of:	Mis-selling Rejection of claim
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant incepted a Life Plan policy with the Company on **21 November 2011**. He applied for this policy through a Company Agent on 4 November 2011 and the Company issued him with the policy documentation on 10 November 2011. For clarity, Company documentation on file states that the person who sold the policy to the Complainant is a *"QFA, who has a contract with* [the Company] *to sell products from the Company only"* and is therefore referred to herein as the Company Agent.

The Complainant's Case

The Complainant met with the Company Agent in his own home on 4 November 2011, during which he completed an application for the Company's Life Plan policy. This policy provided the Complainant with life cover in the amount of €100,000, along with cover for critical illness, surgical cash, personal accident and hospital cash. The policy commenced on 21 November 2011. It should be noted in that regard that the policy meets the definition of a "*long-term financial service*" within the meaning prescribed by ***section 2*** of the ***Financial Services and Pensions Ombudsman Act 2017***.

In July 2014, the Complainant, a self-employed farmer, *"had a farm accident while calving a cow and had a lot of pain in my right shoulder"*. After a number of x-rays and an MRI, the Complainant eventually underwent an operation to his right shoulder in January 2016. The Complainant states that he was also unable to work for 13 weeks after the surgery.

The Company declined the Complainant's ensuing Surgical Cash Benefit claim as it concluded that the type of surgery the Complainant had undergone, namely, a right shoulder arthroscopy for repair of subscapularis and rotator cuff surgery, was not a covered surgery under the relevant policy terms and conditions. In addition, the Company stated that the Complainant was not entitled to any Personal Accident Benefit as the type of injury suffered was not a covered accidental injury under the relevant policy terms and conditions.

The Complainant states *"I was told by* [the Company Agent] *that I would be covered in the event of an accident. This was and is important to me as I am self-employed and have no income if I can't work due to accident, injury or sickness".* He is *"extremely disappointed that this Plan did not pay out when I needed cover"* and states that *"when I took out the Policy* [the Company Agent] *said to me that this plan would cover me "no matter what happens""*.

In this regard, the Complainant states that *"*[the Company Agent] *did not at any stage say what I was not covered for. He didn't at any stage call back to me after I received my policy document and explain same to me. I feel that this policy was mis-sold to me and that it was not explained to me about the limited cover there is for surgical cash benefit and also accident cover"*.

The Complainant's first complaint is that in November 2011, the Company mis-sold him his Life Plan policy. His second complaint is that following an accident in July 2014, the Company wrongfully failed to admit his claim into payment. The Complainant calculates that he is due €10,200 in total, that is, a €5,000 Surgical Cash Benefit payment and a €5,200 Personal Accident Benefit payment (13 weekly payments of €400 in respect of the weeks that he was unable to work due to the injury).

The Provider's Case

Company records indicate that the Complainant incepted a Life Plan policy with the Company on 21 November 2011.

On 9 November 2015, the Company received from its Agent who sold the Complainant his policy, a letter from the Complainant's Consultant Orthopaedic Surgeon dated 30 October 2015 regarding the Complainant's shoulder injury, advising that he recommended an *"arthroscopy/repair of damaged structures/biceps tenotomy/decompression if required and co-plaining of the AC joint".* The Company attempted to make contact with the Complainant on 10 November 2015 and again on the following day, 11 November 2015, when its Client Services Department spoke with the Complainant's wife and explained the injuries that are covered under Personal Accident Benefit. It was also explained during the course of this telephone call that the injuries described in the letter from the Complainant's Consultant Orthopaedic Surgeon would not be covered, but that if any of the listed injuries had also been sustained, to contact the Company for a claim form.

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The Complainant himself telephoned the Company on 22 January 2016 seeking a Surgical Cash Benefit claim form, as he had recently undergone surgery, but he did not know at that time what exact surgery had been performed. The Complainant was advised of the surgeries covered under the Surgical Cash Benefit and a claim form was posted to him. The Company telephoned the Complainant on 26 January 2016 and advised again that only surgeries listed in his Policy Provisions were covered under Surgical Cash Benefit. It was agreed to post out the list of surgeries to the Complainant and he could show this list to his doctor, and his doctor could then advise if his surgery was listed, before completing or returning the claim form.

The Complainant later submitted a Surgical Cash Benefit claim to the Company on 16 February 2016 and this claim was reviewed on the same day. The Company concluded that the injury and surgery that the Complainant suffered were not listed in the relevant Policy Provisions and were therefore not covered under the policy. As a result, the Company advised the Complainant by way of correspondence dated 16 February 2016, as follows:

"After assessment of the evidence received, we are unable to make a payment on this claim as the type of surgery that you underwent is not a covered surgery under the terms of this benefit. As certified by the hospital doctor whom you attended you underwent a right shoulder arthroscopy for repair of subscapularis and rotator cuff surgery.

I regret to advise as this type of surgery is not covered, this claim is not valid".

Following receipt of correspondence from the Complainant dated 29 February 2016 wherein he stated he wanted to appeal this decision, the Company carried out a review which it completed on 8 March 2016, when it wrote to the Complainant confirming that the claim was not valid, as follows:

"Your surgeon has advised that you had "Shoulder Surgery". Your Policy Provisions at Section 3.4 – Surgical Cash Benefit details a list of both Major & Minor Surgeries that are covered under this benefit. Also contained within Section 3.4 is an advisory

"If a surgery is not carried out to one of the sites specified under the Major Surgeries or the Intermediate Surgeries above, then it is not covered"

As surgery on your shoulder is not a procedure detailed under the listed Major or Minor Surgeries the claim was correctly declined. I have enclosed a copy of Section 3.4 of your Policy Provisions.

I note your statements that you felt,
"surgeries serious illness cover, life cover and accidents were all covered by the policy"

I wish to advise that your Policy…provides cover for a broad range of conditions, however it is clear in the Policy Documentation sent to you in November 2011, that only certain critical illness conditions of specified severity, specified surgeries (Major & Intermediate), specified injuries are what is covered. In all instances benefits are only payable when the detailed Policy criteria have been fulfilled".

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The Company noted that the Complainant stated in his letter dated 29 February 2016 that he had been *"assured that surgeries, serious illness cover, life cover and accidents were all covered by the policy"* when being sold his policy. It therefore interviewed the Company Agent in question. The Company Agent confirmed that he met with the Complainant in early November 2011 when he conducted a full financial review of the Complainant's financial arrangements at that time. A Protection, Pension and Savings plan were recommended to the Complainant, who then chose to proceed with a Protection Plan with Life Cover, Critical Illness, Hospital Cash, Surgical Cash and Personal Accident benefit. The Company notes that page 2 of the Personal Financial Review (which the Complainant signed on 4 November 2011) advises why the policy was recommended to him. In addition, the Company Agent also confirmed that he went through the Company Benefit Guide for this policy with the Complainant, explaining each of the benefits he applied to be covered for, and what was covered under each benefit and the costing of each and confirmed that at no time did he state that all injures or illnesses were covered by the policy.

Furthermore, the Company posted the Life Plan Provisions booklet to the Complainant in November 2011 when his policy issued. The cover letter sent with the policy documentation asked the Complainant to read his documentation carefully to ensure that he understood the policy and that it met his requirements.

In this regard, the Company notes that Section 3.4, 'Surgical Cash Benefit', of the Life Plan Provisions booklet, lists the Major and Intermediate Surgeries that are covered under this benefit and advises, *"If a Surgery is not carried out to one of the sites specified under the Major Surgeries or the Intermediate Surgeries above, then it is not covered"*. The Company states that as surgery on a shoulder is not a procedure detailed under the listed Major or Intermediate Surgeries, the Complainant's claim was declined. The Life Plan Policy Provisions explicitly state the surgeries covered under Surgical Cash Benefit (pg. 14) and also what is covered under Personal Accident Benefit (pgs. 17-18) and the Company is satisfied that the claim form and letters received from and on behalf of the Complainant confirm that none of these injuries or surgeries occurred in this instance.

The Company is satisfied that the Complainant's policy documentation clearly details what is covered and what is not covered under the policy. In addition, it is also satisfied that the Company Agent in question explained to the Complainant during the application process what was covered under the policy and at no time did he advise the Complainant that all possible surgeries, serious illnesses and accidents were covered under the policy.

Accordingly, the Company is satisfied that the Complainant was not mis-sold his Life Plan policy. The Company is also satisfied that it declined the Complainant's claim at issue, in accordance with the terms and conditions of his Life Plan policy.

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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 19 June 2018, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

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

The first complaint is that the Company mis-sold the Complainant his Life Plan policy in November 2011. In this regard, it is noted that the complaint of mis-selling was made within a period of 3 years of the Complainant being advised that his claim for benefit payment, following an accident in July 2014, was being declined by the Company.

The Complainant met with the Company Agent in his own home on 4 November 2011, during which he completed the Company Life Plan Application Form. This policy provided the Complainant with life cover in the amount of €100,000, along with cover for critical illness, surgical cash, personal accident and hospital cash. The policy commenced on 21 November 2011.

In July 2014, the Complainant, a self-employed farmer, *"had a farm accident while calving a cow and had a lot of pain in my right shoulder"*. After a number of x-rays and an MRI, the Complainant underwent an operation to his right shoulder in January 2016. The Complainant states that he was unable to work for 13 weeks after the surgery. The Company declined his ensuing Surgical Cash Benefit claim as it concluded that the type of surgery the Complainant underwent, namely, *"a right shoulder arthroscopy for repair of*

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subscapularis and rotator cuff surgery", was not a covered surgery under the relevant policy terms and conditions. In addition, the Company also stated that the Complainant was not entitled to any Personal Accident Benefit as it concluded that the type of injury suffered was not a covered accidental injury under the relevant policy terms and conditions.

The Complainant states *"I was told by* [the Company Agent]*…that I would be covered in the event of an accident. This was and is important to me as I am self-employed and have no income if I can't work due to accident, injury or sickness"*. In this regard, the Complainant states that *"*[the Company Agent] *did not at any stage say what I was not covered for. He didn't at any stage call back to me after I received my policy document and explain same…I feel that this policy was mis-sold to me and that it was not explained to me about the limited cover there is for surgical cash benefit and also accident cover"*. In addition, the Complainant states that *"when I took out the Policy* [the Company Agent] *said to me that this plan would cover me "no matter what happens""*.

However, this is disputed by the Company which points to correspondence from the Company Agent in question, dated 12 February 2018 stating, as follows:

"I wish to state the following:

- *I never informed* [the Complainant] *that he was 'covered no matter what happened'*
- *As previously stated I went through* [the Company's] *benefit guide explaining the options available on the company's protection policy, outlining the benefits and explained in detail what each of the benefits covered"*.

There are conflicting accounts from both parties, as to precisely what was discussed during the sales meeting between the Complainant and the Company Agent on 4 November 2011 when the Company Agent sold the Complainant his Life Plan policy. The documentary evidence before me however assists in that regard, in the investigation of this complaint.

I note in this regard that when the Complainant signed the completed Application Form, Page 8 of the form consisted entirely of a "**DECLARATION**" listing 16 different items, the final one of which was as follow:-

*"**16.** I understand that the Contract is subject to the Policy Provisions, a copy of which will be provided to me with the Policy Documents"*.

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I note that immediately below the 16 items listed, the Declaration then contained the following warning, printed in bold:-

*"**Please ensure you have read the Declaration carefully before signing**"*,

I see from the documentary evidence that the Complainant signed this declaration on 4 November 2011, indicating that he was aware that the policy was subject to its provisions, that is, its terms and conditions.

In addition, Company correspondence to the Complainant dated 10 November 2011 included, the following:

"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) *Life Plan 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".

[My emphasis]

I note that the covering letter in question dated 10 November 2011, also advised the Complainant as follows:-

*"I am pleased to advise that we will provide **Free Cover**, effective from today, until your policy commencement date as referred to in your Policy Schedule. The enclosed Life Plan Provisions, along with any Special Provisions detailed on your Policy Schedule, apply in full during this **Free Cover** period.*

When you are satisfied that this policy meets your requirements, please inform your beneficiaries of its existence and where it is kept."

I note in that regard that in the period between 10 November 2011 and 21 November 2011 when the first direct debit was due, the Complainant had an additional period during which cover was free, and during which it was open to him to review the Policy Provisions again, before the first premium payment fell due 11 days later, to ensure that he was satisfied with the extent of the cover put in place.

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The enclosed Policy Schedule detailed, as follows:

*"**Benefits:***

Life Cover	*€100,000*
Critical Illness	*€30,000*
Hospital Cash	*€200*
Surgical Cash	*€20,000*
Personal Accident	*€400*

The Proposal, this Schedule, and Special Provisions and Endorsements attached hereto and the Life Plan Provisions are part of this policy.

In consideration of the payment of the Premiums [the Company] *will pay the Benefits defined in this Policy".*

I am satisfied that the documentation provided by the Company to the Complainant prior to the commencement of his policy on 21 November 2011, that is, the Company Life Plan Application Form, which the Complainant signed on 4 November 2011, and the policy documentation which it posted to the Complainant on 10 November 2011, made clear that his policy was subject to terms and conditions and that the Life Plan Provisions booklet enclosed detailed these terms and conditions. These provisions ran completely contrary to any suggestion that cover would be available "*no matter what*". In addition, I am satisfied that the Company clearly advised the Complainant in its cover letter dated 10 November 2011 to *"Please read these documents carefully to ensure you understand your policy and that it meets your requirements"*. If having done so he was uncertain of or dissatisfied with the policy, it was open to the Complainant to contact the Company or the Company Agent directly to seek clarification but there is no evidence that any such contact was made. Accordingly, I am satisfied that the documentary evidence before me does not indicate that the Complainant was mis-sold his policy.

In July 2014, the Complainant, a self-employed farmer, *"had a farm accident while calving a cow and had a lot of pain in my right shoulder"*. After a number of x-rays and a MRI, the Complainant ultimately underwent surgery to his right shoulder in January 2016. The Complainant states that he was unable to work for 13 weeks after. He seeks for the Company to admit his claim into payment, which he calculates to be €10,200 in total, that is, a €5,000 Surgical Cash Benefit payment and a €5,200 Personal Accident Benefit payment (13 weekly payments of €400 in respect of the weeks that he was unable to work due to the injury). In addition, in his correspondence to this Office dated 8 December 2017, the Complainant states *"anyone reading a Policy that says You have Surgical Cash and Accident Benefit would automatically conclude that if a person has an accident then they are covered and Benefit is paid out, with the same point applying to Surgical Cash"*.

However, the Life Plan policy held by the Complainant, like all insurance policies, does not provide cover for every eventuality; rather the cover is subject to the terms, conditions, endorsements and exclusions set out in the policy documentation. In this regard, Section 3.4, 'Surgical Cash Benefit' of the Life Plan Provisions Booklet, which was issued to the

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Complainant on 10 November 2011 prior to the commencement of premium payments for the policy, includes, at pg, 14, as follows:

*"**What is covered** …*
on the performance of a specified surgery on a Life Assured, we will pay an amount of 100% of the Surgical Cash Benefit for a Major Surgery or 50% of the Surgical Cash Benefit for an Intermediate Surgery …

Major Surgeries
Surgery to the brain or meninges of the brain
Surgery to lungs
Total hip replacement
Knee replacement
Surgery to spinal cord or canal

Intermediate Surgeries
Surgery to spinal vertebrae and intervertebral discs
Total mastectomy
Surgery to adrenal glands
Surgery to bile duct
Surgery to bladder
Surgery to gall bladder
Surgery for hiatus hernia
Hysterectomy
Surgery to kidney
Surgery to larynx
Surgery to liver
Surgery to oesophagus, stomach, duodenum, jejunum, ileum, colon
Surgery to pancreas
Surgery to prostate
Surgery to spleen
Surgery to thymus
Surgery to thyroid or parathyroid
Surgery to ureter …

What is not covered

a) *If a surgery is not carried out to one of the sites specified under the Major Surgeries or the Intermediate Surgeries above, then it is not covered"*.

(It is noted by this office that the Company's letter of 8 March 2016 to the Complainant is unhelpful, insofar as it twice refers to "Minor Surgeries" when in fact the policy provisions refer only to Major Surgeries and Intermediate Surgeries).

I see that correspondence on file from the Complainant's Consultant Orthopaedic Surgeon dated 2 June 2016 states, as follows:

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"[The Complainant] *underwent surgery five months ago following an injury on the farm where he avulsed the subscapularis tendon. Whilst technically not a fracture in the sense of only a bony injury, this was a soft tissue injury with small fragments of bone attached to the undersurface of the subscapularis. This is equivalent to a lesser tuberosity fracture of the humerus just without a significant bony fragment requiring bony fixation repaired with soft tissue fixation instead"*.

In addition, the Surgical Cash Confirmation of Surgery Form which the Complainant's Consultant Orthopaedic Surgeon had previously completed on 15 February 2016 details the site of the operation as *"Right Shoulder"*.

I note that surgery to the shoulder is not one of the surgeries specified under the Major Surgeries or Intermediate Surgeries listed under the Surgical Cash Benefit section of the Life Plan Provisions booklet. Accordingly, I am satisfied that in declining the Complainant's Surgical Cash Benefit claim, that the Company acted in accordance with the terms and conditions of the policy in place.

The Complainant also considers that he is entitled to a payment of €5,200 Personal Accident Benefit (13 weekly payments of €400 in respect of the weeks that he was unable to work due to the injury). I note, however, that there is no documentation before me indicating that the Complainant formally submitted a Personal Accident Benefit claim to the Company. That said, having listened to a recording of the telephone call that the Company made to the Complainant's wife on 12 November 2015, I note the following exchange:

The Complainant's Wife:	*He'll be out for 16 weeks…or sorry, for four months*
Company Agent:	*Yeah*
The Complainant's Wife:	*So could he claim for –*

Company Agent: *Only if there was a break or a dislocation of the shoulder. If there was, there would be two claims forms – a claim for him for the time missed.*

In addition, I note that the Company also advised this Office by email dated 25 January 2018 that*"*[the Complainant] *did not fulfil any of these policy criteria for a valid Surgical Cash or Personal Accident Benefit Claims. Had he fulfilled this criteria, we would have paid this claim upon validation of same"*.

In this regard, Section 3.6, 'Personal Accident Benefit' of the Life Plan Provisions Booklet, which was issued to the Complainant on 10 November 2011 prior to the commencement of his policy, includes, at pgs.17-18, as follows:

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*"**What is covered** …*

We will pay a weekly benefit if the life Assured becomes temporarily disabled, prior to his/her 60th birthday, as a result of suffering a specified injury, as defined in the table overleaf, by means of an accident".

I note that the table referred to includes the specified injury of dislocation of shoulder. However, I am satisfied that it was reasonable for the Company to conclude from the medical and other documentation before it, that in July 2014 the Complainant, though suffering a significant injury, did not however break or dislocate his shoulder and therefore, notwithstanding the significance of the injury to the Complainant, he did not have a valid Personal Accident Benefit claim under his policy.

Finally, I note that the Complainant states in his correspondence to this Office dated 8 December 2017, as follows:

"I feel I have paid for something and now that I have a legitimate Claim I am being told You are not covered. This situation now has me wondering was I ever covered".

Notwithstanding the Complainant's suggestion that it is unclear if he was "ever covered", I note from the documentation before me that the Complainant's cover under this Life Plan Policy gave rise to a valid Personal Accident Benefit claim with the Company arising from *"cracked ribs"* he suffered, when he fell on ice on 28 December 2014. I note in that regard that the Complainant received a benefit payment of €2,114.18 from the Company after he was certified as unfit for work from 31 December 2014 to 20 February 2015.

I am satisfied from the evidence before me that the Complainant's policy provides him with cover and that he is entitled to the ensuing benefits in the event of any claim which meets the policy terms and conditions. Indeed, the Complainant has been in receipt of policy benefits in such circumstances, after he made a claim for his fall in December 2014.

Having considered all of the evidence available, I take the view that the Company acted correctly in declining the Complainant's claim following the injury he suffered in July 2014, as the claim did not meet the policy criteria and in those circumstances, I am of the opinion that the second complaint should not be upheld. Neither do I accept on the basis of the evidence before me, and as outlined above, that the policy was mis-sold to the Complainant in November 2011, by the Company's agent.

Accordingly, for the reasons outlined above, these complaints are not upheld.

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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 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

11 July 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.