An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0150
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Rejection of claim - did not meet policy definition of illness Maladministration
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint concerns the declinature of a claim made by the Complainant under a mortgage protection policy underwritten by the Provider.

The Complainant's Case

The Complainant took out a mortgage protection policy, which was incepted on the 1st of March 2005. In 2011 the Complainant made a claim on his policy for terminal illness benefit. The Provider has declined to pay benefits under the claim on the basis that the Complainant's illness (Fabry Disease) is not a "terminal illness" within the terms of the policy.

The Complainant feels he is entitled to be receive benefits under the policy. He states that Fabry Disease is a terminal illness, and that the policy documentation did not define "terminal illness" in the manner put forward by the Provider.

The complaint is that the Provider has incorrectly and unreasonably refused to pay benefit to the Complainant under the terms of the policy. It is also contended that the Provider delayed unreasonably in furnishing its decision to decline payment under the policy.

The Provider's Case

The Provider's position is that Fabry Disease is not a terminal illness within the terms of the policy, and thus no benefit is payable to the Complainant. The Provider also states that the delay in arriving at a decision was due to the time it took to obtain the medical records necessary to make its decision.

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 24 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.

Following the consideration of an additional submission from the Complainant, received by this Office on 17 August 2018 (a copy of which was furnished to the Provider for its consideration; however, the Provider declined to comment further), my final determination is set out below.

The Policy

The Complainant, through his broker, took out a mortgage protection plan with the Provider which began on the 1st of March 2005.

The proposal form for the policy signed by the Complainant on the 25th of November 2004 contains the following information:

"Term of Cover *10 years"*

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"Death benefit only"

Death benefit only was selected by ticking a box beside it. That box was chosen instead of the "*Accelerated*" box, which would have included critical illness cover. There can be no doubt, therefore, that the policy did not include critical illness cover.

The following information is contained in the *"Quotation for Mortgage Protection"* form dated the 17th of February 2005:

"Term 10 years"

"On diagnosis of a terminal illness where the policy has more than 18 months to run, the Death Benefit will be paid"

By letter dated 17th of February 2005 the Provider appears to have provided copy policy documentation to the Complainant, as well as forwarding the policy itself to his broker.

The Complainant does not believe that he received these documents. It is not possible for me to decide this dispute definitively, however I note that the Complainant signed his acceptance to the schedule of special terms on the 21st of February 2005 which was also sent under cover of letter dated the 17th of February 2005.

I also note that the Complainant's broker was in a position to furnish a copy of the policy to the Complainant's solicitor on the 4th of January 2012. In any event, the policy was available to the Complainant from his broker whenever it was required, and the issue of whether or not a copy was enclosed with the February 2005 letter to him is largely irrelevant in the context of this complaint - there is no evidence to suggest that (a) the policy terms and conditions are different to those contained in the documentation submitted to this office, or (b) that if the Complainant had been aware in 2005 that the policy would not cover a diagnosis of Fabry Disease he would not have taken it out or would have renegotiated those terms.

The schedule to the policy confirms that cover in the event of death applied, and the expiry date was the 28th of February 2015.

The policy terms and conditions provided to this Office by the Provider contain the following pertinent provisions:

"COVER IN THE EVENT OF DEATH

[…]

Benefit payment in the event of terminal illness

[…]

/Cont'd…

Terminal illness means the certification by the medical practitioner involved and acceptance at the Company's chief medical officer's discretion that the Life Assured's life expectancy is no greater than 12 months. Benefit payment in the event of a terminal illness will not apply where there are less than 18 months to go to the Expiry Date"

The policy clearly defines what is meant by a "terminal illness".

The Complainant's Medical History

The Complainant sought to claim benefit under the policy by submitting a "*Terminal Illness Benefit Form"* dated the 24th of November 2011, accompanied by a letter from his general practitioner detailing a serious and difficult decline in the Complainant's health from 2006 onwards, and indicating that the Complainant was suffering from a number of conditions.

I have been provided with extensive medical records for the Complainant.

I have reviewed same, and set out hereunder a timeline of relevant extracts from same.

Date	Relevant extracts	
22/11/11	*"coronary artery disease"; "osteoarthritis"; "obstructive sleep apnoea"; "morbid obesity"; "atrial fibrillation"*	Complainant's GP
28/3/12	"*I do not consider his present condition to be 'Terminal' in the correct definition of that term"*	Mercy Hospital, Cork
20/6/12	*"[The Complainant] does not have a terminal illness"*	Bon Secours Hospital, Kerry
13/7/12	*"looks decline but get specialist report from endocrinologist first"*	CMO comments
25/2/15	*"diagnosed with Fabry disease"; "does not show renal insufficiency"; "life expectancy will probably be shorter, when compared with otherwise age-matched males in the general population"*	Mater Hospital, Dublin

In his post Preliminary Decision submission received by this Office on 17 August, the Complainant provided a further medical report and a further description of the effect of Fabry disease.

Having considered all of these medical reports and history, it is beyond doubt that the Complainant has extensive medical difficulties, some of which could have been covered under a policy which included critical illness cover. However, the Complainant's policy (as applied for by him through his broker) did not include critical illness cover.

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Therefore, the issue that falls to be decided in this complaint is whether the Fabry Disease suffered by the Complainant (or any of the other conditions from which he suffers) constitutes a "terminal illness" within the meaning of that term in the policy? If so, was the claim submitted prior to the 1st of August 2013 (being 18 months prior to the policy Expiry Date)?

I have been provided with, and have considered, information provided on behalf of the Complainant regarding Fabry Disease.

Fabry Disease, also known as Anderson-Fabry Disease, is an hereditary lysosomal storage disease. It involves a missing or deficient enzyme called alpha-galactosidase A which is essential in breaking down certain waste products in the lysosomes of many different types of cell in the body. It presents as a wide range of serious and life changing symptoms. It is a debilitating condition associated with many problems and a shortened life expectancy. There is no known cure.

A prognosis of no greater than twelve months to live is necessary to receive terminal illness benefit under the Complainant's policy. There can be no dispute about that.

However, and despite numerous medical reports and records being furnished over a number of years, nowhere in the documentation presented to this Office as part of the complaint is it suggested that the Complainant's condition has resulted in a life expectancy of no greater than twelve months.

The Complainant has cited the description of the policy in certain letters sent by the Provider's claims handlers as a "critical illness benefit policy". Such a description in the headings of certain letters sent after the claim was made does alter the terms of the policy, which are clear.

The Complainant has also complained of the delay between the claim being submitted and the decision to decline being arrived at. I have reviewed the correspondence file and I accept that the overwhelming portion of the period between the claim being submitted in 2011 and being finally declined in 2015 was due to the Complainant or his representatives, or his treating doctors, not responding promptly to queries from the Provider. Indeed, a large part of the delay was due to the Provider's apparent reluctance to decline the claim without giving the Complainant every opportunity to provide the prognosis necessary for benefit to be paid.

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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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

18 October 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.