Decision Ref:	2018-0165
Sector:	Insurance
Product / Service:	Payment Protection
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

This Complaint concerns the administration of the Complainant's account, and in particular the implementation of a policy of repayment protection insurance held by the Respondent Provider with a third party insurer.

The Complainant's Case

The Complainant held a loan account with the Provider.

He fell into difficulty making repayments under the loan account in or around 2009, at which time he also underwent quadruple bypass heart surgery.

In 2014 the Complainant's loan account was paid off by virtue of an insurance policy the Provider held with a third party insurer, under provisions relating to total and permanent disability.

The complaint is that the Provider failed to claim under this policy in 2009, resulting in the Complainant making payments into the loan account from 2009 to 2014 which, he states, would have been unnecessary had the insurance policy been claimed upon then.

The Provider's Case

The Provider states that it had no evidence upon which to make a claim under the total and permanent incapacity provisions of the relevant insurance policy in 2009, or indeed at all until 2014.

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 9 November 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, I set out below my final determination.

The Provider held a policy of insurance with a third party insurance provider. Under the terms of this insurance, the Provider could submit a claim to the insurer where a customer has become unable to work by reason of total and permanent disability.

Total and permanent disability is defined in the policy as a "*condition of health which by reason of a medically determinable physical or mental impairment (as determined by [the insurer's] chief medical officer) which [sic] renders the Member [in this case, the Complainant] totally and permanently unable to engage in any occupation or gainful activity for remuneration or profit provided always that the Member has undergone all reasonable medical and surgical treatment which would provide a reasonable probability of removing such disability*".

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The Complainant is not a party to this policy. It is made between the Provider and a third party insurer. The Complainant therefore is not entitled to submit a claim on his own behalf directly to the insurer.
The Complainant has, however, made a complaint that the Provider ought to have submitted a claim in relation to his account in 2009, or at least that the claim ultimately submitted should have been applied retrospectively from 2009.

Under the policy, it is for the insurer's chief medical officer to ultimately decide whether the medical evidence supports a claim under the total and permanent disability cover.

In a note to the Provider which accompanies a letter dated the 1st of October 2009, the Complainant explains that he has undergone a quadruple bypass and "*will be unable to work for a few months*". This does not meet the permanent nature of a disability that is necessary for it to be covered under the policy.

Throughout 2011, 2012 and 2013 there is contact between the Provider and the Complainant. At no stage at all does he state that he is unable to work due to illness/injury/disability.

The possibility of illness being a factor was first disclosed during a meeting between the Complainant and the Provider in early February 2014. He was then advised by the Provider that his circumstances may be covered by the insurance policy. This was an active step taken by the Provider, it was not a response to an enquiry made by the Complainant.

A claim form was submitted on behalf of the Complainant carrying the date of the 12th of February 2014. In the claim form, the Complainant's GP notes the date upon which symptoms commenced as 24th of September 2013.

It also notes that the first attendance with the Complainant in connection with the relevant illness/injury was on the 12th of February 2014, however I am satisfied that is simply down to a misunderstanding about the question being asked.

The claim form is primarily concerned with a shoulder injury, and colitis. The only mention of a claim going further back than 2013 is where the Complainant himself notes in the "any other information" column simply that he has been unable to work since 2009.

The claim was assessed by the Insurer's chief medical officer (in accordance with the policy), who examined medical records dating back as far as 1999 and provided a detailed report. His assessment was that the medical evidence supports a finding of total and permanent disability for any occupation from the 24th of September 2013. He found that the medical evidence did not support the contention that the Complainant was suffering from a total and permanent disability for any occupation post-surgery in 2009, in fact he notes that the Complainant appeared to have made an excellent recovery from that surgery and had achieved an excellent exercise tolerance capacity following his cardiac rehabilitation.

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On the 26th of March 2015 the Complainant's GP made a note stating "*that the above named patient was unfit for work from Sept 09 to the present time due to coronary artery bypass grafting*".

In a letter dated the 12th of October 2015 the Complainant's representative asserts that he "*has not been permitted to work even one day, by his GP from that date*".

A five line letter from the Complainant's GP dated the 14th of October 2015 summarises the Complainant's medical history in the briefest possible terms and simply asserts that as a result of the 2009 procedure that he "*has a total and permanent disability requiring life long medical treatment*".

Analysis

There are two strands to this complaint. Firstly, the contention that the Complainant has been suffering from a total and permanent disability within the meaning of the policy since 2009. Secondly, the contention that the Provider ought to have submitted a claim on his behalf on the basis of him suffering from such a disability in 2009.

On whether or not, in retrospect, he is entitled to total and permanent disability benefit from 2009, the policy provides that the ultimate arbiter of that question is the Insurer's chief medical officer.

The Complainant has not provided anything close to sufficient evidence which could support a finding that the conclusion reached by the insurer's chief medical officer was somehow unreasonable, unjust or otherwise wrongful.

As to whether or not the Provider should have submitted a claim in respect of his account in 2009, there was no reason at all for it to do so as the Complainant did not advise it that he had been totally and permanently disabled, or even suggest it. Indeed, when there was a hint that he may be suffering from such a condition, the Provider acted swiftly and diligently to effect a claim for cover in February 2014. The fact a claim was ultimately made was down to the diligence of the Provider. There is no evidence to suggest that such a claim would have been paid out in 2009, or for any period prior to September 2013.

In correspondence on the Complainant's behalf it is repeatedly asserted that (a) the Complainant advised the Provider in 2009 that he was suffering from total and permanent disability that prevented him from working, and (b) the medical evidence supports this contention.

Neither of these assertions are supported by the evidence before me. It is not possible to formulate a claim after the event, when there is no contemporaneous evidence to support it.

For the above reasons, I do not uphold this complaint.

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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

4 December 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.