An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0186
Sector:	Insurance
Product / Service:	Mortgage Protection
Conduct(s) complained of:	Rejection of claim - pre-existing condition
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint relates to the Provider's decision to decline the Complainant's claim on his mortgage protection policy.

The Complainant's Case

In approximately December 2001, the Complainant took out a mortgage repayment cover insurance policy in his own name, with a bank which is now being administered by the Provider **("the Policy")**. At its inception, the Policy was administered by an English company, with an Irish branch. However, since 2016, those companies trade as the Provider. The Policy is covered by Irish law.

The Policy provided cover for *"Disability and Involuntary Unemployment"* and amounted to a benefit of €782 *per* month. "Disability" was defined in the Policy as *"any sickness, disease, condition or injury which stops you from doing any paid work".*

The *"key benefits"* were described in the Policy as follows:-

> *"Disability*
>
> 1. *Pays two monthly benefits after 60 days – back dated to the first day you are certified as unfit for work by a doctor.*
>
> 2. *Monthly benefits continue for each consecutive and complete period of 30 days of absence until:*
>
>   - *The end date; or*
>   - *You fail to provide evidence of your disability; or*
>   - *The outstanding balance has been paid; or*
>   - *You return to work; or*
>   - *We have paid the maximum of 12 monthly benefits for each claim".*

Under the *"key exclusions"* section of the Policy:-

> *"[p]re-existing conditions are excluded where a customer is receiving medical advice, treatment or counselling for an illness in the 6 months prior to the start date of the policy. Claims will be accepted for these pre-existing conditions if you have not had any symptoms and have not consulted a doctor or received treatment for the condition in the 18 months after the start date of the policy".*

"Pre-existing conditions" were defined in the Policy as *"any disability, condition, injury, disease or related condition or symptoms which you knew about or should reasonably have known about at the start date or the restart date, or had seen or arranged to see a doctor about during the 6 months immediately before the start date or the restart date"*. The *"restart date"* was defined as *"the date you have to pay a new monthly premium because you have changed your monthly benefit"*.

The Complainant has been paying approximately €51.02 per month for the Policy since its inception.

On approximately the 23rd March, 2017, the Complainant fell ill and was out of work. On approximately the 24th April, 2017, he submitted a claim to the Provider citing *"hypertension"* as the reason he was unable to work. He authorised his wife to act on his behalf in relation to the claim, due to his illness.

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In the claim form, the Complainant's longstanding GP checked a box in the "Doctor's statement" element of the form that he was consulted by the Complainant for hypertension on the 23rd March, 2017, and certified unfit for work on that date. The GP also stated that the Complainant had previously suffered from hypertension for three months in 2014 and that he was, *"under medical attention and in [the GP's] opinion is/was totally prevented from engaging in his/her normal occupation or profession during the period indicated".* The GP stated that the Complainant would likely be fit for work in 2 months' time.

Various letters passed and phone calls occurred between the parties during this dispute, all of which have been considered and the most relevant of which are referred to below.

By letter dated the 3rd May, 2017, the Provider sought from the Complainant's GP records relevant to the claim, records from the 3rd June, 2013 to the 3rd June, 2014, and evidence that the Complainant was under the care of a specialist or consultant.

There was delay in the submission of those records and in the submission of the Complainant's bank details but in phone calls around that time, the Provider indicated that the matter would be dealt with as soon as possible upon receipt of the records, particularly when it became aware that the Complainant's mortgage was due and payment under the Policy was required to pay it.

By fax dated the 24th May, 2017, the Complainant's GP enclosed a copy of the consultation notes and noted in a cover letter that *"there are no other letters on file".* The consultation notes stated that the Complainant had been provided with *"certs"* at various intervals in late 2014 and June 2016 when it was noted *"[s]tress at work and not appreciated. Cert for two weeks. Meds: Bisoprolol and Amlodopine only"*. The following was noted on the 23rd March, 2017, in relation to the Complainant's absence from work:-

> *"Stressed at work. Wants 2 weeks off. Feels he is not being paid adequately for his work, and that too many duties are placed on him. Advised he needs to discuss with his employer and come to an adequate solution".*

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In a phone call following that letter, the issue of pre-existing conditions was raised by the Provider. It was claimed that the Provider had no clarity on whether this was a pre-existing condition and the claim would not be approved until that was ruled out. The Provider also claimed that the medical information received was minimal. The Complainant's wife noted that the first time the Complainant had suffered from the condition was in 2014. She also noted that the Policy was taken out in 2001 and the Complainant had made a claim in relation to the same condition in 2014 and no medical records were requested at that time. The Provider suggested that the Complainant enter into negotiations with the bank regarding the mortgage payments. The Complainant's wife clarified that they had a tracker mortgage and they were therefore fearful of running into arrears with the bank. The Provider agreed to send the matter to the medical team but it was suggested that it might not be approved. The Complainant's wife stressed that it was a *bona fide* claim.

Thereafter, the Provider phoned the Complainant's wife and said that the Policy issue date was showing up as being June 2014, not 2001. The Provider advised that the Complainant's wife contact the bank because the claim would not be approved in time for the next mortgage payment.

In a further phone call, the Provider complained about the limited nature of the medical records and said that there was no mention of hypertension in the notes, no blood pressure records, there was no mention of certification for hypertension in the notes and there was no mention of the medication which the Complainant was taking for hypertension. The Provider again spoke of having to *"rule out"* pre-existing conditions and confirming that hypertension was in existence in March and May and that there was ongoing treatment. The Complainant's wife reminded the Provider that the Complainant could suffer medically as a result of the manner in which the claim was being handled.

As a result of the foregoing, by letter dated the 29th May, 2017, the Provider sought:-

> *"Original date of diagnosis of hypertension*
>
> *Readings and dates of blood pressure readings since 23/03/2017 to present*

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Details of past and current treatment plan 23/03/2017 to present"

On the 31st May, 2017, the Provider wrote to the Complainant denying the claim in the following terms:-

> *"Unfortunately we have declined your claim as there is no medical evidence of a disability. We have no consultation for hypertension on the date of certification 23.03.2017 or any date afterwards".*

The Complainant learned about the above letter when she phoned up the Provider around that time. The Complainant was very distressed on the phone calls which followed and made generalised attacks on the Provider, although not on the individuals with whom she was dealing. She initially asked to speak to someone at a higher level and when put through to such a person, the latter (wrongly) suggested that the Complainant's wife had said that she was not *"good enough"* to speak to. The Provider said that because there were no consultations for hypertension on the medical records, the claim had been declined.

By letter dated the 1st June, 2017, the Complainant's GP wrote to the Provider enclosing the Complainant's blood pressure readings and advising that the Complainant *"was first diagnosed with hypertension on 10/12/2008...[t]he next reading we have on file was taken on 10/10/2014…[h]e is currently on bisoprolol and Amlodipine to treat the condition".*

By letter dated the 7th June, 2017, the Complainant's GP stated:-

> *"I write in relation to [the Complainant's] application as above. On the 23rd March 2017 [the Complainant] attended me to check his blood pressure and reporting stress due to work. I found his blood pressure to be high and requiring treatment and further monitoring. I felt that this necessitated a period of time off work. It was apparent that he would be unable to attend work in any case due to the stress he was suffering. Whilst we certified him unable to work due to hypertension it is also true that he has been unable to work since the 23rd March due to work related stress".*

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By letter dated the 8th June, 2017, the Provider explained the reasons why it would not uphold the Complainant's disability claim on the Policy by stating:-

> *"The condition you are claiming for is hypertension. Unfortunately your claim was unsuccessful due to there being no medical evidence of disability.*
>
> *We have no consultation for hypertension on the date of certification 23rd March 2017, or any date afterwards.*
>
> > *'Disability means any sickness, disease, condition or injury which stops you from doing any paid work'.*
>
> *If you can provide consultation for hypertension. Upon receipt of this information our claims department will be in a better position to validate your claim further.*
>
> *Although I have not been able to uphold your complaint, I hope my explanation of the position is of some assistance to you. Should you have any queries concerning this letter please do not hesitate to contact this office.*
>
> *This is the final stage in our complaints process. If you remain, dissatisfied, you may refer the matter to the Financial Services Ombudsman's Bureau for their independent arbitration…"*

By letter dated the 20th June, 2017, the Complainant's GP noted the Complainant's blood pressure readings and stated that *"[he] will require further monitoring".*

In a phone call on the 23rd June, 2017, the Provider was asked to mark this matter *"urgent"* as it was having a serious impact on the health of the persons in the family and she had now had to borrow money to pay the mortgage as a result of the failure to meet the claim.

By fax dated the 7th July, 2017, the Complainant's GP enclosed a list of blood pressure readings for the Complainant and noted that *"he has attended here weekly for illness benefit certificates since 23/03/2017 to date".*

In a further letter dated the 11th July, 2017, the Provider stated:-

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"We have received your claim in respect to your Sickness. Upon review of the circumstances and supporting documentation you have provided to us, we are unable to pay your claim.

The following condition/s of the insurance policy has/have not been met:

We note the recent correspondence from your GP is a list of Blood Pressure readings.

Unfortunately, under the terms of your policy this does not confirm regular treatment for the condition of hypertension because it does not provide any clinical consultations, prescriptions or referrals for the condition.

From the information we have received to date, we also note that your condition of hypertension is pre existing to the start date of your policy. [the definition for pre-existing condition it then set out]

If your doctor is able to provide new documented evidence to meet this condition, please send this to us, quoting your claim reference number. When we receive this, we will re-assess your claim based on this new information provided…"

Further correspondence passed between the parties prior to the submission of the complaint to this office. Of particular note is a dispute between the parties when the Provider required the Complainant to issue a cheque for € 6.35 for a data access request and reliance on a company policy of 40 days to respond to same.

The Complainant did not receive any payment from his employer at the relevant time and was in receipt of €193 per week in illness benefit. As his mortgage payments are €1,020 per month, he had to, among other things, borrow money or defer payments on the mortgage as a result of the failure to meet the claim.

The Complainant maintains that this is a genuine claim which should be paid out.

The Provider's Case

The Provider has not provided any information beyond that stated in the correspondence and the records of the phone calls between the parties.

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As appears from the above, the issue of pre-existing conditions was first raised by the Provider in phone calls in late May 2017. However, the first letter declining the claim dated the 31st May, 2017, relies on the lack of medical evidence of a disability due to the lack of a consultation for hypertension on the date of certification.

The second letter dated the 8th June, 2017, declined the claim on the same basis. Although it stated that it was the final stage in the complaints process, it was also suggested that the claim would be reviewed if further information was provided.

The final letter dated the 11th July, 2017, confirmed that the claim had been reviewed and relied on the lack of *"clinical consultations, prescriptions or referrals"* for hypertension and also noted that the condition was *"pre-existing"* to the policy.

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.

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A Preliminary Decision was issued to the parties 11 October 2018, outlining my preliminary determination 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.

Both parties made additional submissions on receipt of my Preliminary Decision, as follows:

(1) Letter from the Provider to this Office dated 23 October 2018.
(2) E-mail from the Complainant to this Office dated 5 November 2018.
(3) E-mail from the Complainant to this Office dated 6 November 2018.
(4) E-mail from the Provider to this Office dated 12 November 2018.

Having considered those additional submission, my final determination is set out below.

I am not satisfied with the manner in which the Provider has dealt with the claim and subsequent complaint arising.

First, it was clear from the claim form that the Complainant had declared and the Complainant's doctor stated that the Complainant had consulted his doctor on the 23rd March, 2017, for hypertension. The doctor also noted, in the claim form, that he had certified the Complainant unfit for work on the 23rd March, 2017, clearly as a result of the hypertension. In the circumstances, it was never correct to state that there had been no consultation for hypertension on the 23rd March, 2017, as stated in the Provider's letters. The letter of the 11th July was written in the face of the explicit confirmation of this fact, by the Complainant's GP on the 7th July.

It has to be accepted that the initial medical notes could have been more detailed or, at least, would have benefited from a more fulsome covering letter. However, they ought to have been read together with the claim form which contains a doctor statement of a

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consultation for hypertension on the 23rd March, 2017. The fact that the consultation notes provided on the 24th May, 2017, did not specifically mention hypertension in the consultation on the 23rd March, 2017, did not alter the claim form. This is particularly so when it was apparent from the medical notes (and ought to have been apparent to the medical team within the Provider), that the Complainant had been taking medication known for treating hypertension in 2014 and 2016, he had been reporting blood pressure readings to his GP and "certs" had been issued on various occasions.

Second, while the Provider was entitled to seek further information from the Complainant's GP as it did on the 29th May, 2017, it should not, two days later, have sent a letter declining the claim without waiting for a response to that letter.

Third, the letter from the Complainant's doctor dated the 1st June, 2017, makes clear that he was first diagnosed with hypertension in 2008. Other than any argument in relation to restart date (and no such argument is made), this ought to have dealt with any of the Provider's concerns regarding pre-existing conditions. Therefore, there was no basis for the Provider's assertion in its letter dated the 8th June, 2017, that *"your condition of hypertension is pre existing to the start date of your policy".*

Fourth the same letter of the 1st June, 2017, clarifies that the Complainant is on medication (the same medication mentioned in the first notes provided to the Provider on the 24th May, 2017) to treat hypertension, as evidenced by blood pressure readings taken by the Complainant at the request of the doctor. It is difficult to understand, therefore, how the Provider could state in its letter of the 8th June, 2017, that the recent correspondence did not confirm regular treatment for the condition of hypertension.

Fifth, the letter of the 7th June, 2017, from the Complainant's GP confirms beyond doubt that the consultation took place on the 23rd March, 2017, and clarifies that the Complainant was also suffering from stress at the relevant time.

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The GP's letter of the 20th June, 2017, confirms his blood pressure readings and that he would require further monitoring. The blood pressure readings provided on the 6th July, 2017, also support the claim. In the circumstances, it is somewhat inexplicable that the letter of the 11th July, 2017, from the Provider suggests that there has been no confirmation of regular treatment for the condition of hypertension.

Sixth, I am also satisfied that the Provider fell far short of its customer service obligations. While the Provider's staff were largely courteous and usually helpful, at times during these phone calls they adopted a dismissive tone toward the Complainant's wife and engaged in unnecessary and counterproductive sparring with her.

While the Complainant's wife was critical of the Provider, as a company, and occasionally became animated and distressed, she was courteous towards the staff and was obviously in a very difficult position. It was incumbent on the Provider's staff to deal with the matter appropriately.

In light of the above, I am satisfied that the Provider acted unreasonably and was not entitled to deny cover under the terms of the Policy.

I believe that this decision to deny cover, which had a most severe impact upon the Complainant and his family, was reached by the Provider in the face of the clear evidence contained in the claim form and, latterly, contained in the correspondence with the GP. I am also satisfied that the Provider fell short of its customer service obligations, given the delay in dealing with the matter and the failures on the phone calls. Therefore, I am satisfied that the Provider's conduct was also unreasonable and unprofessional and greatly added to an already stressful situation for the Complainant and his family.

I note in a post Preliminary Decision submission, the Provider accepts many, if not all of its shortcomings as outlined in my Preliminary Decision and has indicated its intention to admit the Complainant's claim.

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In that submission, the Provider also states that "*throughout the claim there are instances where we reached out to the Complainant to give guidance on what we required and we also at times showed empathy and understanding when frustration was evident on the part of the Complainant on calls*".

The Provider asks that these points are taken into consideration when making a decision in relation to the amount of compensation.

In response to the Provider's post Preliminary Decision submission, the Complainant points out that the Provider's conduct had serious financial implications for him and his family and caused them significant stress.

While I welcome the Provider's acceptance of its failings and in particular, I welcome its apology, it is disappointing that it required a full investigation and adjudication by this Office and the issuing of a Preliminary Decision to achieve this.

For this reason, I uphold the complaint and direct the Provider to admit and pay the claim in the usual manner and to pay a sum of compensation of €10,000 to the Complainant 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) (a), (b) and (e).***

Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to rectify the conduct complained of by admitting and paying the claim in the usual manner and by making a compensatory payment to the Complainant in the sum of €10,000 (in addition to the claim) to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant 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.

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FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

28 November 2018

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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.