An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

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| **Decision Ref:** | 2018-0200 |
| **Sector:** | Insurance |
| **Product / Service:** | Critical & Serious Illness |
| **Conduct(s) complained of:** | Rejection of claim - did not meet policy definition of illness |
| **Outcome:** | Upheld |

## LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

### Background

The complaint concerns the repudiation of a 'Salary Protection Scheme' relating specifically to a 'Specified Illness' cover. The Complainants made a Specific Illness claim in 2013 in respect of a benign brain tumour suffered by the First-named Complainant. The claim was declined "*due to the definition not being met*".

### The Complainant's Case

The First-named Complainant joined a 'Salary Protection Scheme' in 2005 which included amongst its benefits 'Specified Illness' cover. This cover provided for the payment of a lump sum benefit to a scheme member should they suffer from certain specific illnesses within the terms of the policy. This particular benefit was added as a benefit to the First-named Complainant's policy in April 2006.

In or around September 2012, the First-named Complainant began to experience headaches. Thereafter, she was referred for an MRI of the brain and she was ultimately diagnosed with an abnormality in the left temporal lobe. This abnormality was considered likely to be a "*low grade or benign brain tumour*". The First-named Complainant did not undergo a biopsy of the tumour in circumstances where, according to her Consultant Neurosurgeon, same would carry "*a small but definite risk of causing neurological damage*" and in circumstances where "*since the abnormalities as demonstrated have been stable there would be no strong clinical indication to proceeding with a biopsy".* It is however anticipated that a biopsy and/or surgery will be required at some stage in the future.

The aforementioned Consultant Neurosurgeon has also stated that "*it is possible that some of* [the First-named Complainant's] *problems might be due to minor seizure activity for instance the panic attacks*" that the First-named Complainant has reported.

More recently, the Complainants have advised that the First-named Complainant has been diagnosed with "*considerable hearing loss in her left ear*" which the ENT Consultant considered may be caused by the tumour.

The First-named Complainant made a claim under the 'Specified Illness' cover part of the Scheme in November 2013. The claim was declined in December 2013. This declinature was appealed by the First-named Complainant in August/September 2016. The Company rejected the appeal in October 2016.

The Complainants maintain that "*the reasons for refusal of the Specified Illness grant by* [the Company] *are not correct*". In particular, the Complainants dispute the contention that the First-named Complainant "*does not have any neurological deficit with persisting clinical symptoms*". The Complainants also take issue with the Company relying on the fact that the First-named Complainant has not undergone surgery to remove the tumour in circumstances where expert opinion currently advises that same is unnecessary and not recommended. The Complainants submit that the Company should accept the First-named Complainant as qualifying for benefit pursuant to the 'Specified Illness' cover provisions of the Scheme.

The complaint is that the Company has unreasonably refused to accept the First-named Complainant as qualifying for benefit pursuant to the 'Specified Illness' cover provisions of the Scheme. The Complainants seek "*payment of full grant of €20,000*".

**The Provider's Case**

The Company initially declined the First-named Complainant's claim in its letter of the 5th of December 2013 on the basis that the First-named Complainant had "*not undergone surgery to remove the lesion, and it has not caused permanent neurological deficit with persisting clinical symptoms".*

Thereafter, the Company declined the Complainants' internal appeal on the basis that the First-named Complainant did "*not have any neurological deficit with persisting clinical symptoms*" as required by the terms and conditions of the Scheme. The Company also noted that the First-named Complainant had not undergone surgical treatment such as might otherwise have activated the waiver of the necessity to establish the existence of a permanent neurological deficit. The letter noted that the matter would be open to review in the event that the First-named Complainant underwent surgery or in the event that she developed any permanent neurological deficit with persisting clinical symptoms.

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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 Complainants were 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 parties17 October 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, my final determination is set out below.

Prior to considering the substance of the complaint, it will be useful to set out certain terms and conditions of the policy as well as certain legislation.

**Policy Terms and Conditions**

The terms and conditions of the Salary Protection Scheme require the Company to pay a lump sum benefit to a scheme member of 25% of her salary (subject to a "*waiting period*") in the event that she contracts one of the specified illnesses listed in the terms and conditions of the Scheme.

The Insurer has relied upon the definition from the terms and conditions of the Scheme wherein a 'benign brain tumour' features as a specified illness giving rise, if established to exist, to "*full payment*". The definition within the terms and conditions of the Scheme provides as follows:

> *Benign Brain Tumour - A non-malignant tumour or cyst in the brain, cranial nerves or meninges within the skull, resulting in permanent neurological deficit with persisting clinical symptoms i.e. symptoms of dysfunction in the nervous system that are*

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*present on clinical examination and are expected to last throughout the Insured Person's lifetime.*

*The diagnosis must be made by a Consultant Neurologist or Neurosurgeon and must be supported by CT, MRI or histopathological evidence.*

*The requirement for permanent neurological deficit will be waived if the benign brain tumour is surgically removed or treated with stereotactic radiosurgery.*

*For the avoidance of doubt, tumours in the pituitary gland, angiomas, abnormalities seen on the brain without definite related clinical symptoms and neurological signs occurring without symptomatic abnormalities are specifically excluded from this definition.*

**Analysis**

This complaint revolves solely around the question of whether or not the illness suffered by the First-named Complainant falls within the definition of a benign brain tumour as defined in the Scheme such that would render the illness a "*Specified Illness*" entitling the First-named Complainant to the benefit of a lump sum payment.

The definition is as set out above however I note that the letters from the Company of the 5th of December 2013 and the 6th of October 2016 (declining the original claim and declining the appeal, respectively) for some reason do not reproduce the exact wording of the Scheme notwithstanding that the provisions are set out in italics as if in the form of a quotation. The aforementioned letters cite the following as the relevant definition:

***Benign Brain tumour:***

*A non-malignant tumour or cyst in the brain, cranial nerves or meninges within the skull, resulting in permanent neurological deficit with persisting clinical symptoms. The requirement for permanent neurological deficit will be waived if the benign brain tumour is surgically removed or treated with stereotactic radiosurgery.*

*Permanent neurological deficit with persisting clinical symptoms is defined as-*

*Symptoms of dysfunction in the nervous system that are present on clinical examination are expected to last throughout the insured person's life*

*Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulties in walking, lack coordination, tremor, seizures, dementia, delirium and coma.*

***The following are not covered:***

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*An abnormality seen on brain or other scans without definite related clinical symptoms*

*Neurological signs occurring without symptomatic abnormality e.g. brisk reflexes without other symptoms.*

I believe it was neither prudent nor helpful for the Company to provide a separate definition to that which existed in the Terms & Conditions. Further, it is not clear to me what the origins of the definition set out in the correspondence are.

I will consider this complaint in the context of the actual Terms & Conditions as provided in the policy.

Referring to the precise wording of the Scheme, in this case the First-named Complainant has clearly been diagnosed by a "*Consultant Neurosurgeon"* as suffering from a "*non-malignant tumour or cyst in the brain"* which diagnosis has been supported by an MRI scan. The question that requires to be addressed is whether the First-named Complainant's tumour has resulted in "*permanent neurological deficit with persisting clinical symptoms".* There is no question of the operation of the waiver which might otherwise have spared the First-named Complainant from the necessity to establish the suffering of a permanent neurological deficit as she has not, as of yet at any rate, undergone surgical removal of the tumour or treatment with stereotactic radiosurgery.

The Complainants have argued that this waiver should be extended nonetheless in circumstances where the First-named Complainant's doctors have advised that biopsies and surgery are not currently recommended. The terms of the Scheme provide for a specific set of circumstances which will attract the payment of the benefit. These are that the tumour results in a permanent neurological deficit or, if it does not, that the Scheme member is nonetheless required to undergo surgery or stereotactic treatment. I accept that, in the context of a contract for illness cover, the Company was entitled to exclude from the category of illnesses attracting cover brain tumours which do not result in permanent neurological deficit and which do not require surgery or stereotactic radiosurgery.

Accordingly, the determinative question for the purpose of this complaint is whether or not the First-named Complainant's brain tumour has resulted in *"permanent neurological deficit with persisting clinical symptoms".* The wording of the Scheme seeks to illustrate the meaning of "*permanent neurological deficit with persisting clinical symptoms"* by referring to *"symptoms of dysfunction in the nervous system that are present on clinical examination and are expected to last throughout the Insured Person's lifetime".* The Company, in its two letters referred to above, simply state that the Complainant "*does not have any neurological deficit with persisting clinical symptoms".* Unhelpfully, the Company does not address the various symptoms described by the Complainants in their various submissions.

The Complainants have provided medical evidence that the Complainant suffers regularly from headaches and from panic attacks. In respect of the headaches, the First-named Complainant's Consultant Neurosurgeon states in his letter of the 18th of October 2013 that

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he thinks that "*the headaches are not secondary to any increased intracranial pressure arising from her abnormality in her temporal lobe*". The Complainants have pointed to no other medical opinion which gainsays this proposition or qualifies it any way. Indeed, the First-named Complainant's General Practitioner expresses doubt as to whether the aetiology of the headaches is the tumour and suggests that they may be a manifestation of stress and anxiety, Furthermore, the medical report (12/12/2014) prepared on behalf of the Company by a specialist in occupational health records the author's opinion that she "*suspects that the headaches have a significant psychosomatic component relating to her underlying anxiety*".

The Consultant Neurosurgeon in a letter dated 18 October 2013 states:

> "*while she does have ongoing symptoms at present, including headaches, panic attacks and difficulty in concentration, I think the headaches are not secondary to any increased intracranial pressure arising from her abnormality in the temporal lobe although her report of panic attacks might be secondary to minor seizure activity related to the abnormality in her temporal lobe*".

The Complainant's GP in lengthy correspondence to the Provider on 14 November 2013 wrote the following:

> "*In the correspondence [Consultant Neurosurgeon] notes that [the Complainant] may be experiencing some seizure activity that may be manifesting as panic attacks and that perhaps prescription of anti convulsant medication may be beneficial.*

He goes on to state:

> "*[the Consultant Neurosurgeon] is of the opinion that some of the anxiety like symptoms that [the Complainant] complains of may be a manifestation of seizure activity and he has recommended that she be commenced on anti convulsant medication and further, the [Consultant Neurosurgeon] feels that she may be experiencing subtle seizure activity*".

He also states:

> "*I am concerned that there may also be cognitive issues as a consequence of the seizure activity*".

In this correspondence, the GP also informed the provider that he had referred the Complainant to a neurologist and a consultant psychiatrist.

The Provider's Chief Medical Officer's opinion of 5 December 2013 rejecting the claim; gives the reason for the refusal of the claim:

> "***Reason for Referral***
>
> *"See MRI Findings*

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*Does not appear to have PND*

*Definition met?"*

***CMO Opinion***

*"Currently does not meet the criteria for insurance claim.*

*However, she may well have a glioma, and if she undergoes surgery and this is confirmed, she could become eligible for compensation".*

The Provider's Chief Medical Officer's opinion dated 15 September 2016 rejecting the appeal states as follows:

***Reason for Referral***

*"The definition requires PND/surgery*

*See the letter from [Neurologist]"*

***CMO Opinion***

*The most recent letter from [Neurologist] again does not refer to any neurological deficit. She continues to have migrainous type headaches.*

*She does not meet the above definition at this time*".

It appears to me that it is the view of the Consultant Neurosurgeon that the First-named Complainant is suffering from minor seizure activity related to the abnormality in the temporal lobe giving rise to panic attacks. This, in my view, would meet the threshold of qualifying as 'permanent neurological deficit with persisting clinical symptoms'.

It would have been helpful were the Consultant Neurosurgeon to express a more certain view than that something "*might*" be the case. Equally, it would also be helpful for the expert to express a clear view as to whether the brain tumour has indeed given rise to a neurological deficit- a determination which is inherently clinical in nature.

That said, I find the manner in which the Provider has rejected the claim and appeal to be unreasonable.

The Provider has sought to rely on definitions that do not actually appear in the policy in communications with the Complainants.

Furthermore, I believe the Provider did not properly consider or respond to the medical reports submitted by the Complainant.

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The Provider, in its response to this Office, states:

> *"In essence the information provided did not show that [the Complainant] was suffering from a brain tumour which had given rise to a permanent neurological deficit or which required surgical removal*".

In that correspondence the Provider states that the Consultant Neurologist made no reference to any seizure activity.

I find it strange that neither the Chief Medical Officer's report or the response to this Office address the references to seizures contained in the Complainant's GP's correspondence and the Neurosurgeon's reports.

If the Provider does not accept the content of those reports I would have expected that they would either have sought further clarification from the Neurosurgeon or explained to the Complainant and this Office why it believed that "*seizure activity related to the abnormality in the temporal lobe*" referred to by the Neurosurgeon does not meet the definition of a permanent neurological deficit.

As I take the view that it does in fact meet the definition, I uphold this complaint and direct the Provider to admit and pay the claim. Further, I direct that the Provider should pay a sum of €3,000 in compensation in addition to the amount due to the Complainant in respect of the claim.

**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) (b) and (g).***

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 the claim and making a compensatory payment to the Complainant in the sum of €3,000 (in addition to the amount due to the Complainant in respect of 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.***

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**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**

13 November 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.**