An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0208
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Rejection of claim - pre-existing condition Failure to provide correct information
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant incepted an Income Assistance Policy with the Company on **1 October 2010**.

The Complainant's Case

The Complainant was admitted to the Bon Secours Hospital on **15 July 2016** overnight for a "*TRAPEZIECTOMY AND LIGAMENT INTERPOSITION ARTHROPLASTY"* on her left thumb and was certified as unfit for work from that date.

The Company, in its correspondence dated 30 August 2016, declined the Complainant's ensuing claim on the basis that the condition was pre-existing the policy and chronic in nature, *"We have noted that your doctor has confirmed that the condition was diagnosed on the 23/01/2007, which predate* (sic) *the inception of the policy. We also note that the doctor has confirmed it is a chronic condition"*.

When submitting this complaint to the FSO in **December 2016**, the Complainant stated that:

"this condition was first treated in January 2007 following an accident. After this I remained treatment and symptom free until 2013. My policy states that I am not entitled to benefit if I am unable to work due to accident or sickness which results form a Pre-existing Medical Condition. However such conditions may be covered after two years, as

long as, during that period you have remained free of treatment, advice or medication for that condition. Given that I remained treatment, symptom and medication free for the period from 2007 to 2013 (6 years) I have met this condition".

In addition, the Complainant also noted that:

"[the Company] *state that my condition is chronic osteoarthritis. This is incorrect and has been confirmed by the GP along with my treatment dates to be incorrect. The arthritis is solely confined to my thumb following an accident. I do not suffer from any arthritic condition in any other part of my body. For this reason the condition is not classed by my GP or consultant as chronic in nature"*.

In this regard, the Complainant's GP, Dr M.M., stated in her correspondence dated 30 August 2016, *"*[the Complainant] *was diagnosed with arthritis in her thumb in January 2007. She did not receive any treatment at the time and had no symptoms or treatment until 2013".*

In correspondence dated 27 April 2017, the Complainant's Financial Adviser submitted on behalf of the Complainant, as follows:

"The condition cannot be considered pre-existing as although the condition was diagnosed on 23/01/2007 there were no symptoms or treatment until 2013 following that initial diagnosis in January 2007. The policy terms and conditions state quite clearly that pre-existing conditions are covered where the claimant has been symptom free and treatment free for 24 months prior to the policy issue and where the claim has been symptom free and treatment free for 24 months preceding the claim date. As the policy has a start date of 1st October 2010 [the Complainant] *meets this condition. The GP letter of* [30]*.08.16 confirms that there were no treatment or symptoms between 2007 and 2013.*

The diagnosis of osteoarthritis is not a chronic condition and this has been confirmed by her doctor. It is confined solely to her left thumb and is the result of an accident. She does not suffer from any arthritic condition in any other part of her body and…has not been receiving ongoing treatment for this condition".

The Complainant's complaint is that the Company wrongly declined her Income Assistance claim and she has sought to have her claim admitted into payment.

The Company's Case

Company records indicate that the Complainant incepted an Income Assistance Policy with the Company on 1 October 2010. This policy provides cover against certain specified events. All of the insured events, along with any conditions, restrictions or exclusions that may apply, are set out in the policy wording. For a valid claim to arise, it must be shown that one of these specified events has resulted in the claim submitted and is not subject to any condition, restriction or exclusion that may apply to the policy.

/Cont'd…

The Complainant submitted an Accident and Sickness Claim to the Company in July 2016 wherein she confirmed that she had last worked on 14 July 2016 due to an *"arthritic condition"*. Her Employer advised in the Employer's Certificate section of the Claim Form that the Complainant was unfit to work as she was suffering with *"arthritis in thumb joint"*. The Complainant's GP, Dr M.M., advised as part of the Form she signed on 28 July 2016 that the Complainant had first consulted her with symptoms of *"Pain L hand + wrist"* on 18 January 2007, at which time the symptoms has been present *"some years - following previous accident"* and that the Complainant was diagnosed with *"well marked OA* [osteoarthritis]*"* on 23 January 2007.

Following its assessment, the Company declined the Complainant's claim by way of correspondence dated **30 August 2016**, as follows:

"We wish to advise that the policy does not extend to cover claims arising from pre-existing medical conditions, please see below for classification of pre-existing condition and also chronic condition –

*'**Pre-Existing Medical Condition***
A condition or related condition either:
(i) for which You received treatment in the 24 months up to and including the Commencement Date, or
(ii) which You were aware of, or in Our opinion You should have been aware of, during the 24 months up to and including the Commencement Date
Unless You have been symptom free and not consulted a Doctor or received treatment in the 24 months preceding the claim.

Chronic Condition
A condition which has symptoms that are constant or recur, or which requires long-term monitoring, treatment, consultations, check-ups, examinations or tests.'

Taking into consideration of the above terms of the policy, we wish to advise you of the following exclusions under the policy –

*'**When can you not claim for Accident of Sickness Benefit?***
We will not pay any Accident or Sickness benefits if Your Accident or Sickness results directly or indirectly from:

- *any Pre-Existing Medical Condition, unless You have been symptom free and not received treatment or advice for that condition for at least two years preceding a claim;*
- *any Chronic Condition which is existing or which You knew about at the Commencement Date, or of which You were exhibiting the symptoms whether specifically diagnosed or not or of which You were receiving medical treatment or advice during the 24 months preceding the Commencement Date'*

We have noted that your doctor has confirmed that the condition was diagnosed on the 23/01/2007, which predate (sic) *the inception of the policy. We also note that the doctor*

/Cont'd…

has confirmed it is a chronic condition and as such the above exclusions apply to your claim".

The Company thus declined the Complainant's claim as it had concluded that the medical condition giving rise to her submitting a claim was pre-existing as defined in her policy terms and conditions, as the medical information submitted confirmed that she had first consulted her GP in relation to the condition some 6 years previously, was diagnosed with osteoarthritis on 23 January 2007 and that the Complainant had been suffering *"ongoing pain"* for a *"few years"*. In the regard, the Company was satisfied that the Complainant's condition, that is, osteoarthritis, would be considered both pre-existing and chronic in nature, given that it was likely to recur and therefore any claim associated with same was excluded under the policy.

The Complainant was dissatisfied with this decision and forwarded correspondence from her GP, Dr M.M, dated 30 August 2016, wherein it was advised that *"*[the Complainant] *was diagnosed with arthritis in her thumb in January 2007. She did not receive any treatment at the time and had no symptoms or treatment until 2013"*.

The Company says that it conducted a thorough review and then advised the Complainant by way of correspondence dated 3 November 2016 that it was upholding its decision to decline her claim, as follows:

After conducting a thorough review of your case, we are not upholding your complaint and will explain below the reasons for this decision.

…

We note from your section completed in your claim form by your GP that you were first diagnosed with this condition on 23 January 2007 and that the symptoms have been present for 6 years and indeed that you have suffered "ongoing pain" for a "few years".

In this regard the condition would be considered both pre-existing and chronic in nature given that it is likely to recur and therefore any claim associated with same is excluded under the policy. On receipt of your complaint we referred the matter to Underwriters for their instructions and they are satisfied the correct decision was made".

At the time that it declined the Complainant's claim in the first instance in August 2016 and on review in November 2016, the Company employed a third party contractor in Ireland to assess these claims. Recently, in June 2018, having reviewed the communications issued to the Complainant during the assessment and review of her claim in 2016, the Company noted that the terms and conditions relating to both Chronic and Pre-existing Conditions quoted therein were <u>not</u> the terms and conditions that applied to the Complainant's claim.

In this regard, it appears that the contractors used a later version of the policy that applied only to agreements that had commenced after 26 November 2012. As the Complainant's cover commenced on 1 October 2010, the correct policy wording that the Complainant

/Cont'd…

ought to have been quoted when her claim was declined in 2016 should have been, as follows:

"We will not pay any Accident or Sickness benefits if Your Accident or Sickness results directly or indirectly from:

- *any Pre-Existing Medical Condition;*
- *any Chronic Condition which is existing or which You knew about at the Commencement Date, or of which You were exhibiting the symptoms whether specifically diagnosed or not or of which You were receiving medical treatment or advice during the 24 months preceding the Commencement Date"*.

The applicable policy provides the following definitions:

"Chronic Condition
A condition which has symptoms that are constant or recur, or which requires long-term monitoring, treatment, consultations, check-ups, examinations or tests.

Pre-Existing Medical Condition
A condition or related condition either:
(i) for which You received treatment in the 24 months up to and including the Commencement Date, or
(ii) which You were aware of, or in Our opinion You should have been aware of, during the 24 months up to and including the Commencement Date".

The Company noted that even though the incorrect terms and conditions were used when providing notification to the Complainant of the declinature of her claim in 2016, the decision to decline was nevertheless correct. This position is based upon the above noted terms and conditions and taking into consideration all the information in the claim file provided by the Complainant's GP, Dr M.M.

In this regard, the Company notes that the condition osteoarthritis of the carpometacarpal joint of the left thumb, as confirmed by the Complainant's GP, Dr M.M., was diagnosed on 23 January 2007. It is the Company position that osteoarthritis is a chronic condition as that term is defined in the policy conditions. According to the medical information available to it, the Company notes that a normal part of the progression of osteoarthritis is for it to remain pain free for some time, however this does not mean that the condition is not present throughout this period. Osteoarthritis is not a condition from which sufferers recover and reoccurrence and/or degeneration is inevitable.

The Company notes that the 24 month requalification period when symptom free is not applicable to the Complainant's claim, as it is not stated in the applicable policy terms and conditions, rather she was incorrectly advised of incorrect terms previously in 2016. In this regard, the use of incorrect terms and conditions means that the letter written by the Complainant's GP, Dr M.M., on 30 August 2016 wherein it was advised that *"*[the Complainant] *was diagnosed with arthritis in her thumb in January 2007. She did not receive any treatment at the time and had no symptoms or treatment until 2013"* was not

/Cont'd…

relevant to the declinature of the claim as the absence of consultations, was not relevant to the correct policy conditions and would not have affected the claim decision.

The Company is satisfied that its decision to decline the Complainant's claim was correct based on the terms and conditions of cover and the medical condition that is the subject of the claim. The use of incorrect terms and conditions in declining the Complainant's claim in 2016 was unfortunate, however this does not change the claims decision in this case.

Decision

During the investigation of this complaint by this Office, the Company was requested to supply its written response to the complaint and to supply all relevant documents and information. The Company responded in writing to the complaint and supplied a number of items in evidence. The Complainant was given the opportunity to see the Company'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 August 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 additional submissions from the parties, which principally related to level of compensation directed in the Preliminary Decision, the final determination of this office is set out below.

The complaint at hand is, in essence, that the Company wrongly or unfairly declined the Complainant's Income Assistance claim. In this regard, the Complainant incepted an Income Assistance Policy with the Company on 1 October 2010. She was admitted to the Bon Secours Hospital on 15 July 2016 overnight for a *"TRAPEZIECTOMY AND LIGAMENT INTERPOSITION ARTHROPLASTY"* on her left thumb and was certified as unfit for work from that date. The Company, however, in its correspondence dated 30 August 2016 declined the Complainant's ensuing claim on the basis that the condition was pre-existing and chronic in nature, *"We have noted that your doctor has confirmed that the condition*

/Cont'd…

was diagnosed on the 23/01/2007, which predate the inception of the policy. We also note that the doctor has confirmed it is a chronic condition".

Income Assistance policies, like all insurance policies, do not provide cover for every eventuality; rather the cover will be subject to the terms, conditions, endorsements and exclusions set out in the policy documentation and policyholders can always refer to such documentation for clarification in matters relating to their claims. In this regard, Section 3, 'Benefits and Exclusions', of the applicable Income Assistance Policy Document [SOVEPD 07/10] provides at pg. 6, as follows:

"We will not pay any Accident or Sickness benefits if Your Accident or Sickness results directly or indirectly from:

- *any Pre-Existing Medical Condition;*
- *any Chronic Condition which is existing or which You knew about at the Commencement Date, or of which You were exhibiting the symptoms whether specifically diagnosed or not or of which You were receiving medical treatment or advice during the 24 months preceding the Commencement Date"*.

In this regard, Section 9, 'Meaning of Words/Definitions', of this Policy Document provides at pgs. 9-10 the following relevant definitions:

*"**Chronic Condition***
A condition which has symptoms that are constant or recur, or which requires long-term monitoring, treatment, consultations, check-ups, examinations or tests.

Pre-Existing Medical Condition
A condition or related condition either:
(i) for which You received treatment in the 24 months up to and including the Commencement Date, or
(ii) which You were aware of, or in Our opinion You should have been aware of, during the 24 months up to and including the Commencement Date".

I note from the documentary evidence before me that the Complainant submitted an Accident and Sickness Claim to the Company in **July 2016** wherein she confirmed that she had last worked on 14 July 2016 due to an *"arthritic condition"*. Her Employer advised in the Employer's Certificate section of the Claim Form that the Complainant was unfit to work as she was suffering with *"arthritis in thumb joint".*

The Complainant's GP, Dr M.M., advised as part of the Form she signed on 28 July 2016 that the Complainant had first consulted her with symptoms of *"Pain L hand + wrist"* on 18 January 2007, at which time the symptoms has been present *"some years - following previous accident"* and that the Complainant was diagnosed with *"well marked OA* [osteoarthritis]*"* on 23 January 2007.

As the Complainant was diagnosed with *"well marked OA* [osteoarthritis]*"* on 23 January 2007, I am satisfied that it was reasonable for the Company to conclude that her condition

/Cont'd…

was a chronic condition *"existing or which You knew about at the Commencement Date"*, in this instance 1 October 2010, insofar as a chronic condition is defined in the terms and conditions of the Complainant's policy.

Similarly, as she was diagnosed with *"well marked OA* [osteoarthritis]*"* on 23 January 2007, I am also satisfied that it was reasonable for the Company to determine that the Complainant's condition was a pre-existing medical condition *"which You were aware of…during the 24 months up to and including the Commencement Date"*, in this instance 1 October 2010, insofar as a pre-existing medical condition is defined in her policy terms and conditions.

As a result, I am satisfied that the Company declined the Complainant's claim in accordance with the terms and conditions of her Income Assistance policy.
However, in June 2018, and further to the investigation by this office of the Complainant's complaint, the Company advised that it had reviewed the communications issued to the Complainant during the original assessment and review of her claim in 2016. At the time when it declined the Complainant's Income Assistance claim (in the first instance in August 2016, and again on review in November 2016) the Company noted that it employed a third party contractor in Ireland to assess these claims. The Company noted that the terms and conditions relating to both Chronic and Pre-existing Conditions quoted in its initial declinature letter to the Complainant dated 30 August 2016 and in its subsequent review letter dated 3 November 2016 were not the terms and conditions that applied to the Complainant's claim. In this regard, the Company has submitted that it appears that the contractors used a later version of the policy, which applied only to agreements that commenced after 26 November 2012, and which included a 24 month requalification period when symptom free. Had the correct policy been taken into account, it would have been clear that no such "*requalification period*" was relevant to the Complainant.

Administrative errors of this nature are unsatisfactory. The Complainant ought to be able to rely on the expertise of the Company with regard to information concerning her policy. In addition, administrative errors of this nature can cause considerable confusion and frustration, and indeed an expectation, as it has done in this instance, on the basis of an incorrect understanding of the position.

Indeed, it was the use of a later version of the policy wording that applied only to agreements that commenced after 26 November 2012 and which included a 24 month requalification period when symptom free, that led the Complainant in 2016 to appeal the Company's original decision to decline her claim. This was also why she pursued the matter further by way of a complaint to this Office as she considered that she satisfied this 24 month requalification period when symptom free, that it has only recently come to light does not in fact apply to her claim. It was in that context that the Complainant consented to the Company being given access to her historical medical records, when in fact it was not of any potential benefit to her to do so.

It is also unsatisfactory that in its correspondence to the Complainant dated 3 November 2016 the Company advised that:

/Cont'd…

"After conducting a thorough review of your case, we are not upholding your complaint"
[My emphasis]

At that point, notwithstanding its thorough review, once again the Company set out the incorrect policy terms and conditions relating to both Chronic and Pre-existing Conditions.

Whilst I accept that the Complainant was not financially disadvantaged by the Company's administrative error because I accept that the Company's decision to decline the Complainant's claim was correct and in accordance with the correct policy terms and conditions, I am satisfied that the use of the wrong policy wording both in its initial declinature letter to the Complainant dated 30 August 2016, and also in its subsequent review letter dated 3 November 2016 after its thorough review, constituted particularly poor customer service, which very considerably confused the situation and led to an incorrect expectation on the part of the Complainant. For that reason, I consider it appropriate to partially uphold the complaint.

To mark this significant error on the part of the Company, and the inconvenience and delay caused to the Complainant, I direct the Company to pay the Complainant a compensatory amount of €1,200, to an account of her choosing.

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially upheld on the grounds prescribed in ***Section 60(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 making a compensatory payment to the Complainant in the sum of **€1,200** 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.***

/Cont'd…

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

7 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.