An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0030
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Rejection of claim - did not meet policy definition of illness
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint arises out of a Serious Illness healthcare insurance policy and relates to the Provider's refusal to indemnify the Complainant under his policy.

The Complainant's Case

The Complainant holds a Serious Illness health insurance policy with the Provider.

The Complainant states that he took out the Serious Illness policy in 1997 so that he would be insured in the event of suffering any serious illness. He states that it was his understanding, and it was explained to him when he took out the policy in 1997 that if his illness was not directly named on the policy, that any claim would be partially covered by the Provider.

The Complainant states that he became ill in February 2016 after he collapsed and was diagnosed with having an irregular heart beat. He states that he is currently on medication and has to undergo a number or procedures.

The Provider has declined to provide cover for the treatment of this condition as it states that the illness being treated is not a specified Critical Event that is covered under the Serious Illness policy.

The Complainant makes this complaint on the basis that the Provider has wrongfully, unreasonably and through a mistake of law or fact refused to provide cover to the Complainant for the medical costs associated with treating his cardiac condition.

The Provider's Case

The Provider explains that under the Complainant's Serious Illness policy, the Serious Illness sum insured is only payable if it is a listed Serious Illness under Appendix B of the policy document. It states that the Complainant's cardiac condition is not one of the covered illnesses set out in the policy document and therefore the claim is not covered.

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 15 January 2019, 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.

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Following the issuing of my Preliminary Decision in this matter, the Complainant made a further submission (received by this Office on 4 February 2019), a copy of which was transmitted to the Provider for its consideration. The Provider made no further submission.

Following consideration of the Complainant's further submission and all of the evidence before me, I set out below my final determination.

The Complainant's relevant medical records have been provided. They demonstrate that on 27 February 2016, the Complainant was admitted to St James's Hospital after suffering a collapse. The admission record notes that he had been discovered collapsed on the street with no obvious injury. The notes also record that he had been apparently drunk and was admitted with a low Glasgow Coma Scale following alcohol consumption.

In addition, the Complainant was noted to be in atrial fibrillation on admission and complaining of palpitations and presyncopal episodes for the previous four or five months. He was reviewed by cardiology and had an echocardiogram which returned a normal result. A cardiology follow up was scheduled.

The Complainant submitted a Hospital Cash Claim form which is signed and dated 7 April 2016 by the Complainant. This claim specifies that the reason for which the Complainant was hospitalised was "atrial fibrillation". It specifies that he was admitted at 11 pm on 27 February 2016 and then discharged at 2 pm on 7 March 2016.

I note that the Provider has advised that it did pay the Hospital Cash Claim for this admission upon receipt of hospital records. In this regard, the Provider stated the following:-

> "Medical records were received from St. James's Hospital on 20/07/2016 and the claim was admitted and paid for Hospital Cash benefit for the amount of €1,976.00. The payment letter was issued on 21/07/2016".

It is further stated by the Provider:-

> "When we did receive the hospital records we paid the Hospital Cash Claim in full".

Arising out of the Complainant's hospital admission in February 2016, he was diagnosed with atrial fibrillation and has had to undergo a number of tests and procedures since then in relation to his cardiac problems. There is also the suggestion that he may have to undergo further procedures. The Complainant submits that treatment for his cardiac problem should be covered under the terms of the Serious Illness policy.

The Serious Illness policy document was supplied in evidence by the Provider. The Provider relies on the fact that the Complainant's condition is not a serious illness or *Critical Event* within the meaning of the terms and conditions of the policy.

The introduction part of the policy states:

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> "This is a Serious Illness policy. Its aim is the provision of a lump sum in the event of either a *Critical Event* or Death."

Section 7 of the policy deals with "Serious Illness Benefit". It states, amongst other things:

> "1. This section only applies if there is a serious illness sum insured shown in section 1, policy details.
>
> 2. On proof that a *Critical Event* has happened to a life insured who then survived for 14 days, [the Provider] will pay the serious illness sum insured, subject to the specific restrictions given in this section and the general terms and conditions of this policy."

Appendix A of the policy defines the term Critical Event as:

> "An illness, occurrence or event that [the Provider] covers for Serious Illness Benefit. Full details are given in Appendix B."

Appendix B of the policy sets out and deals with the definition of a Critical Event. It states, amongst other things:

> "CRITICAL EVENTS can result from a large number of different conditions or events. These are listed below giving a strict definition (in italics) together with some explanation and in some cases details of conditions or events [the Provider] will not pay for.
>
> It is important to appreciate that [the Provider] will pay the Serious Illness Sum Insured only in respect of conditions or events described below and not for others which may or may not be regarded as serious."

From a close examination of the conditions or events explicitly listed in Appendix B of the policy as conditions or events that will be covered, the only cardiac related conditions are as follows:

> "AORTIC GRAFT SURGERY – *the undergoing of surgery to correct any narrowing, dissection or aneurysm of the thoracic or abdominal aorta;*
>
> CORONARY ARTERY DISEASE REQUIRING SURGERY - *the undergoing of open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts on the advice of a cardiologist who has been appointed as a consultant physician.*
>
> CORONARY CATHETER TREATMENT INCLUDING ANGIOPLASTY – *the undergoing of any interventional technique and the advice of a cardiologist who has been appointed as a consultant physician which involves the use of transluminal coronary catheters. The procedure must be correct to at least*

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> *50% diameter narrowing of two or more coronary arteries. Angiographic evidence to support the necessity for the procedure will be required.*
>
> HEART ATTACK – *the death of a portion of the heart muscle as a result of inadequate blood supply. Diagnosis must be based on all of the following:*
>
> - *An episode of typical chest pain;*
> - *new electrocardiographic changes; and*
> - *elevation of cardiac enzymes.*
>
> HEART VALVE AND STRUCTURAL SURGERY – *the undergoing of open heart surgery, on the advice of a cardiologist who has been appointed as a consultant physician to correct valvular or structural abnormalities"*

It is the Complainant's own position that he has been diagnosed with an irregular heart rhythm and that he is currently on medication and undergoing intermittent hospital treatment with further procedures being planned into the future. The medical records submitted as part of this complaint support the fact that the Complainant has been diagnosed with an irregular heart rhythm and/or atrial fibrillation. From a review of the medical records therefore, it is evident that the Complainant has not been diagnosed with or is not suffering from the above listed cardiac related conditions nor does he require any of the above listed surgical interventions.

I note the Complainant asserts that when he took out the policy in 1997, he was told that if an illness was not directly defined as being covered by the policy, there would still be partial cover for that illness. These are assertions as to representations allegedly made over 20 years ago. Regarding the sale of the policy in 1997, the Provider has stated the following:-

> "[the Provider's] own Financial Planner sold the policy to the client in 1997 and the agency was transferred to [third party] in July 2003".

The time limits for making complaints are set out in ***section 51*** of the Financial Services and Pensions Ombudsman Act 2017.

Complaints made to this office in relation to any "*long-term financial service*" can be made outside of the 6 year timeframe but only subject to certain conditions. A "Death Benefit" is set out in Section Six of the policy and therefore, I accept, that the policy could be construed to be a "*long-term financial service*" because of the manner in which this term is defined by the legislation.

However unless there are circumstances in which it would be just and equitable to extend the period, any complaint made in relation to a *"long-term financial service*" is subject to an overall condition which requires that any conduct complained of must have occurred during or after 2002.

Further, I believe that the conversations that are said to have taken place occurred at "too remote a time to justify investigation as provided in ***Section 52(1)*** of the 2017 Act".

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Therefore, I will not make any determination in relation to that element of the complaint.

In light of all of the foregoing circumstances, where the Complainant's cardiac condition does not come within the ambit or the definition of a *Critical Event* as defined in Appendix B of the policy, I accept that the Provider was entitled, under the terms and conditions of the Policy, to decline the claim and accordingly I do not uphold the complaint.

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

26 February 2019

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.