An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0055
Sector:	Insurance
Product / Service:	Term Insurance
Conduct(s) complained of:	Rejection of claim – partial rejection
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint is made on behalf of the estate of a deceased person who purchased a mortgage related Life Assurance Policy ("the policy") with the Respondent Provider on 27 March 2008 and sadly passed away in **May 2015**. The estate of the deceased then sought the benefit provided for under the policy. The Provider expressed concern that the deceased had failed to disclose a material fact as regards her health - namely the deceased had attended a Consultant Psychiatrist for depression on 20 February 2005, 7 April 2005, 28 July 2005 and 8 September 2005, and was prescribed anti-depressants until January 2006 and from October 2011 – at the time of the inception of the policy. Specifically, the deceased answered in the negative to two medical questions relating to whether she had attended a specialist in any hospital or clinic for advice or treatment, and whether she ever suffered from, or had treatment for, mental illness.

The Provider insisted that had it been aware at the time of the application for the policy of the medical evidence supplied to it in January 2017, then a rating would have been applied to the deceased's plan, which would have meant either an increase in the premium or a proportionate decrease in the amount of cover offered.

Rather than decline the claim due to non-disclosure of material fact, as the Provider claimed it was entitled to do, the Provider applied the appropriate rating to the level of cover and paid a lower proportionate claim.

The Complainants' Case

The Complainants now seek the full benefit from the policy. It is their submission that in making a substantial reduction to the amount paid out on foot of the policy, the Provider did not adequately review the medical evidence, and incorrectly and inappropriately diagnosed the deceased as suffering from depression.

The Complainants maintain that, while the deceased did suffer from some anxiety and stress in relation to exams, and had sought help from her doctor, she did not have a diagnosis of depression, and that therefore she had not failed to disclose any material facts regarding her health.

The Complainants also submit that the product sold to the deceased was incorrect, as they say it is not clear from documentation (a) whether the deceased was offered any other similar type of product at the time, (b) why this particular life assurance policy was chosen or activated on her behalf, and (c) whether she was offered independent legal advice before completing the relevant documentation.

The Complainants further submit that the financial review and subsequent application process regarding the policy were carried out in a hurried manner, with a failure to emphasise the importance of answering all the medical questions posed. They also maintain that the Provider was not acting in compliance with requirement 5 of Chapter 5, and requirement 24 of Chapter 2 of the Consumer Protection Code 2006.

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The complaint is that the Provider has wrongly refused to meet the Complainants' claim in full and mis-sold the product to the deceased.

The Provider's Case

The Provider submits that its decision to decline to allow a full claim but to allow a lower proportionate claim was based on a comparison of the factual information it received from the deceased's GP in relation to her medical history and the responses to two key questions contained within the deceased's life cover application.

The deceased answered in "No" to the following two medical questions in the application form:

> *Question 6*
>
> *Within the past five years have you attended or been advised to attend a specialist at any hospital or clinic as an out-patient for advice, treatment, medical tests, investigations, surgical operations or follow up?*
>
> *Question 9*
>
> *Have you ever suffered from or had treatment for mental illness, alcohol abuse or drug addiction?*

The Provider submits that medical evidence provided by the deceased's general practitioner contradicted those negative answers, and clearly demonstrated that in the five years prior to the application for the policy, the deceased had attended a Consultant Psychiatrist for depression on 20 February 2005, 7 April 2005, 28 July 2005 and 8 September 2005 and was regularly prescribed anti-depressants between 2005 and 2007. The Provider is of the view that, having reviewed those records, it was apparent that the deceased had received medical treatment repeatedly for depression, and that this was medical information that should have been disclosed to it under the above questions.

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The Provider insists that had it been aware when it commenced the policy of the medical evidence later supplied by the deceased's General Practitioner (in January 2017), a rating would have been applied to the deceased's plan.

This would have meant either an increase in the premium or a proportionate decrease in the amount of cover offered. The Provider submits that had the deceased answered yes and had the underwriters become aware of the information before the cover commenced, they would not have been able to offer life and serious illness cover to the deceased at standard rates. They would have applied an increased payment charge in respect of the deceased's life and serious illness cover.

The Provider maintains that this constituted non-disclosure of material facts which, in line with Section 2 (2.1) of the Terms and Conditions of the policy, permitted the Provider to declare the cover in relation to the plan to be void. However, rather than void the cover completely due to non-disclosure of material fact, which the Provider submits it was entitled to do, the Provider applied the appropriate rating to the level of cover and paid a lower proportionate claim, and effectively put the deceased's estate in the position it would have been had the information regarding the medical history been disclosed.

The Provider therefore paid the revised benefit payable, taking into account the medical history, which was a sum of €75,598.00. A cheque for that amount, plus a payment refund of €302.16 was issued in January 2017 to the Complainants.

In relation to requirements 5 and 8 of the Consumer Protection Code 2006, the Provider points to the following excerpts from various documents where the explanation to her of the consequence of failure to make full disclosure on the proposal form of her medical details or history was put before her:

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Declaration to the Provider in the Customer Application Booklet:

I have read and understand the note concerning my obligation to tell [the Provider] about all material facts in connection with the application [Online application process and telling the Provider about material facts] in the booklet and understand that if I do not tell [the Provider] all material facts, this cover could be void.

I declare that all statements recorded in answers to the questions in my online application form as well as those about tobacco consumption (including any statements written down by me) are true and complete. I understand that I will receive a copy of the online application form questions and any answers for my own records.

1. **Application Record (5 March 2008) from Page 4 Important Points**:

Please remember that you must tell us everything relevant when answering all of the questions on the application form. If you do not, or if any of the answers to these questions are not true and complete, we could treat the plan as void. If this happens there will be no cover under the plan and we will not refund the payments. In these circumstances we will not pay a claim. A material fact (relevant information) includes anything that a reputable insurer would treat as likely to influence the assessment and acceptance of an application for insurance. If you are not sure whether something is relevant, you should tell us anyway. As this is an automated process we can only regard information recorded on the system as having been disclosed. Any acceptance terms are invalid if hand written information is subsequently added. We will rely on what you tell us and you must not assume that we will automatically clarify or confirm any information you provide. You can provide any highly confidential information directly to [the Provider's] Chief Medical Officer in a sealed envelope…"

2. **Welcome Pack (27 March 2008) in the Introductory Letter**:

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Our decision to accept you for cover is based on the information you provided in either your paper or online application form. It is important that you take note of the following:

It is important that you have told us all relevant information that is likely to influence the assessment and acceptance of your application.

You must carefully review your answers to the health questions to make sure they are correct.

If any recorded details are incorrect or if there has been a change in the health of the life covered between the date you applied for cover and now, you must let us know immediately.

We have noted in out records that [the deceased] is a non-smoker.

*If any of the information is not correct or we have not received all relevant information, we may end your cover and refuse to pay a claim. If this happens you will lose all rights under the plan and we will not refund your payments. Therefore if your details are incorrect or you feel there is further information we should be aware of, please do not hesitate to contact our Customer Service Team immediately on *******.*

As long as all information is correct and we have received all relevant information, cover will begin from the start date of the plan.

3. **Welcome Pack (27 March 2008) in the Customer Information Notice**:

We may terminate your cover and refuse to pay a claim if you did not give us information (or if you gave us incorrect information) regarding an illness or condition that would affect our assessment of your application at the time you completed the

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application for this plan. A summary of the medical information you have given us is enclosed. Our decision to accept you for cover is based on this information.

If that information is not true and complete or if we have not received all relevant information, we may end your cover and refuse to pay any claim.

If this happens you will lose all rights under the plan and we will not refund your payments. Relevant information includes anything that a reputable insurer might regard as likely to influence the assessment and acceptance of your application. We will provide a photocopy of your application form or any other forms that you have filled in for us if you ask.

4. Terms and Conditions – Section 2 Basis of Cover

We have agreed to provide cover to the proposer, on your life, under the master plan on the understanding that the information given by you in the application form and any related document is true and complete and that we have been given all relevant information. If this is not the case, we will be entitled to declare cover in relation to you under the master plan void. If this happens, the proposer will lose all rights under the master plan in relation to you, we will not pay any claim and we will not return any payments. Information is 'relevant' if it might influence the judgement of a reputable insurer when fixing the payment or level of benefits or when deciding to provide cover at all.

The Provider states that the underwriting process was completed and all relevant information was received by 27 March 2008, with the deceased receiving them the following day.

Regarding the Complainants' contention that the product was mis-sold to the deceased, the Provider submits that the representative who sold the policy to the deceased confirmed that

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it was his process to explain the product to the customer, and that the onus is always on the customer to ensure that they read the application form and understand the questions which are being asked before signing it.

Therefore, the Provider submits that it is fair to assume that if the deceased did not understand the questions, she could have asked the representative at the time in order to clarify any matter. The Provider found no evidence of the deceased making contact following her review, and submits that it is therefore fair to assume that the deceased was happy with her plan and with the Financial Review which was carried out at the time.

In relation to the requirements 24, 30 and 31 of Chapter 2 of the Consumer Protection Code 2006, the Provider rejects the Complainants' submission that the product sold to the deceased was incorrect. The Complainants have stated that it is not clear from documentation (a) whether the deceased was offered any other similar type of product at the time, (b) why this particular life assurance policy was chosen or activated on her behalf, and (c) whether she was offered independent legal advice before completing the relevant documentation.

The Provider maintains that following an application for a mortgage with [a bank], which is a tied agent of the Provider for life assurance, the deceased was invited to meet with a representative of the Provider ("the representative") to discuss the mortgage protection cover. The Provider notes that that representative is a fully qualified QFA. The Provider maintains that as it only had one mortgage protection product on offer at the time, there would have been no comparison with other types of product, and so the decision to accept the offer of the policy would have been largely based on a competitive quote for the cover needed. The Provider submits that there was no obligation on the deceased to accept the Provider's representative's recommendation and she was free to apply for mortgage protection with any other provider, but she would have been obliged to assign any plan taken out with another provider to [the bank].

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The Provider maintains that on the basis that the deceased was not interested in any other form of life assurance cover, pension, investment or savings products, and that it was her sole intention to make an application for mortgage protection cover, the Provider's only mortgage protection cover was deemed the most suitable product on offer to meet her needs.

The Provider insists that the representative would have conducted the financial review with the deceased in a professional manner and after stressing the importance of answering all the medical questions truthfully, he would have given her every opportunity to disclose all relevant medical and material information during the application process.

The Provider insists that its representative would not direct any customer to sign any declarations contained in its application forms prior to the customer being brought through the full content of the application and completing all the relevant questions. It is clear from the fact that the Provider's representative recorded the medication the deceased was on for her asthmatic condition that the deceased had the ability and opportunity to engage with each of the medical questions.

The Provider submits that the deceased was afforded multiple opportunities to review both the questions and her answers provided during the application process. Indeed, following her meeting with the Provider's representative, a report containing the full details of the information collected during the application process was posted to the deceased on 27 March 2008.

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.

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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 parties 14 February 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.

Following the issuing of my Preliminary Decision, the Complainants' Representative e-mailed this Office on 27 February 2019 pointing out two errors in the Preliminary Decision in relation to the Date of Death of the deceased and the medication which she was prescribed. I have corrected these in this Decision.

I now set out below my final determination.

In considering the issues which arise, it is useful to set out the terms of the policy relied upon by the Provider as well as the relevant passages from the deceased's proposal for cover:

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Policy Terms and Conditions

The policy document provides as follows:

Basis of cover

Section 2

2.1

We have agreed to provide cover to the proposer, on your life, under the master plan on the understanding that the information given by you in the application form and any related document is true and complete and that we have been given all relevant information. If this is not the case, we will be entitled to declare cover in relation to you under the master plan void. If this happens, the proposer will lose all rights under the master plan in relation to you, we will not pay any claim and we will not return any payments. Information is 'relevant' if it might influence the judgement of a reputable insurer when fixing the payment or level of benefits or when deciding whether to provide cover at all.

Application for Cover

The deceased answered "No" to the following two medical questions in the application form:

Question 6

Within the past five years have you attended or been advised to attend a specialist at any hospital or clinic as an out-patient for advice, treatment, medical tests, investigations, surgical operations or follow up?

Question 9

Have you ever suffered from or had treatment for mental illness, alcohol abuse or drug addiction?

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The application form also set out as follows:

> *Important Notes – telling [the Provider] about material facts*
>
> *Please remember that you must tell us everything relevant when answering all of the questions on the application form. If you do not, or if any of the answers to these questions are not true and complete, we could treat the plan as void. If this happens there will be no cover under the plan and we will not refund the payments. In these circumstances we will not pay a claim. A material fact (relevant information) includes anything that a reputable insurer would treat as likely to influence the assessment and acceptance of an application for insurance. As this is an automated process we can only regard information recorded on the system as having been disclosed. Any acceptance terms are invalid if hand written information is subsequently added. We will rely on what you tell us and you must not assume that we will automatically clarify or confirm any information you provide.*
>
> *You can provide any highly confidential information directly to [the Provider's] Chief Medical Officer in a sealed envelope…"*

Proposal Documents

Having completed the application form, the Provider issued the deceased with a document summarising her application. This document contained the following:

> *Our decision on whether to accept your application, and if so on what terms, is based on the information you provided in answer to the questions asked in the online application form.*
>
> *Therefore, please carefully review your answers to ensure that they are true and complete. I would again draw your attention to the note on Material Facts.*

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Analysis

The Provider has sought to rely on the deceased's material non-disclosure as the basis for not admitting the claim in its entirety. I accept, on the basis of the terms and conditions set out in the policy document and on the basis of the various warnings included in the application procedures, that this is a course of action that was open to the Provider if it established that there was a non-disclosure of a material fact.

It is common case in this dispute that the deceased did not disclose any detail of her depression, stress or anxiety. In addition to noting the deceased had attended a Consultant Psychiatrist for depression on 20 February 2005, 7 April 2005, 28 July 2005 and 8 September 2005, and was regularly prescribed anti-depressants between 2005 and 2007, the GP records document as follows:

> *27/01/2005 Depression – cut wrists in college…introverted.. not sleeping, moody – Zimovane 7.5mg one nocte. Lexapro 10mg one daily*

The Complainants maintain nonetheless that the deceased was under no obligation to disclose any such detail as she did not in fact have a diagnosis of depression. However I do not find this to be the case. Question 9 on the application form reproduced above clearly enquires whether the proposer ever suffered from or had treatment for mental illness, alcohol abuse or drug addiction. Quite apart from any of her own convictions as to her state of health that the deceased may have had, it is clear that the deceased was prescribed medication for depression (Lexapro) which she appears to have taken regularly. I must accept that this unequivocally amounts to treatment for depression during the period outlined and would have required a "Yes" answer to Question 9.

A material fact is one which would influence a reasonable Provider if disclosed. The policy document refers to this when it states that "*a material fact (relevant information) includes anything that a reputable insurer would treat as likely to influence the assessment and acceptance of an application for insurance*." The fact that the deceased had attended a Consultant Psychiatrist for depression on 20 February 2005, 7 April 2005, 28 July 2005 and

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8 September 2005 and was prescribed anti-depressant treatment between 2005 and 2007 would quite reasonably have had an influence on the Provider in terms of the premium level payable or in the amount of cover offered. This would have been the case, regardless of the deceased's beliefs as to her own health.

I do not have any difficulty in accepting that the deceased genuinely believed that she did not have depression and that she simply had anxiety or stress. I am of the view, however, that the obligation to disclose this existed nonetheless, notwithstanding any such beliefs that she may have held.

In coming to this conclusion, I am mindful of the decision in *Chariot Inns Ltd v Assizurazioni Generali spa* [1981] IR 199, wherein the Supreme Court stated that the test for materiality is as follows:-

> *"a matter or circumstances which would reasonably influence the judgment of a prudent insurer in deciding whether he would take the risk, and if so, in determining the premium which he would demand. The standard by which materiality is to be determined is objective and not subjective."*

I have also had regard to the High Court decision of *Earls v The Financial Services Ombudsman & Anor.* [2015] IEHC 536, where the High Court carried out a detailed analysis of previous case law on non-disclosure and the principles to be applied. From this decision it is clear that this Office should not proceed on the basis that if a material fact was not disclosed then, by that very fact, there has been a breach of the duty of disclosure.

Rather, in the Court's opinion, this may not always be the case, as the duty arising for an insured in this regard is to exercise a genuine effort to achieve accuracy using all reasonably available sources, so that for example if the form of questions asked in a proposal form might limit the duty of disclosure arising, such an issue would require consideration.

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Furthermore, that High Court decision pointed to the fact that materiality falls to be gauged by reference to the hypothetical prudent proposer for insurance. The Court held that the arbiter must also give consideration to what a reasonable insured would think relevant and relevance in this particular context is not determined by reference to an insurer alone.

In this instance, I must accept that a hypothetical prudent proposer for insurance, with the deceased's medical history, would not have answered "No" in relation to suffering from, or treated for, mental illness to Question 9 on the proposal form.

In light of my conclusion that the deceased failed, for whatever reason, to disclose a material fact, I accept that the Provider would have been entitled to void the policy in its entirety as per the terms and conditions of the policy.

In that event, no benefit whatsoever would have been paid. Instead, the Provider opted to make a reduced payment in applying the proportionate rating to the level of cover and paying a lower proportionate claim, effectively putting the deceased's estate in the position it would have been had the information regarding the medical history been disclosed. The Provider therefore paid the revised benefit payable, taking into account the medical history, which was a sum of €75,598.00.

The Complainants also submit that the product was mis-sold to the deceased, as they say it is not clear from documentation (a) whether the deceased was offered any other similar type of product at the time, (b) why this particular life assurance policy was chosen or activated on her behalf, and (c) whether she was offered independent legal advice before completing the relevant documentation.

The evidence supplied to this Office indicates that the Provider conducted a review with the deceased. Following this review, a proposal was put to the Complainant for mortgage protection cover. It would appear that mortgage cover was what the deceased had sought and requested.

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Accordingly, I have been provided with no evidence to support the contention that the policy was mis-sold to the deceased. Furthermore, it is of note that although the full benefit has not been paid on foot of the policy, a sum of €75,900 has been paid.

I accept that the Provider's action in paying a proportionate benefit is reasonable in the circumstances.

In light of the entirety of the foregoing, and in the absence of evidence of wrongdoing by the Provider or conduct within the terms of Section 60(2) of the Financial Services and Pensions Ombudsman Act 2017 that could ground a Decision in favour of the Complainants, I do not uphold this 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

28 March 2019

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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.