An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0088
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Rejection of claim - fit to return to work
Outcome:	Upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This is a complaint about the cessation of the payment of benefit under a Personal Income Protection Plan to the Complainant as the policyholder, by the Provider. The policy commenced in 25 September 2008.

The Complainant was employed as a Project/Finance Administrator with her employer, working 35 hours per week.

The Complainant described her job as "Accounts and payroll for the company, project administrator. Getting quotes for new equipment/pricing for maintenance of the building, changing suppliers, managing stocks etc".

The Provider has accepted that the Complainant's medical condition, asthenopia, prevented her from carrying out her full time occupation, and it duly paid a partial benefit.

In 2015 the Provider ceased paying the incapacity benefit on the basis that due to the amount being received by the Complainant from her employer there was no financial

liability and that its appointed Specialists had deemed the Complainant fit to return to full time work.

The complaint is that the Provider incorrectly and unreasonably ceased the partial incapacity benefit.

The Complainant's Case

The Complainant suffers from asthenopia and says that this gives rise to eyestrain and severe headaches. The Complainant states that as a result she can only work five half days per week. The Complainant submits that almost all her work is carried out on a computer. The Complainant says that prior to this condition she worked full time for over 30 years.

The Complainant attends a Pain Management Consultant on an ongoing basis and receive Lignocaine and Ketamine infusions for pain relief.

The Complainant states that as a result of working only ½ days her wages are restricted. The Complainant submits that as a result of the refusal of payment by the Provider she is now receiving Family Income Supplement (FIS) of €143 per week and that this leaves a shortfall of €123.71 per week. Prior to the refusal of payment of income protection the Complainant had been receiving FIS amounting to €50 per week. The Complainant seeks the re-instatement of payment of the income protection.

The Provider's Case

The Provider explains that the Complainant took out a Personal Income Protection Plan with the Provider on 25 September 2008. Under the terms of the policy, incapacity is defined as follows:

> *"Incapacity means that you are totally unable to carry out the main duties of your normal occupation as shown in the application form. You must also not be following any other occupation. This incapacity must arise as a result of illness or injury and must be confirmed by our Chief Medical Officer. Your main duties are those you normally need to carry out in your job and which you cannot reasonably leave out or alter".*

The Provider states that the Complainant completed her income protection claim form on 6 December 2012, advising that she was suffering from "Headache — across forehead pain, severe eye strain, concentration difficult when in pain". The Complainant's GP completed

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the Medical Certificate on 3 December 2012 which stated that the nature of the Complainant's disability was "Asthenopia".

The Provider states that the Complainant also confirmed that due to her medical condition she reduced her normal working week from 35 hours to 20 hours and the Provider agreed to consider a proportionate claim on her behalf.

The Provider says that it assessed the claim in the normal manner and on 9 July 2013, it wrote to the Complainant confirming it was happy to admit her claim.

The Provider states that Income Protection claims are assessed from both a medical and financial perspective and for a claim to be paid a person must satisfy the definition of disability and suffer a loss of income.

The Provider submits that when it admitted the claim, it pointed out to the Complainant that Section 4.6 of her policy states that if she goes back to work at reduced earnings it may pay a partial benefit which would be calculated by reducing the insured benefit by the amount of her current earnings.

The Provider states that the exact quote from the Policy Document states that:

"If, after a period of incapacity for which we pay incapacity benefit, you go back to your normal occupation in a limited capacity at reduced earnings or take up another occupation at reduced earnings, we may pay part of the benefit. This depends on the conditions that:

- *You remain totally unable to carry out the main duties of your normal occupation in the opinion of our chief medical officer; and*

- *We agree beforehand".*

In these circumstances, we will reduce the incapacity benefit by any earnings you receive from your new occupation. All the normal plan terms and conditions apply to this benefit."

The Provider states that in the Complainant's case, the insured benefit was €16,590, but the earnings she was continuing to receive were €19,905.60. The Provider states that there was therefore never any financial liability on this claim for the Provider.

The Provider submits however, that at the time it agreed to use a more favourable proportionate benefit formula which would provide the Complainant with a partial benefit of €7,727.00. The Provider states that this decision was made in an effort to support the Complainant's attempt to remain in work and taking the medical evidence into account which predicted she should be able to resume her full time duties in the not too distant future. The Provider says that the Complainant had also indicated on her claim form she was hoping to resume fulltime work within six months.

The Provider explains that all Income Protection claim are subject to ongoing reviews to ensure that the claimant continues to meet the definition of disablement as required by the

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policy. As part of a review of the Complainant's claim, the Provider arranged for the Complainant to attend for a Medical Examination with a Specialist in Occupational Health, on 21 July 2015.

The Provider states that in her report, the Specialist in Occupational Health, advised:

"In my opinion [the Complainant] is fit to return to full normal work duties. I am at a loss as to why she can tolerate part time hours, but claims to be incapable of full time hours."

The Specialist in Occupational Health, goes on to state:

> *"When assessing fitness for work the issues to consider are safety, capacity and tolerance. There is no objective medical evidence to indicate that it would be unsafe for [the Complainant] to increase to normal working hours or that she lacks the physical or mental capacity to do so. The only basis to her claim that she is unfit for full time work is her own subjective reports of intolerance of normal working hours. "*

The Specialist in Occupational Health, finishes by stating:

> *"In my opinion [the Complainant] does not meet the definition of Disability as required under this policy. I am not satisfied that she is disabled or unable by reason of illness to carry out the duties of her normal occupation. "*

The Provider states that it was therefore its opinion based on the medical evidence received that the Complainant was fit to carry out her normal occupation on a full time basis and no longer met the definition of disablement under the policy. The Provider says that at the time it also reviewed the financial concession which was no longer relevant as the Complainant was found not to be incapacitated as per the policy definition.

The Provider states that it wrote to the Complainant on 20 August 2015 to confirm its decision from both a medical and financial perspective. The Provider says it also explained that payments on the claim would continue to the 1 November 2015 in order to allow sufficient time for arrangements to be made for the Complainant to full time return to work, and outlined the appeals process.

On 23 September, the Complainant submitted a letter from her Specialist (Consultant Anaesthetist & Specialist in Pain Medicine) and a copy of an Admission Form by way of appealing the decision on her claim.

The Provider wrote to the Complainant on 13 October 2015 confirming that, having reviewed the evidence submitted, it remained its opinion that there was no objective medical evidence provided in support of her appeal and the Provider was therefore unable

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to alter its decision. The Provider also informed that its decision to cease the claim was based on both financial and medical reviews which had been completed.

On 30 October the Complainant wrote to the Provider confirming she did not accept the decision on her claim and wished to further appeal. The Complainant enclosed a report from Dr DH dated 27 October 2015 in support of her appeal.

The Provider states that taking the content of this report into account and in order to fully consider the Complainant's appeal, it arranged for the Complainant to attend a further independent medical examination with Dr S, an Occupational Physician/Therapist, on 11 December 2015. In his report, Dr S advised:

"Objectively there is no medical contra-indication for a resumption of 35 hr week'.

The Provider submits that it was therefore its opinion, based on all the medical evidence received, that the Complainant was not currently totally disabled from following her normal occupation, as required by the policy, and she was fit to return to work on a full time basis.

The Provider says however, before making its final decision, it requested copies of the Complainants 2013 and 2014 P60s. The Provider states that the P60's confirmed that her part time earnings had increased while she had been on claim and exceeded the €19,905 which it had been using as the basis for paying the Complainant a partial claim.

The Provider's position is that having considered the matter fully it is no longer in a position to make a financial concession on the Complainant's claim. The Provider says that regardless of that past concession, two Independent Medical Examiners have confirmed that the Complainant is fit to carry out her pre-disability occupation so there is no liability from both a medical or financial aspect.

The Provider states that it notes the medical issues described by the Complainant and that she wants the Provider to make up some of her short fall in earnings by paying an income protection claim. The Provider's response is that taking the policy definition on incapacity benefit if someone is working part-time it is clear there is no actual benefit payable under the claim due to the Complainant's level of earnings. The Provider says that in addition, the medical evidence also does not support payment of a claim and it is for these two reasons it states that it is unable to alter its decision.

The Provider states that throughout the Complainant has advised she is unfit for her fulltime role, and says it is unclear whether any attempts were made to work beyond her part time duties since the claim commenced. The Provider says that it notes from a letter submitted by the Complainant's employer (undated, but received 10/02/2015) that the role itself is now 20 hours per week and not the 35 it used to be. The Provider submits that if the role no longer requires 35 hours per week, this is a valid reason why the Complainant may not have attempted any increase, but it is not something that income protection is designed to

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cover. The Provider states that it remains satisfied with its original decision to cease the claim on both financial and medical grounds.

The Provider informs that when a person satisfies the definition of incapacity, the policy allows for a partial benefit in certain circumstances when they go back to work at reduced earnings and/or hours.

In the Complainant's case, the insured benefit was €16,590 but the earnings she was continuing to receive were €19,905.60. The Provider says there is therefore no financial liability under the claim.

Incapacity is defined as:

> *"Incapacity means that you are totally unable to carry out the main duties of your normal occupation as shown in the application form. You must also not be following any other occupation. This incapacity must arise as a result of illness or injury and must be confirmed by our Chief Medical Officer. Your main duties are those you normally need to carry out in your job and which you cannot reasonably leave out or alter".*

The Provider states that two medical assessments found the Complainant fit to resume her fulltime work and the Provider is satisfied the weight of medical evidence available supports its view she no longer meets the definition.

The Provider submits that while it did make a concession on the financial aspect for a limited time due to the evidence showing that this should be a short term claim, it would also like to point out it made an additional concession in that the Complainant did not actually ever meet the incapacity benefit in that the Provider allowed her to serve a deferred period while remaining on at part time work. Usually a person would be out of work completely while serving a deferred period but the Provider did not use this as a reason not to consider her claim at the time.

The Provider says that as explained above it is clear from the terms and conditions that it does not have any financial liability on the claim in view of the Complainant's ongoing earnings from her employer being too high compared to her insured benefit. The Provider says that up until the point the claim was stopped the Provider had been paying a benefit as a concession which amounted to €7,272 per annum. The Provider says this concession has been withdrawn due to the change in circumstances of being found fit, and also not increasing her hours previously as expected. The Provider believes there is therefore no ongoing claim benefit to information to provide.

The Provider says the claim was paid under concession from 3 February 2013 up to 1 November 2015.

The Complainant confirmed that she ceased work on the 2 November 2012, but returned to work at reduced hours from 5 November 2012, doing 20 hours per week. The deferred period under the scheme is 13 weeks so the end of the deferred period was the 2 February

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2013. The Complainant did not actually serve a deferred period as such due to the fact she was actually working reduced hours. However, as a concession the Provider allowed her to continue working in a reduced capacity and serve a deferred period at the same time.

Submissions from the parties after receipt of the Provider's response to this Office in relation to the complaint:

The Complainant's response to the Provider's submission of 6th August 2017

The Complainant highlights some additional points for consideration.

The Complainant states that from the beginning of the claims process the condition from which she suffers was highlighted as being eye related and that:

(a) In her income protection claim form of December 2012, she described the condition from which she was suffering as "severe eye strain".
(b) her G.P., on completing the associated Medical Certificate, confirmed that the exact nature and cause of disability was "Asthenopia – poor convergence".

The Complainant states that from the time she developed her medical condition, independently she has pursued numerous consultations and treatments, both medical & alternative, in an effort to find a solution for the condition. The Complainant states that the following were shared with the Provider on the 7/5/2013.

- That she has been attending her GP on an ongoing basis regarding this issue since 2009.
- Her Optician arranged a referral to an Orthoptist in 2010
- February to August 2010 she attended the Orthoptist on 6 occasions
- October 2010 she attended Dr F, Consultant Opthalmic Surgeon
- February to December 2011 she attended an Acupuncture & Traditional Chinese Medicine Clinic on 10 occasions
- August 2012 she attended an Opthalmic Surgeon and Neuro-Opthalmologist.
- October / November 2012 she had Physical and Biomedical Therapy on 6 occasions.
- November 2012 – March 2013 she attended a Consultant Anaesthetist and Specialist in Pain Medicine.
- She continues to see the Consultant Anaesthetist and Specialist in Pain Medicine for pain relief infusions on a regular basis.
- April 13 originally and on subsequent occasions she attended a Consultant Neurologist.

In addition to the above the Complainant states she has also attended her Optician on several occasions and the following:-

- April 2016 she attended a Consultant Ophthalmic Surgeon

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- February 2017 she attended National Optometry centre in Dublin (Binocular Vision Clinic).
- July 2017 – attended her Orthoptist as referred by GP.

The Complainant states that at an early stage a dual approach emerged for managing her condition comprising of reduced work hours and ongoing pain management.

In August 2012 Dr. L Ophthalmic Surgeon and Neuro-Ophthalmologist suggested that

a) her work hours be reduced:-

In the above regard the Complainant states that she approached her employer with a letter from Dr. L with a view to reducing her work hours. The Complainant says her Employer agreed in August 2012 to allow the Complainant work part time for a trial period of 6 months commencing in November 2012. The Complainant states that this necessitated the Employer employing an additional staff member to cover the balance of the hours relating to her position for the period involved.

The Complainant states that this temporary person was tasked with the more intense/detailed computer aspects of her role thereby minimising the Complainant's exposure to this work which adversely affects her condition. The Complaint states that during this period she worked on tasks which were less demanding on her eyes. The Complainant state however, that she maintained overall responsibility for the position.

The Complainant submits that at the latter end of the trial period she was approached by her Employer as to whether she could resume her full time position. The Complainant states that she decided, based on the success of the trial from her personal perspective to continue with the part time position and this remains in place. The Complainant states that this decision was not made lightly due to the fact that it impacted on her income and in having to give up her full time position. The Complainant states that her colleague continues to fulfil the remaining part time hours of the original full time position.

The Complainant says that on 19th November 2014 her Consultant Anaesthetist & Pain Specialist in Pain Medicine confirmed to the Provider's Chief Medical Officer that: *"I do not ever envision [the Complainant] returning to full working hours as a financial administrator."* The Complainant states that on 27 October 2015 her Consultant Anaesthetist & Pain Specialist in Pain Medicine re-confirmed that she was not in a position to return to a 35 hour week when he stated: "I have advised [the Complainant] that she is not in a position to return to full working hours as a financial administrator due to her pain."

In addition Dr. T stated that the Complainant was in her opinion currently not fit to return to my normal full time hours, 35 hrs per weeks as project/finance administrator.

(b) attend a pain management specialist

The Complainant submits that her Consultant Anaesthetist and Specialist in Pain Medicine is overseeing the management of her pain since November 2012 to date.

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The Complainant states that following the trial of various pain medications, it was decided to pursue the IV Lignocaine Infusion route solely. The Complainant says this involves attending as a day patient on a 3 to 4 monthly basis.

The Complainant says that having reviewed in detail the documentation as submitted by the Provider, she points out the following:-

As regards the Provider's positon that: "while we did make a concession on the financial aspect for a limited time due to the evidence showing that this should be a short term claim", the Complainant states:

"As it has transpired my condition is deemed to be ongoing, as outlined above.

If the claim was deemed valid on a short term basis then surely it should be reasonable to assume that it would be valid for a long term scenario.

The Complainant acknowledges, that in the early stage of the claims process she had indicated a wish to return to full time employment. She says however, it transpired that this was not possible for the reasons as outlined.

The Complainant submits that in her opinion despite the fact that her medical evidence, submitted right from the beginning clearly indicated the condition as being Asthenopia i.e. Eye strain due to poor convergence, the Medical assessments that she attended at the Provider's request, did not focus sufficiently on this. She says for example:- she attended Dr. S at the request of the Provider on 11/12/15. The Complainant refers to the confidential medical report dated 12/12/15, where under13.0 - Opinion, he states as follows: "[The Complainant] is working as an Administrator and she was referred for an independent medical assessment of her fitness to return to her usual hours of 35hr weekly".

The Complainant states that this referral by the Provider missed an opportunity to have her condition examined in detail on their behalf, with a view to substantiating her claim. The Complainant says that all that was examined in relation to her eyes at this assessment as listed in 10.0 of his report was: "pupils equal and reactive to light. Vision – near unaided N5 & distance aided 6/6. CVS / Resp: normal."

The Complainant says that there was a failure on behalf of either the Provider to inform Dr. S of the Asthenopia condition from which she is suffering or for him to take consideration of this condition based on the medical reports supplied by the Provider to him.

The Complainant states that this in her opinion resulted in an inaccurate assessment of her condition. The Complainant says that this condition had been clearly highlighted by her and her medical team from the outset. The Complainant says it had also been confirmed by several medical reports submitted on her behalf to the Provider.

The Complainant submits that she can only describe the Provider's statement that: "there has been no loss of earnings for me" as being erroneous. The Complainant states that when

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she had to reduce her work hours in November 2012 to assist in the management of her medical issue her annual salary reduced from €35K to €20K approx. The Complainant states that in February 2013 (*I would contest, after a 13 week deferred period as required under the policy*) a benefit from the Provider of €7.7K per year commenced (this was withdrawn in November 2015). The Complainant says that this resulted in a net annual reduction in earnings of €7.3K and this continues to be endured by her going forward.

As regards the house visit report by the Provider's Senior Health Claims Advisor dated 27th February 2013, where she states under Conclusions/Recommendations: "I feel that [the Complainant] if her condition is not sorted could be on the maximum hours that she is able for." The Complainant states that this was four months into the initial part time trial of six months, that is, was working 20 hours per week at that time and not 35 hours. The Complainant says that this is yet another example of the Provider ignoring valuable/relevant information pertaining to her claim.

The Complainant states that there are 3 main aspects for consideration as follows:-

- For the past 7 years she has suffered with this condition and will continue to do so for the future. During this time she independently sought medical advice/treatments with a view to trying to solve her problem. However early on in the process it was established that this would not be possible and that going forward she would have to manage the issue by means of the "dual approach".
- it is the Complainant's opinion that the Provider failed to focus on her condition as submitted by herself, her GP and the medical practitioners that she had independently attended. The Complainant says the Provider also failed to take into consideration details as reported to it by their staff and appointed representatives which would have helped her claim.

- The Complainant says that financially she continue to endure a significant shortfall in earnings due to her condition.

<u>The Provider's submission of 16 August 2017</u>

The Provider reiterates that it has never had a financial liability on this case. The Provider states that it made a concession considering the claim despite no deferred period being served, and also a further concession to pay out a favourable partial benefit for a time period on the basis this seemed like it would be a short term claim. The Provider's position is that these concessions were made so as not to penalise the Complainant by remaining at work and performing reduced hours and secondly to be supportive helping her towards her goal of full time work. The Provider states that the fact these concessions were made do not alter the fact that there is no financial liability as the Complainant's earnings from her reduced hours exceeded the level that would have allowed any benefit be due.

As regards the Complainant's belief the independent doctors were not fully aware of her condition, the Provider states that at the time of each medical examination a full copy of its medical file was made available to the doctors and the Provider did not withhold any

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information. The Provider says it is satisfied the doctors concerned had all the knowledge and ability required in order to correctly assess the Complainant's fitness for work. The Provider says it does not dispute that the Complainant has a medical diagnosis but must point out a diagnosis does not necessarily have to equate to a work disability which was the findings of its independent medical assessments.

In relation to the Complainant's comment about her home visit in 2013, the Provider's response is that this was with a non-medically qualified Health Claims Advisor who was not there to conduct an assessment. The Provider says the Advisor provided an opinion as to what might happen if the Complainant's condition did not improve. The Provider states that at all times, Income Protection claims must be assessed on an individuals' current ability at that time to carry out their normal occupation. The Provider submits that the medical examination at issue here took place in July and December 2015, neither of which could provide an objective medical reason which was preventing the Complainant from returning to her fulltime hours.

The Provider states that the fact a claim may have been medically admissible at one point in time does not mean it has to remain so indefinitely as turned out to be the case here and as shown through the independent medical examinations.

The Provider states that opinions from both the Complainant's treating doctors and the independent doctors were taken into account and it is satisfied the weight of the objective evidence shows it made the correct decision. The Provider says that furthermore, following the policy in question here, there is actually no financial liability on this claim for the Provider.

<u>The Complainant's submission of 21 August 2017</u>

The Complainant set out some matters and clarification as follows:

1. *"A deferred period of 13 weeks was served between my claim being lodged in November 2012 & February 2013 when I received the first benefit payment. It is therefore incorrect in [the Provider] stating "despite no deferred period being served".*
2. *Thankfully it appears that [the Provider] do not dispute that I have a medical diagnosis. They claim that: "a diagnosis does not necessarily have to equate to a work disability". Disability is defined as "as an impairment that may be cognitive, developmental, intellectual, mental, physical, sensory, or some combination of these. It substantially affects a person's life activities." I therefore fail to understand why they feel that my inability to work full time hours based on my medical teams diagnosis and advice does not equate to a work disability.*
3. *Despite [the Provider] accepting my claim as being medically admissible from the outset, they have chosen to place all their weight behind their 2 nominated medical examination reports in coming to their determination. In my opinion they have ignored all of my medical reports and ongoing treatment of my condition".*

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The Provider's submission of 31st August 2017

The Provider refers to the Complainant's comments on the deferred period and states that. The policy defines this as:

"There is an interval between the date each period of incapacity begins and the beginning of the period for which we will pay incapacity benefit. This interval is called the deferred period and is for either 13, 26 or 52 weeks in a row (see your schedule).

While, Incapacity is defined as:

Incapacity means that you are totally unable to carry out the main duties of your normal occupation as shown in the application form (or any new occupation which you told us about in line with section 7.1 and which we accepted in writing). You must also not be following any other occupation. This incapacity must arise as a result of illness or injury and must be confirmed by our chief medical officer. Your main duties are those you normally need to carry out in your job and which you cannot reasonably leave out or alter.

The Provider states that the Complainant did not have a period of time where she was completely off work (i.e. totally unable to carry out the main duties of her occupation) and therefore no deferred period was served. The Provider states that rather than insisting on the Complainant ceasing work completely, it was happy for her to continue working part time and the Provider essentially allowed the Complainant first 13 weeks of this part time working arrangement to be considered the same as a deferred period.

The Provider says it believes the weight of the objective medical evidence from its two medical examinations in 2015 (it says that the doctors in each case had copies of the full medical file at the time of each examination) shows that the Complainant was actually fit to resume her normal fulltime working hours. The Provider says that regardless of the medical aspect of this complaint, it does not have any financial liability as the Complainant's continuing earnings exceeded the maximum benefit allowable under this policy.

The Provider submits that it remains satisfied there is no financial liability for it and that it has also shown the weight of the medical evidence supports its opinion that the Complainant is fit to work fulltime.

Complainant's submission 4th September 2017

The Complainant states that having re-read the Provider's Terms and Conditions booklet Section 4.6 "Partial Benefit" clearly states:

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> *"If, you go back to your normal occupation in a limited capacity at reduced earnings or take up another occupation at reduced earnings, we may pay part of the benefit."*

The Complainant states that this must have been the basis on which the Provider granted partial benefit to her on her original claim.

The Complainant re-iterates the following:-

1. *"My condition continues to be managed, as detailed in my submission dated 4/8/2017.*
2. *This includes ongoing pain management by Lignocaine and Ketamine infusions plus having to work reduced hours, backed up by detailed medical evidence.*
3. *In my opinion [the Provider] have ignored my medical evidence.*
4. *As also stated by me in my submission of 4/8/2017 one of the two independent medical examinations in 2015 i.e. the one carried out by [Dr. S] on 11/12/2015 never even addressed my convergence issue (asthenopia) which had been highlighted to him. This is the "weight of the objective medical evidence" on which they based their decision.*

Finally, [the Provider] state "they do not have any financial liability as [the Complainant] continued earnings exceeded the maximum benefit allowable under this policy." This does not make any sense:-

5. *Partial benefit is allowable under the policy*
6. *I cannot find any reference in the Terms and Conditions booklet backing up their statement".*

<u>The Provider's response of 7th September 2017</u>

The Provider reiterates that it is satisfied all medical reports on file were made available and considered by Dr S at the time of his assessment and the weight of the medical reports show the Complainant is fit to resume her normal duties.

The Provider states that as set out in the Terms and Conditions booklet, partial benefit is only payable after a period of full incapacity. The Provider says that the Complainant never ceased work completely so did not serve a period of full incapacity. The Provider submits however, that it waived this requirement when looking at the Complainant's partial benefit.

The Provider refers to the details of the "limits to the amount we will pay" which is Section 5 of the Policy Document. The policy defines this as:

> *"The actual amount you will receive cannot be more than the lower of the following.....the amount of any salary, earnings, profit , reward or other earned income which you continue to receive from any source.."*

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The Provider states that in the Complainant's case, the insured benefit was €16,590 but the earnings she was continuing to receive were €19,905.60 and as her continuing earnings are larger than the insured benefit, there is no financial liability due.

The Provider states that it remains satisfied there is no financial liability for the Provider and that it has also shown the weight of the medical evidence supports its opinion that the Complainant is fit to work fulltime.

The Complainant's submission of 11 September 2017

The Complainant states that in relation to "partial benefit" this was granted to her by the Provider from the outset and therefore needs no further comment.

The Complainant says however, that in relation to the "financial liability due" aspect of the Provider's correspondence she wishes to state the following:-

a) *"they have failed to point out where in their Terms and Conditions does it cover their incorrect statement that they do not have any financial liability to myself under the policy.*
b) *they state correctly under Section 5 of the policy Terms and Conditions that the limit to the amount they will pay is the lower of (1) the amount of any earned income received or (2) the benefit which in the case of my policy was €16,590.*

Clearly, the policy benefit of €16,590 is the lower of these amounts.

Therefore, when they state that my current salary of €19,905 exceeds the benefit of €16,590 and as a result there is "no financial liability due", they are misleading and incorrect.

Finally, I wish to clarify again here that the benefit they withdrew was less than the €16,590 maximum allowed under the policy. I fully understand that the benefit received by me previously i.e. €8530 was based on a proportional basis due to the fact that I continued to work on a part-time basis.

It is this benefit of €8530 that I wish to have re-instated not the €16,590".

The Provider's response of 14 September 2017

The Provider states that in the Complainant's case, the insured benefit is €16,590 but the earnings she continued to receive were €19,905.60. The Provider says as set out in the Policy Document under Section 5 — Limits to the amount we will pay it states:

"The actual amount you will receive cannot be more than the lower of the following:

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(a) *Our overall maximum incapacity benefit of €150,000 a year or any higher amount we may decide to use.*

And

(b) 75% of the first €80,000 of your yearly earnings plus 50% of any yearly earnings over €80,000 less:

- *the amount of any salary, earnings, profit, reward or other earned income which you continue to receive from any source;*
- *the amount of any income you receive from a pension fund;*
- *The amount of any state disability or other benefit, for example, in Ireland any payments under the Social Welfare (Consolidation) Act 1993 together with any other further amendments, you are entitled to (including adult dependent allowance but not including any amount for dependent children); and*
    - *The amount of any regular benefit you are receiving from any other insurance for incapacity or disability".*

The definition of earnings under the policy is:

"salary or wage before deductions for PAYE assessment purposes. This includes overtime and regular bonuses for the 12 months up to and ending at the start of the deferred period".

The Provider submits that the Complainant reduced her working hours in November 2012 and it calculates her pre-disability earnings as €31,668.27 for the 12 month period prior to her ceasing work. The Provider says that it also noted that at that time, the Complainant was entitled to a social welfare benefit payment of €6,084 pa.

The Provider's positon is that in the Complainant's case, the calculation would be as follow:

75% x €31 ,668.27 less €6,084 = €17,667.20 less continuing income of €19,905.60 = a negative amount i.e. no benefit is payable.

The Provider says it remains satisfied there is no financial liability for the Provider and that it has also shown the weight of the medical evidence supports its opinion that the Complainant is fit to work fulltime.

<u>The Complainant's submission of 15th September 2017</u>

The Complainant states that her original claim was admitted by the Provider in its letter dated 09 July 2013. The Provider confirmed this based on the medical evidence the Complainant provided at the time. The Complainant states that the Provider calculated the proportionate benefit initially based on an incorrect salary of €31,668.27 which she highlighted was incorrect and subsequently it issued a revised proportionate benefit based on the correct figure at the time of €34,709.06 in its letter dated 16 August 2013. The

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Complainant says that this error has been duplicated by the Provider yet again in its letter dated 14 September 2017.

The Complainant states that the proportionate benefit formula as confirmed to her by the Provider in its letter dated 16/08/2013 is as follows:-

Pre-disability earnings – (85% of current earnings) X benefit
Pre-disability earnings

The Complainant submits that the 85% of current earnings used therein contradicts the Terms and Conditions where it states that 75% of current earnings is taken into account. The Complainant says that this is a key point, as she has only just realised that based on the 85% rule an underpayment of €940.53 annually has resulted to her during the period when she was in receipt of benefit.

The Complainant summarises the issue as follows:

a) *[The Provider] accepted the claim based on my original medical evidence. This has been further substantiated by additional medical updates supplied by me and yet they have ignored these in favour of their 2 once off medical evidence reports.*

   I wish to re-iterate that the management of my condition is on-going as previously outlined.

b) *Various mathematical errors were made by [the Provider] in determining my case. The most recent being in their last letter. However, by far the most important of these is where they used the "85%" rule instead of the 75%. This needs to be addressed by them".*

The Provider's response of 4th October 2017

The Provider's position is that when it was assessing the Complainant's claim in 2013, it recognised the efforts that she had made to remain in work at that time. The Provider says it noted that the Partial Benefit Clause in her policy did not allow for any benefit to be payable and instead of applying the policy conditions it agreed to use a more favourable partial benefit formula which provided the Complainant with a partial benefit of €8,513 per annum. The Provider says that this decision was made in an effort to support the Complainant's attempts to remain in work and in making this concession it took into account the medical evidence at that time which indicated that she should be able to resume her full time duties in the not too distant future. The Provider says that in addition, the Complainant had indicated on her claim form she was hoping to resume full-time work within six months. The Provider states that all such concessions are subject to ongoing review.

The Provider says that the insured benefit payable under the policy at the time that the Complainant submitted her claim was €16,590 per annum. This the Provider says is the maximum amount payable under any claim under this policy. The Provider states that when

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an insured person returns to work, the policy provides for a partial benefit to be payable under Clause 4.6 of the policy which states:

> *"If after a period of incapacity for which we pay incapacity benefit, you go back to your normal occupation in a limited capacity at reduced earnings or take up another occupation at reduced earnings, we may pay part of the benefit. This depends on the conditions that:*
>
> - *You remain totally unable to carry out the main duties of your normal occupation in the opinion of our chief medical officer; and*
> - *We agree beforehand"*
>
> *In these circumstances we will reduce the incapacity benefit by any new earnings you received from your new occupation. All the normal plan terms and conditions apply to this benefit".*

The Provider states that in the Complainant's case, the figures are:

Insured Benefit of €16,590 less part-time earnings of €19,905.60 = a negative amount, i.e. no benefit payable.

The Provider says that this financial concession that it made was subsequently reviewed and, given the medical evidence, which indicated that the Complainant no longer met the definition of incapacity as required by the policy, it was not in a position to maintain this financial concession and, therefore, the payments under the claim ceased.

The Provider says that in its last letter, it also outlined the details of Clause 5 of the policy. However, it says it was not correct to cite this Clause in its last letter as the Partial Benefit Clause 4.6 as outlined above is the Clause that applies when a claimant returns to work at reduced earnings.

The Provider says that it also notes the Complainant's comments on the additional medical updates supplied by her and can confirm that all medical evidence was taken into consideration in arriving at its decision on her claim. The Provider's position is that the weight of the objective medical evidence confirmed that the Complainant was fit to carry out her pre-disability occupation on a full-time basis and therefore, it was not in a position to continue to pay a claim.

The Provider states that in relation to the salary figure quoted in its letter of 15 September 2017, the Complainant is correct in saying that the Provider used an incorrect salary figure in showing the calculation of the potential benefit payable under her claim. The Provider says that it apologises sincerely for this error on its part. The Provider says that when the claim was initially admitted, it used a salary figure of €31,668.27 but it later agreed to use a revised salary figure of €34,749.06 following contact from the Complainant. The Provider says that it acknowledged this in its letter of 16 August 2013 and it adjusted the benefit payments at that time.

The Provider submits that in summary, it apologises for the errors and misstatements in its last letter. However, it says it is satisfied that these do not have any impact on the outcome

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of the Complainant's claim and that the correct decision has been made. The Provider states that the medical evidence clearly indicates that the Complainant no longer meets the definition of incapacity as required by the policy and the Partial Benefit Clause means that, in any event, there is no benefit payable under the claim based on the Complainant's current earnings.

The Complainant's submission of 5th October 2017

"Firstly, I note the numerous apologies from [the Provider] as outlined in their response, but I do take issue with some of the points made.

1, They state in paragraph 3 that they made an error in referencing Clause 5 of their policy and that Partial Benefit Clause 4.6 applies instead. I wish to highlight that if this indeed is the Clause that applies (and I dispute this further on) then there would be no possibility of me ever being awarded a Partial Benefit due to the result always being negative based on my salary and the maximum benefit amount payable under the policy. Surely this makes no sense and is in my opinion unfair? I also wish to confirm that this discrepancy was never highlighted to me at the time of me taking up the policy by the [Provider] representative!

2. *The acceptance of my claim was confirmed to me by [the Provider] in the letter dated 09/07/13. In it they stated that; "Based on the financial information which you submitted, you are entitled to the insured benefit under the policy which is €16,590 per annum." Was this yet another error made by [the Provider] for which they may now wish to offer yet another apology?*

3. *They then, in said letter, go on to confirm that there was no financial liability for [the Provider] based on Clause 4.6, however subsequently they stated; "Under the circumstances we agreed to use a more favourable formula to calculate the proportionate benefit" and attached details of the calculation for me which confirmed that they'd used 85% of current earnings in the calculation.*

On this point I wish to ask why;

a. *There is no reference to this formula in the Policy Terms & Conditions.*
b. *"Section 5.1(b) Limit to the amount we will pay"- states that the actual amount you will receive cannot be more than 75% of the first €80,000 of yearly earnings. Surely this percentile should apply to a Proportionate Benefit formula and therefore I would be due a rebate.*

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4. *Also in said letter they confirmed that "the deferred period expired on 02/02/13." This implied that I had served a deferred period as per their Terms & Conditions. This is yet another error on behalf of [the Provider] when they subsequently stated that I had not served a deferred period.*

The fact that so many errors have been made by [the Provider] since my claim was submitted and approved, for example in calculating the benefit due or more recently errors in correspondence from them, doesn't exactly instil confidence in the way that they conducted their business with me, especially when now 4 years later they continue to make errors.

A summary of my case is as follows and is backed up by documentation that you have on file from both parties;

- *Nov. 2012 — On medical advice I was advised to reduce my work hours from Full-time to Part-time.*
- *06/12/12 — I submitted my original Claim form including Medical Certificate. This stated that I'd commenced P/T hours per above and that I'd hoped to resume full time hours in 6 months dependant on medical advice. Perhaps if I had given up work completely on medical grounds at that time I would not have experienced the current issues with [the Provider].*
- *09/07/13 Letter received from [the Provider] confirming that they were admitting my Claim and it was backdated to 03/02/13.*
- *28/08/14— I completed the [the Provider's] Certificate of Continued Disablement. In section 2.9, I confirmed that my Pain Management Consultant recommended that I continued with part time hours,*
- *08/09/14 — I completed [the Provider's] Medical Questionnaire. In Section 5, my GP confirmed that full time hours were not an option for me.*
- *19/11/14 — [The Provider's Chief Medical Officer], requested ([the Complainant's] pain Consultant) to issue a detailed medical report on me. In his report [the Consultant] clearly states that "I have advised [the Complainant] that she would not be in a position to return to full working hours. I do not ever envision [the Complainant] returning to full working hours".*
- *09/06/15 I attended [the Provider's appointed] Occupational Physician at the request of [the Provider].*
- *20/08/15 — I received a letter from [the Provider] stating that payments on the Claim would cease from 01/11/15 following [the Occupational Physician's] report.*
- *I subsequently appealed their decision 23/09/15 to [the Provider] who in turn forwarded it on to The Appeals Committee. This did not result in a resolution.*
- *August 2015 — My Consultant Anaesthetist & Specialist In Pain Medicine, .., confirmed that I was attending the Pain Management unit at [X] Hospital on an ongoing basis. He went on to state that, " She is currently employed twenty hours per week and I would envisage that this is appropriate from a pain*

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management perspective. I feel that [the Complainant] should maintain these working hours if possible but I feel that she is not suited to full time employment. If you have any queries regarding this, please do not hesitate to contact me directly." This was copied to [the Provider].

- *To this day and for the foreseeable future I will have to attend the above Pain Management Clinic approx 3 times per year for pain infusions. This forms part of the management of the condition from which I suffer combined with working part time hours.*
- *11/12/15 —I attended [the Provider 2nd appointed] Occupational Physician/Therapist at the request of [the Provider] after I had confirmed that I'd appeal their decision to cease benefit payments.*

In relation to the summary above, firstly, I wish to ask if [the Provider's] Chief Medical Officer, … ever availed of the opportunity to make direct contact with [her medical Specialist] upon receipt of my detailed medical report and or subsequent letter from [her medical Specialist] almost a year later where he openly requested contact should further clarification be required?

Secondly, whereas I fully understand that ongoing claims are reviewed by [the Provider] as stated in their Policy documents, it is my re-stated contention that they have ignored all of my medical evidence in favour of the medical reports from their 2 nominated medical persons. I now understand (although this was not clarified sufficiently to me at the time, ref. their letter dated 09/07/13) that it was a concession on their part that allowed me to receive benefit for a period of 2 years and 9 months. None the less benefit was granted but subsequently revoked following my attendance with [the Occupational Physician]

Unfortunately, due to the part time hours that I now have to work my income has reduced by 50 % approx. The very reason why I took out the Income Protection policy with [the Provider] has arrived at my door! They initially granted benefit to me under the policy only to revoke same subsequently.

Conveniently from [the Provider's] point of view, it transpires that the very policy which I took out with them to cover me in such an eventuality and on which they initially paid benefit to me, no longer meets their criteria upon review. Meanwhile I continue to suffer from the condition and have to "manage" same.
I fail to see why [the Provider] decided to stop the benefit as granted originally to me following my claim submission when I have been and continue to live with this condition. In my opinion they are determined not to resume payments to me to a point where they now contradict their own words as submitted during this process and brush them off with apologies.

From the beginning of the Ombudsman appeal process I have had to get a dear friend to assist me in responding at each and every stage. This type of concentrated/detailed work does not help my condition. I therefore would like at this stage for this to proceed to adjudication".

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The Provider's response of 13 October 2017

"In relation to the points raised by [the Complainant] I wish to respond as follows:

1. [The Complainant] is correct in saying that in a situation where a person returns to work, or in [the Complainant's] case continues to work, no benefit would be payable if the continuing income is greater than the benefit amount. In [the Complainant's] case she received €19,905.60 from her employer whereas her insured benefit was €16,590.00. Therefore there was no benefit payable. Had [the Complainant] ceased work altogether she would have been entitled to a benefit. However as previously advised we chose to pay a partial benefit in support of [the Complainant's] efforts to remain in work when it appeared she would be increasing her hours over time.

   I wish to point out that the non-payment of a benefit in such circumstances is not due to discrepancy but is the application of Section 4.6 of the policy.
   I refer to our letter of 26 September 2008 that was sent to [the Complainant] when she applied for income protection cover, in particular to the IMPORTANT INFORMATION on the second page which draws attention to:

   "The precise circumstances under which benefits become payable, together with the amounts actually payable are explained in the terms and conditions booklet. "

2. *I refer you to our letter of 9th July 2013 which we included with our submission. In particular I refer to the section of the letter quoted below.*

   Based on the financial information which you submitted, you are entitled to insured benefit under the policy which is €16,590 per annum.

   As [the Complainant] continued to work on reduced hours and receive an income from her employers we must take this income into account. A partial benefit is payable on a claim if the ongoing earnings are less than the insured benefit as outlined under Section 4.6 of the Policy.

   In [the Complainant's] case the insured benefit is €16,590 which is lower than the €19,905.60 [the Complainant] was in receipt of for her part time work and as such there is no benefit actually payable.

   "Under the circumstances we agreed to use a more favourable formula to calculate the proportionate benefit…"

3. Section 4.6 of the policy deals with the payment of a partial benefit and allows for the deduction of 100% of ongoing earnings. Where we believe it is appropriate to support a policyholder in their efforts to return to their normal occupation we can

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choose to deduct less than 100% of those earnings as we did this in [the Complainant's] case by deducting 85%. This is not contained in the policy and if we had strictly enforced the policy at the beginning no benefit would ever have been paid to [the Complainant].

Section 5.1 of the policy refers to the most we will ever pay on a claim and is designed to ensure that when a person meets the definition of disablement and a claim is payable their income from all sources is 75% of their pre-disability income.

4. Section 1 of the policy says, in relation to a deferred period:

There is an interval between the date each period of incapacity begins and the beginning of the period for which we will pay incapacity benefit. This interval is called the deferred period and is for either 13, 26 or 52 weeks in a row.

[The Complainant] chose a deferred period of 13 weeks. However she did not stop working for 13 weeks in a row and did not as such complete a deferred period. In admitting her claim we recognised that [the Complainant] had reduced her working hours due to her medical condition and believed it reasonable to pay a benefit. To do so, we assumed a notional deferred period had being served. Our decision was supported by the medical evidence available to us at that time which suggested [the Complainant] would be returning to her fulltime hours in the near future. So in reality, a deferred period was not served but we assumed one had in order to pay her the partial claim. This issue does not make a material difference to this dispute.

In relation to [the Complainant's] question regarding if [the Provider's CMO] contacted [the Complainant's Specialist] directly I wish to advise that he did not. [The Complainant's Specialist's] reports were reviewed and considered along with all the medical evidence that was received in this case. It remains our position that on balance the weight of medical evidence available supports our opinion that [the Complainant] is fit to carry out her normal occupation. Therefore she does not meet the definition of incapacity in the policy and a claim is not payable. As above, we also do not have a financial liability. Similar to [the Complainant] we remain happy for case to proceed to adjudication.

<u>The Complainant's submission of 23rd October 2017</u>

"The information/clarification from [the Provider] in their last letter and previous correspondences has clarified matters in relation to the Policy which I'd taken out with them. Among the most recent confirmation received they state that "Had [the Complainant] ceased work altogether she would have been entitled to a benefit." But thankfully I'm an individual who wishes to work and avail of the many positive benefits from it. It's also ironic as if I had ceased gainful employment due to my condition then I wouldn't necessarily have had to undergo this long drawn out

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process of appeal when the benefit granted originally was withdrawn by [the Provider].

[The Provider] granted my claim for benefit based on all of the details supplied by me at the time including detailed medical reports from the medical people I was attending, indeed I'm still attending these for ongoing pain management. Nothing has changed in this regard from my side.

In addition, my Optician has over time referred me for assessment to an Orthoptist, Ophthalmologist, Neuro-Ophthalmologist and the National Optometry Centre Binocular Vision Clinic. In her most recent letter dated 04/08/17, a copy of which was sent to you on 06/08/17, she confirms that

> *"She (me) has been diagnosed with a chronic binocular vision muscle imbalance, which has most likely existed since childhood. Her convergence is poor and this causes severe eyestrain & headaches at persistent close work."*

It's to my detriment that [the Provider's] Chief Medical Officer did not arrive at the same determination having reviewed all of the medical reports furnished by me and both of the medical personnel I attended at their request. In fact, the only medical persons who determined that I'm fit to return to work were those 2 [Provider] medical representatives.

Given these opposing views on my suitability to return to work and the resulting cessation of benefit to myself, I must again point out that [the Provider's] Medical Officer did not avail of the opportunity to contact [the Complainant's Specialist] who had made himself available and continues to treat me in his Pain Management Clinic. Surely this should have been pursued to ensure that the weight of medical evidence was balanced, as this is a cornerstone to why they ceased benefit payments to me.

From my perspective nothing has changed in relation to my medical diagnosis from the time I submitted my original claim. In fact, if anything I have increased my understanding of the detail relating to the medical condition from which I will continue to suffer. I however must continue to "manage" it by means of a combination of working part time and regular pain management treatments <u>on medical advice</u> as previously detailed.

If you have any queries please don't hesitate to get back to me. I wish for this to proceed to adjudication".

<u>Policy Schedule</u>

"Deferred Period – 13 weeks
..
Your protection benefits
Our Income Protection payments may be reviewed. Please see your terms & conditions booklet for details of this and the rules for benefits.

/Cont'd…

Your benefit
Incapacity Benefit €15,800
..
Indexation applies to this plan. Your payment will increase each year"

Customer Information Notice

"Incapacity Benefit
We will pay the Incapacity Benefit shown on your plan schedule plus any increases due to indexation if you are unable to work due to illness or injury. Your terms and conditions booklet gives details of the maximum amount of incapacity benefit we will pay if you make a claim. The benefit you receive will increase annually by the lower of 5% or the increase in CPI from the date of receipt of the first benefit payment.

To qualify for benefit our Medical Officer will decide whether your claim satisfies the necessary requirements described in the plan conditions. The benefit will become payable on a monthly basis once the deferred period of 13 weeks has expired. We will continue to pay the Incapacity Benefit while your illness or injury prevents you from doing your usual job, and while you are not following another occupation".

Policy Provisions

"Definitions
Deferred Period
There is an interval between the date each period of incapacity begins and the beginning of the period for which we will pay incapacity benefit. This interval is called the deferred period and is for either 13, 26 or 52 weeks in a row (see your schedule).

Earnings
If you are an employed person – your salary or wage before deductions for PAYE assessment purposes. This includes overtime and regular bonuses for the 12 months up to and ending at the start of the deferred period.

Incapacity
Incapacity means that you are totally unable to carry out the main duties of your normal occupation as shown in the application form (or any new occupation which you told us about in line with section 7.1 and which we accepted in writing). You must also not be following any other occupation. This incapacity must arise as a result of illness or injury and must be confirmed by our chief medical officer. Your main duties are those you normally need to carry out in your job and which you cannot reasonably leave out or alter".

"4.6 Partial benefit
If, after a period of incapacity for which we pay incapacity benefit, you go back to your normal occupation in a limited capacity at reduced earnings or take up another

/Cont'd…

occupation at reduced earnings, we may pay part of the benefit. This depends on the conditions that:

- *You remain totally unable to carry out the main duties of your normal occupation in the opinion of our chief medical officer; and*
- *We agree beforehand*

In these circumstances, we will reduce the incapacity benefit by any earnings you receive from your new occupation. All the normal plan terms and conditions apply to this benefit.

Section 5
Limits to the amount we will pay

.. the actual amount you will receive cannot be more than the lower of the following.

(a) Our overall maximum incapacity benefit of €150,000 a year or any higher amount we may decide to use.

And

(b) 75 % of the first €80,000 of your yearly earnings plus 50% of any yearly earnings over €80,000 less:

- *The amount of any salary, earnings, profit, reward or other earned income which you continue to receive from any source;*
- *The amount of any income you receive from a pension fund;*
- *The amount of any state disability or other benefit, for example, in Ireland any payment under the Social Welfare (Consolidation) Act 1993 together with any other further amendments, you are entitled to (including adult dependant allowance but not including any amounts for dependent children); and*
- *The amount of any regular benefit you are receiving from any other insurance for incapacity or disability.*

We will carry out this calculation from time to time during any claim. We have designed the calculation to make sure that you have enough financial incentive to return to work while we are paying incapacity benefit.

We will not refund any payments if, as a result of this condition, we pay less than the incapacity benefit shown in the schedule.

Section 10
Claims
If you are an self-employed person, we will need:

- *A copy of your P60 for the tax year immediately before the start of the deferred period; and*
- *A note from your employer confirming your earnings in the 12 months immediately before the start of the deferred period.*

…

We will only accept your claim if we are satisfied that you are entitled to incapacity benefit and, in particular, that you meet the definition of incapacity.

/Cont'd…

This means that there will be a delay between the date on which you make your claim and the date on which we might accept it. "

Claim Form

Additional Information

"On medical advise from specialist have reduced my working hours as the pain became more frequent making every day life very difficult. My work requires concentration which is computer based and this is difficult".

Internal Provider communications:

18 October 2012

"I contacted claims approx. 3 weeks ago on this case and while was told usually claims only paid if fully out of work – was told this is reviewed on case to case basis – I would appreciate it if you would consider this case as client is an excellent [Provider] customer with a number of policies".

8th November 2012

"I note that you have reduced your working hours due to your current condition. Under the policy, an income protection claim is payable when the insured person is totally unable to carry out the main duties of their normal job. In your case, as you continue to work reduced hours you do not fully satisfy this definition of disability. However, we will consider your claim further on receipt of the Claim Forms and make a final decision at that stage".

10th January 2013 – Provider to Consultant Neurologist

"[The Complainant] is employed as a Administration Worker. [The Complainant] is employed 35 hours per week. However, she reduced her hours to 20 hours per week from the 05/11/2012 on medical advice. We want you to assess whether or not she is capable of performing all the duties of her normal occupation on a full time basis including PC work.

Please note that the illness or disability must be assessed in relation to the exact nature of the job requirements. You should also note that the availability of such work is not an issue".

19th January 2013 – Employer

"This is to confirm that [the Complainant] .. gross weekly earnings were €382.80 per week for a 20hr week. Prior to November 2012 she worked a 35 hr week and her gross earnings were €669.90"

/Cont'd…

27th February 2013 – Senior Health Claims Advisor

> *"I feel that [the Complainant] if her condition is not sorted could be on the maximum hours that she is able for. [The Complainant] said that if it deteriorates that she may have to reduce those hours".*

22nd May 2013 – Provider

> *"We have completed our review of this claim and based on the evidence we are happy to admit [the Complainant's] claim. As she has remained in work we are making a concession here but will support her part time work by paying a proportionate benefit to her based on her current hours and earnings".*

28th May 2013 – Social Welfare confirm payment of €117 per week.

21st June 2013 – Provider

> *"We have calculated the proportionate benefit [the Complainant] will receive from [the Provider]. The total is €7,727.00 per annum €643.92 per month".*

9th July 2013 – Provider to the Complainant

> *"As previously advised, based on the medical evidence received, I am pleased to confirm that we are admitting your claim. …*
> *In your case the insured benefit is €16,590 however, you continue to receive €19,905.60 from your employers. As you can see, if we apply this formula there would be no financial liability for [the Provider] and no claim to consider.*
>
> *Under the circumstances we agreed to use a more favourable formula to calculate the proportionate benefit,…"*

<u>Calculation for Proportionate Benefit Case</u>

> *"From all sources she is receiving less than 85% of her PDE*
> *She is getting more than the Max ben but less than her salary for 2012 which was 34K. We need to monitor this going forward and may need to adjust if a RTW dosen't look likely at all"*

6 June 2014 – Provider to its appointed Consultant Neurologist

"In your report, you advise that [the Complainant] reports an unreadiness to increase her hours, and also that it is difficult to predict when she will declare herself ready to do so.

/Cont'd…

1. *Based on your examination of [the Complainant], was there any objective evidence of symptoms that wold prevent [the Complainant] from returning to her normal 35 hour week as a Project / Finance Administrator?*
2. *In your opinion, is [the Complainant] medically fit to return her normal full-time 35 hours per week?"*

8th September 2014 – Medical Questionnaire

Extent of Disability

> *"If your patient is currently unfit for his/her normal occupation, what aspects is he / she unable to perform?*
>
> **Answer:** *"Not suitable for full time work due to nature of work being heavily computer orientated"*
> ..

3. *Is the claimant in your opinion currently fit to resume his/her normal occupation on a part-time basis?*
   ***Answer** "Yes"*
   If yes, please outline below the nature of work and the number of hours per week that could be performed.

   Answer: *"Part-time at present"*

10th February 2015 – Complainant's Employer to Provider

> *"This correspondence is to verify that [the Complainant] is employed [with employer] as Project Administrator …*
>
> *As you are aware, the Administrative post has changed from a 35hr position to 20hrs per week.*
>
> *The Project Administrative role is varied with a number of duties, a lot of which are centred on the use of a computer".*

23rd April 2015 – Claims Management Service – IME with an ophthalmologist would be of benefit here.

THE PROVIDER ARRANGES A MEDICAL EXAMINATION WITH AN OCCUPATIONAL PHYSICIAN

20th August 2015 – Provider to the Complainant

> *"We recently received the results of your independent medical examination with .. Specialist in Occupational Health. [The Specialist] has confirmed that there is no objective medical evidence to indicate that it would be unsafe for you to increase to*

/Cont'd…

normal working hours. It is our opinion, based on the medical evidence received, that your are not currently totally disabled from following your normal occupation as required by the policy and you are fit to work on a full time basis. Payments on this claim must therefore cease. …

On separate note, I would like to point out the following exert from your Policy Document regarding the calculation of a partial benefit "We will reduce the incapacity benefit by any earnings you receive from your new occupation". I wish to confirm that [the Provider] allowed a concession on your claim since the beginning by only taking a percentage of 85% of your partial earning into account and I wish to confirm that we are no longer in a position to do this. Insured Benefit is €16,590 and your current earnings are €19,905, therefore your benefit is effectively zero".

27 November 2015 – the Provider arranges a second assessment with another Occupational Physician.

"6.In your opinion, is [the Complainant] currently fit to carry out her normal occupation on a full time basis i.e. 35 hours per week?"

27th January 2016 – Provider to the Complainant

"When we admitted your claim, we pointed out that Section 4.6 of your policy states that if you go back to work at reduced earnings we may pay a partial benefit which would be calculated by reducing the insured benefit by your current earnings.
In your case, the insured benefit was €16590 but the earnings you were continuing to receive were €19,905.60. Strictly speaking there would have been no financial liability and no claim to consider for [the Provider]"
However, at the time we agreed to use a more favourable proportionate benefit formula which would provide you with a partial benefit of €7,727.00. This decision was made in an effort support your attempt to remain in work and in the hope that you would eventually return to your full time hours". ..
As outlined previously having considered the matter fully we are no longer in a positon to make a concession on your claim by using the more favourable formula. We must now apply the correct formula, insured benefit payable less current earnings, as outlined under the policy which results in [the Provider] having no financial liability on your claim".

3rd August 2017 – Complainant's Employer

"Please note that we agreed to [the Complainant] reducing her hours worked from 35hrs to 20hrs per week based on the medical evidence supplied at the time and following an initial trial period of 6 months [we] then employed an additional staff member to make up the balance of 15hrs per week. The job share arrangement continues for the foreseeable future".

<u>Medical Evidence</u>

/Cont'd…

14th August 2012 – The Complainant's Ophthalmic Surgeon and neuro Ophthalmologist:

> *"This is to certify that I saw [the Complainant] for a consultation today and I would suggest that she reduce her working hours each day to four to five hours in a working day. I feel this will help this ongoing eye problem. I have also advised her to consult with a pain specialist"*

19th November 2012 – Consultant Anaesthetist & Specialist in Pain Medicine

> *"Many thanks for your kind referral of this delightful lady, who has got astehnopia due to convergence issue. She reports her left eye as being worse than the right. I note she has previously been reviewed by … Both ophthalmologists advised performing convergence exercises with respect to both eyes. She reports she is willing to do the same as a consequence of the pain".*

29 November 2012 – Ophthalmic Surgeon and Neuro-Ophthalmologist

> *"I feel that she requires pain management at this stage as I do not feel her slightly limited convergence is the cause of her eye strain and it may be that she has some unusual headache / migraine syndrome which is he real cause of her problems"*

4th April 2013 – Provider's appointed specialist – Neurologist

> *"At the present time due to her significant pain I do not feel that she is capable of working more than 20 hours per week. I am however optimistic that with appropriate treatment for chronic migraine that the symptoms will improve and that she will be able to return to a full working week. I cannot give a specific time as to when this may occur. I feel that the prognosis of her condition is good".*

16th May 2014 – Provider's appointed specialist – Consultant Neurologist

> *"I tried to establish the minimum amount of reading which would be required to trigger a significant increase or precipitation of eye and frontal pain. No exact number of pages was forthcoming. She could manage perhaps 4 or 5 with reasonable ease. The effect was said to be a cumulative matter, over time. She did not feel she could manage more hours than half time. The current arrangement consists of five 4 hour shifts.*
>
> *Physical examination discloses no distress. The fundi are normal with good venous pulsations. Range of motion of the neck is normal. There are no orbital or carotid bruits. Visual fields are full to confrontation. VA 6/6 OU if not better. She reads unfamiliar text fluently without any complaint of pain. The pupils are equal and reactive, including accommodation. The remainder of routine neurological examination is normal".*

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10th June 2014 - Provider's appointed specialist – Consultant Neurologist

"In your opinion is [the Complainant] medically fit to return her normal full-time 35 hours per week?"
If she were under my care, I believe I would have pushed harder to achieve a return to fitness before surrender to her unusual compensatory arrangement. As it stands, I think the matter is unresolved, but I cannot undertake treatment here. For the moment she asserts that she cannot work beyond a specified number of hours. It is her word against mine. As implied, I am not convinced and there are no objective findings. Her condition falls into one of those nebulous zones. Intermittent visual blurring without abnormalities on physical examination is often without conventional foundation.

May I suggest that you press the patient to seek an orderly sequence of treatment for atypical migraine. She may improve and regain full functionality. Conversely, if she fails, the question of motivation and the psychological domain may have to be explored more thoroughly".

19th November 2014 – The Complainant's Consultant Anaesthetist & Specialist in Pain Medicine

"At this juncture, I note [the Complainant] does not have much intense computer screen visualisation in her role as a financial administrator. I have advised [the Complainant] that she would not be in a position to return to full working hours. I do not ever envision [the Complainant] will be attending the Pain Management Unit for interventions as described above in February 2015 and is also under the ongoing care of .. Consultant neurologist, and is due to be reviewed in the coming weeks".

27 January 2015 – Medical Questionnaire

"Please explain what difficulties would [the Complainant] have in the workplace if she were to increase her hours?
***Answe**r: Difficulty concentrating, using computer, taking phone calls".*
"do you feel that she could gradually increase her current 20 hour week on a phased basis (if so please provide a phasing plan).
***Answer**: "Possibly increase X 2 hours every 6 wks – 2 months?? Might work"*

29th July 2015 – Provider's Specialist in Occupational Health

"Conclusions and Recommendations:
Diagnosis
[The Complainant] has migraine and astehnopia. Fortunately serious underlying pathology has been outruled following intensive investigations. Nevertheless she reports significant subjective symptoms despite the lack of objective clinical findings. The only abnormality appears to be poor convergence. I find [the Complainant] to be in good general health and not in any obvious distress.

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Fitness for work:
In my opinion [the Complainant] is fit to return to full normal work duties. I am at a loss as to whey she can tolerate part time hours, but claims to be incapable of fulltime hours. Her working condition should conform to the Health Safety and Welfare at Work Act (general applications) Display Screen Equipment 2007 to prevent undue eye strain and ensure a s safe place of work.
When assessing fitness for work the issues to consider are safety capacity and tolerance. There is no objective medical evidence to indicate that it would be unsafe for [the Complainant] to increase to normal working hours or that she lacks the physical or mental capacity to do so. The only basis to her claim that she is unfit for full time work is her own subjective reports of intolerance of normal working hours. However, she has not even attempted to increase her work hours for the past 2 ½ years. In addition she functions normally in her daily life and manages part time work. Therefore I believe she is fit at the very least, to attempt to increase to normal hours.

Avoiding working full time on the basis that doing so may aggravate subjective symptoms is not sufficient grounds to justify insurance benefit.

In my opinion [the Complainant] does not meet the definition of disability as required under this policy. I am not satisfied that she is disabled or unable by reason of illness to carry out the duties of her normal occupation. Regretfully I am unable to support her ongoing claim for insurance benefit".

27th October 2015 – Consultant Anaesthetist & Specialist in Pain Medicine

"[The Complainant] attends the pain management unit at [X] Hospital with severe ongoing headache and ocular migraine. [The Complainant] uses Indomethacin 25mg b.d./t.id for management of her persistent headache. In addition, she attends for IV Lignocaine and Ketamine Infusions.

I have advised [the Complainant] that she is not in a position to return to full working hours as a financial administrator due to her pain. If necessary, please do not hesitate to contact me directly with any queries regarding this".

30 June 2016 – Complainant to Provider – medical submission from her Pain Management Consultant

"[The Complainant] attends the Pain Management Unit at … Hospital on an ongoing basis. She is currently employed twenty hours per week and I would envisage that this is appropriate from a pain management perspective. I feel that [the Complainant] should maintain these working hours if possible but I feel that she is not suited to full time employment. If you have any queries regarding this, please do not hesitate to contact me directly".

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12 December 2015 – Provider's appointed Specialist Occupational Health Physician (2nd appointed Specialist)

> *"Is she currently fit for her normal occupation on a full time basis (35hr weekly):*
> *Subjectively [the Complainant] does not feel she can resume 35hr working week. She was concerned about the potential of her symptoms worsening with longer duration of computer use / paper work if she increases her work hours. I noted she is able to tolerate such activities at present, albeit on a shorter work hours. She has not tried returning to 35hr week since being commenced on her current treatment. Therefore it is not definitive that her condition is an absolute contra-indication for at least a trial of returning to her usual work hours.*
> *In addition, from my assessment, I noted her normal activity level after work and also a normal clinical examination.*
> *Therefore objectively there was no medical contra-indication for a resumption of 35hr week. I recommend a trial of phased return to 35hr week e.g. gradually increase her working hours over a period of 4-6 weeks to achieve the 35hr weekly. Task rotations at work and DSE / ergonomic assessment of her work station is recommended".*

4th August 2017 – the Complainant's Optician

> *"[The Complainant] has been our patient since 2009. Since then she has consistently c/o asthenopia & headaches at closework.*
> *Since then we have referred [the Complainant] to assessment by the following:*
> *..Orthoptist*
> *Ophthalmologist*
> *Neuro-Ophthalmologist*
> *National Optometry Centre Binocular Vision Clinic*
>
> *She has been diagnosed with a chronic binocular vision muscle imbalance, which has most likely existed since childhood.*
>
> *Her convergence is poor and this causes severe eyestrain & headaches at persistent closework. In many cases there is a possibility that incorporating prism into reading spectacles can relieve eyestrain. However when this was tried for [the Complainant] she did not notice any improvement.*
>
> *As this muscle imbalance has persisted for many years, it is unlikely that it will ever be cured.*
>
> *Orthoptist exercises have been of no benefit. The best outcome would be relief of her symptoms through prism, which will be an on-going issue.*
>
> *We will continue to work with [the Complainant's] orthoptist to try to relieve her symptoms".*

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The Complaint for Adjudication

The complaint for investigation and adjudication is whether the Provider correctly and reasonably assessed the claim for partial incapacity benefit.

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 on 18th 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.

In the absence of additional submissions from the parties, the final determination of this office is set out below.

Analysis

Having examined the submissions and the policy documentation I note the following.

The maximum liability of the Provider is as set out in the policy schedule, that is: *Incapacity Benefit €15,800* (which is index linked each year).

Where a partial benefit is payable, as was accepted by the Provider here, the Provider's maximum liability would be the amount which would bring the Complainant's overall payments up to 75% of her pre disability salary. In it submissions the Provider states:

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> *"Section 5.1 of the policy refers to the most we will ever pay on a claim and is designed to ensure that when a person meets the definition of disablement and a claim is payable their income from all sources is 75% of their pre-disability income".*

I consider that this applies whether full benefit is being paid or where partial benefit is being paid.

The Provider has referred to how it calculated the partial benefit and in its many submissions it sets out those calculations. However, the Provider unfortunately does not set out in the Policy documentation how such calculations are to be arrived at.

I note that the Provider's calculation of the partial benefit resulted in a payment that exceeded 75% of the pre disability income. I consider a more straight forward calculation of the partial benefit would have been achieved by the Provider simply calculating 75% of the Complainant's Pre Disability Earnings, adding up the Complainant's current income with any state benefits and bringing that figure up to the 75% calculation. The 75% threshold is achieved by adding an amount, which then represents the incapacity benefit. The most that ever would be paid by the Provider in this way would be the stated policy incapacity benefit, (as stated on the Policy Schedule subject to indexation).

Therefore, I consider that the Provider is incorrect in stating that it would have had no liability based on the Complainant's current earnings. The base line figure should always be 75% of the Pre Disability Earnings and any shortfall as between current earnings + state benefits, becomes the incapacity benefit that the Provider would be liable for. I consider that even leaving aside the Provider's concession of applying an 85% calculation there was a benefit payable, albeit a small sum. Due to the Indexation and the fluctuating state benefits the amount payable would also fluctuate, and on occasion, may result in no payment of incapacity benefit being payable.

When considering any Income from state benefits, and while it is unclear what state benefits were considered in this claim, I question the appropriateness of including Family Income Supplement (now known as Working Family Payment (WFP)) in the calculations, when deciding what payment is due to a claimant. This is because FIS / WFP is designed to supplement low income families.

Turning to the matter of whether the Complainant continues to meet the policy definition of disability. I have examined all the documentation, and I find little evidence to show how the Complainant's medical condition (that the Provider accepted as preventing her from carrying out her occupation), has improved or altered to suggest that a full time return to work was possible. There are some medical opinions provided which indicate that such a return is possible, but I consider that the Provider should have sought the opinion of a Specialist in the particular area that was preventing the Complainant from working. It is noted that in April 2015, the Provider's Claims Management Service recommended an Independent Medical Examination with an Ophthalmologist. The Provider did not follow this advice, but had the Complainant examined by a Neurologist and with two Specialists in Occupational Health. I believe it was not reasonable of the Provider not to have followed

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it's Claims Management Service's advice to have the Complainant examined by an Ophthalmologist or Neuro- Ophthalmologist to give an opinion on the Complainant's capacity to return to full time work.

I have had particular regard to the efforts of the Complainant to remain in the workplace with her medical condition and I consider it appropriate that such efforts are encouraged by both employers and Providers of income protection benefits.

Having regard to all of the above, it is my Legally Binding Decision that the complaint is upheld and that I direct that the Provider recommence payment of benefit and backdate payment to the date it stopped paying the incapacity benefit. While it is noted that the Provider had been paying incapacity benefit which brought the Complainant over the 75% Pre Disability Earnings threshold, I direct that this overpayment is not claimed back by the Provider, but going forward from the date of its last payment I direct that the more straight forward calculation be used, that is, the Complainant's current earnings + any relevant state benefits are to brought up to 75% threshold by the addition of the appropriate amount of incapacity benefit (if any). I would point out to the Complainant that with increases in state benefits or in her earnings may result in no income protection benefit being payable. I would also point out that income protection claims are reviewable by the Provider at its discretion. I direct that should the Provider medically review this claim again, that it would have the Complainant medically reviewed by an Ophthalmologist to establish the extent of her incapacity.

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)(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 recommence the payment of incapacity benefit using the 75% threshold and back date any payment of same since it was last paid. I also direct that should the Provider wish to review the claim again it should appoint an Ophthalmologist to give an opinion as to the Complainant's capacity for full time work.

- 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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

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15th March 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

ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.