An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0094
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Rejection of claim
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants incepted a mortgage protection policy with the Provider on 11 May 2001, which provided them with joint life death benefit and critical illness cover, including permanent disability quality of life cover.

The Complainants' Case

The First Complainant was diagnosed with [named medical condition] and submitted a critical illness claim to the Provider in September 2012. The Provider subsequently declined the First Complainant's claim on 21 March 2013 as it determined that her diagnosis was not one of the medical conditions listed in the Complainants' policy as a critical illness. In addition, as part of its claim assessment, the Provider referred the First Complainant for a Functional Capacity Evaluation test in February 2013, which indicated that she did not meet the criteria for permanent disability quality of life cover as defined in the policy conditions. In this regard, the First Complainant notes that "the policy has not covered her loss of income".

As a result, the Complainants seek for the Provider to admit the First Complainant's claim or refund all premiums paid in respect of their policy.

The Provider's Case

Provider records indicate that the Complainants became members of the Provider's Group Mortgage Protection Scheme on 11 May 2001, which provided them with joint life death benefit and critical illness cover, including permanent disability quality of life cover.

The First Complainant submitted a Critical Illness Claim Form dated 4 September 2012 wherein she detailed her medical condition as "Permanent nerve damage to back and leg". The Medical Report from Dr V., Consultant in Pain and Management and Anaesthetics, dated 17 December 2012 confirmed the First Complainant's diagnosis to be [named medical condition] and this was the condition upon which the Provider assessed the claim.

The Provider notes that the [named medical condition] is not one of the critical illnesses listed in the Complainants' policy conditions, thus it was unable to assess a Critical Illness claim in respect of the First Complainant's medical condition. However, the Complainants' policy also provides permanent disability quality of life cover and the Provider also assessed the First Complainant's claim applying the relevant policy definition. As part of its claim assessment, the Provider referred the First Complainant for a Functional Capacity Evaluation test in February 2013, the results of which indicated that she did not meet the criteria for permanent disability quality of life cover, as defined in the policy conditions. The Provider notes that the Functional Capacity Evaluation medical evidence was quite categorical in its findings. It is acknowledged that the bar is quite high to have a valid claim under the policy definition, which is reflected in the premium apportioned for this benefit.

The Provider notes that the First Complainant's medical condition is not one of the critical illnesses listed in the Complainants' policy conditions. In addition, the Provider concluded from the medical reports before it that the First Complainant did not meet the criteria for permanent disability quality of life cover, as defined in the policy conditions. As a result, the Provider declined the First Complainant's claim by way of correspondence dated 21 March 2013.

Whilst the First Complainant submits that "the policy has not covered her loss of income", the Provider notes that there is no income protection cover under the Complainants' policy. The Complainants' policy benefits are death benefit and critical illness benefit, which included permanent disability under a quality of life definition. The Complainants chose Permanent Disability quality of life cover when completing the policy application in May 2001 and again when they applied for an increase in cover in April 2004. In this regard, the Provider notes that the income protection cover that may have provided the First Complainant with benefit in these circumstances, was not applied for in May 2001 or April 2004. It also notes that income protection cover is a relatively expensive cover in comparison to the existing policy benefits.

The Provider is satisfied that the First Complainant has a medical condition that is not covered under the policy. The Complainants' policy remains in force and continues to provide the cover applied for. As a result, there is no basis for a refund of premiums from inception as the Provider has been on risk since May 2001. The Provider is satisfied that it

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declined the First Complainant's claim in accordance with the terms and conditions of the Complainants' policy.

Complaint for Adjudication

The Complainants' complaint is that the Provider wrongly or unfairly declined the First Complainant's claim.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainants were given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on 14 March 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.

As the Complainant's named medical condition is relatively rare, it has not been identified by name within this decision, in order to protect the identity of the First Complainant, when the Legally Binding Decision is ultimately published by this office.

The complaint at hand is that the Provider wrongly or unfairly declined the First Complainant's claim. In this regard, the Complainants incepted a mortgage protection policy with the Provider on 11 May 2001, which provided them with joint life death benefit and critical illness cover, including permanent disability quality of life cover.

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The First Complainant was diagnosed with [named medical condition] and submitted a critical illness claim to the Provider in **September 2012**. The Provider subsequently declined this claim on **21 March 2013** as it determined that the First Complainant's diagnosis was not one of the medical conditions listed in the Complainants' policy as a critical illness. In addition, as part of its claim assessment, the Provider referred the First Complainant for a Functional Capacity Evaluation test in **February 2013**, which indicated that she did not meet the criteria for permanent disability quality of life cover as defined in the policy conditions.

The Complainants' mortgage protection policy, like all insurance policies, does not provide cover for every eventuality; rather the cover is subject to the terms, conditions, endorsements and exclusions set out in the policy documentation. In this regard, **Part 5, 'Main benefits'**, of the applicable Policy Conditions booklet provides, inter alia, at pg. 10, as follows:

"16. Critical illness benefit

To qualify for critical illness benefit, a life assured must be diagnosed by a consultant physician in a major or public hospital in Ireland or the United Kingdom as suffering from any of the illnesses defined below. Unless the critical illness benefit in respect of a life assured is an accelerated benefit, the life assured must also be alive at least 14 days after the date the illness was first diagnosed.

[My emphasis]

Our Chief Medical Officer must verify the diagnosis of any critical illness.

The critical illnesses covered are listed below:

- Alzheimer's Disease …
- Angioplasty …
- Aorta surgery …
- Bacterial Meningitis …
- Benign brain tumour …
- Blindness …
- Burns (severe)…
- Cancer …
- Chronic Liver Disease …
- Coma …
- Coronary artery surgery …
- Creutzfeldt-Jakob Disease …
- Deafness …
- Emphysema …
- Heart attack …
- Heart value and a structural surgery …
- HIV or AIDS (from a blood transfusion or needlestick injury or physical assault) …
- Kidney failure …
- Limbs (loss of) …

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- Major head injury …
- Major organ transplant …
- Motor Neurone Disease …
- Multiple Sclerosis …
- Muscular Dystrophy …
- Paralysis …
- Parkinson's Disease …
- Rheumatoid Arthritis …
- Speech (loss of) …
- Stroke …
- Systemic Lupus Erythematosus …
- Terminal Illness (applies only is the critical illness benefit is an accelerated benefit)".

The Complainants' policy only provides critical illness benefit in respect of those critical illnesses listed in the policy conditions listed above (and only where the diagnosis meets the definition of the critical illness provided therein). In this regard, **Part 5, 'Main benefits**', of the Policy Conditions booklet provides, inter alia, at pg. 9, as follows:

> **"Note: …**
>
> **If you are covered for critical illness benefit, please remember that you will only be considered critically ill if you meet the exact definition of the illnesses listed below".**

I note from the documentary evidence before me that in her report dated 17 December 2017, Dr V., Consultant in Pain and Management and Anaesthetics advises that "[the First Complainant] underwent an L5/S1 microdiscectomy under the care of [Mr D., Consultant Neurosurgeon] on 7/03/10 for a [named medical condition]". Having reviewed the policy conditions, I am satisfied that this diagnosis is not one of the critical illnesses listed in the policy document.

I note that the Provider also assessed the First Complainant's diagnosis under the Complainants' permanent disability quality of life policy cover. In this regard, **Part 5, 'Main benefits'**, of the applicable Policy Conditions booklet provides, inter alia, at pg. 14, as follows:

> **"18. Permanent disability**
>
> If your policy includes permanent disability the list of critical illnesses in condition 16 will also include permanent disability …
>
> Up to age 60 …

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If the certificate of cover refers to 'quality of life', disabled will mean that the life assured has either suffered mental illness which has not responded to treatment, which requires continuous psychotropic medication, professional psychiatric supervision and care, and which results in persistent severe mental dysfunctioning or has permanently lost the ability to do two or more of the following activities

Walking Walk for more than 200 metres, on a level surface with a walking stick or other aid, without stopping or severe discomfort.

Lifting and Carrying Pick up, with either hand, a one kilogram weight from table height and carry it for 5 metres.

Operating Controls Physically able to operate standard light switches or taps with either hand.

Hearing Hear, while using a hearing aid, well enough to understand someone speaking a common language in a normal voice in a quiet room.

Speaking Be understood by other people when speaking in a common language in a quiet room.

Vision See well enough, when using glasses, contact lenses or other aids, to read a large print book. By large print we mean 16 point typeface such as

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.... We will not pay any benefit unless disability has continued without interruption for six consecutive months (the 'qualifying period') or for any longer period we may reasonably decide to be sure that the disability is permanent".

I note that there are additional policy provisions which apply "When a life assured has reached age 60", but in this instance, as the First Complainant has not reached age 60, these policy provisions are not relevant and have not been quoted in this decision.

As part of the Provider's assessment, I note that the First Complainant's GP completed the Report Critical Illness Claim (Permanent Disability) form on 16 November 2012, as follows:

"In order for a claim to be paid the following definition must be met:

"For policyholders up to the age of 60, the policy conditions specify that to be **permanently disabled** the policy holder must have **lost permanently the ability to do two or more of the following activities"**.

Walking Walk for more than 200 metres, on a level surface with a walking stick or other aid, without stopping or severe discomfort. **This is not possible for [the First Complainant]**

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Lifting and Carrying Pick up, with either hand, a one kilogram weight from table height and carry it for 5 metres. **N/A No problems in these areas**

Operating Controls Physically able to operate standard light switches or taps with either hand. **N/A No problems in these areas**

Hearing Hear, while using a hearing aid, well enough to understand someone speaking a common language in a normal voice in a quiet room. **N/A No problems in these areas**

Speaking Be understood by other people when speaking in a common language in a quiet room. **N/A No problems in these areas**

Vision See well enough, when using glasses, contact lenses or other aids, to read a large print book. By large print we mean 16 point typeface such as

A B C D E F

N/A No problems in these areas".

In addition, at the request of the Provider, the First Complainant also attended for a Functional Capacity Evaluation on 11 February and 12 February 2013 at the Irish Centre for Assessment Rehabilitation & Ergonomics. In this regard, in her Summary Report dated 12 February 2013, I note that Ms. C. advised, inter alia, as follows:

"This is a Critical illness claim. The following definition has to be met as outlined by [the Provider]. "The policy holder must have lost permanently the ability to do tow or more of the following activities":

1. Walking: Walk for more than 200 metres, on a level surface with a walking stick or other aid, without stopping or severe discomfort. [The First Complainant] is fit to perform this task.

2. Lifting & Carrying: Pick up, with either hand, a one kilogram weight from table height and carry it for 5 metres. [The First Complainant] is fit to perform this task.

3. Operating Controls: Physically able to operate standard light switches or taps with either hand. [The First Complainant] is fit to perform this task.

RECOMMENDATIONS:

1. [The First Complainant] meets all 3 of the above physically (sic) requirements & as such does not meet the conditions of being permanently disabled as outlined above".

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Accordingly, I am satisfied that it was reasonable for the Provider to conclude from the medical evidence before it that the First Complainant's medical condition did not meet the policy definition for a critical illness or a permanent disability quality of life claim as defined within the policy, and that it therefore declined her claim in accordance with the terms and conditions of the Complainants' policy.

I note that the First Complainant submits that the Complainants' policy "has not covered her loss of income". In this regard, the Provider states that the Complainants' policy does not provide them with income protection cover. I note from the documentary evidence before me that the policy application signed by the Complainants on 22 April 2001 indicates that they chose life cover, critical illness cover and permanent disability cover, ticked as quality of life. In addition, the same cover was selected in the application the Complainants signed on 20 April 2004 when they applied to increase their level of cover.

Part 5, 'Main benefits', of the applicable Policy Conditions booklet provides at pg. 9, as follows:

> "The main benefits provided under the Protection Provider are Death benefit and Critical Illness benefit (with or without permanent disability benefit. Your policy schedule will show:
>
> - which of these benefits apply to your policy;
> - what the sum assured is in respect of each life assured".

In this regard, I note that the Provider wrote to the Complainants on 11 May 2001 and that the enclosed Certificate of Cover provides, inter alia, as follows:

> "The sums assured are payable when the corresponding life assured suffers an insured event as defined in the policy conditions.
>
> | Insured events: | Sum assured Life 1 | Sum assured Life 2 |
> |---|---|---|
> | Death | £50,000.00 | £50,000.00 |
> | Critical illness or permanent disability (quality of life) | £20,000.00* | £20,000.00* |
>
> * this sum assured is an accelerated benefit and therefore if it becomes payable first, the amount payable on the death of that life assured will be reduced by a corresponding amount".

I am satisfied that it was clear from this Certificate of Cover that the Complainants' policy only provided death and critical illness or permanent disability (quality of life) cover. In this regard, there is no reference on the application forms completed and signed by the Complainants on 22 April 2001 and 20 April 2004 or on their Certificate of Cover, to any element of income protection cover.

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In all of the circumstances, whilst one must sympathise with the First Complainant for the very difficult circumstances in which she finds herself, I am satisfied that the evidence discloses no wrongdoing on the part of the Provider and in those circumstances there is no reasonable basis upon which this complaint can be upheld.

It is my Decision therefore, on the evidence before me that this complaint is rejected.

Conclusion

My Decision pursuant to **Section 60(1)** of the **Financial Services and Pensions Ombudsman Act 2017**, is that this complaint is rejected.

The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION AND LEGAL SERVICES

8 April 2019

Pursuant to Section 62 of the Financial Services and Pensions Ombudsman Act 2017, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that—
(a) ensures that—
(i) a complainant shall not be identified by name, address or otherwise,
(ii) a provider shall not be identified by name or address,
and
(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.