An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0303
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Rejection of claim - late notification
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant is a farmer who was injured in the course of his employment. The Provider refused to admit his claim on the basis that he informed them too long after sustaining his injury.

The Complainant's Case

The Complainant took out an insurance policy with the Provider on **21 October 2014.** The Complainant made a claim to the Provider on **19 January 2017** under this policy for an injury he sustained while working on his farm. Initially, the Complainant stated this injury happened **1 April 2016,** nine months before he made this claim.

The Complainant stated that his right shoulder had been injured on that occasion by a kick from an animal. On **31st May 2017**, following clarification from his medical practitioners, the Complainant wrote as follows to the Provider,

> *"The date 1 April 16 was an error. 1 April 2015 was the correct date. I was a bit mixed up at the time."*

The Complainant believes that the Provider had acted arbitrarily in not paying his claim under the policy and seeks that the Provider settle his claim in the region of €10,000. He

states that the Provider has used his error in identifying the year the injury was sustained in order to refuse to settle his claim.

The Provider's Case

The Provider's position is that the incorrect identification of the year of the injury being sustained is not relevant to this complaint: it refers to the delay in informing the Provider as crucial to the refusal of indemnity.

When the claim was first made on **19 January 2017**, the Provider's agent spoke to the Complainant by telephone. The Provider states that it informed the Complainant that the Provider would reserve its rights under the policy because of the late notification and send him a claim form.

The Provider states that on **24 January 2017**, it telephoned the Complainant seeking confirmation that he had received the claim form. The Provider's agent, having discussed the severity of the Complainant's injury and impact it had on him, asked him to complete the forms and return them. The agent re-iterated that she would send out the late notification form since the previous letter had not been saved onto its computer system.

On **24 January 2017**, the Provider states that it wrote to the Complainant about the exclusions, exceptions and conditions to the Policy the Complainant held. This letter reserved the Provider's rights due to the late notification of the injury. Its letter refers among other things, to, *"In addition, compliance with the notification condition is a condition precedent to the liability of the company providing indemnity under the policy."*

On **27 January 2017**, the Provider's case notes refer to a previous claim by the Complainant for an injury to his left shoulder in 2014 sustained while working on his farm.

The Provider states it received the completed claim form on **2 February 2017,** describing how the injury to the Complainant's right shoulder was sustained on **1 April 2016**. The Provider further states that after clarifying details of medical notes and histories from the Complainant's GP and surgeon, it became apparent that there were two separate injuries and also that the dates of the medical notes were incompatible with the details of the Complainant's claim form.

The Provider states in a letter to the Complainant dated **8 March 2017**, that the Complainant's GP referred to an MRI scan on an injured right shoulder and that in May 2016, the GP referred to an injury sustained one year previously. The Complainant's surgeon corresponded with the Complainant's GP on **9 September 2016**, discussing the right shoulder injury, which had been sustained in 2015. In its letter the Provider stated it could not confirm the cover based on the information available. Initially, the Provider thought that it may have been a pre-existing condition, since the medical notes furnished to it suggested an injury which pre-dated the harm described in the claim form.

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On **31 May 2017** the Complainant wrote to the Provider stating. *"The date 1-4-16 was an error. 1-4-15 was the correct date. I was a bit mixed up at the time."*

The Provider states that it then reviewed the medical evidence that the injury had actually been sustained on **1 April 2015**. On that basis, having already reserved its position on the basis of late notification, the Provider declined the claim on the basis of a late notification, some 21 months after the incident had occurred. On **16 June 2017**, the Provider informed the Complainant of its declinature of his claim relying on the 21 month time period between the injury and the notification of the claim. The Provider also refers to a previous claim from December 2014, which it did not settle with the Complainant until March 2016.

The Complaint for Adjudication

The complaint is that the Provider unreasonably declined the Complainant's claim for personal injury under his insurance policy, based on the Complainant's mistake in writing an incorrect year on the claim form.

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 22 August 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, within the period permitted, I set out below my final determination.

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I note that the date of the injury sustained by the Complainant while working on his farm is no longer in dispute. Although the Complainant did make an error of 12 months, the Provider had reserved its right to decline the claim immediately in its letter of **24 January 2017,** based on the late notification. The date accepted by both parties to the dispute is **1 April 2015**, this was arrived at after consideration of the medical submissions by the GP and surgeon.

I note the Provider's reliance on the terms and conditions of the policy for rejecting the claim. In the section titled, 'Special Conditions and Exceptions', the policy contains the following, "*Immediate notice in writing must be sent to the Head Office or any branch office of the Company of any accident to the insured person who must as early as possible place himself / herself under the care of a fully qualified Medical Practitioner."*
Initially the Provider thought the period of late notification was 9 months, but it later turned out to be 21 months.

In its Final Response Letter of **16 June 2017**, the Provider stated that:

> *"We have reviewed your recent correspondence and additional medical information supplied by your surgeon in respect of the date of the incident when you had injured your right shoulder…..We must inform you that under your Personal Accident Plan-Based policy there are a number of special conditions and exceptions to the cover provided which also includes claim notification as set out below…..Immediate notice in writing must be sent to the Head Office or any branch office of the Company of any accident to the insured person who must as early as possible place himself / herself under the care of a fully qualified Medical Practitioner.*
>
> *As the injury to your right shoulder as confirmed both by you and your own treating surgeon had occurred almost 21 months before we were notified of the incident we must advise that we will be unable to provide the benefit of the protection offered by the policy on this occasion".*

While there is no precise definition of the term, "immediate notice" nor clear guidance on how it should be interpreted within the terms and conditions, it is in my view clear that a 21 month delay in notification is not reasonable and cannot be considered to be immediate. I do not accept that the error in originally submitting the date **1 April 2016** and then altering it to **1 April 2015** had any material effect on the position of the Provider, who had already taken steps on the basis of a nine month delay to reserve its position, before it discovered the delay was actually 21 months.

The Provider has furnished recordings of two telephone calls with the Complainant, the content of which I have considered. The first, dated **19 January 2017**, the day the claim was submitted, clearly states that the Provider considered it to be a late notification and would reserve its rights.

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I also note that the Complainant had a previous claim for personal injury with the Provider under the same policy from December 2014, which it did not settle with the Complainant until March 2016. It would seem reasonable that the Complainant would communicate with his Provider that a second injury, to the other shoulder, had been sustained while the settlement of the first claim was being undertaken. It seems extraordinary that, having been injured again in April 2015, the Complainant would make no mention of that fact during the eleven months until the first claim was settled.

I accept that under the terms and conditions of the policy it was reasonable for the Provider to decline the claim on the basis of the late notification of the injury.

I note that in its letter dated **24 January 2017**, reserving its rights due to the late notification, the Provider also states, "*In addition, compliance with the notification condition is a condition precedent to the liability of the company providing indemnity under the policy*".

While it is clear that the notification to the Provider of an incident that may give rise to a claim is a condition of the policy, it is less clear if it is a 'condition precedent' to liability under that claim; that is, a condition which must be satisfied before the Provider becomes liable to pay the claim. The Provider states in its letter to the Complainant of **24 January *2017*** *'In addition [to] compliance with the notification condition [it] is a condition precedent to the liability of the company providing indemnity under the policy,'* but does not make specific reference to any part of the terms of the conditions which make that stipulation.

While there is no specific clause within the policy which references conditions precedent, under the section, Operative Clause, the insurance policy states that:

> *"The Company AGREES to insure in the manner and to the extent hereinafter provided in the respective sections specified in the current schedule and appendices thereto, (which the section and every appendix thereto shall be deemed to be incorporated in and form part of this Policy) in respect of event occurring in the Territorial Limits during the period of insurance specified in the schedule or any period for which the Company accepts the premium required for the renewal of this Policy. NOW THIS POLICY WITNESSETH: - that subject to the terms and conditions contained herein or endorsed or otherwise expressed herein."*

It could be reasonably interpreted as the provider's intention to insure the Complainant, '*subject to the terms and conditions contained herein'*. This however is inadequate for the purposes of constructing a condition precedent. Relevant case law provides that there will be no finding of a condition precedent in the absence of the clearest possible language *(George Hunt Cranes Ltd vs Scottish Boiler and General Insurance Co. Ltd. [2001] ERCA. Civ 1964).* The courts will not construe an insurance condition to be a condition precedent unless it is expressed to be a condition precedent, or the policy contains a general condition precedent provision. *(Buckley on Insurance Law 4th Edition, paragraphs 5 – 64.)*

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There is no specific or general condition precedent, or a reference to one in the policy relevant to this complaint which makes it clear that the condition of immediate notification was a condition precedent to liability. Therefore, while it is a condition within the policy, it is not a condition precedent to liability.

Where the term is not a condition precedent to liability, the Provider's remedy for a breach of the notification condition would either be termination of the entire policy from the date of the breach (which is only available where the breach goes to the heart of the contract) or damages (which is only available where loss can be proved.) A remedy not available to the Provider is to decline to accept liability in respect of a particular claim.

On that basis, while I find that the Complainant has clearly breached the notification requirements of the policy, that notification is not a condition precedent to liability of the Provider for indemnity under the policy.

That said, given the extent of the late notification, I find that it was not unreasonable for the Provider to reject the claim.

For that reason, I do not uphold this complaint.

Conclusion

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

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

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

23 September 2019

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Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that—

(a) ensures that—

(i) a complainant shall not be identified by name, address or otherwise,

(ii) a provider shall not be identified by name or address, and

(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.