An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0326
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Rejection of claim - did not meet policy definition of illness
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants incepted a Total Care policy with the Provider in **September 1994**.

During **2014** the First Complainant underwent surgery to remove his right kidney due to the presence of a tumour. Following his surgery, the First Complainant made a claim under the policy. The Provider refused the claim on the grounds that the First Complainant did not satisfy the definition of cancer contained in the policy. The First Complainant believes that he has satisfied the definition of cancer and further states that the Provider failed to explain that non-invasive cancer was not covered by the policy.

The Complainants' Case

The Complainants state that they were sold a Total Care policy by the Provider in **1994**. The Complainants state that the First Complainant was diagnosed with cancer of the right kidney and underwent surgery. The Complainants then made a claim under the policy for critical illness benefit. The Complainants state that their claim was refused on the basis that the definition of critical illness was not met.

The Complainants submit that their surgeon reviewed the First Complainant's medical records and formed the view that the cancer was invasive and should therefore, be defined

as a critical illness under the policy. The Complainants submit that they were never informed that *non-invasive* as distinct from *invasive* cancers were not covered by the policy. In resolution of this complaint that Complainants want *"[p]ayment on foot of the policy."*

The Provider's Case

The Initial Claim

The Provider states that the Complainants took out a Total Care policy on **15 September 1994**. The policy schedule and conditions were issued to the Complainants by letter dated **15 September 1994** which set out the initial benefits under the policy.

The Provider states that it received a telephone call from the First Complainant on **10 October 2014** enquiring about the level of benefits offered by the policy. The Provider states that the First Complainant was advised as to the level of cover offered by the policy, and during the call he advised that he was due to undergo surgery to remove one of his kidneys.

The Provider states that the First Complainant was not advised during this call that his claim for cancer would be admitted. The Provider states that he was advised that cancer was one of the illnesses covered under the policy and that for a claim to be admitted, his diagnosis must fully meet the definition of cancer as set out in the policy. The Provider states that this definition was read to the First Complainant during the call and he was informed that it was not possible to determine over the telephone whether or not his diagnosis satisfied that definition. The Provider states that the First Complainant was advised that such a determination could only be made after a careful assessment of his claim form together with the medical information that would be obtained from his treating specialists. A claim form was issued to the First Complainant on **10 October 2014** and a completed claim form was received on **14 October 2014**.

Following receipt of the claim form, the Provider wrote to the First Complainant's GP on **17 October 2014** requesting that he complete a private medical attendant report and also provide a copy of the First Complainant's histology report. The Provider states that it wrote to the First Complainant's consultant urologist and requested that he complete a specialist medical report for cancer. The Provider also wrote to the First Complainant by way of update and to request further details in relation to his family history.

The First Complainant's GP report and supporting documentation was received on **24 October 2014** and he provided the requested information regarding his family history on **30 October 2014**. The Provider states that the information supplied by the First Complainant's GP was assessed and a letter issued to the GP on **12 November 2014** requesting additional information. The Provider states that the First Complainant's specialist medical report on cancer, was received on **3 December 2014**. The Provider states that the First Complainant's consultant:

> *"… confirmed in his report that* [the First Complainant's] *tumor was a 'low grade Tcc Ta Tcc', which means that the tumor was in-situ. … and confirmed that the tumor*

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was completely localised, that there was no invasion of adjacent tissue, that there were no regional lymph nodes involved and that there were no distant metastases."

The Provider states that the information made available by the First Complainant's GP and consultant were assessed by its claims department and one of its Chief Medical Officers (**CMO**). The Provider states that based on the evidence received it was concluded that the definition of cancer was not met because *"… there was no evidence of an uncontrolled growth and spread of malignant cells, there was no evidence of an invasion of tissue, the tumor had been categorised as non-invasive and in-situ and there was no evidence of malignancy."* The Provider states that before confirming the final claim decision to First Complainant, it awaited receipt of the additional information which was sought from his GP.

The Provider states that the First Complainant contacted its office on **15 December 2014** for an update on his claim and was advised that on the basis of the medical evidence obtained at that point, it appeared that his claim would not be admitted as the definition of cancer had not been met.

The Provider states that the additional information requested from the First Complainant's GP was received 3 months later, on **30 March 2015**. The Provider then wrote to the First Complainant on **8 April 2015** to confirm receipt of this information and to request some final details in relation to his family history.

The Provider states that following a review of all of the information obtained in respect of the claim, it informed the First Complainant by letter dated **13 May 2015** that the definition of cancer contained in the policy, had not been met and that his claim was not admitted.

The First Appeal

The Provider states that 10 months after the First Complainant's claim was declined, the First Complainant's consultant wrote to it on **15 March 2016** to advise that the First Complainant had been diagnosed with a high grade transitional cell carcinoma and consequently he believed that the cancer should be deemed to be invasive.

The Provider's claims department assessed this additional information in conjunction with a different CMO. The Provider states that while the First Complainant's consultant had taken the view that the tumour should be considered invasive as it was ultimately treated as a high rather than a low grade transitional cell carcinoma, the medical reports still confirmed the final staging of the tumour to be *Ta* which is a non-invasive transitional cell carcinoma. The Provider submits that the fact that the tumour was high grade rather than low grade, did not alter the decision regarding the First Complainant's claim as the tumour was non-invasive and there was still no evidence of malignancy. The Provider states that it maintained its decision to decline the First Complainant's claim and advised the First Complainant of its decision by letter dated **12 April 2016**.

The Provider states that it received a telephone call from First Complainant requesting that its CMO write to his consultant explaining the reasons why the appeal was declined. The Provider states that its CMO wrote to the consultant on **26 May 2016**.

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The Second Appeal

The Provider states that the First Complainant referred the matter to his solicitor in **August 2016**. The Provider received a letter from the Complainant's solicitor on **15 August 2016** requesting a copy of the medical reports obtained from the First Complainant's GP and consultant. Following receipt of these reports, the Provider states that it received a letter from the Complainant's solicitor requesting that it re-consider its decision in respect of the claim. The Provider states that its claims department completed another assessment of the Complainant's medial information in conjunction with both of its CMOs. One of the Provider's CMO advised that he would be happy to review the claim further, if additional histological reports were received. On the advice of the second CMO, a report was sought from an independent consultant histopathologist. This report was received on **14 March 2017**.

The Provider states that the independent consultant *"… was neither in a position to confirm that the tumour was invasive, nor could he confirm the presence of any malignancy."* The Provider states that following a review of this report the decision to decline the Complainant's claim remained unchanged and the First Complainant was advised of this by letter dated **6 April 2017**. The Provider states that a copy of this report was provided to the First Complainant's solicitor, who then forwarded it to the Complainant's consultant.

Further Review of the Claim

The Provider was forwarded a letter written by the Complainant's consultant dated **8 June 2017** by the Complainant's solicitor on **8 June 2017**. The Provider states that the letter advised that the Complainant's consultant had reviewed some additional reports that had not been previously reviewed and which had not been furnished to the Provider. The Provider states that having considered the contents of this letter it wrote to the Complainant's solicitor on **9 October 2017** to confirm that the decision to decline the claim remained.

The Provider states that it requested the Complainant's full histology report from the consultant in **January 2018** as it appeared that this had not been provided up to that point. The Provider submits that the full histology reports were received on **1 February 2018**. The Provider states that the last page on the histology reports dated **23 October 2014** confirm that *"… 'there is no evidence of malignancy'."*

The Provider submits that this report provides conclusive evidence that the Complainant's tumour was not malignant. The Provider further submits that there is no reference in the reports to invasiveness of tissue. The Provider states that on **19 January 2018** one of its CMOs reviewed the full file again, including the additional histology reports and stated that *"An area of local urothelial hyperplasia is noted. No evidence of malignancy, not even an in-situ tumour. Claim remains a decline."*

The Provider advises that prior to responding to the Schedule of Questions provided to it by this Office, it asked another of its CMOs to complete a review of the Complainant's medical

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file. The Provider states that this review was completed on **21 August 2018** and the CMO was of the view that the Complainant did not satisfy the required definition.

The Provider submits that the medical evidence confirms that the tumour was in-situ and an in-situ tumour is specifically excluded under the policy terms and conditions; the histology reports confirm that there was no evidence of malignancy; and the medical reports confirm that the tumour was not invasive.

The Provider states that the policy continues to be administered in accordance with the terms and conditions provided to the Complainants in **1994** and the definition of cancer has not changed over the years.

The Complaint for Adjudication

The complaint is that the Provider wrongfully and/or unreasonably declined the First Complainant's claim for critical illness benefit. The Complainant is very unhappy with the decision, and he suggests that the Provider failed to advise the Complainants at the time they incepted their policy in 1994, that non-invasive cancer (as distinct from invasive cancer) was not covered by the policy.

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 on7 October 2019, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

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

It is important to emphasise that, for the purpose of assessing this complaint, it is not the role of this Office to comment on or form an opinion as to the nature or severity of the First Complainant's illness or condition. It is the duty of this Office to establish whether, on the basis of an objective assessment of the medical evidence submitted, the Provider adequately assessed the First Complainant's claim and whether it was reasonably entitled to arrive at the decision it did, following its assessment of the medical evidence submitted, to decline the claim.

The Policy

The Complainants completed a Total Care proposal form dated **6 September 1994**. By letter dated **15 September 1994** the Provider wrote to the Complainants enclosing a copy of the policy and a notice containing some important features of the policy. The letter advised the Complainants that if they had any questions regarding their policy that they should contact their insurance adviser.

I note that Section 19 of the policy, deals with critical illness benefit and states as follows:

> *"19.2 Critical Illness means in respect of a Life Assured the diagnosis and certification by a medical practitioner registered in the Approved Territories, and by other consultant physicians if specified below, and verification at the Company's Chief Medical Officer's discretion of the first occurrence after the Commencement Date of any of the following:-*
> *…*
>
> ***CANCER***
> *A malignant tumour characterised by the uncontrolled growth and spread of malignant cells and the invasion of tissue. This includes leukaemia but excludes non-invasive cancer in situ, tumours in the presence of any human immunodeficiency virus and any skin cancer other than malignant melanoma. …".*

Specialist Medical Report

The First Complainant's consultant furnished the Provider with a report dated **1 December 2014**. In the Medical Details section of this report the consultant described the First Complainant's diagnosis and tumour as *"low grade Tee Ta Tee."* The consultant then describes the histology as *"low grade Tee."* When asked what stage the cancer reached the consultant answered *"Ta – Tee."* When asked if there was invasion of adjacent tissue the consultant ticked 'No'. In answer to question 7, the consultant states *"Initial … was high grade Tee but subsequent analysis of kidney revealed low grade tee."*

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Assessment of the Claim

The Provider's claims specialist advised the First Complainant by letter dated **16 December 2014** that his claim was still being assessed but *"… from speaking with my colleagues unfortunately your claim does not satisfy the policy definition as had been emailed to you."* By letter dated **13 May 2015** the First Complainant was advised that his claim was being declined:

> *"… We received reports from [the First Complainant's consultant]* and [the First Complainant's GP] *in order to assess your claim. Our Chief Medical Officer has reviewed these reports and I am sorry that, in this instance, there is no claim payable in respect of the critical illness benefit attaching to your policy.*
>
> *In order to qualify for payment under critical illness benefit you must meet the following criteria:*
>
> *Definition to be met …*
>
> *As you are aware according to the medical information received our Chief Medical Officer is satisfied that this definition has not been met. From the information received from your specialist we are aware that* [the First Complainant] *was diagnosed with a low grade Transitional cell carcinoma of the right kidney which is deemed a non-invasive cancer. …"*

In a letter dated **15 March 2016** from the First Complainant's consultant to the Provider, the consultant writes:

> *"I am in receipt of a letter which you have written to [the Complainants] dated 13/5/2015 regarding their claim.*
> *As you have in paragraph 5 reported that [the First Complainant] was diagnosed with a low grade transitional cell carcinoma of the R kidney, however it was actually on a high grade transitional cell carcinoma of the R kidney which I proceeded to do his surgery. I am attaching the report of the initial biopsy and cytology which should be deemed invasive cancer."*

The Provider advised the First Complainant that it was maintaining its decision to decline the claim by letter dated **12 April 2016**. I note the following paragraph from this letter:

> *"Our Chief Medical Officer also sought an independent Oncologist view in order to assess the claim further. According to the histology report that we received the final stage was TA which is non-invasive Transitional Cell Carcinoma. Our Chief Medical Officer and the independent oncologist are satisfied that the above definition has not been met and that this cancer has been confirmed as non-invasive."*

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As requested by the First Complainant, the Provider's CMO wrote to the Complainant's consultant by letter dated **26 May 2016** explaining the reasons for the decision to decline the claim. The relevant parts of the letter state:

> *"*[The Complainant] *has claimed under his critical illness policy which requires the presence of an invasive carcinoma with spread of malignant cells and the invasion of tissue. Unfortunately from our reading of the histological report of kidney tumour, this does not appear to have been an invasive tumour. There was no histological evidence of invasion. The final histological report on the infected specimen indicated a low grade transitional cell carcinoma with no mention of invasion.*
>
> *As such, in my opinion,* [the Complainant's*] tumour does not meet the level of severity required for payment of this claim."*

By letter dated **14 December 2016** the Complainant's solicitor wrote to the Provider expressing the view that the claim should not have been declined, and requested that the claim be reconsidered.

The Provider received a report from an independent consultant histopathologist dated **13 March 2017**. I note the following parts of this report:

> *"Comment:*
>
> *The diagnosis of upper urinary tract transitional cell carcinoma … is difficult, much more so than for carcinomas of the bladder. The endoscopes used to access the renal pelvis and calyces are very small and biopsies taken during these endoscopic procedures are usually small and fragmented and frequently demonstrate significant crush artefact. The radiographic and endoscopic appearances are important in establishing the diagnosis, and surgeons sometimes proceed to nephroureterectomy without a preoperative histological diagnosis of neoplasm.*
>
> *There are three main categories of transitional call carcinoma: non-invasive papillary urothelial carcinoma, carcinoma in situ (CIS) and invasive transitional cell carcinoma. The 1st two are non-invasive but have the potential to progress to invasive disease over time. In the case under consideration, the presence of a visible "raised area" effectively excludes CIS, which by definition is a flat lesion. Most non-invasive papillary transitional cell carcinomas in the upper urinary tract are high-grade.*
> *…*
>
> *Conclusion:*
>
> *Patients who have invasive transitional cell carcinoma of the upper urinary tract are as likely as not, to have preoperative biopsy specimens that demonstrate non-invasive disease only. This is in contrast to other sites (e.g. skin, colon) wherein preoperative biopsies are in general accurate in predicting the tumour stage. In my opinion, it is not reasonable to apply the policy definition that excludes non-invasive cancer in-situ, to neoplasms of the upper urinary tract."*

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The Provider appears to have received correspondence from its reinsurers, in respect of the Complainant's claim on **23 March 2017** which states as follows:

> *"Thank you for your patience while I referred this to our CMO.*
>
> *He replied 'The key question is whether there was invasive cancer in the renal pelvis or renal calyces. (This disease is similar to bladder cancer and many cases are Ta which do not satisfy the definition.)*
>
> *The information provided is for the endoscopic biopsy and cytology. These do not confirm invasion and I would decline the Cl at this stage.*
>
> *Did he subsequently have a nephrouretectomy (removal of kidney and ureter). This would be required to confirm invasive disease.'"*

The Provider advised the Complainant's solicitor of its decision to further decline the claim by letter dated **6 April 2017**.

By letter dated **4 September 2017** the Complainant's solicitor furnished the Provider with a letter written by the Complainant's consultant dated **8 June 2017** wherein the consultant states:

> *"… I have reviewed the chart on [the First Complainant] in its entirety and have found this attached letter from Professor […] who initially reported on same and later got a second opinion from Dr […] Consultant Pathologist in xxx University hospital.*
>
> *This letter further highlights that it was quite a difficult and challenging case, however she does mention that there is probably a micropapillary variant on TCC but it lacks all the features of that entity however Ms […] does confirm urothelial carcinoma but could not exclude low grade but did feel that high grade was not the case.*
>
> *As regards to invasiveness it would mean if it has gone into the muscles which are beyond the mucosa, if by definition of invasiveness* [the Provider] *feel which I understand is invasion into the muscles then certainly it is not an invasive cancer but certainly the discussion that I would have had here was between high and low grade. Dr […], Consultant Pathologist initially reported high grade TCC but on getting a second opinion from Dr […] in November 2014 the report came back as low grade."*

The Complainant's solicitor was advised that the claim was still being declined by letter dated **9 October 2017**.

The Provider's CMO conducted a further review of the Complainant's claim in light of the above report and the correspondence received from the Complainant's consultant and made the following observations in an email dated **21 August 2018**:

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"Policy holder claiming under cancer definition for urothelial tumour. Policy definition of cancer requires amongst others that tumour is invasive. In this case despite several histology reports there is no evidence presented that tumour is invasive and this is why policy has not been admitted – policy terms have not yet been met.
I note letter from [the Complainant's consultant] *of 8/6/2017. There is discussion about whether or not the tumour is high grade or low grade. If the tumour was shown to be invasive we would admit the claim regardless of the grade*. [The Complainant's consultant] *accepts that the biopsy will indicate no invasion but that when the full kidney is removed invasion may then be found. I accept this. To date however, invasion has not been found.*

I note that eventually a nephrectomy was undertaken and full histology became available no invasion was described.

In my opinion this does not meet the definition required."

Analysis

The First Complainant submitted a claim form to the Provider in **October 2014** in respect of a cancerous tumour in his right kidney. The First Complainant's claim was assessed by two of the Provider's CMOs, an opinion was received from the CMO for the Provider's reinsurer, one of the Provider's CMO consulted with an independent oncologist and the Provider also commissioned a report from an independent consultant histopathologist. Following a number of assessments of the claim, the Provider formed the view that the Complainant did not satisfy the definition of cancer contained in the policy. In particular, the Provider states that the tumour was in-situ, and that there was no evidence of invasiveness or malignancy.

The correspondence outlined above shows that the First Complainant's consultant/surgeon subsequently categorised the tumour as high grade as opposed to the initial diagnosis of low grade and has expressed the view that the tumour should be deemed invasive. However, in a letter dated **8 June 2017**, he appears to agree that the cancer was not invasive.

The definition of cancer, amongst other forms of critical illness, is set out in the Complainants' policy. While the First Complainant may have had a form of cancer, nevertheless, in order to have his claim under the policy admitted into payment, his condition must satisfy the definition of cancer as contained in the policy. As stated above, it is the duty of this Office to establish whether, on the basis of an objective assessment of the medical evidence submitted, the Provider has adequately assessed the First Complainant's claim and whether it was reasonably entitled to arrive at the decision it did following its assessment of the medical evidence submitted.

The Provider assessed the First Complainant's claim on a number of occasions. I note that the Complainants have not submitted any expert or specialist evidence, (beyond the views expressed by the First Complainant's surgeon) which demonstrates that the definition of cancer has been met. Furthermore, the First Complainant's histology reports have not been disputed. Taking these matters into consideration and having considered the definition of

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cancer contained in the policy, I accept that the Provider was entitled to decline the Complainant's claim.

In many respects, the Complainant's situation is a good and happy one, because none of the medical evidence suggests that the cancer was characterised by the uncontrolled growth and spread of malignant cells, and the invasion of tissue. If such invasiveness had been noted, the Complainant might well have met the criteria in the policy and may have been entitled to the payment of benefit, but his medical prognosis would have indicated a much more serious situation.

The Complainants have indicated an unhappiness that at the time when the policy was incepted in 1994, it was not made sufficiently clear to them that non-invasive cancer (as distinct from invasive cancer) would not give rise to the payment of any benefit as it was not covered by the policy. As the policy was incepted in 1994, the sale of the policy is not a matter which falls within the jurisdiction of the FSPO. Complaints to the FSPO are governed by the provisions of ***Section 51*** of the ***Financial Services and Pensions Ombudsman Act 2017*** which provides, *inter alia*, that in a complaint regarding a product of this nature, the conduct complained of must have occurred during or after 2002. In this instance however, the policy was purchased by the Complainants, almost a decade before that. I therefore consider it sufficient to note that the First Complainant states that he had a 3 hour discussion with the Provider at the time of deciding to purchase the policy, and the policy documentation subsequently sent to the Complainants encouraged them to raise any query with their insurance advisor if they had any questions regarding the policy in question.

Finally, I note that the Complainants' letter of 8 August 2016 indicates that the Provider confirmed during a telephone call which occurred on 10 October 2014 that the Complainant's condition was covered by the policy. I do not accept this however. I am satisfied that the Complainant was advised by the Provider at the relevant time during the telephone call and, in addition, during the subsequent phonecall on 13 October 2014, that the policy provided cover for cancer, but that in order to be eligible for benefit, the definition of cancer contained in the policy would need to be satisfied.

Accordingly, having considered the issues in this complaint I am satisfied that there was no wrongdoing on the part of the Provider and in those circumstances, it is not appropriate to uphold this complaint.

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Conclusion

My Decision is that this complaint is rejected, pursuant to ***Section 60(1)*** 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.

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION AND LEGAL SERVICES

30 October 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.