An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0339
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Failure to process instructions
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants completed the Underwriter's *Guaranteed Term and Mortgage Protection* application form in **February 2013** and submitted it to the Provider in **March 2013**. During the underwriting process the Second Complainant was involved in a work related accident which occurred in **May 2013**. The Complainants subsequently informed the Provider of the accident and were advised that the Second Complainant was not covered at the time of the accident because the underwriting process was still ongoing and no policy had been issued. The Complainants submit that the Provider delayed in processing their application and as a result of this they were not covered at the time of the Second Complainant's accident.

The Complainants' Case

The First Complainant states that because payments in respect of their mortgage protection policy were no longer being processed by way of salary deduction, a decision was made to switch to a provider who could process mortgage protection payments in this manner. The First Complainant states that the Provider is an insurance broker and administers a number of types of insurance policies on behalf of the Second Complainant's employer. The Complainants decided to take out personal accident and mortgage protection insurance policies through the Provider. The First Complainant states that she rang the Provider *"… for a quote, told [the Provider] all my details and [the Provider] quoted a figure over the phone, it suited us so I said we would take that, so all I had to do was fill in a form and sent it back*

to them." The First Complainant states that *"I then did the wrong thing of cancelling my insurance with [the current provider]."* The First Complainant states "*I sent my forms back to [the Provider] after 27/02/2013 …"*

In the course of her submissions, the First Complainant refers to an advertisement contained in a magazine published by the Second Complainant's trade union which states acceptance is guaranteed in respect of personal accident insurance. The First Complainant states that the Underwriter refused to provide her with personal accident benefit on the basis of her medical report but later informed her that this should not have been refused and applied 100% loading to her cover.

The First Complainant states that the Second Complainant had a work related accident in **May 2013** and when she rang the Provider to notify it of the accident *"… they said that [the Underwriter] had rejected the policy, they failed to tell me this earlier."* The First Complainant submits that *"[i]f [the Provider/Underwriter] had not rejected our application form my husband would have been insured when he had [the] accident in May 2013, he was out of work for 8 months and in 2015 he had to have surgery arising out of [the] accident and was out of work for 9 months."*

The First Complainant states that *"I feel that [the Provider] only started putting my application through after I rang about my husband's accident."*

The Provider's Case

The Provider states that it was contacted by the First Complainant on **5 February 2013** requesting a mortgage protection quote. It further states that the Complainants did not request that any personal accident benefit be included. The Complainants' application form and its signed terms of business were received and scanned on **1 March 2013**. The Provider states that it was noticed that the application form was not signed by the Second Complainant. The application form was returned to the Complainants on **6 March 2013** in order for the Second Complainant to sign it. The Provider states that the application form was accompanied by an updated quote to include Hospital Cash/Personal Accident cover because this option had been selected by the Complainants a new quote was required to be issued. The Provider states that the unsigned application form was inputted to the Underwriter's system on the same day. The Provider states that it wrote to the Complainants on **7 March 2013** advising them of the revised quote, the Underwriter's underwriting requirements and also enclosed a number of medical questionnaires.

The Provider submits that it cannot verify when the Second Complainant signed the application form as the original dates of **27 February 2013** were on the from when it was returned. The Provider states that the completed application form and medical questionnaires dated **12 March 2013** were received on **22 May 2013**. The Provider states that these documents were scanned and emailed to the Underwriter on the same day and were processed by the Underwriters without querying the dates.

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The Provider states that the First Complainant called its office on **31 May 2013** regarding the Underwriter's underwriting requirements which had been issued the previous day. The Provider states *"Surprisingly, on this call, [the First Complainant] did not reveal that [the Second Complainant] had suffered an accident on 03/05/2013."*

The Provider submits that it was not until **20 June 2013** that it became aware of the accident when the Second Complainant contacted its office to advise that he was involved in an accident at work and enquired about the mortgage protection policy. The Provider states that the Second Complainant was advised that the mortgage protection application was still at the proposal stage and was awaiting medical information from the First Complainant's GP. The Provider states that the Second Complainant was advised that no cover would be in force until the underwriting terms were accepted and a policy document issued. The Provider also states that the Second Complainant was informed that the injuries he sustained as a result of the accident would also have to be disclosed to the Underwriter as all material facts must be disclosed.

The Provider states that it is company policy to give best advice and it is satisfied that it explained to the Complainants that the policy would not be in force until all relevant information was received and approved by the Underwriter. The Provider states that it was advised at the quotation stage that the Complainants' mortgage protection application was in respect of an existing mortgage but it was not informed that any such policy would be replacing an existing mortgage protection policy. The Provider states that the first time it was notified of the cancellation of the Complainants' previous policy was on **25 June 2013**. The Provider submits that cancelling an existing policy before confirmation of new cover is contrary to its best policy advice.

In respect of the Complainants' submission that acceptance into a personal accident scheme is guaranteed, the Provider states that the documentation submitted by the Complainants relates to a separate policy which contains two separate personal accident schemes negotiated by the Second Complainant's trade union and did not form part of the Underwriter's mortgage protection application or quotation.

The Complaint for Adjudication

The complaint for adjudication is that the Provider delayed in submitting the Complainants' application form for mortgage protection and personal accident insurance to the Underwriter and this delay resulted in the Complainants having no cover at the time of the Second Complainant's accident which occurred on **3 May 2013**.

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

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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 9 September 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.

Quotation

Following a telephone call from the First Complainant on **5 February 2013** the Provider furnished the Complainants with a list of quotations in respect of mortgage protection by letter dated **6 February 2013**. The Provider also sent the Complainants a *Client's Best Interest Letter* dated **6 February 2013** in which it recommended the cover being offered by the Underwriter. This letter states:

> *"[The Underwriter] has a turnover time of 3 to 4 working days between receiving a fully completed proposal and the issuing of the policy, assuming all required information has been submitted."*

The documentation provided to the Complainants also included a quotation in respect of the Underwriter's *Guaranteed Mortgage Protection* policy. This quotation did not contain hospital cash cover or personal accident cover. On the final page of this quotation it states:

> *"**Important Notes***
>
> *…*
>
> - *Please note that this quotation is for illustrative purposes only and is not an offer of contract.*

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- *The Terms and Conditions of acceptance are subject to our normal underwriting requirements."*

The Complainants were also given an application form in respect of the Underwriter's policy and the Provider's terms of business.

The Application Form

The Complainants completed the Underwriter's *Guaranteed Term and Mortgage Protection* application form dated **27 February 2013**. On the first page of the form it states:

> *"To make sure you complete this application form correctly, please refer to the checklist in Section I at the end of this form."*

The checklist appears on page 11 of the form and states:

> ***"Please ensure that the following details have been completed on the application form.***
> ***Please tick ✓***
>
> *…*
>
> *Indicated whether this replaces an existing policy in whole or in part, and that the Customer Financial Adviser Declarations have been signed. …*
>
> *The Declaration has been signed and dated by the Life (Lives) Insured and Policy Owner(s). …"*

The Provider wrote to the Complainants by letter dated **6 March 2013** to inform them that the application form was required to be signed by the Second Complainant. The letter also enclosed a revised *Disclosure Quotation* as the Complainants had selected hospital cash and personal accident cover on the application form.

The Provider has also furnished in evidence an email from the Underwriter dated **6 March 2013** acknowledging its submission of the Complainants' application form.

Underwriting

The Underwriter wrote to the Provider by letter dated **6 March 2013** advising that the Second Complainant's application had been accepted at standard rate but requested that a number of medical questionnaires be completed in respect of the First Complainant. The Underwriter also requested the original application form.

The Provider sent the various questionnaires to the Complainants under cover of letter dated **7 March 2013**. The questionnaires were completed by the First Complainant and

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dated **12 March 2013**. The completed application form and completed questionnaire was sent via email by the Provider to the Underwriter on **22 May 2013**.

In this email the Provider also asked the Underwriter to advise on any further underwriting requirements or acceptance terms. In a letter dated **24 May 2013** the Underwriter requested a private medical attendant's report from the First Complainant' GP with papers issuing to the her GP that day. The letter also requested that the First Complainant confirm full details of her answer to question 10(v) of the application form. The Underwriter further advised that personal accident cover was declined in respect of the First Complainant. The Provider wrote to the Complainants informing them of these matters by letter dated **30 May 2013**.

By email dated **31 May 2013** the Provider wrote to the Underwriter with further details in respect of the First Complainant's answer to question 10(v) and also advised that the First Complainant requested that a letter be issued to her GP explaining why personal accident cover had been refused. By letter dated **5 June 2013** the Underwriter informed the Provider that personal accident cover should not have been refused in respect of the First Complainant.

By letter dated **17 June 2013** the Underwriter informed the Provider that it had written to the First Complainant's GP requesting further information (including a copy of a previously unattached medical report) and on receipt of same it would give the Complainants' proposal further consideration. The Provider wrote to the Complainants updating them on these matters by letter dated **19 June 2013**.

The Provider wrote to the Underwriter by email dated **20 June 2013** advising it that the First Complainant contacted its office that morning to inform the Provider that the Second Complainant was involved in a work place accident on **3 May 2013**.

In a letter dated **26 June 2013** from the Underwriter to the Complainants, the Underwriter explains that the private medical attendant's report was received on **14 June 2013** and further additional medical information was requested on **18 June 2013** and received on **21 June 2013**. Following this, a decision as to underwriting was made on **24 June 2013**.

On **25** and **27 June 2013** the Provider sent the Complainants letters from the Underwriter detailing its revised terms. The revised terms are as follows:

> *"The cost of Life Sum Insured has been increased by 100% in view of the Health of the second life insured.*
>
> *Hospital Cash and Personal accident benefit is postponed for 1 year for Life one. Hospital cash and Personal accident benefit is declined for Life two."*

By letter dated **6 September 2013** the Provider wrote to the Complainants stating that it had not received a signed copy of the revised terms. A signed copy of the revised terms was submitted by the Provider to the Underwriter by email dated **13 September 2013**.

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Analysis

The Complainants returned an application form to the Provider between **27 February 2013** and **1 March 2013**. The Provider uploaded the form to the Underwriter's system on **6 March 2013**. On **7 March 2013** the Provider returned the application form to the Complainants as it had not been signed by the Second Complainant. The Provider submits that it cannot verify when the Second Complainant signed the application form as the original date of **27 February 2013** was recorded on it. The Provider states that a completed application form and medical questionnaires dated **12 March 2013** were received on **22 May 2013**.

The Provider states that these documents were scanned and emailed to the Underwriter on the same day. There is a gap of almost two and a half months between the date contained on the medical questionnaires and the date the Provider received the completed application form and medical questionnaires. The Complainants have not produced any evidence which shows the date on which they returned these documents to the Provider.

The Complainants assert that the Provider only began processing their application form after the Second Complainant informed it of his workplace accident. In a call which took place between the First Complainant and the Provider on **25 June 2013**, the Provider's call log states:

> *"[The First Complainant] wanted to know why [the Second Complainant's employer] did not notify [the Provider] of [the Second Complainant's] accident. I explained … not all … staff would be members of the [trade union] and therefore [the Second Complainant's employer] would not notify us of accidents of staff whilst at work. I advs if a [trade union] member has an accident it would be up to the member to notify the Union of the claim and the [trade union] send out a claim form which is sent into [the Provider] on completion."*

In relation to a phone call between the First Complainant and the Provider on **31 May 2013** which post-dates the Second Complainant's accident, the First Complainant states in her submission to this Office dated **12 March 2019**:

> *"In response to [the Provider's] dates first contact was made in Feb 2013, then again in March 2013, long before [the Second Complainant's] accident, [the Second Complainant's] accident in May we didn't realize the extent of long term injuries until later, that is why I didn't mention it in phone call."*

The Second Complainant's accident occurred on **3 May 2013** but was not notified to the Provider until **20 June 2013** despite the First Complainant contacting the Provider on **31 May 2013**. I accept from the evidence before me that the Complainants did not inform the Provider about the Second Complainant's accident until **20 June 2013**. The Provider states that it received the Complainants' application on **22 May 2013** which pre-dates that date on which it was advised of the Second Complainant's accident. Furthermore, the evidence in this complainant demonstrates that several aspects of the underwriting process were being addressed by the Provider during **May** and **June 2013**.

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Having considered the sequence of events which occurred following the Complainants' application for cover, I accept from the evidence available in this complaint that the Provider's underwriting process was advancing at an acceptable rate in the time leading up to **20 June 2013** when the Provider became aware of the Second Complainant's accident. As the underwriting process was still ongoing on **20 June 2013**, the Second Complainant's accident was a factor which was required to be disclosed to the Underwriter for underwriting purposes.

I do not accept that the Underwriter's declinature of cover on **24 May 2013** delayed the commencement of the Complainants' policy as further medical information in respect of the First Complainant was still required at that point in time. Additionally, the Complainants had not yet notified the Provider or the Underwriter of the Second Complainant's accident. As the underwriting process was ongoing, the Complainants were obliged to inform the Provider about the accident. Any delay that arose from the Second Complainant's notification of the accident could have been mitigated if the Complainants notified the Provider of the accident sooner. Instead, the Complainants waited over six weeks before notifying the Provider of the accident and maintain that the Provider only began to process their application on foot of this notification. Therefore, I find that the Complainants' suggestion that the Provider only began processing their application form after the Second Complainant informed it of his accident is not supported by the evidence.

The Complainants submit that acceptance to the Underwriter's policy is guaranteed. The Complainants' position is based on an advertisement contained in the Second Complainant's trade union magazine. In their submissions dated **15 February 2019** the Complainants state:

> *"… the reason [the First Complainant] contacted [the Provider] in the first instance was to take up their offer of cheaper mortgage protection as stated in their advert in the [trade union] employee magazine …"*

In further submissions dated **2 April 2019**, the Second Complainant states:

> *"As previously discussed … every time [the Second Complainant's employer] send out a company magazine [the Provider]/[trade union] advertise Personal Accident Insurance to all employees, paid by asleep deduction, this is what I wished to be part of …"*

In an email to this Office dated **12 April 2019** the Second Complainant states:

> *"I think all has been said for the moment. Just that advertised advert in union booklet advertising personal accident cover does not require medical information from gp etc, …"*

The submission by the Complainants suggests that the Complainants believed that the policy being offered by the Provider was the same as the one advertised in the trade union magazine. Furthermore, the Complainants believed that acceptance to such a policy was guaranteed and based on this belief the Complainants cancelled their existing policy.

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The policy offered to the Complainants was not the policy advertised in the trade union magazine. The policy recommended by the Provider was subject to certain terms and conditions. Additionally, whether or not acceptance was guaranteed, it was not automatic and the Complainants were required to undergo the Underwriter's underwriting process. Following this process, cover was offered to the Complainants toward the end of **June 2013**.

I note the Complainants cancelled an insurance policy with a third party provider that they say they had for 16 years prior to incepting a new policy. This was most unfortunate but it is not something which I can find the Provider responsible for.

For the reasons set out above, 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

4 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.