An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0344
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Claim handling delays or issues Delayed or inadequate communication Disagreement regarding Medical evidence submitted Poor wording/ambiguity of policy 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 critical illness policy with the Provider on **27 January 1995**. This policy was surrendered on **30 August 2018**.

The Complainants' Case

The Complainants submitted a critical illness claim to the Provider on **15 August 2017** in respect of the First Complainant's diagnosis of ovarian cancer. The First Complainant notes that *"radical surgery was performed to eliminate potential spread. If untreated successfully, potentially could have been very different outcome"*.

In its email to the Second Complainant on **28 July 2017**, the Provider confirmed that the critical illness sum assured at that time was GBP £54,681.86.

Following its assessment, the Provider declined the First Complainant's claim by way of correspondence dated **3 November 2017**. In this regard, the First Complainant notes that

"no explanation [was] *given"* by the Provider but instead she was simply *"told to contact own GP"*.

The First Complainant states that she has had a *"horrendous experience"* with the Provider and sets out her complaint, as follows:

> *"Constant delays whilst processing the claim.*
>
> *Failure to explain fully the reason for decline of claim except for clip and paste definition saying does not meet criteria with no explanation as why this decision was made or further information to alleviate dissatisfaction and to understand fully the reason for decline, causing distress.*
> *Misleading definition: On further personal research on topic it appears it may make it very difficult to claim for ovarian cancer unless neglecting treatment until terminal stage. If this is the case I strongly believe that an exception should have been written into policy definition similar to skin cancer"*.

The First Complainant raised a complaint with the Provider on **21 November 2017** regarding its lack of explanation for the declinature of her claim and its poor customer service. Having received no response to this complaint, the First Complainant then emailed the Provider on 9 December, 13 December and 22 December 2017 seeking an update and later in January 2018 she states that she *"received cheque for* [GBP] *£150 with no explanation"* from the Provider.

The First Complainant submits, as follows:

> *"As you can appreciate this has been an extremely anxious and difficult time during recovery following total hysterectomy and BSO* [Bilateral Salpingo-Oophorectomy]*. On morning of procedure was also marked for potential colostomy should the cancer have included bowel.*
>
> *I strongly believe that this whole process demonstrates the worst possible customer service during an already stressful time and that the whole process was horrendous. Whilst I appreciate that I may be potentially clear of Cancer now this still causes anxiety regarding potential return. My husband* [the Second Complainant] *had to have considerable time off work and his mental health suffered. I would not like any other person who may wish to make a claim to be subjected to the same experience as ourselves. I believe the definition used potentially excludes ovarian cancer unless terminal and as this may be the case the definition should have been more explicit as to what types of cancer are or aren't covered. Not everyone is an oncologist and* [the Provider's] *Chief Medical Officer fails to fully give an explanation even though this was requested"*.

In this regard, the First Complainant considers that there was by the Provider a

> *"Failure to acknowledge or address concerns raised regarding definition of cancer; Protracted claims process*; *Extremely poor customer service*; *Definition of cancer not*

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> *excluding range of cancers that can be treated* [and] *Incomplete information/misleading policy wording"*.

In addition, in his email to this Office dated 28 September 2018, the Second Complainant submits that

> *"if surgery not performed eventual decline as a result of condition would have triggered a payment. Surely this is not an acceptable moral or ethical reason for declining on basis of successful surgical intervention".*

The Complainants have sought an *"apology, compensation, rewording of policy* [and] *improvements to claims process"* from the Provider.

The Provider's Case

Provider records indicate that the Complainants incepted a critical illness policy with the Provider on 27 January 1995, which was later surrendered on 30 August 2018. This policy was a regular premium unit-linked assurance and critical illness contract issued in the joint names of the Complainants on a joint life first death basis or if earlier, upon admittance of a critical illness claim.

The Complainants submitted a critical illness claim to the Provider on 15 August 2017 in respect of the First Complainant's diagnosis of ovarian cancer. Following its assessment, the Provider wrote to the Complainants on 3 November 2017 declining this claim. The Provider is satisfied that once it was in receipt of all of the requested medical information required, that it assessed the First Complainant's claim without delay. The Provider was reliant on the timely receipt of the medical reports requested from the First Complainant's GP and medical professionals attended; once these were received, it was then in a position to make a final decision on the claim. In this regard, the Provider received the medical report from the First Complainant's treating Specialist on 13 October 2017 and from her GP on 1 November 2017.

When the Provider wrote to the Complainants on 3 November 2017 it confirmed that it had declined the critical illness claim as the First Complainant's diagnosis did not fulfil the criteria for cancer, as set out in the policy terms and conditions. This letter confirmed the policy definition of cancer but purposely did not state the specific medical reasons as to why the claim was declined, as it is Provider procedure not to disclose sensitive medical information to policyholders directly. The Provider did offer to write to the First Complainant's GP to confirm its reasons for declining the claim so that the First Complainant would then be able to discuss this further with her GP. In this regard, the Provider furnished the First Complainant's GP with details of the case and the medical reason for declining the claim on 8 November 2017. The Provider recommended that the First Complainant contact her GP's surgery to arrange to discuss the contents of the declinature letter further.

The Provider does not disclose sensitive medical information directly to a policyholder either verbally or in writing, rather it is Provider procedure to only disclose such information to the policyholder's medical professional(s). This is standard industry recognised practice amongst insurance companies involved in the assessment of medical claims.

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The reason the Provider does so is that it is important that any sensitive medical information is discussed with the policyholder by a suitably qualified medical professional such as their GP, with whom they have a direct relationship in terms of their medical history and who is best placed and best qualified to discuss the information with them in the appropriate environment of the GP surgery and to answer any concerns or queries that the policyholder may have in relation to their medical condition. In this regard, the Provider does not expect the GP to discuss the assessment process or acceptable criteria but instead to communicate the medical information made available by the Provider to the GP, following a claim decision, to the policyholders.

The Complainants raised an initial complaint on 3 November 2017 regarding the service provided by the Provider in respect of the handling of the critical illness claim to date. The Provider emailed the Complainants on 9 November 2017 acknowledging that the service that they had received between June and July 2017 had been of a poor standard, insofar as it had failed to provide the correct policy information, had sent incorrect information regarding what type of benefit the First Complainant wished to claim for and had not furnished her with the correct terms and conditions booklet promptly. In this regard, the Provider confirmed an *ex-gratia* payment of GBP £150 and this was transferred to the Complainants' bank account on 10 November 2017. The Provider has no record of making a further cheque payment of £150 in January 2018, as contended by the Complainants.

Following the claim declinature, the First Complainant raised a second complaint with the Provider by email on 21 November 2017, advising *"we have been to see our GP. The definition appears to exclude ovarian cancer/tumour due to differing medical opinion. I strongly believe that this detail is not fully inherent within policy"*.

The Provider accepts that there was a delay in acknowledging this second complaint, as an acknowledgement email was not sent until 13 December 2017. By email to the First Complainant dated 11 January 2018, the Provider explained that for a claim to be admitted for a diagnosis of cancer, the Provider must be satisfied that the medical information submitted fulfils the definition of cancer as set out in the policy terms and conditions, as follows:

> *"An unequivocal diagnosis of 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 cancers in situ, tumours in the presence of any Human Immunodeficiency Virus (HIV) and any skin cancer other than Invasive Malignant Melanoma"*.

The Provider is satisfied that this definition of cancer is clear and unambiguous and is applicable regardless of the type of cancer being claimed for. The Provider submits that it is not possible to provide an equivalent understanding of the policy definition of cancer with reference to the common stages of cancer. However, the Provider is satisfied that the policy definition of cancer is clear, specific and confirms that in order for a claim to be accepted it must be *"an unequivocal diagnosis of a malignant tumour characterised by the uncontrolled growth and spread of malignant cells and the invasion of tissue"*.

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The Provider relied upon medical reports from the medical professionals who attended the First Complainant in order to come to a decision on her critical illness claim. The Provider also relied upon the opinion of its Senior Claims Assessment Manager and its Chief Medical Officer. The medical reports received were assessed by the Chief Medical Officer and Senior Claims Manager and referred to the Oncology Chief Medical Officer against the policy definition for 'cancer' and it was found that, based on the medical evidence received, the claim did not fully meet the policy definition of cancer.

In this regard, in handling the First Complainant's critical illness claim and the Complainants' subsequent complaint to the claim decision, the Provider has had all the medical reports received reviewed by three different medical professionals who have all, independent of each other, found that the claim did not meet the policy definition for cancer.

The Provider regrets that the Complainants remain unhappy with its decision to decline the First Complainant's critical illness claim but it is satisfied that this claim was correctly assessed and declined in accordance with the terms and conditions of the Complainants' critical illness policy, and that this was done within a reasonable and acceptable timeframe.

The Complaint for Adjudication

The Complainants' complaint is that the Provider wrongly or unfairly declined the First Complainant's critical illness 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 11 September 2019, outlining the preliminary determination of this office in relation to the complaint. The parties were

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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.

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

The Complainants' complaint is that the Provider wrongly or unfairly declined the First Complainant's critical illness claim. In this regard, the Complainants held a critical illness policy with the Provider from 27 January 1995 to 30 August 2018.

The Complainants submitted a critical illness claim to the Provider on 15 August 2017 in respect of the First Complainant's diagnosis of ovarian cancer. The First Complainant notes that:

> *"radical surgery was performed to eliminate potential spread. If untreated successfully, potentially could have been very different outcome"*.

Following its assessment, the Provider declined the First Complainant's claim by way of correspondence dated 3 November 2017. The First Complainant submits that *"no explanation* [was] *given"* by the Provider for declining the claim but instead she was simply *"told to contact own GP"*.

The First Complainant states that she has had a *"horrendous experience"* with the Provider that included *"constant delays whilst processing the claim"* and a *"failure to explain fully the reason for decline of claim except for clip and paste definition saying does not meet criteria with no explanation as why this decision was made"*. In this regard, the First Complainant considers that the policy definition of cancer used by the Provider is *"misleading…it may make it very difficult to claim for ovarian cancer unless neglecting treatment until terminal stage. If this is the case I strongly believe that an exception should have been written into policy definition similar to skin cancer"*.

The Complainants' critical illness policy, like all insurance policies, did not provide cover for every eventuality; rather the cover was subject to the terms, conditions, endorsements and exclusions set out in the policy documentation. The Complainants' policy only provided critical illness benefit in respect of those critical illnesses listed in the policy conditions, and only where the diagnosis met the policy definition of the critical illness provided therein.

In this regard, the '**Appendix – Provisions Relating to Critical Illness**' section of the Flexible Critical Illness Plan Policy Conditions booklet provides, *inter alia*, at pg. 23, as follows:

> ***"1 Definition of Critical Illness***
> *Critical Illness shall mean one or more of the following conditions as hereinafter defined:- …*

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(vi) ***Cancer***

Unequivocal diagnosis of a malignant tumour characterised by the uncontrolled growth and spread of malignant cells and the invasion of tissue. This definition includes leukaemia, but excludes non-invasive cancers in situ, tumours in the presence of any human immune-deficiency virus [H.I.V.], and any skin cancer other than invasive malignant melanoma".

I am satisfied that this policy definition of cancer is clear and specific. In this regard, the Complainants' critical illness policy was an insurance policy like any other contract, that is, it is based on the legal principles of offer, acceptance and consideration. The Provider may offer terms which can be accepted by those seeking insurance, who then elect to pay the premium requested, which represents the consideration for the contract. It is for the Provider to define clearly the risks, in this instance the critical illnesses, that it is willing to offer cover for.

With regard to the First Complainant's critical illness claim, I note from the documentary evidence before me that Mr N. Department of Gynaecology & Oncology at [S] Hospital completed a medical report for the Provider on 6 October 2017 and in Section B, '**Details of The Assured's Illness'**, provided the following answers:

*"**1.*** ***a) Please give details of the exact diagnosis.***
Figo 1A Left Ovarian Borderline Tumor …

2. ***What stage did the disease reach? Please describe this using whichever classification is appropriate.***
Figo 1A …

4. ***If there is any further information which in your opinion, will assist us in assessing this claim, please furnish such information …***
This is a borderline tumor. Not an invasive malignancy".

I am satisfied that it was reasonable for the Provider to conclude from this information that the First Complainant's diagnosis did not satisfy the policy definition of cancer. As a result, I note that the Provider wrote to the Complainants on 3 November 2017, as follows:

"After careful consideration of all the medical evidence received, our Chief Medical Officer regrets to advise that we are unable to proceed with the processing of [the First Complainant's] *Critical Illness Claim.* ***Based on the medical information received he has confirmed that your condition does not fulfil our criteria for Cancer under our plan conditions.***

Our definition of Cancer is as follows:

"…an unequivocal diagnosis of 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 cancers in situ, tumours

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> *in the presence of any Human Immunodeficiency Virus [HIV] and any skin cancer other than Invasive Malignant Melanoma"*.
>
> *If you would like more details on the reasoning for this decline please let us know and we will write to your GP who will then be able to discuss this with you"*.

[Emphasis added]

In this regard, and following an email request from the Second Complainant to the Provider on 6 November 2017 asking it *"to clarify on what medical basis the claim has been rejected"*, I note that the Provider wrote to the First Complainant's GP on 8 November 2017, as follows:

> *"Thank you for your report dated 24 October 2017 on* [the First Complainant]*. I am writing back to you regarding her claim for Critical Illness Benefit which has recently been declined by our Chief Medical Officer,* [Dr I.].
>
> [The First Complainant's] *claim is for Cancer and our definition, as per our policy terms and conditions, is as follows:*
>
> > *"This is defined as an unequivocal diagnosis of 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 cancers in situ, tumours in the presence of any Human Immunodeficiency Virus [HIV] and any skin cancer other than Invasive Malignant Melanoma".*
>
> *You state in your aforementioned report that* [the First Complainant] *has been diagnosed with a Stage 1a borderline serious tumour. A further report received from* [Mr N.] *from [S] Hospital confirms the diagnosis was a FIGO 1A left ovarian borderline tumour and adds that "this is a borderline tumour not an invasive malignancy". Given that the tumour is not malignant then* [the First Complainant's] *condition is one that does not fulfil our criteria for a valid claim under the benefit.*
>
> *I have written to* [the First Complainant] *to confirm our decision and I believe that she and her husband will be in contact with you to discuss the reasoning behind our decision"*.

I note that the Complainants are dissatisfied that the Provider wrote to the First Complainant's GP. In this regard, in his email to this Office dated 28 September 2018, the Second Complainant submits, *inter alia*, as follows:

> *"As this matter is directly my wife's health she has the right to be informed directly, not to go through a third party. The policy is my wife's not my GP's and as such she should be informed of outcome and specific reasons that anyone can understand and then given option of discussing further with GP"*.

In addition, in their more recent email to this Office dated 17 June 2019, the Complainants submit, *inter alia*, as follows:

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> *"It is still our opinion a contract existed between* [the Provider] *and ourselves and therefore the onus to provide a clear explanation of decline of claim be* [on] [the Provider] *not a third party, our GP. The policy does not state that the GP is responsible to explain reason for decline of a claim"*.

I am satisfied, however, that having advised the Complainants in its correspondence dated 3 November 2017 that *"If you would like more details on the reasoning for this decline please let us know and we will write to your GP who will then be able to discuss this with you"*, that it was reasonable for the Provider, having subsequently received an email request from the Second Complainant on 6 November 2017 asking it *"to clarify on what medical basis the claim has been rejected"*, to then write to the First Complainant's GP as it had indicated it would. I note that it did so on 8 November 2017 setting out its reason for declining the claim, that is, that the First Complainant's particular diagnosis did not satisfy the policy definition of cancer.

I note the Provider's position that it is standard industry recognised practice amongst insurance companies involved in the assessment of medical claims to communicate any medical decisions directly to the policyholder's GP so that any sensitive medical information is discussed with the policyholder by a suitably qualified medical professional with whom they typically have a direct and regular relationship in terms of their medical history and who is best placed and best qualified to discuss such information with them in the appropriate environment of the GP surgery. In addition, as insurance companies involved in the assessment of medical claims will always seek a medical report and/or records from the policyholder's GP, it is the GP who in many instances, will be better positioned than the policyholder to ensure that any reason cited for the declinature of a medical claim, is in accordance with the medical facts.

If however, the Complainants have any concerns about the details in the Provider's letter of 8 November 2017, being sent to the GP, they may of course raise concerns regarding any Data Protection issues, with the appropriate Data Protection Commissioner.

Having reviewed the evidence, I am satisfied that the Provider subsequently, carried out a full review of its decision to decline the First Complainant's claim. For example, I note that in his email to the Provider dated 5 December 2017, the Provider's Chief Medical Officer, Dr I. advised, as follows:

> *"Firstly the consultant has clearly stated that this is a borderline tumour and not an invasive malignancy.*
>
> *The behaviour of these borderline tumours (sometimes called tumours of low malignant potential) is distinct from low grade malignant ovarian tumours and they are considered a distinct clinical entity. The pathology of these tumours is that they are non-invasive neoplasms ie microscopically they do not invade the surrounding tissue (called the stroma). They can progress, however, and in a small number of cases go on to become a true invasive malignancy which is why these women are kept under review.*

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> *Decision: There is no question that these tumours are not invasive malignancies as such even though they have the potential to become so in the future (and this is clearly stated by her own consultant) and the claim cannot be admitted"*.

In addition, in its letter to this Office dated 23 May 2019, the Provider advises, as follows:

> *"It is a fact that a borderline tumour is not an invasive malignant tumour. This is confirmed by the* [First Complainant's] *own consultant and any histopatholgist would substantiate this fact. The potential to become malignant is not the same and the definition in* [the Complainants'] *Terms & Conditions which states that there must be an unequivocal diagnosis of a malignancy characterised by uncontrolled growth and the spread of malignant cells with invasion of tissue. This* [First Complainant's] *tumour does not have malignant cells, nor uncontrolled growth, nor has there been spread of malignant cells with invasion into tissue.*
>
> *With regard to the potential to become invasive this is correct if left untreated, but in this case it was caught early and thankfully did not reach that stage.*
>
> *The file has been fully reviewed again and it is quite clearly diagnosed as a borderline ovarian tumour and not an invasive tumour and as such is excluded under the policy definition"*.

In this regard, I am satisfied that it was reasonable for the Provider to conclude from the medical information provided by the First Complainant's treating medical professionals that her diagnosis did not satisfy the policy definition of cancer. I am thus satisfied that the Provider declined the First Complainant's critical illness claim in accordance with the terms and conditions of the Complainants' critical illness policy.

In many respects, the First 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 First Complainant might well have met the criteria in the policy and may have been entitled to the payment of benefit, but her medical prognosis would have indicated a much more serious situation.

The Complainants have also submitted that there were *"constant delays whilst processing the claim"*. In this regard, I note from the documentary evidence before me that having received from the First Complainant, a completed critical illness claim form on 15 August 2017, the Provider then requested medical reports from both the First Complainant's GP and her Specialist on 28 August 2017. Having received neither, the Provider sent reminders on 25 September 2017, having previously advised the Complainants by email on 8th September that it would do so on 25th if no medical reports had been received by then. I note that the Provider received the Specialist Report on 13 October 2017 and the GP's Report on 1 November 2017.

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It is reasonable and necessary that the Provider would require medical reports from the First Complainant's treating doctors before it would be in a position to make a decision on her critical illness claim. Having received the last such report on 1 November 2017, I note that the Provider wrote to the Complainants on 3 November 2017, two days later, advising that it had declined the First Complainant's critical illness claim. As a result, I do not consider that the Provider delayed in processing the claim in question.

Although doubtless, the First Complainant has been through a difficult time, nevertheless, on the basis of the medical evidence made available to the Provider, I am satisfied that it was entitled to adopt the position which it did. It is my Decision therefore, on the evidence before me that this complaint cannot be upheld.

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

31 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.