An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0355
Sector:	Insurance
Product / Service:	Mortgage Protection
Conduct(s) complained of:	Claim handling delays or issues Maladministration
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants completed the Provider's *Guaranteed Term and Mortgage Protection* application form in **February 2013** and submitted it to their insurance broker in **March 2013**. During the underwriting process the Second Complainant was involved in a work related accident in **May 2013**. The Complainants subsequently informed the broker 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 Complainants decided to take out personal accident and mortgage protection insurance policies through an insurance broker who administers a number of types of insurance policies on behalf of the Second Complainant's employer. The First Complainant states that she rang the broker *"… for a quote, told [the broker] all my details and [the broker] 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 broker] 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 Provider 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 broker to notify it of the accident *“… they said that [the Provider] had rejected the policy, they failed to tell me this earlier.”* The First Complainant submits that *“[i]f [the broker/Provider] 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 broker] only started putting my application through after I rang about my husband’s accident.”*

The Provider’s Case

The Provider states that the Complainants applied for life cover and personal accident benefit in **March 2013**. When the application was being considered/underwritten, the Second Complainant had an accident. The Provider submits that as the policy was not *on risk* at the time of the accident and was still being underwritten, it had no liability. The Provider states that the details of this accident were taken into account in the overall assessment of the benefits requested by the Complainants as there is a duty of disclosure of all material facts prior to the policy being issued. The Provider states that revised terms were offered to the Complainants and they accepted these terms acknowledging there was no cover for personal accident benefit and the policy was issued for life cover benefit only.

The Provider states that there was no liability on the policy until it was issued; therefore, the Complainants had no cover with it when the accident occurred in **May 2013**. It further submits that there were no delays in the underwriting process.

On life insurance policies, the Provider states that cover only commences from the date of issue of the policy. On the application form, the Complainants agreed that they would inform the Provider of any changes that took place from the date the application form was completed to the date the policy was issued. It was confirmed that the Second Complainant’s accident took place in **May 2013** and the original proposal form was received by the Provider on **22 May 2013** by which time the accident had already taken place. The Provider states that the underwriting process was completed on **24 June 2013** at which point a special terms letter was issued. This letter did not allow personal accident benefit for

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either of the Complainants. The Provider states that the revised terms were accepted by the Complainants in **September 2013** and the policy was issued on **20 September 2013**.

The Complaint for Adjudication

The complaint for adjudication is that the Provider delayed in underwriting the Complainants' application for mortgage protection and personal accident insurance 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 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

The broker furnished the Complainants with a list of quotations in respect of mortgage protection by letter dated **6 February 2013**. The broker also sent the Complainants a *Client's Best Interest Letter* dated **6 February 2013** in which it recommended the cover being offered by the Provider.

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This letter states:

> *"[The Provider] 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 Provider'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.*
> - *The Terms and Conditions of acceptance are subject to our normal underwriting requirements."*

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

The Application Form

The Complainants completed the Provider'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 broker 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.

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The Provider has furnished in evidence a copy of the application form submitted to it by the broker via its website on **6 March 2013**.

Underwriting

The Provider wrote to the broker 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 Provider also requested the Complainants' original application form.

The broker sent the various questionnaires to the Complainants under cover of letter dated **7 March 2013**. The questionnaires were completed by the First Complainant and dated **12 March 2013**.

The completed application form and completed questionnaire was sent via email by the broker to the Provider on **22 May 2013**. In this email the broker also asked the Provider to advise on any further underwriting requirements or acceptance terms. In a letter dated **24 May 2013** the Provider requested a private medical attendant's report from the First Complainant' GP with papers issuing to her GP that day (a copy of this letter has been furnished by the Provider). The letter also requested that the First Complainant confirm full details of her answer to question 10(v) of the application form. The Provider further advised that personal accident cover was declined in respect of the First Complainant. The broker wrote to the Complainants informing them of these matters by letter dated **30 May 2013**.

By email dated **31 May 2013** the broker wrote to the Provider 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. The requested letter was sent to the First Complainant's GP on **15 July 2013**. By letter dated **5 June 2013** the Provider informed the broker that personal accident cover should not have been refused in respect of the First Complainant. By letter dated **17 June 2013** the Provider informed the broker 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. By letter dated **18 June 2013**, the Provider wrote to the First Complainant's GP requesting this information.

The broker wrote to the Provider by email dated **20 June 2013** advising it that the First Complainant contacted its office that morning to inform the broker that the Second Complainant was involved in a work place accident on **3 May 2013**. By letter dated **21 June 2013**, the Provider received correspondence from a re-insurer in respect of the cover to be offered to the First Complainant. In a letter dated **26 June 2013** from the Provider to the Complainants, the Provider explained 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**.

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Following this, a decision as to underwriting was made on **24 June 2013**. By letter dated **24 June 2013**, the Provider sent a copy of its revised terms to the broker.
On **25** and **27 June 2013** the broker sent the Complainants letters from the Provider 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 broker 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 broker to the Provider by email dated **13 September 2013**.

Analysis

The previous section sets out the sequence of events which occurred following the Complainants' application for cover. I accept from the evidence 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. Furthermore, I cannot accept the Complainants' assertion, which is contrary to the timeline of events as supported by the evidence available to me that the Provider only began its underwriting process once it became aware of the Second Complainant's accident. The evidence in this complainant demonstrates that a number of aspects of the underwriting process were being addressed by the Provider during **May** and **June 2013**.

Furthermore, I do not accept that the Provider'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 broker 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. I also note that the Complainants were in contact with the Provider following the accident and prior to their notification of the accident but failed to inform the Provider of the accident.

The Complainants submit that acceptance to the Provider'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:

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> *"… the reason [the First Complainant] contacted [the insurance broker] 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 insurance broker]/[trade union] advertise Personal Accident Insurance to all employees, paid by salary 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.

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, regardless of whether or not acceptance was guaranteed, acceptance was not automatic and the Complainants were required to undergo the Provider's underwriting process. Following this process, cover was offered to the Complainants toward the end of **June 2013**.

I note in an e-mail to this Office dated 8 July 2019, the Complainant states that the Provider, through a third party insurer, has refused [the second Complainant's] application for mortgage protection because of the accident in May 2013.

The Provider responded that following completion of the process of considering a recent application for a life cover policy, it refused life cover not due to his accident, but based on his current health position.

I accept that it was most unfortunate that the Complainants decided to cancel the existing policy prior to incepting the new policy but I have been presented with no evidence that there was any delay by the Provider in underwriting the Complainants' application.

Therefore, for the reasons set out above, I do not uphold this complaint.

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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.