An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0376
Sector:	Insurance
Product / Service:	Personal Accident
Conduct(s) complained of:	Rejection of claim - non-disclosure
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant incepted an income assistance policy with the Provider on **10 August 2012**, via a named Broker. This policy lapsed on 9 February 2015, due to the non-payment of premium.

The Complainant's Case

The Complainant submits, as follows:

> *"The proposal was completed with the assistance and following the advice of* [the Broker]. [The Broker] *having made a careful assessment of my requirements offered me advice and put these advices in writing in a letter dated 17th August, 2012, and this letter was accompanied by a document headed 'Demands and Need Statement'. In that document,* [the Broker] *stated clearly and I quote,*
>
> > *"This plan is underwritten on a moratorium basis, which means, you are not entitled to claim for a period of two years from the commencement of the policy if you are unable to work due to Accident or Sickness which results from a Pre-existing Medical Condition. Such condition may be covered after two years, as long as, during the two year period, you have remained free of symptoms, treatment, advice or medication for that condition" …*

> *On 24th October, 2014, I had a sudden onset of pain in my low back. I was again assessed and it transpired that I had a new problem which was at L3/L4 on the left side.* [Mr M.]*, Consultant Neurosurgeon, saw me immediately. There was no prior history of any left-hand sided pain and it was clear that the injury sustained in 2011* [on the right hand side] *which was operated on was not related to the problem that occurred in October, 2014"*.

The Complainant was medically certified as unfit for work from 24 October 2014 and underwent surgery on 20 November 2014. He submitted a disability (accident/sickness) claim to the Provider in December 2014 detailing the nature of his sickness as *"acute lower back pain post operation on 20/11/2014"*. The Provider however declined this claim by way of correspondence dated 29 January 2015 *"due to* [the Complainant's] *medical condition being pre-existing at* [his] *policy start date"* on 10 August 2012, a decision it upheld on appeal on 24 February 2015.

The Complainant *"do*[es] *not accept the grounds for declining cover and I suggest they are not based on the facts"*. He submits that his back pain that commenced on 24 October 2014 was totally unrelated to his previous back pain and surgery, in August 2011. In this regard, the Complainant previously underwent microdiscectomy back surgery in August 2011 on his right hand L2/L3 disc and states, *"I recovered from that operation and returned to work"*, whilst the back surgery he underwent on 20 November 2014 was in relation to *"a new problem which was at L3/L4 on the left side"*.

The Complainant thus considers that the Provider was wrong to decline his claim and that to do so *"contradicts entirely what* [the Broker] *has stated in his correspondence* [of 17 August 2012]*. I relied on and I believe I am entitled to rely on the advices given by* [the Broker] *and the assurances given to me in his letter"*, as cited above.

As a result, the Complainant seeks for the Provider to admit his income assistance claim, which the Provider has calculated would have been a monthly benefit of €1,783.99, with a total of 12 months benefit possible.

The Provider's Case

Provider records indicate that the Complainant incepted an income assistance policy with the Provider on **10 August 2012**, via a named Broker. This policy later lapsed on 9 February 2015, due to the non-payment of premium.

The Complainant submitted a disability (accident/sickness) claim to the Provider on **22 December 2014** as he was medically certified as unfit for work from 24 October 2014, detailing the nature of his sickness as *"acute lower back pain post operation on 20/11/2014"*. The Complainant's GP, Dr S., advised in the claim form that this had *"developed suddenly…pain at work of 23/10/14, stooped over and could not straighten up"*.

In order to assess this claim fully, the Claims Assessor requested further medical information from the Complainant's GP on 6 January 2015, which was received on 19 January 2015 and

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assessed on 28 January 2015. The Provider is satisfied that the information made available by his GP confirmed that the Complainant's condition was pre-existing to the start date of the policy. As a result, the Provider declined this claim by way of correspondence dated 29 January 2015 *"due to* [the Complainant's] *medical condition being pre-existing at your policy start date"* on 10 August 2012.

The Complainant telephoned the Claims Department on 30 January 2015 seeking an update on his claim. The Agent explained that the claim had been declined and the reason for this. The Complainant did not consider that his current medical condition related to his previous medical condition, and he requested that the Claim Assessor contact him to discuss this further.

The Claim Assessor telephoned the Complainant on **2 February 2015** and explained that the MRI of July 2011 (that it had received as part of the Complainant's medical history) confirmed degenerative change and as his current condition was related to this, the Provider was unable to admit his claim. The Complainant expressed concerns in regard to this and also in relation to the policy terms and conditions. The Claim Assessor could not locate the section in the policy terms that the Complainant's concerns related to and requested that the Complainant send these for him to review.

The Claims Team Manager contacted the Complainant on **5 February 2015**. The Complainant explained that he did not agree with the decision on his claim. The Claims Team Manager asked if the Complainant had reviewed the declinature letter with his GP, in regard to an appeal and advised that in order for the Provider to consider any change to its claims decision, it would require evidence to support the appeal. The Complainant advised that he had not received the declinature letter and the Claims Team Manager arranged for this to be both posted and emailed to him. The Complainant further advised that at the time of sale he had received policy documents from the Broker which did not match the terms and conditions cited by the Provider, insofar as he had been advised of a different time period in relation to pre-existing medical conditions whereby the condition may be covered after two years, as long as, during that two year period, he had remained symptom free. The Claims Team Manager requested the Complainant to forward his policy documents to the Provider for review.

The Provider next received correspondence from the Complainant's solicitor on **16 February 2015** appealing the claim declinature. This information was passed to the Claims Team in order to carry out a further review of the Complainant's claim. The additional information was reviewed by a different Claims Assessor on **24 February 2015**, who concluded that this information provided no confirmation that the Complainant's condition was not pre-existing or related to his previous back pain and surgery in August 2011 and the initial decision to decline the claim was upheld.

The Provider wrote to the Complainant's solicitor on **24 February 2015** to notify same and also to advise that it had not received a copy of the policy documentation provided to the Complainant by the Broker at the sale of his policy and therefore could not take into account his concerns that the terms differed from those relied upon by the Provider in its declinature. In this regard, the Provider is satisfied that the decision to decline the

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Complainant's claim was made in accordance with terms and conditions provided and confirmed to it as applicable by the Broker.

The terms and conditions of the Complainant's policy specifically excludes cover in respect of any pre-existing medical conditions. The Provider notes that the medical information it received in support of the Complainant's claim included an MRI report dated 30 July 2011 that confirmed *"generalised disc disease in the lower dorsal and throughout the lumbar region … The dominant abnormality is at L3/L4 on the right where there is a large right lateral disc protrusion at the level of the exit foramen with marked compression of the exiting right sided third lumbar nerve root"*.

In this regard, the Provider notes that the current claim was in relation to the onset of pain in the Complainant's lower back that was diagnosed to be related to L3/L4 and was operated on. The Provider has reviewed the medical information provided with its Independent Medical Consultant, who has confirmed that prolapsed discs would be a manifestation of lumbar disc disease and has expressed that even at a different level, the conditions would be related to the lumbar disc disease evidenced in the MRI of July 2011. As the condition diagnosed was within the 24 months prior to the Complainant incepting his income assistance policy with the Provider on 12 August 2012, his claim falls into the exclusion of cover due to it being related to a pre-existing condition.

The Provider notes that the Complainant raised concerns regarding the wording of the policy terms that he was provided with, but in this regard the Provider is satisfied that the documents submitted by the Complainant's solicitor do not include an extract that contradicts the policy terms held by the Provider. As a result, the Provider is satisfied that the Complainant's claim has been assessed in line with the terms and conditions specific to his income assistance policy.

The Complaint for Adjudication

The complaint is that the Provider wrongly or unfairly declined the Complainant's income assistance 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 Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

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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 16 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.

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

The complaint at hand is, in essence, that the Provider wrongly or unfairly declined the Complainant's income assistance claim. In this regard, the Complainant incepted an income assistance policy with the Provider on 10 August 2012, via a named Broker.

The Complainant was medically certified as unfit for work from 24 October 2014 and underwent surgery on 20 November 2014. He submitted a disability claim to the Provider in December 2014 detailing the nature of his sickness as *"acute lower back pain post operation on 20/11/2014"*. The Provider subsequently declined this claim by way of correspondence dated 29 January 2015 *"due to* [the Complainant's] *medical condition being pre-existing at* [his] *policy start date"*, a decision it upheld on appeal on 24 February 2015.

The Complainant however submits that his back pain that commenced on 24 October 2014 was totally unrelated to his previous back pain. In that regard, the Complainant previously underwent microdiscectomy back surgery in August 2011 on his right hand L2/L3 disc and states, *"I recovered from that operation and returned to work"* in August 2012, whilst the back surgery he underwent on 20 November 2014 was in relation to *"a new problem which was at L3/L4 on the left side"*.

The Complainant's income assistance policy, like all insurance policies, does not provide cover for every eventuality; rather the cover will be subject to the terms, conditions, endorsements and exclusions set out in the policy documentation. In this regard, **Section 3**, '**Benefits and Exclusions'**, of the applicable income assistance policy document provides, *inter alia*, at pg. 6:

> *"**When can you not make a claim for Accident or Sickness Benefit?***
> *We will not pay any Accident or Sickness benefits if Your Accident or Sickness results directly or indirectly from:*
>
> - *any **Pre-Existing Medical Condition**".*

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Section 9, '**Meaning of Words/Definitions'**, of this policy document provides, *inter alia*, at pg. 11, as follows:

> *"**Pre-Existing Medical Condition***
> *A condition or related condition either:*
> *(i) for which You received treatment in the 24 months up to and including the Commencement Date, or*
> *(ii) which You were aware of, or in Our opinion You should have been aware of, during the 24 months up to and including the Commencement Date"*.

As a result, I am satisfied that in accordance with the terms and conditions of his income assistance policy, no benefit is payable where the Complainant is medically certified as unfit for work due directly or indirectly to a condition or related condition that he received treatment for, or was aware of or should have been aware of in the 24 months prior to his incepting his policy with the Provider on 10 August 2012.

The Complainant submits that his back pain that commenced on 24 October 2014 was totally unrelated to his previous back pain. In that regard, he previously underwent microdiscectomy back surgery in August 2011 on his right hand L2/L3 disc and states, *"I recovered from that operation and returned to work"* in August 2012, whilst the back surgery he underwent on 20 November 2014 was in relation to *"a new problem which was at L3/L4 on the left side"*.

I note from the documentary evidence before me that the Complainant's GP, Dr S. wrote to the Provider on **16 January 2015** to advise, as follows:

> *"*[The Complainant] *had a previous laminectomy but it was a different level in his back and a different site"*.

In addition, correspondence from Mr M., Consultant Neurosurgeon dated **26 November 2014** advises, as follows:

> *"**Principal Diagnosis:***
>
> *Left L3/4 disc sequestration*
> *Previous L2/3 microdiscectomy*
>
> ***Principal Operation:***
>
> *Left L3/4 sequestrectomy"*

In his correspondence dated **8 April 2013**, Mr M., Consultant Neurosurgeon also advised, as follows:

> *"*[The Complainant] *returned for a further opinion. As you are aware, he underwent a right L2/3 discectomy via an interarticularis approach in August 2011 with a superb result. He now presents with a short history of right-sided groin pain, back pain and*

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> *right leg pain, suggestive of a recurrence. It is not too bad but won't go away. He has had to curtain his work activities. He has no left-sided symptoms …*
>
> *Repeat MRI reveals surgical changes on the right at L2/3. The findings at the operative site are unclear as gadolinium was not administered. There are minor degenerative changes in the other discs".*
>
> [My emphasis]

I also note from the documentary evidence before me the Complainant's MRI Report dated **30 July 2011**, which states, as follows:

> *"There is generalised disc disease in the lower dorsal and throughout the lumbar region … The dominant abnormality is at L3/L4 on the right where there is a large right lateral disc protrusion at the level of the exit foramen with marked compression of the exiting right sided third lumbar nerve root …*
>
> *Conclusion: Generalised degenerative change with a substantial right lateral disc protrusion at L3-L4 with right exiting nerve root compression. Clinical correlation advised".*
>
> [My emphasis]

Having reviewed its initial claim declinature of 29 January 2015 along with the new information submitted on behalf of the Complainant on 16 February 2015, I note that the Provider wrote to the Complaint's solicitors on 24 February 2015, as follows:

> *"I have fully reviewed the claim file …*
>
> *Based on the available information, I regret to advise that we remain unable to accept* [the Complainant's] *claim. This is due to his medical condition being pre-existing at his policy start sate …*
>
> *I have fully reviewed the claim file and all the medical information we hold and note from the information provided by* [the Complainant's] *Doctor that an MRI scan undertaken on 30 July 2011 revealed "generalised disc disease in the lower dorsal and lumbar region". I note that the original microdiscectomy surgery undertaken in August 2011 was performed on disc L2/L3 and the current disc problem is affecting disc L3/L4, requiring surgical intervention. I accept that the current disc sequestration noted by* [Mr. M.] *on 29 October 2014 is at a different level within the lumbar spine. However in light of the medical information provided, the current condition is directly related to the lumbar disc disease noted on the MRI examination of 30 July 2011.*
>
> [The Complainant's] *insurance policy started on 10 August 2012. The lumbar disc disease noted on the MRI scan was discovered and diagnosed in the 24 months immediately prior to the start date of* [the Complainant's] *policy. I am therefore of the opinion that the subsequent and current issues relating to* [the Complainant's] *back fall within the policy terms as being "directly or indirectly" related to Pre-Existing medical condition, specifically lumbar disc degeneration, as defined above".*

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I am satisfied that in accordance with the terms and conditions of his income assistance policy, no benefit is payable where the Complainant is medically certified as unfit for work due, directly or indirectly, to a condition or related condition that he received treatment for or was aware of or should have been aware of in the 24 months prior to his incepting his policy with the Provider on 10 August 2012.

Having considered the documentary evidence before me, I consider it reasonable for the Provider to relate the back pain and surgery that the Complainant had in August 2011 with the back pain he suffered in October 2014 and had surgery on in November 2014 and to conclude that both were related to and arising from the diagnosis of generalised disc disease in the lower dorsal and throughout the lumbar region, that the Complainant's MRI Report dated 30 July 2011 confirmed.

As both his MRI Report in July 2011 and his previous back surgery in August 2011 were within 24 months prior to his incepting his income assistance policy with the Provider on 12 August 2012, I am satisfied that it was reasonable for the Provider to determine that the Complainant's illness in October 2014 was due directly or indirectly to a pre-existing medical condition or related pre-existing medical condition. Accordingly, I am satisfied that the Provider declined the Complainant's income assistance claim in accordance with the terms and conditions of his policy.

I note from the documentary evidence before me that the Complainant's solicitors sent to this Office on 23 November 2015 a copy of the income assistance policy document held by the Complainant. I am satisfied that this policy document was in fact the same policy document as the one relied upon and presented to this Office by the Provider and which I have quoted from above.

In addition, I note that the Complainant considers that the Provider was wrong to decline his claim and that to do so *"contradicts entirely what* [the Broker] *has stated in his correspondence* [of 17 August 2012]*. I relied on and I believe I am entitled to rely on the advices given by* [the Broker] *and the assurances given to me in his letter"*, as follows:

> *"This plan is underwritten on a moratorium basis, which means, you are not entitled to claim for a period of two years from the commencement of the policy if you are unable to work due to Accident or Sickness which results from a Pre-existing Medical Condition. Such condition may be covered after two years, as long as, during the two year period, you have remained free of symptoms, treatment, advice or medication for that condition".*
>
> [My emphasis]

It seems in that respect that the Complainant may believe that his claim should have been admitted, because he had been free of symptoms, treatment, advice and medication for a period of 2 years before his claim. In this regard, I note that the Patient History made available by the Complainant's GP, Dr S. to the Provider on 16 January 2015 contains the following consultation notes:

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*"**Friday 9 November 2012** …*
acute low back pain down l. buttock very like original pain where he had disc operation - he occasioned it at work this am using shovel …
contralateral pain on other [side] *of disc - cert for time off - letter for mri*
Friday 4 January 2013
Letter for [Mr M.] *re disc problem …*
Referral letter with drugs"

These consultation notes confirm that the Complainant presented to his GP with back pain on 9 November 2012, three months after incepting his policy with the Provider, and again two months later, on 4 January 2013 (prior to attending Mr. M. in April 2013, as referred to above). As a result, at the time when the Complainant made his claim, it appears from the medical evidence that he was not free of symptoms, treatment, advice or medication for his pre-existing medical condition, that is, back pain, for two years after he incepted his income assistance policy with the Provider on 12 August 2012.

I am satisfied therefore that the portion of the Broker's letter of 17 August 2012, relied upon by the Complainant, and which I have quoted, is of no assistance to him, in light of those medical records. I am therefore satisfied on the evidence before me that the Provider did not act wrongfully in making a decision to decline the claim and it is my Decision 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

8 November 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.