An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0383
Sector:	Insurance
Product / Service:	Payment Protection
Conduct(s) complained of:	Mis-selling (insurance)
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant incepted an income assistance policy with a named Insurer via the Provider, an insurance broker, on **10 August 2012**.

The Complainant's Case

The Complainant met with a consultant of the Provider (referred to below as the Provider) on whose recommendation the Complainant incepted an income assistance policy with a named Insurer on 10 August 2012. In this regard, the Complainant submits, as follows:

> *"The proposal was completed with the assistance and following the advice of* [the Provider]. [The Provider] *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 Provider] *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".*"

The Complainant was later medically certified as unfit for work from 24 October 2014 and underwent back surgery on 20 November 2014. He submitted a disability claim to the Insurer in December 2014 but the Insurer declined this claim as it concluded that the Complainant's medical condition was a pre-existing medical condition present prior to the commencement date of cover 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 August 2011. 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"*, 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 reason provided by the Insurer for declining his claim *"contradicts entirely what* [the Provider] *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 Provider] *and the assurances given to me in his letter"*, as cited above.

The Provider's Case

Provider records indicate that the Complainant incepted an income assistance policy with a named Insurer via the Provider, an insurance broker, on **10 August 2012**.

The Complainant's complaint arises from his income assistance claim having been declined by the Insurer. The Provider notes that his income assistance policy was sold to the Complainant with the underwriting on a moratorium basis and that the moratorium clause was confirmed in the Important Information and Declaration section of the policy application that the Complainant signed on 10 August 2017, as follows:

> *"**Moratorium Clause – Pre-existing medical conditions***
> *You will not be covered for any pre-existing medical conditions for symptoms which you have sought or received advice, treatment or counselling far in the two years prior to the policy start date. Conditions may be covered once the policy has been inforce for two years providing that during that time you have not had any further symptoms, treatment (including medication) consultation or tests"*.

In addition, the Provider confirmed this moratorium clause in its correspondence to the Complainant confirming cover, dated **17 August 2012**.

The Provider is satisfied that the Complainant's income assistance policy was recommended to him in line with the documentation which was "*agreed and signed off*" by the Insurer. In this regard, all of the documentation used to confirm the moratorium clause, for example, the policy application form and brochure, is agreed and signed off by the Insurer.

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A Provider carried out a fact find with the Complainant and recommended the income assistance policy to him. In this regard, the Factfind Confidential Customer Questionnaire states that *"*[The Complainant] *understands that he will not be covered for his accident for 2 years. He is back to work and fully recovered from accident"* and the Complainant signed on 10 August 2012, confirming same.

The Insurer assessed the Complainant's income assistance claim and the Provider understands that based on the medical information provided to it, the Insurer concluded that the medical condition being claimed for was a pre-existing medical condition and thus excluded from benefit. The Provider is not responsible for claim assessments and therefore cannot comment on the claims evidence or the assessment made by the Insurer. From the claims explanation provided, it appears that the Insurer took the view that the Complainant was not fully recovered from his previous medical condition and that this was continuously ongoing and present when he presented the claim in December 2014, therefore it considered the condition to be a "*pre-existing condition*" and excluded from benefit under the policy terms and conditions.

The Provider is satisfied that the moratorium clause was explained in full to the Complainant prior to his incepting his income assistance policy. The Provider believes that his complaint instead is that the Insurer applied the moratorium clause incorrectly. The Provider does not believe that there is any dispute regarding the suitability or recommendation of the income assistance policy to the Complainant, rather it appears that the complaint is based on his claim having being declined by the Insurer when the Complainant believes it should be accepted. Therefore the Provider considers that this complaint should be directed at the Insurer as it is the Insurer which is responsible for the assessment of the Complainant's claim and for applying the terms and conditions of his income assistance policy.

The Complaint for Adjudication

The complaint is that the Provider mis-sold the Complainant his income assistance policy in August 2012.

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 mis-sold the Complainant an income assistance policy. In this regard, the Complainant met with the Provider and on the Provider's recommendation, the Complainant incepted an income assistance policy with a named Insurer on 10 August 2012. The Complainant submits, as follows:

> *"The proposal was completed with the assistance and following the advice of* [the Provider]. [The Provider] *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 Provider] *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"."*

The Complainant was later medically certified as unfit for work from 24 October 2014 and underwent back surgery on 20 November 2014. He submitted a disability claim to the Insurer in December 2014 but the Insurer declined this claim as it concluded that the Complainant's medical condition was a pre-existing medical condition present prior to the commencement date of cover 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 August 2011. 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"*, 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"*.

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As a result, the Complainant considers that the Provider mis-sold him his income assistance policy. He maintains that the reason provided by the Insurer for declining his claim *"contradicts entirely what* [the Provider] *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 Provider] *and the assurances given to me in his letter"*, as cited above.

I note from the documentary evidence before me that 'IMPORTANT INFORMATION & DECLARATION – please read carefully' section of the applicable income assistance policy application form provides as follows:

> *"**Moratorium Clause – Pre-existing medical conditions:***
> *You will not be covered for any pre-existing medical conditions for symptoms which you have sought or received advice, treatment or counselling far in the two years prior to the policy start date. Conditions may be covered once the policy has been in force for two years providing that during that time you have not had any further symptoms, treatment (including medication) consultation or tests …*
>
> ***The following have been explained/given to me/us:***
>
> *Key Facts/ Policy Document:* ✓ …
>
> *I understand the exclusions & restrictions of the plan:* ✓
>
> *The moratorium clause & Customer Declaration has been explained and is understood:* ✓

I note that the Complainant signed this application form on 10 August 2012, indicating that he understood and accepted the moratorium clause.

In addition, I note that the '**Recommendation Following Discussion'** section of the Factfind Confidential Customer Questionnaire, is completed in handwriting and provides, *inter alia*, at pg. 9:

> *"*[The Complainant] *understands that he will not be covered for his accident for 2 years. He is back to work and fully recovered from accident"*.

The '**IMPORTANT INFORMATION & DECLARATION** – please read carefully' section on the next page of this Questionnaire provides, *inter alia*, at pg. 10:

> *"**Client Declaration***
> *I confirm that the information I have provided is to the best of my knowledge correct. I have provided the information understanding that it is to be used to form the basis of any advice and recommendations made to me and that I am not under any obligation to take up any recommendation made"*.

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This Questionnaire was signed by the Complainant on **10 August 2012**, indicating that he understood the exclusions regarding pre-existing medical conditions.

Furthermore, I note that the Provider wrote to the Complainant on **17 August 2012** and the enclosed '**DEMANDS & NEED STATEMENT'** advised, *inter alia*, 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.*
>
> *The full eligibility requirements and exclusions for this plan can be found in the enclosed Key Facts and Policy Document which we would strongly advise you to read".*

In this regard, Section 3, '**Benefits and Exclusions'**, of the enclosed 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**".*

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".*

I am thus satisfied from the documentary evidence before me, that the Provider furnished the Complainant with appropriate notice of the income assistance policy exclusions, regarding pre-existing medical conditions and that the Complainant signed by way of indication that these were explained to him and that he understood them.

In addition, I am also satisfied that the income assistance policy that the Provider sold to the Complainant provided him with valuable cover in the event of him being medically certified and unfit for work due to an accident or illness that was not directly or indirectly related to any pre-existing medical condition.

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Ultimately, when the Complainant made a claim on the policy, it was a matter for the Insurer to assess that claim and make a decision to admit it for payment, or to decline it. Insofar as the complaint against this Provider (the Broker) is concerned, that the policy was mis-sold to the Complainant in August 2012, I take the view that the evidence confirms that all of the required and necessary information was given by the Provider to the Complainant, regarding the manner in which the policy would operate. Accordingly, in the absence of any wrongdoing on the part of the Provider, it is my Decision that this complaint cannot be upheld.

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.

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.