An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

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| **Decision Ref:** | 2019-0415 |
| **Sector:** | Insurance |
| **Product / Service:** | Critical & Serious Illness |
| **Conduct(s) complained of:** | Claim handling delays or issues<br>Delayed or inadequate communication |
| **Outcome:** | Partially upheld |

## LEGALLY BINDING DECISION
## OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

### Background

This complaint concerns the Complainants' serious illness cover plan with the Provider.

The complaint is that the Provider misrepresented the level of serious illness cover in respect of the First Complainant in communications issuing to the Complainants after the First Complainant made a claim on his plan in **May 2017**. The Complainants also complain that the Provider mishandled their complaint.

### The Complainants' Case

The Complainants have a serious illness cover plan with the Provider. On **3 May 2017**, the First Complainant made a successful claim on this policy in respect of a cancer diagnosis. By letter dated **9 June 2017**, the Provider enclosed a cheque in the sum of €44,999 in settlement of that serious illness claim.

Thereafter, on **19 June 2017**, the Provider reviewed the Complainants' plan. Amongst other things, the schedule to the revised policy set out that the First Complainant was still covered for serious illness.

By letter dated **1 August 2017**, the Provider contacted the Complainants outlining that it originally contacted them on **19 June 2017** enclosing a review of the plan and noting that it

did not receive a reply. The **1 August 2017** letter also set out the revised benefits in table form, again noting that the First Complainant was still covered for serious illness.

The Complainants submit that on the **14 October 2017** the First Complainant had a heart attack during cancer surgery. The Complainants assert that there were no prior signs of any heart disease and that the First Complainant had passed recent earlier stress and heart tests before the cancer diagnosis.

The First Complainant contacted the Provider on **21 December 2017**, seeking clarification on the inclusion of specified illness cover for him as had been set out in the revised benefits received on **19 June 2017** and **1 August 2017**.

The Provider confirmed to the Complainants on **2 January 2018**, that the inclusion of serious illness for the First Complainant in the revised policy was an error and a further amendment letter wold be sent to the Complainants.

By letter dated **5 February 2018**, the Provider contacted the Complainants in reply to the *"recent contact made to our offices"* and apologised for the delay in replying. The Provider, in this letter, states:-

> *"The below contains the content that should have been present in our letter from **August 1st 2017**. Last year, in that letter, you were provided with incorrect information about the level of cover on your plan."*

As a result of the above, the Complainants say that the Provider has stated that there was an error by it and that the serious illness cover is no longer in place for the First Complainant. The Complainants submit that this error discloses a *"major breakdown in the systems"* of the Provider.

The Complainants submit that when the Provider issued the revised policy document on **19 June 2017** and **1 August 2017**, the revised policy document included cover for the First Complainant for serious illness and this led the Complainants to believe that the First Complainant was covered for serious illness. The Complainants say that they were under the impression that the First Complainant was only excluded in the event of a further serious illness claim arising out of another cancer diagnosis.

The Complainants submit that the self-described errors in the revised policy document were only discovered by the Provider as a result of the First Complainant's correspondence of **21 December 2017**.

On **2 June 2018**, the Second Complainant raised a query about making a serious illness claim for the First Complainant's heart attack which occurred in **October 2017**. The Provider declined this claim on the basis that benefits under this plan ceased for the First Complainant once the first serious illness claim had been paid.

The Complainants contend that they relied on the revised policy schedule to their detriment. They state that they are self-employed and that they reviewed their financial needs,

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financial position and their health needs taking into account the revised policy, which stated that the First Complainant had cover for serious illness.

The Complainants submit that if they had been aware that there were errors in the revised policy and that the First Complainant was not covered for further serious illness, they would have taken that fact into account when planning for their financial and healthcare needs.

In further correspondence sent to this Office by the Complainants dated **15 July 2019**, the Complainants state that they did not make enquiries into securing additional serious illness cover elsewhere for the First Complainant as they understood that they had sufficient cover already in place with the Provider. They further state that if it was not possible to get additional serious illness cover for the First Complainant, they would have still managed their financial affairs differently had they been aware of the error and loss of serious illness cover. In particular, they state that they would have set aside particular funds from savings or managed their income and outlays differently or alternatively, taken out other types of insurance cover.

In this correspondence dated **15 July 2019**, the Complainants clarify that the First Complainant was not aware of any possible issue with the policy until **21 December 2017** as the Complainants were focusing all of their time and efforts on the health of the First Complainant who was suffering extreme and catastrophic personal and medical circumstances with a less than 10% chance of survival. They state that in **December 2017**, the First Complainant came across an article about serious/critical illness cover and this led him to query what level of cover his policy retained. The Complainants state that the First Complainant contacted the Provider at this stage as he did not fully understand the revised insurance policy document and wanted to clarify this before submitting his claim for the heart attack he had suffered. The Complainants state that up until **December 2017**, they took the revised policy documents at face value and had no reason to think otherwise, especially as their monthly premium cost had not changed.

The Complainants further state that the Provider indicated that it had overcharged the Complainants for the policy and for the cover since the cancer claim. By letter dated **12 October 2018**, the Complainants state that the Provider acknowledged the error in respect of the overcharging and refunded €666.06 into the Complainants' bank account. The Complainants state that if the First Complainant had not contacted the Provider on **21 December 2017**, the errors in the revised policy would not have come to light and the Provider would still have been collecting an incorrect monthly premium for cover that it was not going to accept a claim on.

Ultimately, the Complainants want the Provider to pay out for their second claim under the serious illness cover plan for the First Complainant's heart attack, as they state that this claim was covered as per the policy documents that were in place at the actual date of the event and they want redress for the financial loss they have suffered as a result of their reliance on the Provider's error, to their detriment.

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**The Provider's Case**

By way of response, the Provider submits that on **9 June 2017**, the Provider paid a specified illness cover claim on a diagnosis of bowl cancer in relation to the First Complainant.

A cheque for €44,999 was issued in relation to this claim as per the terms and conditions of the cover. The Provider states that at this point, the permanent total disability cover was removed for the First Complainant from the policy but not the specified illness cover. The Provider submits that this was due to human error and acknowledges that this was incorrect.

The Provider submits that once the error in respect of the revised policy terms came to its attention by reason of the enquiry from the First Complainant on **21 December 2017**, the error was remedied. This involved the incorrect figure for the specified illness cover being reduced to zero, in line with the terms and conditions of the policy. In its initial response letter to this complaint dated **8 July 2019**, the Provider stated that this was confirmed to the Complainants in writing on **5 February 2017**, however, it clarified in a follow up letter dated **22 July 2019** that the correct date of this confirmation letter was **5 February 2018**.

The Provider confirms that on **2 June 2018** the Second Complainant raised a query about making a specified illness cover claim for the First Complainant's heart attack that had occurred in **October 2017**. The Provider responded to confirm that, as per the terms and conditions of this serious illness cover plan, the cover will *"cease to be payable on payment of a serious illness or permanent total disablement claim in respect of the second lives insured where the insurance is dual life"*. Therefore, the Provider submits that the error it made does not negate the terms and conditions of the plan, given that the plan expressly states that once a claim is paid to an insured person on the serious illness cover plan, any other benefits on the plan will cease for that insured person.

The Provider also contends that, notwithstanding the error, it is clear that the First Complainant was aware and demonstrated an awareness that the continued inclusion of specified illness cover for him was not correct, as evidenced by his querying of same in his email of **21 December 2017**.

Furthermore, the Provider contends that if the Complainants had a genuine expectation that they could make a second specified illness cover claim for the heart attack suffered by the First Complainant in **October 2017**, then they would have submitted a claim before **January 2018**, within a reasonable timeframe following the event

The Provider further states that due to the First Complainant's diagnosis with bowl cancer, prior to his heart attack in **October 2017**, he would not have been in a position to obtain further specified illness cover, either with the current Provider or any other Provider, based on current underwriting criteria, standard across the industry. Therefore, the Provider states that regardless of the admitted error, it cannot see what actions the Complainants could have taken to mitigate the financial impact of the First Complainant's heart attack during the period between **June** and **October 2017**. In its letter dated **12 October 2018**, the Provider stated that:

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> *"I am sorry that you* [the Complainants] *were provided with incorrect information, however, based on* [the First Complainant's] *medical history and the fact that a serious illness claim was paid out on him he would have been accepted for serious illness cover elsewhere"* (emphasis added)

In its response letter to this complaint dated **8 July 2019**, the Provider states that this is a typographical error and the comment should read:

> *"…however based on* [the First Complainant's] *medical history and the fact that a serious illness claim was paid out on him he would **not** have been accepted for serious illness cover elsewhere"*

In its response letter to this complaint dated **8 July 2019**, the Provider apologises for this error.

The Provider accepts that it continued to collect a premium portion for the specified illness cover for the First Complainant after it states that its cover for specific illness should have ended; it states that it refunded this overcharge in full once this error came to light. The Provider clarifies that the amount of €666.06 was returned to the Complainants in **October 2018** and this represents a refund of the difference between the incorrect post claim review Option B monthly premium of €79.98, applied in **June 2017**, and the corrected premium of €40.41 which was applied in **October 2018** together with interest.

The Provider states that it is fully satisfied that the Complainants' complaint was dealt with in a fair and balanced manner and that the final response to this complaint reflected the correct interpretation of the applicable terms and conditions, taking into account the particular circumstances of the case. The Provider issued a complaint acknowledgement letter dated **24 August 2018**, a 15 day update letter dated **7 September 2018**, a 30 day update letter dated **28 September 2018** and a final response letter dated **12 October 2018**. The Provider is also confident that, notwithstanding the correspondence with the First Complainant on **21 December 2017**, that it would have picked up on the error in the revised policy at the next scheduled review of the plan.

In acknowledgment of its *"customer service failure"*, the Provider wishes to offer the Complainants a customer service payment of €500.

## The Complaints for Adjudication

The complaint is that, after the First Complainant made a claim on his plan in May 2017, the Provider then misrepresented the level of serious illness cover available to him, in communications issuing to the Complainants. The Complainants also believe that the Provider mishandled their complaint.

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**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 7 November 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 Complainants are annoyed that the Provider misrepresented the level of serious illness cover in respect of the First Complainant in communications issuing to them after the First Complainant made a claim on his plan in **May 2017**, I note that the Provider has accepted that there was a mistake in the revised policy which incorrectly attributed serious illness cover to the First Complainant, despite the fact that he had already made a successful claim for serious illness benefit under the policy. The explanation of the Provider that this mistake was a result of a human error on its part is not contested by the Complainants and I accept that the mistake was inadvertent.

I also accept the explanation of the Complainants for the rationale behind the First Complainant's correspondence with the Provider on **21 December 2017**. It is entirely natural and understandable that the Complainants would take the erroneously revised policy documentation at face value, especially given that this had been sent to the Complainants on two separate occasions, namely **19 June 2017** and **1 August 2017**. This is even more understandable when one considers the severe physical and emotional stresses the Complainants were under at the time in question, due to the serious and debilitating physical difficulties suffered by the First Complainant as a result of his cancer diagnosis and subsequent heart attack.

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Furthermore, the First Complainant is to be credited for his proactive actions in writing to the Provider on **21 December 2017** to clarify the nature and scope of the cover contained in the revised policy. I do not accept, nor is there any evidence to support the view put forward by the Provider, that this correspondence from the First Complainant in some way goes to show a knowledge or understanding on the part of the Complainants that the statement of the cover contained within the revised serious illness policy was erroneous. The confusion surrounding the cover in place for the First Complainant was caused wholly by the error of the Provider and it took the actions of the First Complainant to alert the Provider to this error. This action by the First Complainant, led to the ambits of the cover being clarified by the Provider and a corresponding correction of the monthly premium to be paid by the Complainants. This Office also notes that no evidence has been put forward by the Provider to support its submission that, notwithstanding the correspondence with the First Complainant on **21 December 2017**, it would have picked up on the error in the revised policy at the next scheduled review of the plan.

Notwithstanding the above, I accept that the serious illness cover plan, entered into initially by the Complainants in or around **1994/1995**, clearly and unambiguously states at paragraph 22 that for a claim to be valid under this policy it is a pre-requisite that *"no benefit has been previously claimed in respect of the life insured"*. This is further elaborated on in the 'Claims' section of the policy document which states that policy holders

> *"should be aware that you can only receive one payment under your serious illness cover plan. In other words you cannot claim, for example, for a heart attack and subsequently claim for a separate claim for a separate illness".*

That this clear and unambiguous policy term was subject to such prolonged subsequent confusion is entirely the fault of the Provider. Not only did the Provider incorrectly inform the Complainants on **19 June 2017** and **1 August 2017** that the First Complainant still retained serious illness cover despite having already made a successful claim for this benefit, it further compounded this error by overcharging the Complainants in respect of their monthly premium pursuant to the plan. Even subsequent to the error being brought to the Provider's attention, the Provider persisted in conveying inaccurate, incorrect information to the Complainants which only served to muddy the issues further. In particular, the Provider made a serious typographical error in its letter to the Complainants dated **18 October 2018** and a further typographical error in its initial response letter to this complaint dated **8 July 2019**. These errors understandably confused the Complainants as to the position of the Provider in relation to the dispute and necessitated further responses from the Complainants and the Provider, thereby further prolonging the resolution of the complaint. These errors by the Provider are particularly concerning given the vulnerable nature of the Complainants due to the severe and serious injuries suffered by the First Complainant as a result of his cancer diagnosis and subsequent heart attack.

I accept that the aforementioned errors by the Provider led the Complainants to believe from **June 2017** to **December 2017** that they retained serious illness cover under the policy and I further accept that these errors had a real and demonstrable effect on the Complainants' ability to accurately financially plan for the future. However, I accept the position of the Provider that, even if the Provider had acted properly and informed the

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Complainants that the serious illness cover in respect of the First Complainant had ceased following his claim, the First Complainant would not, in all likelihood, have been able to secure serious illness cover with another provider due to his health history.

Accordingly, while I understand the frustration and distress the Complainants have suffered in respect of these errors by the Provider, I accept that the errors from the Provider do not negate the terms and conditions of the serious illness cover plan, given that the plan expressly states that once a claim is paid to an insured person, on the serious illness cover plan, any other benefits on the plan will cease for that insured person. Therefore, I accept that the Provider was entitled to refuse the Complainants' second claim for serious illness benefit arising from the First Complainant's heart attack.

The aforementioned errors by the Provider and the failure by the Provider to class the Complainants as vulnerable consumers have led to multiple breaches of the Consumer Protection Code 2012 (as amended) ('the CPC') by the Provider.
In particular there is no evidence that the Provider dealt with or accommodated the Complainants in accordance with its vulnerable consumer policy and therefore in my opinion, its actions were contrary to provision 3.1 of the CPC which states that:

> *"where a regulated entity has identified that a personal consumer is a vulnerable consumer, the regulated entity must ensure that the vulnerable consumer is provided with such reasonable arrangements and/or assistance that may be necessary to facilitate him or her in his or her dealings with the regulated entity."*

The Provider also acted contrary to provisions 2.2 and 2.3 of the CPC by failing to act with *"due skill, care and diligence in the best interests"* (2.2) of the Complainants and also arguably misleading the Complainants *"as to the real or perceived advantages or disadvantages"* of the serious illness cover plan (2.3). Furthermore, the Provider acted contrary to provision 4.1 of the CPC by failing to ensure that the information it provided to the Complainants was *"clear, accurate and up to date"*.

In terms of the handling of the complaint by the Provider, setting aside the errors in the responses outlined above, I accept that the Provider handled the complaint appropriately and in line with the CPC requirements. I accept that the Provider issued a complaint acknowledgement letter dated **24 August 2018**, a 15 day update letter dated **7 September 2018**, a 30 day update letter dated **28 September 2018** and a final response letter dated **12 October 2018**.

Having regard to the particular circumstances of this complaint, in particular the errors on the part of the Provider to clearly and accurately convey the revised policy terms to the Complainants, I consider it appropriate to partially uphold this complaint and I direct the Provider to make a compensatory payment of €3,000 (three thousand euro) to the Complainants.

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**Conclusion**

- My Decision is that this complaint is partially upheld, pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, on the grounds prescribed in ***Section 60(2) (g).***

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainants in the sum of €3,000 to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants to the Provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

- The Provider is also required to comply with ***Section 60(8)(b)*** 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**

2 December 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.**