An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

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| **Decision Ref:** | 2020-0129 |
| **Sector:** | Insurance |
| **Product / Service:** | Income Protection and Permanent Health |
| **Conduct(s) complained of:** | Rejection of claim - fibromyalgia<br>Lapse/cancellation of policy<br>Disagreement regarding Medical evidence submitted |
| **Outcome:** | Substantially upheld |

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

### Background

The complaint concerns a Group Scheme Income Protection Policy. The policy was put in place by the Complainant's employer. The Complainant is a Member of the Scheme. Following a road traffic accident the Complainant made a claim for disability benefit under the policy. The Provider accepted the claim and paid benefit to the Complainant. While in receipt of benefit the Complainant became entitled to maternity leave payments. The Complainant's employer made additional payment in respect of the Complainant's leave, and on being informed of this payment, the Provider ceased benefit.

When the Complainant applied to have the disability benefit restored the Provider classified her claim as linked claim. Under the policy a linked claim had to be progressed within 6 months of cessation of benefit. As the Complainant's had not made the claim for re-instatement of the benefit, the Provider did not re-instate benefit. The Complainant sought the assistance of a solicitor, and upon a further review of the claim, the Provider's Chief Medical Officer deemed the Complainant eligible for benefit and deemed the claim as a continuance claim and re-instated benefit, backdated to when last paid. It took much effort on the Complainant's part to reach this outcome, and the Complainant alleges mismanagement of the claim by the Provider.

The complaint is that the Provider did not correctly administer the Complainant's claim for disability benefit and the Complainant is seeking the monies she expended by having her

solicitor intervene in the matter. The Solicitor's cost are €11k+. The Provider offered a payment of €4,000.

**The Complainant's Case**

The Complainant states that in relation to her disability claim she received unfair and unreasonable treatment from the Provider. The Complainant was the victim of a car crash in 2013. The Provider accepted the claim and paid the income protection benefit from 17th July 2013 to 12th December 2013. The Complainant states that from December 2013 her employer, temporarily made payments due to her maternity. The Complainant's position is that prior to her maternity leave, she enquired what the process would be if she continued to be unfit for work at the end of her maternity leave on 4th October 2014. In response to her query through the employer's human resource department, the Provider communicated that, should the Complainant continue to be unfit for work, she should submit medical evidence supporting this before the end of her maternity leave.

The Complainant states that the Provider did not request her to attend a medical assessment to ascertain her fitness to return to work before she commenced maternity leave. During the Complainant's maternity leave, her employer changed insurance providers for income protection for their employees. The Complainant states that she was never made aware of this. The Complainant says she found this out in January 2016 when the Provider rejected her appeal.

The Complainant states that all correspondence with the Provider, prior to her appeal of 30 September 2015 was through her Employer's HR department / the Scheme Broker. Therefore, all information she received, was received third hand.

The Complainant alleges that there was:

1. An absence of transparency in the Provider's process which ultimately discriminated against her because of her maternity.
2. An arbitrary election by the Provider to deem her continued inability to work after maternity leave as making what the Provider define as a "linked claim" and then putting an onus on the Complainant to prove a "relapse" when she had never recovered from the crash in the first place. The Complainant states that after extensive legal intervention by her legal representative on her behalf, and 2 years of fighting for her income protection benefit, the Provider recanted this assertion in September 2016 and finally classed her as having a 'continuous' period of disability, rather than a 'linked' period of disability.
3. A time limit was put in place by the Provider of "*prior to the expiry of [her] maternity leave*" for the submission of medical evidence. The Provider then reduced that time limit, after the earlier deadline had elapsed, to within 6 months of the start of maternity leave, that is, 12/06/2014. The Complainant submits that the Provider then claimed that she provided "insufficient" medical evidence due to non-compliance with the June 2014 deadline which the Provider gave her in June 2015. The Complainant states that there is evidence that the Provider was aware that her maternity leave had "an anticipated return of October 2014".

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4. Reliance by the Provider on a definition of a 'linked claim' in "condition 4.7" of a policy document, that was not given to the Complainant despite her requesting it. The Complainant states that she did receive a document which states:

   *"Your long term disability benefit would be payable until recovery, withdrawal from service, retirement or death, whichever is earlier".*

   The Complainant notes that Pregnancy is not cited as a condition for termination of a claim nor is there any definition in this document of what a *"linked claim"* refers to or the conditions attaching to a linked claim.

5. Blatant selective interpretation of medical evidence by the Provider, to the point where the Provider's continued rejection of her claim defied all reason.

   The Complainant gives the following examples:

- The Provider's medical officer stated in August 2013 that the Complainant had 'chronic pain syndrome' as well as back pain which he believed to be 'multifactorial in nature'. In addition to 'soft tissue type pains'. The medical officer refers to 'reactive type anxiety and the Complainant's 'background history of slow to recover soft tissue symptoms post-accident ..'. On this basis, the Provider paid the claim from July to December 2013.

- Before the end of the Complainant's maternity leave, in September 2014, her GP wrote a report confirming that the Complainant had "thumping headache. Neck pain radiating to left arm. Radiates to shoulder area. Thoracic lumbar spine." And that her symptoms were consistent with the accident of January 2013.

- The Provider's appointed specialist saw the Complainant in April 2015 and confirmed in a report solicited and paid for by the Complainant in November 2015 that she showed *"50% loss of range of movement of neck globally. Diffuse fibromyalgia type tender points in mid and lower thoracic".*

  The Complainant says that the Provider rejected the GP's report as it was not dated within 6 months of her maternity leave start date; although it was dated before her maternity leave ended, which she says complied with the instruction the Provider had originally given her.

- The Provider rejected the appointed specialist's medical report as not being "objective" although it had solicited and paid for the report.

- Although the Complainant's original claim was honoured based on the Provider's medical officer's assessment, which clearly states that her condition was not a simple case of soft tissue injury, because symptoms had worsened, and perhaps more importantly because the Employer had changed insurance providers during maternity leave, the Provider was claiming that it honoured the claim originally due

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to neck and back pain only and that the Provider did not have liability for her *"debilitating symptom".*

6. Continued excessive delay after delay by the Provider in resolving the claim.

The Complainant's position is that overall, this was extremely difficult and a wholly inequitable battle with the Provider. The Complainant states that she was never medically fit to return to work after the crash, and the "battle" would not have happened if the Provider had not unilaterally deemed maternity as being an opt out clause for their liability, without any supporting medical evidence to this end. The Complainant submits that perhaps equally if her Employer had not changed insurance providers during her maternity leave, the Provider may not have classed her continued inability to return to work as an "in this instance" scenario for which it wished to pass on liability to the Provider's new insurance provider.

The Complainant submits that the Provider was relying on her being too unwell to pursue her claim and she says, indeed she was, and had no choice, after exhausting all the internal means of appeal, but to obtain legal advice and support. The Complainant's position is that without the detailed review and independent legal assessment, by her solicitors, of all aspects of her income protection claim (employment personnel file relating to income protection claim, data protection request file from the Provider, medical file from employer's occupational health assessors), all correspondence between her and employer HR, the Provider would never have admitted liability. The Complainant states that she does not feel that it was a reasonable expectation to have to go to these lengths for a fair assessment by the Provider.

The Complainant questions whether the Provider's behaviour was best practice. The Complainant's position is that she had to incur significant debt, endure extreme emotional distress and financial worry on top of her continued disability over an arduous period of two years in order to obtain the income protection that the Provider was contractually obliged to pay. The Complainant says that had the Provider acknowledged her continued disability in a reasonable timeframe and had they followed a clear, fair process, with direct channels of communication, none of this would have happened.

**The Provider's Case**

The Provider states that the dispute is in relation to a claim for the payment of legal fees in the sum of €11,869.50 following the disputed claim payment which is now reinstated.

This claim followed a road traffic accident (RTA) in 2013 and a claim was submitted for a primary' diagnosis of back & neck injuries. The Provider commenced payment of this claim benefit from 17/7/2013. The Provider states that the claim benefit ceased upon maternity leave per the Policy Terms and Conditions as the employer then paid a salary from 12/12/2013.

The Provider's position is that there was an expectation based on the medical file available to the Provider that the Complainant would recover during her Maternity leave. The

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Provider says that if this was not to occur it had detailed the criteria for a reinstatement of the claim benefit in its letter dated 2/12/13 to the scheme broker, namely that the Provider would need a medical report supporting the Complainant's claim prior to the end of her maternity leave which the Provider says is usually after six months. The Provider says that it understands that a period of four months unpaid leave was then taken up to October 2014. The Provider states that it was notified of a potential claim by telephone call from the scheme broker on 29/10/2014 and a complete claim form was only received on 8/1/2015.
The Provider submits that there were potentially three possibilities following the Complainant's maternity leave:

- *"A continuous claim would normally be supported with a medical file demonstrating that the accident or illness has been ongoing requiring treatment, medication and regular medical appointments since the road traffic accident in 2013.*

- *In order to consider a Linked claim you would expect the medical evidence to support the view that the accident or illness is the same / linked to the previous condition in 2013. This is usually for cases where there has been a period of recovery and there is a relapse of the original condition.*

- *You can also have a new period of claim for a new illness or accident. However in the interim period the Underwriters changed and [the Provider] would not be responsible for such a claim".*

The Provider's position is that the whole issue as to whether this was a linked claim to the previous condition in 2013 or a continuous claim from 2013 has caused delay and confusion. The Provider states that the key points impacting (n its view) were:

(1) *"When the claim benefit ceased upon [the Complainant's] receiving salary maternity payments via her employer, [the Provider] detailed the basis upon which the income protection benefit would recommence in [a] letter dated 2/12/2013. [The Provider] did not receive 'a report from [the Complainant] attending specialist prior to the expiry of her maternity leave' as required.*

(2) *There was a considerable time delay in reverting to [the Provider] following the period of maternity leave. [The Complainant] went on maternity leave effective from [end of 2013] and [the Provider] were only notified that there was a potential further claim by telephone call on 29/10/2014, when we were advised that [the Complainant] had taken a period of unpaid leave and had a GP certificate stating that she was unfit for work from 2/10/14. We then only received a claim form on 8th January 2015. We understand that there was also a 4 month period of unpaid leave in 2014. This was a key factor in not reviewing this claim as a continuous claim from December 2013 to January 2015. [The Provider] would normally have expected to receive notification of a continuous claim in mid-2014 when the employer maternity leave salary payments ceased with supporting medical evidence from December 2013.*

(3) *The medical evidence produced in 2015 pointed to the possibility of a linked claim.*

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*[Employer CMO] report dated 22/10/2014 stated "felt well following pregnancy" and "symptoms reoccurred in June 2015'*

*Initial claim in 2013 was mainly for back and neck pain following a road traffic accident with a good prognosis for an early return to work.*

*The claim submitted in January 2015 indicated a new onset of symptoms where the primary diagnosis was confirmed 'uncertain' per the GP claim form.*

*Our [Chief Medical Officer (CMO)] reviewed this medical evidence in 2015 and was of the opinion that the Complainant's current condition diagnosed as possible Fibromyalgia was not linked to her previous RTA 2013 claim.*

*It was only on 11/2/2016 that the possibility of a continuous claim was raised.*

*[The Provider] then obtained the GP records for the Complainant by report dated 25/5/16.*

*(4) The information we received from the Scheme Owner in November 2014 and January 2015 was that this was a linked claim and this was supported by a Medical report from the company's CMO dated 22/10/2014".*

The Provider states that upon review it can understand the frustration with this process for the Complainant. The Provider however says it can only assess claims based upon the information received. The Provider submits that it received no explanation for why the secondary claim was only submitted on 8/1/2015 some six months after when it would expect such a claim would be submitted, or why the Complainant took unpaid leave instead of resubmitting a claim.

The Provider's position is that in its view it could reasonably have refused to review this claim due to the time delay in submitting such a claim in 2015 and not following the criteria for such a claim as detailed in the Provider's letter & email dated 2/12/2013 to the Scheme Owner.

The Provider considers that a very reasonable approach was taken by its Health Claims team in conjunction with its CMO to accept this late notification claim from January 2015. It is also the Provider's view that it has taken quite a sympathetic view on the medical evidence eventually submitted from the GP in 2015. The Provider notes that there was only one consultation by the Complainant with her GP within the 7 months from December 2013 in respect of the 2013 RTA.

The Provider states that in its view all the parties involved here could have unravelled this matter, at an earlier time, as to whether this was a new, linked or continuous claim from 2013 when the company ceased paying maternity leave salary in June 2014. The Provider states that this could have been done by providing the supporting medical evidence to a level sufficient for the Provider to accept such a continuous claim. The Provider states that it is also of the view that it is quite an unusual set of

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medical circumstances for a road traffic accident with the medical evidence produced in 2013 to end up with the continuous claim that now exists.

The Provider's position is that it is the medical evidence that drives the assessment of this claim and the scheme owner, on behalf of their scheme member, has a responsibility to ensure that the Provider receives the correct notification of the claim type along with the supporting medical evidence.

The Provider states that if the Complainant has any issues with the communications between the Provider and the scheme owner / Scheme broker then she needs to raise these directly with her employer. The Provider says that its communication on this claim is with the scheme owner in line with the normal practice for this scheme. The Provider states it understands that the Complainant would have preferred a more direct communication and again would direct the Complainant to the Scheme owner / employer on this point. The Provider states that the policy Terms and Conditions are also agreed with the Scheme Owner and again the Complainant needs to raise any concerns / enquires she has on these with her employer as the scheme owner. The Provider states that in its view a more direct communication is usually more effective and may have assisted and avoided some of the argument and delay from January 2015 to September 2016, but that is not the basis for communication under this scheme.

The Provider submits that it has read the legal argument but suggests that if more time and effort was spent in obtaining medical reports to support the continuous claim from December 2013, it could have dealt with this matter at a much earlier stage.

The Provider states that upon review of its file it is satisfied that its decisions in respect of this claim were based upon the medical file available to the Provider at the time of each claim decision. The Provider states that the Complainant has submitted a view that this has to do with her maternity leave and the legal contract. The Provider states that it does not see any evidence for this nor does it see the claimant had no alternative but to engage legal advice. It is the Provider's positon that it clearly advised the Complainant through the scheme owner that if she wished to appeal the Provider's decision to decline her claim that she would need to obtain medical evidence to support her claim. The Provider states that this was confirmed within the letter from the Complainant's employer's HR Department to the Complainant dated 11th June 2015. The Provider states that when the appropriate medical evidence and information was furnished to support the possibility of a continuous period of disability, the Provider paid the claim albeit after some delay and discussion.

The Provider submits that the Complainant also could have engaged the Scheme Owner who is also her employer and / or the scheme brokers without cost to explain and clarify the position on this claim for her. The Provider states that the Complainant also had the option to refer this matter to the Financial Services Ombudsman at an earlier stage if she so wished. The Provider accepts that there have however been delays in what became quite a convoluted and complicated matter. The Provider says that the delay to January 2015 in notifying the Provider of this

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secondary claim was a major factor in this and the Provider's acceptance of this late notification claim was in the Provider's view quite a conciliatory offer to resolve this matter.

The Provider submits that notwithstanding this, the Provider wishes to put an offer, formally on the record, in the sum of €4,000 on an *ex-gratia* basis to further assist in resolving this matter.

**Evidence**

Policy Terms and Conditions

*1. Contract Definitions*

*Earned Income*
*In respect of the Insured means gross earned income from his Normal Occupation less any amount allowable against income tax as expenses for the period of one year immediately prior to the commencement of the Period of Disability or such other period as [the Provider] may agree".*

*Period of Disability*
*A period throughout which a Member is totally unable to carry out his Normal Occupation due to a recognised illness or accident and during which the Member is not involved in carrying out any other occupation for profit, reward or remuneration of any kind whatsoever whether sedentary or otherwise and whether or not entirely different from his Normal Occupation.*

*3.4 Limitation of Benefit*
*(i) 75% of Member's Earned Income .. less*
*(a) the annual rate of any continuing Salary, commission, pension or other income, and*
*(b) the current Social Welfare Benefit …*
*(c ) the annual amount of any compensation for loss of earnings …*
*(d) the annual rate of benefits payable under any other insurances against disability.*

*4.1 Disability Benefit*
*Disability Benefit will be payable from the end of the Deferred Period if, in the opinion of [the Provider], having regard to all of the information available to it, the Member is suffering a Period of Disability. [the Provider] will continue to pay benefit until:*

*(i) The Member, in the opinion of the [the Provider], having regard to all of the information available to it, is no longer suffering a Period of Disability; or*
*(ii) The Member dies; or*

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*(iii) The Member returns fully to his Normal Occupation or another equivalent occupation; or*
*(iv) The Expiry Date; or*
*(v) The date on which the Member ceases to be in the Employer's service (subject to Section 4.9)*

*Whichever happens first.*

*4.6 Payment of Benefit*
*Payment of Benefit in respect of a Member will be made to the Employer and will be subject .. to a corresponding payment being made by the Employer to the Member by way of Salary.*

*4.7 Linked Claims*

*If a Member suffers a relapse caused by the same injury or illness within six calendar months of the end of a period during which the Member was receiving Disability Benefit .. may recommence without the imposition of a further Deferred Period, in the opinion of [the Provider] having regard to all of the information available to it, the Member is suffering a Period of Disability.*

Claim / Complaint events

Early 2013 – Complainant suffered Road Traffic Accident

9 August 2013 – Occupational Health Physician

*"While I do not feel soft tissue symptoms alone are barriers to her return to work, these pains in combination with her anxiety are likely to make her incapable of providing an efficient / reliable service at work at present. The clinical findings from this assessment are consistent with her reported symptoms. I therefore do not feel she is fit to resume work at present".*

2 December 2013 – Provider's internal system note:

*"Review completed, benefit to cease wef 09/12/13 as maternity leave with (sic) be paid by employer.*

*Ceased benefit as no financial loss once employer reinstates salary, however when ceasing claim there is no opinion (sic) for 'no financial loss' as when declining, therefore had to cease as not totally disabled, due to limited options".*

2 December 2013 – The Complainant to Scheme Broker

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*"Did you get a chance to confirm whether the PHI is effective immediately at the end of any maternity (if the company doctor still deems me unfit for work for a period) or whether I would have to reapply for the insurance cover?"*

2 December 2013 – Provider to Complainant's employer

*"To answer your query, [the Complainant] would not have to fully reply, in that she will not be required to complete a new claim form, etc, once the disability is the same as before we will just require a specialist report prior to the expiry of her maternity leave so we can reconsidered (sic) a continued period of disability, however depending on the medical evidence provided we may need an independent medical assessment".*

2 December 2013 – Provider to Scheme Broker

*"As [the Complainant] is due to commence maternity leave, I can confirm that the entitlement to benefit will cease once salary has been reinstated by the employer on the 9/12/13. Should [the Complainant] remain unfit to carry out her normal occupational duties, due the same illness on the expiry of maternity leave, we can consider a linked claim at that point if appropriate.*

*[The Complainant] will need to provide a report from her attending specialist prior to the expiry of her maternity leave in order for [the Provider] to consider a linked claim".*

5 December 2013 – Complainant to the Scheme Broker

*"Could you put it in your diary to schedule a visit to the company doctor for me at the start of August then please so that if … concerns still persist, that she could provide this report for [the Provider]"*

22 May 2015 – Provider's cessation of benefit

6 January 2015 – Following a review of the Complainant's appeal the Provider upheld its decision to decline benefit. "The initial claim following your road traffic accident [early 2013], was paid for the period 17/07/13 – 12/12/13, at which time your claim ceased" .. "as your previous claim ceased with [the Provider] on 12/12/13, the six month period for a linked claim expired on the 12/06/14".

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- Provider's CMO Referral

  *"This claim was initial for the period [January 2013] – [December 2013], at which time maternity leave commenced and our benefit ceased.*

  *[The Complainant] was due to return from maternity leave in October 2014, however this return did not take place. The medical evidence indicates [the Complainant] had initially recovered until June 2014 when new symptoms commenced".*

- *CMO – "New diagnosis deemed to be Fibromyalgia .. no linkage per OH IME"*

21 May 2015 – Provider to Scheme Broker

*"As the medical evidence confirms that the current absence is not linked to the previous absence, I regret to advise we must decline a linked claim for [the Complainant's] instance".*

29 May 2015 – the Scheme Broker to Employer

*"[The Provider] have stated that a linked claim is defined as a relapse caused by the same injury or illness within six calendar months" .. "[The Complainant] was initially out of work due to neck and back pain due to a road traffic accident. [the Provider] believe the medical evidence provided from … Occupational Health Physician and … Consultant Neurologist does not provide a link between [the Complainant's] current condition and the accident on …"*

30 September 2015 – The Complainant to the Provider

*"At no stage since the time of the accident have my neck and back symptoms and headaches dissipated completely nor has any doctor been of the view that I was symptom free. In June 2014, while I was still on maternity leave I experienced a significant flare up of my neck and back pain". "I note that you are relying a report from [Consultant Neurologist] dated 28th February 2015 as evidence that my current symptoms are not linked to the symptoms I had prior to my maternity leave. However, nowhere in his report does he say that my current symptoms are not linked to my post-accident symptoms".*

17 November 2015 – Consultant Rheumatologist & General Physician

*"50% loss of range movement of neck globally. .. lower back and this pains"*
*"I believe her prognosis is very guarded given the chronicity to date of her symptoms and signs. I feel it is unlikely that she will ever be without this active diagnosis, be it to a greater or lesser extent over time".*

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25 November 2015 – Employer to the Complainant

> *"The forms are required because [the Provider] was unaware there may be a continued linked claim on cessation of maternity leave therefore there was a gap in terms of requesting the linked claim and [the Provider] are now seeking new documents to assess first the claim and, if accepted, whether it will be linked to the original claim".*

6 January 2016 – Provider to the Complainant

Confirming that it would be upholding its decision to decline a linked claim.

> *"In order to claim benefit under the above group scheme a member must be deemed totally unable to carry out their normal occupation due to a recognised illness or accident. The initial claim following your road traffic accident on [Date], was paid for the period 17/07/13 – 12/12/13, at which time your claim ceased.*
>
> *[Employer/ owner] scheme transferred to a new insurer on 01/04/13, and [the Provider] will only have liability for your current absence if deemed a relapse caused by the same injury or illness within six calendar months of the previous claim, as confirmed under condition 4.7 of your policy document".*

11 February 2016 – Complainant's Solicitor to the Provider questioning the Provider's refusal to reinstate benefit.

> *"We do not accept that [the Complainant's] claim can be deemed automatically to have "ceased" due to reinstatement of her salary due to maternity leave in December 2013 and re-iterate that no provision for cessation in such circumstances is outlined in the employee Long Term Disability Plan as referred to above. As a consequence, neither do we accept your characterisation of your insured member's entitlements since October 2014 to be that of "a linked claim".*
>
> *We are concerned that, having deemed her salary reinstatement in circumstances of maternity, in lieu of income protection payment, as a cessation of claim, where future entitlements of the insured member to income protection payments in the period immediately following any such maternity leave are gravely prejudiced, (where you have suggested that "the six month period for a linked claim expired on 12/06/14"), that you did not write in clear terms to your insured member to outline your position at that time and/or take such appropriate steps to ensure that she would be fully appraised of such a situation. We would remind you that as insurers, you bear a reciprocal duty of uberrimae fides and your failure to deal in good faith with your insured member in this respect constitutes, at least sharp practice".*

23 March 2016 – Solicitor to Provider referring to letters of 11 and 24 February 2016 and not receiving a response.

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11 April 2016 – Solicitor to Provider – refers to letter their letter of 11 February 2016 –

> *"some two months later, we have yet to receive a reply". "Lack of response is understandably causing great distress to our client".*

15 April 2016 – Provider to the Solicitor – file referred to Health Claims Manager for review – contact again next week.

29 April 2016 – Provider to GP seeking medical records

29 April 2016 – Provider to the Solicitor – requested report from GP

> *"I will contact you again shortly once we have received a response from [GP] and provide a time frame for our response".*

7 June 2016 – Solicitor to Provider seeking update further to Provider's letter of 29 April 2016. Understand that Provider has all relevant documentation as requested from GP.

1 July 2016 – Solicitor to the Provider – letter of 7th June, telephone calls of 21 and 28 June gone unanswered. Delay "causing our client anxiety and distress"

6 July 2016 – Provider to solicitor – "I will contact you again next week once our decision has been finalised".

28 July 2016 – Solicitor to Provider – not getting a response as promised in letter of 6th July 2016

9 August 2016 – Provider advising that review not finalised.

29 August 2016 – Solicitor referring to last letter of 9th August 2016 and that delay causing client distress.

07 September 2016 – The Provider to the Complainant's solicitor advising of reinstatement of benefit based on the original claim and paying benefit from when salary ceased on 03/10/2014. Letter received by solicitor on 19 September 2016.

> *"We have now carried out a full review of the claim for [the Complainant], on the basis this has been a continuous period of disability, rather than a linked period of disability to the original incident date [date of accident].*
>
> *Our Chief Medical Officer has now fully reviewed the medical evidence provided by [GP], and I am pleased to confirm we are satisfied to re-instate benefit based on the original claim, from when salary ceased for [the Complainant] on the 03/10/14"*

14 September 2016 – letter from solicitor setting time frame involved and the delays by the Provider.

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10 October 2016 – Solicitor's invoice to Provider

28 October 2016 – Provider to the Complainant's solicitor

> *"We are not in a position to accede to your request for the payment of fees incurred by your client having engaged your services in this mater, and for which [the Provider] has no liability"*

10 November 2016 – Complainant's solicitor to Provider seeking costs on basis of its intervention caused the Provider to reconsider its position.

> *"In circumstances where you have now reinstated her claim and revisited your earlier refusals of her claims for illness benefit under her income protection policy, it necessarily follows that [the Complainant] should not be penalised in having to bear the costs of the work incurred by us in obtaining this result for her".*

Further submissions from the parties

5 November 2018 – Submission from the Provider

The Provider refers to its further backdating of the claim benefit to May 2014.
The Provider further refers to the other parties involved in the claim, that is the Complainant's employer and the Scheme Brooker, as follows:

1. *The requirement to notify [the Provider] prior to May 2014 that there may be an ongoing claim*
2. *The requirement to provide specialist medical reports to substantiate such a claim prior to May 2014*
3. *The period from May 2014 to October 2014 is when sick leave notice should have commenced with [the Complainant's employer with medical certification to validate this period of claim. This is what should have occurred in the circumstances where there was an ongoing claim. You would also expect an employer's payroll area to assist [the Complainant] with this if such detail was not covered within the employee handbook. A period of unpaid maternity leave would normally occur when someone is fit for work.*
4. *With the medical complications that then arose for [the Complainant] I believe it was also reasonable for [the Provider] to expect a more detailed medical file for the period from December 2013 to January 2015"*

The Provider's position is that if these requirements were met the resultant problems and delays would have been minimised / eliminated. The Provider's position is that if the Complainant had consulted with the employer / broker to scheme, in 2015/2016 it may have been more productive.

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11 November 2018 - The Complainant responded to the above as follows.

The Complainant disputes that the Provider is dealing with the complaint in line with what is set out in the policy provisions.

The Complainant considers that the Provider incorrectly ceased her claim, and incorrectly sought to reassess the claim as a linked claim. The Complainant accepts that the Provider could have reduced benefit where other monies were being received by the claimant, but not cease the claim on this basis.

20 November 2018 – The Provider's submission

The Provider states that it was advised to cease benefit by the employer in December 2013. As regards the amount that the employer paid in respect of maternity leave this was something that should be directed to the employer. The Provider states that it was not aware of the net payments made by the employer to the employee.

26 November 2018 – The Complainant's submission

The Complainant's position is that it was the Provider's responsibility to evidence exactly how much gross "other income" she was predetermined to receive as paid maternity benefit from the employer so as to reduce the benefit by this amount under Section 3.4 Limitation of Benefit of the policy. The Complainant states that cessation of a claim during an active Period of Disability is not permitted under Section 3.4 Limitation of Benefit. The Complainant states that On 12 December 2013, when maternity leave began she was due to have 70% loss of gross income from her Employer for the following year, with 100% loss of gross income from her Employer in the years that followed. The Complainant states that this should not be new information to the Provider. The Complainant states that despite the medical evidence supporting continuous disability, the Provider would not accept her post maternity claim and reinstate her income protection payments. That this persisted for over two years and required intervention by her legal representative before it was rectified.

4 December 2018 – the Provider's submission

The Provider's position is that that it was the lack of referral by the Complainant to her employer that resulted in the ongoing issues with the payments. That on the basis of what the Complainant says about entitlement to 70% payment from her employer, it appears that an overpayment arises. That this is new and conflicting information. The Provider states that:

> *"If there was clear, periodical and detailed medical evidence to support a continuous claim to the satisfaction of [the Provider] from December 2013 to January 2015 we would not be in dispute. This is the crux of the matter and the point upon which I believe [the Provider] have been quite conciliatory when the claim was eventually accepted".*

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> *"Our CMO could only review the medical records for the period in question, and concluded in the absence of objective medical evidence to the standard we would normally expect that it was "reasonable to consider disability ongoing", hence my believe that we have been quite conciliatory in paying this claim and a further backdating of payment to May 2014".*

23 December 2018 – the Complainant's submission – re calculation of benefit – seeks clarification from the Provider.

15 January 2019 – The Provider further advise on payments and seek further clarifications itself regarding payments made to the Complainant.

17 January 2019 – The Complainant's submission

The Complainant further query the December 2018 underpayments and advises of occasions where Provider deals directly with her and where the broker was involved.

As regards the cessation by the Provider of her claim in December 2013 and the taking of 2 years to reinstate the claim post maternity the Complainant concludes her submission as follows:

> *"Having spoken to the broker, he once again mentioned the fact that he was not a legal adviser, that the office of the Financial Services Ombudsman was the correct avenue to assess whether [the Provider's] treatment of my claim was equitable, fair or reasonable and whether it was compliant with the explicit and implicit legal provisions of the income protection contract. The broker however did advise that cessation of an income protection claim without medical evidence of fitness to work is not industry standard. The broker also advised that suspension of claim benefit during maternity with timely reinstatement thereafter is the industry standard for cases where maternity occurs during a continuous Period of Disability, whereas cessation of claim in this circumstance is not industry standard. [The Provider's] outright cessation of my claim at the start of maternity (with no medical evidence of recovery, with neither the value nor the duration of maternity benefit to be received assessed -yet still used as justification for claim cessation), [the Provider] requirement for me to undergo the lengthy reapplication process from scratch in the post maternity period, and [the Provider's] subsequent protracted attempts to evade liability for my continuous disability for 2 years was not industry standard treatment for circumstances like mine".*

29 January 2019 – the Provider's submission

The Provider states that it is reliant on the figures provided by the Employer and the Broker for the scheme.

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24 February 2019 – the Complainant's submission

*"The Financial Services Ombudsman has the terms and conditions of the policy document in the file. To avoid misinterpretation of the policy, the applicable terms used in the terms and conditions are clearly defined on pages 2 to 4. The 75% "Earned income" policy limitation, to which [the Provider] refers in his current submission (3.4 Limitation of Benefit) is 75% of "gross earned income from his (Member's) Normal Occupation...<u>for the period of one year</u> immediately prior to the commencement of the Period of Disability". Being that this "earned income" was 49,929eur, I will leave for adjudication by the Financial Services Ombudsman, [the Provider] contention that receipt of 730.18eur of maternity benefit from my Employer, somehow gave [the Provider] authorisation under the policy to cease my claim in December 2013. This is all the more spurious since [the Provider] neglected to ask any party in 2013 how much or for how long I would be in receipt of any maternity benefit from my Employer and simply ceased my claim regardless. 16,434.36eur of maternity benefit is 32% of "Earned Income", as explicitly defined in the policy.*

*The Financial Services Ombudsman can see from the file that the [Provider] have presented no actual evidence of any alleged instruction from my Employer to cease my claim in December 2013 with the effect of limiting [the Provider's] subsequent liability to a relapse claim within 6 calendar months of original claim cessation. Neither has [the Provider] provided any document which would give my Employer (the insured party) any such authority to supersede the terms and conditions of the policy.*

*The Financial Services Ombudsman can see from the file that immediately when the claims assessor accepted my claim on 11th September 2013, he set an "initial ECD for end of year as maternity leave should commence around then". This was despite the expert medical opinion of [the Provider's] Chief Medical Officer that my disability would continue into maternity. It is evident from the file that [the Provider] made no attempt to have me medically assessed prior to ceasing my claim in December 2013.*

*The Financial Services Ombudsman can see from the file that [the Provider's representative], in his role as Customer Relations Manager with [the Provider], has regularly coined non-policy terms such as "linked continuous claim" just as his colleague … used the term "linked claim" to my Employer in his December 2013 correspondence as being synonymous with continuous disability. The Financial Services Ombudsman will also see from the file that a "linked claim" is in fact specifically defined in the policy terms and conditions as only being a relapse claim within six exact calendar months of the date of original claim cessation. Being that a relapse first requires recovery and a return to work, the claims assessor was negligent when using this term in relation to a disabled woman commencing maternity. The claims assessor was under the distinct impression, as evidenced in his rejection letter of 6th January 2016, that when assessing both my post maternity claim and Appeal that:*

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*"As your previous claim ceased with [the Provider] on 12/12/13, the six month period for a linked claim expired on the 12/06/14" and that "[the employer] group scheme transferred to a new insurer on 01/04/13, and [the Provider] will only have liability for your current absence if deemed a relapse caused by the same injury or illness within six calendar months of the previous claim." This 12/06/2014 deadline had no bearing on when my Employer ceased maternity benefit contributions as these ended on 15/05/2014. This date was only significant as [the Provider] were under the impression that cessation of a claim regardless of ability to work entitled them to 6 months of liability only and only when a relapse specifically was medically evidenced. Evidence of continuous disability was completely disregarded by the claims assessor.*

*[The Provider] have no language to deal with a continuous disability claim which is ceased as this undermines the very basis of the policy. [The Provider's] insistence after my full maternity had expired that they were rejecting my genuine claim to income protection because I did not forego the protected maternity period is a matter for the Financial Services Ombudsman. It is industry standard to suspend income protection payments for the duration of maternity with timely reinstatement thereafter, so that the protected maternity period has no impact on the contract benefits. The treatment of [the Provider] of my claim pre and post maternity is a matter for the adjudication of the Financial Services Ombudsman.*

*The Financial Services Ombudsman can see from [GP's] report of September 2014 (prior to the expiry of my maternity in October 2014) that I was very much continuously disabled since the [date of the] crash. [GP] explicitly states in her report that my injuries are consistent with the accident. [The Provider] alleges however that the claims assessor's correspondence to the broker/my Employer in December 2013 regarding medical evidence should not have been directly quoted. [The Provider] alleges that instead of directly quoting the claims assessor that medical evidence supporting continuous disability prior to the expiry of my maternity was required, that my Employer/the broker should instead have interpreted this instruction and communicated an interpretation to me. This interpretation being that "expiry of maternity", as explicitly stated, was not in fact the deadline for this supporting report but instead 22 weeks into 42 weeks of maternity when my Employer ceased maternity benefit contributions. It would have been very convenient for [the Provider] if my employer's policy was to pay maternity contributions for the full statutory maternity period- ending 12th June 2014- which would tie conveniently into his colleague's requirement for reports by 12th June 2014 for a relapse/linked claim but this was not in fact the case. Quite apart from [the Provider's] notion of not directly quoting an insurance company's instructions being completely bizarre, it also gives insurance companies leave to reject claims by saying that their specific instructions were misinterpreted/misquoted. [The Provider] is in fact alleging here that my Employer should have instructed me that the full protections of the Maternity Acts did not apply, in [the Provider's] opinion, to my income protection policy and as such I was prohibited from taking full maternity leave if I wanted my income protection to be reinstated post maternity. This is a matter for adjudication by the Financial Services Ombudsman in terms of legality and discrimination.*

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*The Financial Services Ombudsman can see evidence from the medical file of my "50% loss of range of movement of neck globally....diffuse tender points in mid and lower thoracic spine paraspinal area....lower back and thigh pains". It was medically evidenced by [specialist] that "These symptoms would make it difficult for her to continue at a desk job I believe. I believe her prognosis is very guarded given the chronicity to date of her symptoms and signs. I feel it is unlikely that she will ever be without this active diagnosis".*

*The Financial Services Ombudsman can also see from the medical file that the [Provider] claims assessor rejected not only my post maternity claim (rejection letter May 2015) but also my Appeal (rejection letter January 2016) based on medical evidence from a Doctor …. who did not in fact exist.* [The Complainant appears to dispute attending a doctor referred to by the Provider in its correspondence]

*[The Provider] has had ample opportunity in this forum to point to the specific medical evidence which [the Provider] did not have on file for my Appeal but on which they later relied to reinstate my claim in September 2016 after a 2 year battle.*
*[The Provider] cannot point to this evidence as all the medical evidence objectively supporting continuous disability, including that which [the Provider's] CMO cites for reinstatement of my claim, had already been presented to [the Provider] for my Appeal and yet my Appeal was still summarily rejected by [the Provider].*

*The evidence file presented by [the Provider] for review by the Financial Services Ombudsman was an absolute mess, in my opinion, and was in no way indicative of how [the Provider] received the information originally. With blatant omissions, half reports and internal [Provider] memos stamped as received 5 months after they were signed/dated by both parties, it is no wonder that the claims assessor relied twice on an imaginary doctor to reject my claim/Appeal nor that it took [the Provider] 2 years to reinstate my claim with this level of disorganisation. Nothing has been presented by [the Provider] for review by the Financial Services Ombudsman in a chronological or logical order, making the medical evidence potentially difficult to interpret. I have done my best in my submissions to counter this, filling in the omissions where I can and giving a chronology of medical evidence detailed on pages 7 and 8 of my 29th June 2018 submission.*

*I am completely reliant on my income protection benefit from [the Provider]. I have lived the nightmare of being unable to move with pain and having no income for a period of 2 years because [the Provider] continually rejected my medical evidence of continuous chronic disability and my genuine claim to income protection. Quite apart from the legal fees and the tax liability I unnecessarily suffered because of the unreasonable 2 years it took [the Provider] to reinstate my claim, I live with the knowledge that unchecked and unsupervised, [The Provider] have unilateral power. Income protection is intended to give a level of comfort and assurance when you are unable to work. My experience with [the Provider] gives me no such comfort and only the additional constant stress that despite my continued disability [the Provider] have free reign to treat my claim as they so choose at any point in the future".*

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5 March 2019 – the Provider's submission.

*"At this stage we clearly have a different point of view on how an Income Protection scheme and claims within are managed. We have outlined the claims process for group schemes and have communicated that this process was followed for this claim. In particular:*

1. *We received instruction from the employer / scheme broker to cease this income protection claim benefit when they reinstated salary due to maternity leave. This is correct and normal process. If there is an issue with this, amounts then paid by the employer or dates involved I would again respectfully suggest that these are matters for [the Complainant] and her employer. We have paid this claim in full for the periods advised by the employer and supported by the medical file as is normal process.*
2. *At the time in December 2013 it was our view, again as stated previously, that [the Complainant] would recover and be in a position to return to work during the maternity leave period, for her then claim condition, based upon our assessment of the medical file at that time. I appreciate from correspondence that [the Complainant] disputes this point.*
3. *The onus was then on the employer / scheme broker to contact us again when maternity salary ceased if there was an ongoing claim. This is clearly documented communication on the file and would be normal process for such group claims. All the resulting issues with this claim would have been reduced or mostly avoided, in my view, if the notice and up to date medical file was produced in May 2014 as it should have been and as was requested.*

*I feel these are the key points are getting lost and need to be clarified. All other points have been addressed previously as they relate to the payment of legal fees for this case".*

**The Complaint for Adjudication**

The complaint is that the Provider did not correctly administer the Complainant's claim for disability benefit and the Complainant is seeking the monies she expended by having her solicitor intervene in the matter.

**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

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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.

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 **20 March 2020**, 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.

**Analysis**

From the evidence submitted, I accept that the Provider should not have deemed the Complainant's claim as ceased from 12 December 2013 without first medically assessing the Complainant's disability or making the appropriate enquiries regarding her ability for a return to work. I accept that the payment of benefit could only have been temporarily suspended due to maternity leave, and not ceased outright by the Provider. I accept the Provider incorrectly sought to reassess the claim as a linked claim.

I consider that there should have been greater communication from the Provider with the Employer / Scheme Broker as to what would happen / what was required, when the Complainant's maternity benefit ceased. I consider that in the first instance, it was the Provider who should have set out the requirements and that it should have specifically advised the Employer / Broker to the Scheme to inform the Complainant of what would happen / what was required, for her to continue receiving disability benefit. I do not find any evidence of the Provider setting out a time limit within which it was to receive supporting medical evidence in relation to the disability claim, upon expiry of maternity leave. There does not appear to have been any enquiry by the Provider as to when the Complainant's maternity leave would expire, nor as to what payment was being made by the employer in respect of maternity leave.

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The following are my conclusions on this complaint:

- I accept that the Provider incorrectly assessed the continuing disability as a new / linked claim and subsequently engaged in a lengthy reapplication process.

- I accept that the Provider failed to query what payment was being received by the Complainant in respect of her maternity leave or the dates of the cessation of such payments.

- I accept that there was a need for a financial assessment by the Provider when the Complainant's financial circumstances changed on 12 December 2013. This financial assessment did not happen then.

- I accept that the Provider incorrectly classified the claim as a ceased claim in December 2013 without first carrying out a medical assessment. There was no communication to the Complainant at this time to indicate to the Complainant that this is what the Provider was doing.

- As I accept the Provider incorrectly classified the Complainant's claim as a ceased claim, the conclusion can only be that it incorrectly sought to reassess the claim as a linked claim. I accept that the Provider could have reduced benefit payments where other monies were being received by the Complainant, but not cease the claim solely on this basis. I can understand that if it was the positon that the Complainant was going to be receiving income / payments equal to her salary into the future, the Provider might question eligibility for benefit on a financial basis, but when the payment from the employer was so uncertain, the cessation of the claim was unreasonable in the circumstances.

- The Provider inaccurately referred to the Complainant's claim as a "linked" claim. This is so, as a "linked claim" first requires recovery and a return to work, whereas "continuous disability" involves non recovery and a non return to work". The latter was the Complainant's situation.

- The evidence shows that the Provider's change of stance in classifying the claim as a "linked" claim to that of a "continuous period of disability" came about with the intervention of the Complainant's solicitor in February 2016. While the intervention could have come from the employer or from the broker to the scheme, I accept that the Complainant reasonably escalated the matter to this professional level, to achieve what was her rights under the policy.

- As regards the medical evidence and its completeness at time of rejection of the claim, and later acceptance of the claim, the position is that the Provider's Chief Medical Officer had the same medical evidence at acceptance of claim as that which formed the basis of the rejection of the claim in January 2016. Therefore, it is difficult to see what difference any additional medical information was required to reach a conclusion on the matter.

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- I accept that the Provider incorrectly failed to reassess payments and make any adjustments when it became aware that the Employer was making payment in respect of maternity leave, but instead incorrectly classified the claim as ceased, and did so without the usual medical assessment or financial enquiry.

- I accept that the Provider's administration of the claim was not in accordance with the provisions of the income protection policy.

- The Provider failed to get the fullest information regarding the Complainant's maternity leave, in particular information as to the amount being received by the Complainant and the duration of the payment.

- There was a lack of record keeping by the Provider as to what the actual information it received from the employer was, as regards the Complainant's maternity leave.

While I accept that the employer and scheme broker had a role as regards the information they provided, I would have expected to see a more structured policy or procedure in place concerning the respective parties roles as to communication of information to the Provider. I would also have expected to see some specific information available to the parties from the Provider as to how the Provider would deal with a claim where maternity leave occurs during a period where disability benefit is being paid.

The evidence shows that there were delays experienced with the Provider reaching a decision to correctly re-instate benefit.

It must be noted that for a considerable period of time right up to the last submission to this office from the parties, there was uncertainty as to whether the correct payments were made to the Complainant. I consider that these uncertainties would have been avoided if there were better procedures in place regarding disability payments when pregnancy occurs during a period where disability benefit is being paid. I consider that the responsibility for this clarity in policy and procedures on such claims, lies firstly with the Provider. I also consider that the greater responsibility for ensuring that the claim for benefit was correctly administered lay firmly with the Provider. I consider that the Provider fell down in its customer service, in failing to correctly administer the Complainant's disability claim. Having regard to all of the above, I am substantially upholding this complaint.

I do not propose to direct the payment of the Complainant's solicitor's fees as the use of a solicitor is a personal choice, and other means of pursuing the complaint were available. The employer as contract owner and the Broker to the scheme could have been contacted to assist in raising the matters with the Provider. However, I am directing a substantial compensatory payment of €15,000 (fifteen thousand euro) be paid to the Complainant for the inconvenience in pursuing her rightful entitlement under the policy provisions attaching to this income protection scheme.

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I also direct that the Provider fully establish (by seeking the appropriate vouched information from the relevant parties) the accurate benefit that should have been paid to the Complainant over the duration of the claim. In this regard I direct that the Provider should liaise with the Complainant's employer to establish the exact payments and duration of those payments that were made to the Complainant in respect of her maternity leave. I direct that any shortfalls in benefit payments are to be paid to the Complainant without delay. In the circumstances, I direct that in the event that an overall overpayment is discovered, it is not to be sought back from the Complainant.

**Conclusion**

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is substantially upheld, 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 (i) pay the Complainant the compensatory payment of €15,000 (ii) review the benefit payments that have been paid to establish that they are correct, and if not correct, I direct that any shortfall be paid to the Complainant, and (iii) in the event that an overall overpayment is discovered, I direct that it is not to be sought back from the Complainant.

- The compensatory payment to the Complainant in the sum of €15,000, is to be made to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant 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.**

**GER DEERING**
**FINANCIAL SERVICES AND PENSIONS OMBUDSMAN**

15 April 2020

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**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**

**ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.**