An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0187
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Misrepresentation (at point of sale or after)
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint arises out of a Serious Illness healthcare insurance policy and relates to the customer service given by the Provider, an intermediary, against which this complaint is made.

The Complainant's Case

The Complainant held a Serious Illness health insurance policy with [a third party insurance company]. The Provider was the Complainant's financial advisor.

The Complainant took out the Serious Illness policy in 1997. He is unhappy about the poor customer service he allegedly received from the Provider following a claim made under his policy. It is the Complainant's contention that the Provider delayed in notifying the underwriter of a claim under the policy in around July 2016 following an incident in 2016 when the Complainant collapsed and was diagnosed with having an irregular heartbeat.

Subsequent to this, the Complainant alleges that he had wanted to cancel the policy but that the Provider advised him not to cancel it. The Complainant alleges that he explained that he had hip trouble following a fall and he asked the Provider if he was covered under the policy if he needed a hip replacement. The Complainant states that the Provider informed him that he was not covered for this under the policy and therefore the Complainant told him that he was cancelling the policy as he felt that he was paying too much for it and not getting what he was promised out of it. The Complainant alleges that his hip problem got a lot worse and he needed to get a bilateral hip replacement.

The Complainant cancelled his policy in August 2016. He states that he subsequently found out that his policy did cover the cost of hip replacement surgery and he then contacted [the insurance company] immediately to explain that he had cancelled his policy in August 2016 but that the problems had started in April 2016, when the policy was still live. He says that [the insurance company] sent a claim form but ultimately wrote back saying that he would have to have had the surgery during the lifetime of the policy in order to be eligible for cover.

The Complainant states that he rang the Provider who told him yet again that his hip surgery was not covered and which the Complainant says was wrong advice. It is the Complainant's contention that he would not have cancelled the policy had it not been for the misinformation or incorrect interpretation of the policy given to him by the Provider and that as a result of this he is now left with serious financial pressure because the hip surgeries that he needs will not be covered by an insurer.

The complaint is that the Provider delayed in following up on the Complainant's claim in respect of his heart problem and secondly that the Provider gave him misinformation in respect of whether he would have been covered for hip replacement surgery which directly influenced him to cancel his policy with the underwriter.

The Provider's Case

The Provider denies any wrongdoing or delay in assisting the Complainant or processing his surgical cash claim in relation to his cardiac problem. The Provider also disputes that it advised the Complainant's that hip replacement surgery was not covered under the policy and that it was not aware that the Complainant had cancelled the policy at that time.

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.

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.

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A Preliminary Decision was issued to the parties on 15 April 2020, outlining my preliminary determination 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.

Following the issue of my Preliminary Decision, the Complainant made a further submission under cover of his e-mail to this Office dated 29 April 2020, a copy of which was transmitted to the Provider for its consideration.

The Provider, under cover of its e-mail to this Office dated 30 April 2020, advised it had no further submission to make.

Having considered the Complainant's additional submission and all of the submissions and evidence furnished to this Office by the parties, I set out below my final determination.

I note that much of the Complainant's post Preliminary Decision submission reiterates previous statements and matters previously considered. Nothing in that submission alters my views as set out in my Preliminary Decision.

Dealing firstly with that aspect of the complaint of the delay on the part of the Provider in progressing or submitting the Complainant's claim arising out of his heart condition. A significant amount of correspondence was furnished in evidence to this office. I have considered all of the evidence and submissions between the Provider and the Complainant and the Provider and the insurer in relation to the Complainant's claim arising out of his cardiac condition.

It is clear from that correspondence that the Provider was constantly engaged with and on behalf of the Complainant in this regard and that he notified the insurer within three working days of the Complainant's initial collapse in relation to his cardiac problem. In addition, the Complainant did receive a surgical cash claim payment arising out of this under the policy and the correspondence on file demonstrates that there was a significant amount of effort on the part of the Provider in bringing this particular payment to conclusion.

In relation to the second aspect of this complaint, the Complainant asserts that he was misinformed by the Provider that he would not be covered under the policy of insurance for hip replacement surgery and as a result of this he cancelled his policy and it subsequently transpired that he would have been covered and he is now left without insurance cover for the cost of the bilateral hip replacement surgery that he states that he requires.

From a review of the evidence and correspondence, the following is evident:

On 22 July 2016, the insurer emailed the Provider to inform it that the Complainant was not entitled to serious illness benefit in relation to his cardiac problem. A number of hours later on the same day, the Provider emailed the respondent to inform him of this.

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On 5 August 2016, the Complainant wrote directly to the insurer by way of handwritten letter which refers to a conversation with a member of customer services in the Provider on 29 July 2016 where the Complainant explained his disappointment and annoyance at how his claim had been handled. Amongst other things, this letter goes on to complain about the insurer's delay in processing his cardiac claim and to refer to the numerous exchanges between the Complainant and the Provider and their mutual annoyance with the insurer at the delay in processing the claim.

The letter goes on to state as follows:

> *"I have no hesitation in cancelling my policy [policy number] with immediate effect after my conversation with [J] on the 29/7/2016. I feel I should have cancelled this policy a long time ago if taken out at all."*

On 25 August 2016, the Provider wrote the Complainant to discuss the serious illness policy with the insurer. This correspondence dealt with the review of the serious illness policy in comparison to other products on the market in terms of the price of the premiums and the amount of cover being offered. The Provider advised the Complainant to wait until the insurer reviews the policy closer to December 2016.

On 31 August 2016, the insurer wrote directly to the Complainant cancelling the policy on the instructions of the Complainant.

On 1 September 2016, the Complainant emailed the Provider to inform him that he had cancelled the policy with the insurer.

Correspondence in April and May 2017 from the insurer to the Complainant confirms that the Complainant had made an enquiry regarding a surgical cash claim and he was informed that it would only be considered if the surgery had been carried out prior to the cessation of the policy.

On 5 September 2017, the Complainant wrote the Provider expressing his dissatisfaction and stating expressly:

> *"I need your response in the final letter to me about our conversations about my hip problems, when you said they weren't covered by [insurance company] when they were covered, therefore I cancelled my policy when I was covered".*

On 8 September 2017, the Provider responded to the Complainant stating, amongst other things the following:

> *"At absolutely no stage did I ever tell you that your hips weren't covered by [insurance company] therefore you cancelled your policy.*
>
> *You wrote directly into [insurance company] to cancel the policy on 5 August 2016 without telling me you're going to cancel it."*

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Having considered all of the evidence furnished by the parties, I find I have not been provided with any evidence of any advices given or discussion surrounding hip problems or eligibility under the health insurance policy of cover for hip replacement surgery between the Complainant and the Provider until September 2017 after the Complainant had cancelled his policy through direct instruction with the insurer and not through the Provider. In fact, the evidence shows that the Provider advised the Complainant not to cancel the policy but that the Complainant wrote directly to the insurer on foot of a conversation with the customer services Department of the insurer and the declinature of his cardiac claim and he decided to cancel the policy of his own volition without any reference to hip problems or cover under the policy in relation to hip problems or hip surgery.

For the reasons outlined above, I do not uphold this complaint.

Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is rejected.

The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

25 May 2020

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,

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and

(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.