An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0275
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Rejection of claim - did not meet policy definition of disability Claim handling delays or issues Dissatisfaction with customer service Maladministration
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant has the benefit of an income protection insurance policy with the Provider since **1 October 2004**.

The Complainant's Case

The Complainant, a customer service manager, completed a Claim Form to the Provider on **22 May 2017**, stating that she had been certified as unfit for work, more than a year earlier, on **[date redacted]** as she was suffering with *"Anxiety"*.

Her GP, Dr B. completed a GP Claim Form to the Provider on **24 April 2017**, stating that the Complainant had been first diagnosed and certified as unfit for work on [date redacted], as follows:

> *"**Symptoms:** Anxious, poor sleep (varying levels of sleep disturbance), irritability, poor/decreased concentration, low mood, sad, occasionally tearful, feeling of loss & lack of value/respect*
>
> ***Diagnosis:** Anxiety/Depression in relation to work stress".*

In assessing her income protection claim, the Provider arranged for the Complainant to attend for a medical examination with Consultant Psychiatrist Dr F. on **3 August 2017**, who

concluded in his Report, *"In my opinion* [the Complainant] *is currently fit to carry out her normal occupation".*
Following its assessment, the Provider admitted the Complainant's income protection claim from the end of the policy deferred period of 52 weeks to the date of her examination with Dr F. only, that is, from 8 May 2017 to 3 August 2017.

In January 2018, the Complainant appealed this decision by way of furnishing the Provider with a Report from her treating Consultant Psychiatrist Dr J. dated 10 December 2017, which stated, as follows:

> *"*[The Complainant] *first attended me for psychiatric assessment and treatment at the request of her family doctor on the 7th December 2016. Since then I have seen her on numerous occasions to date. She suffers from major depressive illness with severe symptoms of anxiety as a result of problems at work. Her treatment consisted of appropriate antidepressant medication, dietary supplements and Cognitive Behavioural Therapy (CBT), exercise, breathing and relaxation exercise and mindfulness.* [The Complainant] *has at all times been fully compliant with her treatment regimen. As a result of her illness she has retired form work on grounds of ill health. Her response to treatment to date has not led as yet to full recovery as yet and she remains unfit for work. She will need to continue on treatment as outlined above indefinitely"*.

As part of its appeal process, the Provider arranged for the Complainant to attend for a medical examination with Consultant Psychiatrist Dr M. on 8 August 2018, who acknowledged in his Report that she had *"developed an episode of anxiety and depression which has now largely remitted"* and concluded, *"I think* [the Complainant] *is well enough to be able to return to work"*.

Following its assessment of her appeal, the Provider upheld its previous decision to cease payment of the Complainant's income protection claim and it informed her by letter dated 4 January 2019 that her appeal had been unsuccessful. The Complainant does not accept the findings of the medical examinations nor the decisions of the Provider in relation to her claim, as she submits she was still too ill to return to work at that time and that her GP continued to certify her as unfit for work until 10 September 2019.

In this regard, the Complainant submits in her Complaint Form, as follows:

> *"Under* [section 4.1] *of my policy I was covered for payment of Disability Benefit, which is defined as being unable to fully carry out my normal occupation, i.e. as a Customer Service Manager. In my appeal I sought payment from 3.8.2016 to 8.8.2017 in this regard, which has been refused.*
>
> *Under* [section 4.2] *of the policy I was covered for Proportionate Benefit for any period of sick leave when Disability Benefit is not payable. A second medical on 8.8.2017, arranged by* [the Provider]*, provides a snapshot on that date, which confirms my improved condition. I would expect payment, described as 'Proportionate Benefit' under the policy conditions, from that date to present* (it is

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noted that the Complainant has since been certified as fit for work from 10 September 2019). *The* [Provider] *has refused to pay either benefit"*.

In addition, in her letter dated 12 February 2020, the Complainant states, *inter alia*, as follows:

> *"I am totally satisfied that my submissions over this protracted period of time are more than sufficient to validate my claim"*.

With reference to her medical examination with Consultant Psychiatrist Dr F. on 3 August 2017, in correspondence dated 24 February 2020, the Complainant submits, *inter alia*, as follows:

> *"I did not feel well enough to work when I met* [Dr F.] *and I told him so. My own medical advice at the time confirms this …*
>
> *I wish to point out that this assessment was undertaken in an environment in which I felt unsafe"*.

In this regard, in her email on 19 March 2019, the Complainant submits, *inter alia*, as follows:

> *"At request of* [Provider] *I attended medical with* [Dr F.] *on 3.8.2017. I was expecting to attend in a usual consultation environment, i.e. to see a Private Consultant in private rooms. This was not the case and I was immediately taken aback as the medical took place in a secure psychiatric area in* [Named] *Public Hospital. I found the experience both disturbing, unnerving and much more stressful than it ought to have been"*.

In addition, in her letter dated 16 October 2019, the Complainant submits, *"the location of my IME with* [Dr F.] *had a material bearing on the outcome of the medical"* and for that reason, in her letter dated 9 December 2019, she considers that the Provider should *"set aside"* the findings of Dr F. as his examination was *"held in an unsafe environment"*.

With reference to her medical examination with Consultant Psychiatrist Dr M. on 8 August 2018, in her letter dated 16 October 2019, the Complainant submits, *inter alia*, as follows:

> *"*[Dr M.'s] *recommendations did not deny my claim.* [Dr M.] *had found that I had suffered an "episode of anxiety and depression which has now largely remitted" and "from which she had made a good recovery". In essence, this means that I met policy criteria of "period of disability" up to the point of seeing him"*.

In addition, in correspondence dated 24 February 2020, the Complainant submits as follows:

> *"On 8.8.2018* [Dr M.] *found me,* ***<u>on that date</u>*** *to have "experienced an episode of significant anxiety and depression" and from which I was largely remitted on that date. That was 12 months after* [Dr F.'s] *report and, during which time I was recovering. At this medical I told* [Dr M.] *that I was feeling improved and was hoping I would be able to work the following year".*

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Given that the Provider had admitted her claim from 8 May to 3 August 2017 and as Dr M. had found during his examination on 8 August 2018 that her condition had, as she describes in her letter of 12 February 2020 *"largely but not fully remitted"*, the Complainant considers *"there is a clear sequencing between Disability Benefit…and Proportionate Benefit"*.

As to the medical examinations that she attended with Consultant Psychiatrists Dr F. on 3 August 2017 and Dr M. on 8 August 2018 in general, the Complainant submits in her letter dated 16 October 2019, as follows:

> *"The fact remains that neither of the IME's, attended by me, was an <u>independent</u> medical in the true sense of the word".*

In addition, the Complainant also complains that the Provider provided her with a poor level of customer service throughout its handling of her claim, appeal and subsequent complaint.

For example, the Complainant notes that the Provider did not arrange for her to attend for a medical examination as part of its assessment of her appeal until August 2018, some seven months after she had furnished it with her appeal evidence in January 2018, and that it then delayed another five months until January 2019 before informing her of the outcome of her appeal.

In this regard, the Complainant notes in her Complaint Form, as follows:

> *"*[The Provider] *has acknowledged in correspondence to me, the inordinate delay in processing my appeal* [and] *have offered a small ex-gratia payment in compensation"*.

In a previous email to the Provider on 25 February 2019 the Complainant had requested *"a meaningful offer in relation to the service delays"*, but in her letter dated 11 July 2019 advised that *"this sum is derisory and has been rejected … this payment is inadequate"*.

In addition, the Complainant also notes that the Provider failed to reimburse her in a timely manner for her expenses for attending the medical examination on 8 August 2018. In this regard, the Complainant furnished receipts in the amount of €90.85 to the Provider on 9 August 2018 and submits in her Complaint Form, as follows:

> *"Expenses for attendance at first medical* [Dr F. on 3 August 2017] *were paid to me, however those in respect of the second medical* [with Dr M. on 8 August 2018] *remain outstanding for payment. I now seek payment of this small sum"*.

In addition, the Complainant also submits in her Complaint Form, as follows:

> *"I continued to pay monthly premia, on a voluntary basis during the appeal, on the advice of my Broker, based on information he received from* [the Provider] *when I queried this matter. I seek return of all premia paid for that period"*.

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The Provider's Case

Provider records indicate that the Complainant, a customer service manager, completed an income protection claim form on 24 May 2017 stating that she last worked on [date redacted]as she was suffering with *"Anxiety"*. In addition, the Complainant's GP completed a GP Claim Form on 24 April 2017, wherein she stated that the Complainant had been first diagnosed and certified as unfit for work on [date redacted], as follows:

> *"**Symptoms:** Anxious, poor sleep (varying levels of sleep disturbance), irritability, poor/decreased concentration, low mood, sad, occasionally tearful, feeling of loss & lack of value/respect …*
> ***Diagnosis:** Anxiety/Depression in relation to work stress".*

In order for an income protection claim to be payable, the policyholder must satisfy the policy definition of period of disability. In this regard, Section 1, '**Contract and definitions'**, of the applicable Income Protection Plan - Individual Policy Conditions booklet provides, *inter alia*, at pg. 2, as follows:

> *"**Period of Disability***
>
> *A period throughout which the Insured is totally unable to carry out his Normal Occupation due to a recognised illness or accident and during which the Insured 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".*

The policy provides a benefit once the Provider is satisfied that this policy definition is met, payable after the completion of the 52 week deferred period. As the Complainant was certified an unfit for work on [date redacted], any Provider liability would commence from 8 May 2017.

In order to assess her claim, the Provider wrote to the Complainant's treating Consultant Psychiatrist Dr J. on 1 June 2017 seeking a contemporaneous medical report. Following a further reminder dated 20 June 2017, the Provider received a Report from Dr J. dated 24 June 2017, wherein he advised, *inter alia*, as follows:

> *"*[The Complainant] *is suffering from Major Depressive Illness with severe anxiety and stress. She was subjectively and objectively depressed. She complained of disturbance of her sleep, loss of drive and energy, poor concentration, lack of confidence and self-esteem, anxiety and tension, all of which rendered* [her] *unfit to work.*
>
> *Her treatment consisted of appropriate antidepressant medication, dietary supplements and Cognitive Behavioural Therapy (CBT), exercise, breathing and relation exercise and mindfulness …*

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> *She is currently unfit to return to work and in any case has retired from her post in the* [employer] *on grounds of ill health"*.

The Provider's Chief Medical Officer reviewed this Report on 4 July 2017 and recommended that the Complainant attend for a psychiatric independent medical examination. The Provider arranged for the Complainant to attend with Consultant Psychiatrist Dr F. on 3 August 2017, who concluded in his Report of the same date, as follows:

> *"*[The Complainant] *has been diagnosed with major depressive disorder and anxiety by her treating consultant* [Dr J.]*. Currently there is evidence of mild symptoms and therefore one has to assume that there has been significant improvement since the initial diagnosis …*
>
> *In my opinion* [the Complainant] *is currently fit to carry out her normal occupation if it was available to her. There is no objective evidence of disabling psychiatric illness that would prevent her from performing the material and substantial duties of her normal occupation. Any residual symptoms are not disabling in nature.*
>
> *It is reasonable to return to work when there are residual symptoms of psychiatric illness because work and achievement of occupational functioning have therapeutic benefits. Occupational functioning is recognised to be an integral and essential part of recovery from psychiatric illness"*.

The Provider received this Report on 23 August 2017 and upon review of the file on 29 August 2017, the Chief Medical Officer concluded that the Complainant was *"fit for work currently"*.

In this regard, the Provider is satisfied that it was clear from Dr F.'s detailed assessment that the Complainant did not meet the policy definition of period of disability and that she was medically fit to carry out her normal occupation.

Nevertheless, the Provider decided to pay the Complainant income protection benefit from the end of the policy deferred period to the date of her independent medical examination with Dr F. when he concluded that she was at that time fit to carry out her normal occupation, that is, from 8 May to 3 August 2017, which the Provider considers was a fair and reasonable action in the circumstances.

The Provider wrote to the Complainant on **8 September 2017** to advise, as follows:

> *"I can confirm that the claim has now been accepted from the end of the deferred period, 08.05.2017, up to the date that you attended the medical assessment with* [Dr F.]*, 03.08.2017.*
>
> *Our Chief Medical Officer has reviewed the medical reports received from your GP…,* [Dr J.]*, Consultant Psychiatrist and from* [Dr F.]*, Consultant Psychiatrist, whom you attended for an Independent Assessment and based on the reports received feels that you are now fit to return to work …*

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> *As is our usual practice should you wish to submit any further medical evidence which might support the claim, we would be happy to review the matter."*

The Provider forwarded the Report from Dr F. to the Complainant's GP, Dr B. on 11 September 2017, which it confirmed to the Complainant by email on 22 September 2017.

The Complainant emailed the Provider on 11 January 2018 attaching as appeal evidence a Report from her treating Consultant Psychiatrist Dr J. dated 10 December 2017, which stated, as follows:

> *"*[The Complainant] *first attended me for psychiatric assessment and treatment at the request of her family doctor on the 7th December 2016. Since then I have seen her on numerous occasions to date. She suffers from major depressive illness with severe symptoms of anxiety as a result of problems at work. Her treatment consisted of appropriate antidepressant medication, dietary supplements and Cognitive Behavioural Therapy (CBT), exercise, breathing and relaxation exercise and mind fullness.* [The Complainant] *has at all times been fully compliant with her treatment regimen. As a result of her illness she has retired form work on grounds of ill health. Her response to treatment to date has not led as yet to full recovery as yet and she remains unfit for work. She will need to continue on treatment as outlined above indefinitely"*.

This Report was reviewed by the Chief Medical Officer on 16 January 2018, who instructed that the Report from Consultant Psychiatrist Dr F.'s independent medical examination with the Complainant on 3 August 2017 be sent to Dr J. for his response, which the Provider did on 23 January 2018, with reminders send on 21 February and 26 March 2018.

As it became apparent in April 2018 that Dr J. had likely retired and that the Complainant no longer attended him, the Provider, in order to progress her appeal, arranged for the Complainant to attend for an independent medical examination with Consultant Psychiatrist Dr M. on 8 August 2018. In his Report of the same date, Dr M. concluded, as follows:

> *"*[The Complainant] *is a fifty-nine year old woman who has a long history of working in* [employer] *and who developed an episode of anxiety and depression which has ow largely remitted. The occurrence of this episode of anxiety and depression has led to an undermining of the confidence in her wellbeing which she always took for granted. However, despite this she has recovered well. She is a conscientious and truthful woman who has experienced an episode of recovery. At this point I think she is well enough to be able to return to work or at least be able to make a decision as to whether she wants to return to her previous role or not"*.

The Chief Medical Officer reviewed the file again on 18 September 2018 and recommended that the Provider should maintain its decision to cease payment of the Complainant's claim.

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In this regard, the Provider wrote to the Complainant on 4 January 2019 to advise, as follows:

> *"Based on the medical evidence obtained at the initial assessment of this claim, you received a benefit from the end of the Deferred Period, 08.05.2017, up to the date that you attended the independent medical assessment with* [Dr F.]*, 03.08.2017.*
> *This decision was taken as based on the medical evidence we were of the view that you no longer satisfied the definition of disability as required by the policy conditions, and wrote to you on 8th September 2017 confirming the decision …*
>
> *As part of the initial consideration of the Appeal, we wrote to* [Consultant Psychiatrist Dr J.] *for further information. However no reply was received as a result of his retirement and in order to complete the consideration of the Appeal we arranged for you to attend a further Independent Medical Assessment with* [Dr M.].
>
> *In line with our appeals procedure and in conjunction with our Chief Medical Officer (CMO) we have considered the additional medical information received and carried out a comprehensive review of your claim.*
>
> *While we acknowledge your ongoing symptoms, the reports from the independent medical assessments both confirm that they are not at such a serious level to prevent you from working. On this basis we are unable to consider that you continue to suffer a Period of Disability, under the terms of the policy, and we are upholding our decision to cease your* [claim from] *03.08.2017"*.

The Provider forwarded the Report from Dr M. to the Complainant's GP, Dr B. on 9 January 2019, which was confirmed to the Complainant by email on that date.

The Provider is satisfied that the medical assessment of the Complainant's income protection claim has been comprehensive and that its decision to cease payment was supported by the independent medical examiners. In addition, its Chief Medical Officer, a specialist in occupational medicine, assessed all of the evidence and whilst both independent medical reports note conditions of anxiety and depression, both specialist consultants were of the view that the Complainant was fit for work at the time of each assessment.

In this regard, the Provider acknowledges that the Complainant did have a medical condition but that at the time of her independent medical examination with Consultant Psychiatrist Dr F. on 3 August 2017, this condition was not at a level of severity to meet the "Period of Disability" policy definition and thus a valid income protection claim under the policy terms from that date onward was not supported by the balance of the medical evidence.

It is the view of the Provider that it then took a reasonable and fair medical assessment of the claim by paying benefit for the period from the end of the policy deferred period, 8 May 2017, to the date of the independent medical examination on 3 August 2017, which deemed the Complainant at that time to be fit to carry out her normal occupation.

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As a result, the Provider is satisfied that the Complainant's claim and subsequent appeal was properly assessed in line with the terms and conditions of her income protection policy.

The Complainant was reviewed by two separate psychiatric consultants - Dr F. on 3 August 2017 and Dr M. on 8 August 2017 - and both found her fit to work. Given that she was deemed fit to carry out her normal occupation on 3 August 2017 when payment of her claim ceased, the Provider is satisfied that the Complainant did not at that time, nor at any time thereafter, satisfy the policy conditions for disability benefit or a proportionate benefit.

With regard to the element of her complaint relating to the location of her examination with Consultant Psychiatrist Dr F. on 3 August 2017, the Provider notes that there was nothing in his Report indicating that the Complainant had advised during the examination that she was dissatisfied with the location. Neither did the Complainant make any complaint to the Provider within a reasonable period thereafter. The Provider also notes that this venue has been used previously for independent medical examination appointments with no complaints. Whilst it appreciates her feedback and will take cognisance of it in the future, the Provider does not accept that it is a matter of such severity that would warrant the setting aside of Dr F.'s medical report in considering her claim, as the Complainant suggests.

The Provider forwarded the Complainant's views on this matter to Dr F. on 23 August 2019 (having previously incorrectly advised that it had already done so in its letter dated 13 March 2019). The Provider apologies for this and in its correspondence to this Office dated 4 October 2019 offered the Complainant a customer service payment of €300 in respect of its error and said it hoped that this offer would resolve this element of her complaint.

With regard to the element of the Complainant's complaint relating to customer service, the Provider acknowledges that there were two periods of delay which were outside the service levels one would normally expect for a claims assessment process.

The first delay took place from April to August 2018. In this regard, the Provider had sought information from the Complainant's treating Consultant Psychiatrist Dr J. on 23 January 2018, with reminders send on 21 February and 26 March 2018. The Complainant first advised the Provider by email on 10 April 2018 that it was likely that Dr J. had retired. However, it was not until 1 August 2018 that the Provider arranged for the Complainant to attend for an independent medical examination on 8 August 2018.

The Provider acknowledges that this should have taken 10 working days at most to arrange and not four months. In its Final Response letter dated 13 March 2019, the Provider offered the Complainant a customer service payment of €300 in respect of this delay. Having reviewed the matter once again as part of this complaints process, in its response to this Office dated 30 August 2019 the Provider advised that a higher amount was merited and increased the offer to €500.

The second delay took place from August 2018 to January 2019. In this regard, the Provider had received the Report from Consultant Psychiatrist Dr J. on 14 August 2018, following his

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examination of the Complainant on 8 August 2018, however it was not until 4 January 2019 that it advised the Complainant of its appeal decision.

The Provider acknowledges that its assessment, including a review by the Chief Medical Officer and the Claims Manager, should have taken four weeks at most to complete and not 4½ months. In its Final Response letter dated 13 March 2019, the Provider offered the Complainant a customer service payment of €400 for this delay. Having reviewed the matter once again as part of this complaints process, in its response to this Office dated 30 August 2019 the Provider advised that a higher amount was merited and increased the offer to €650.

In addition, the Provider acknowledges that it ought to have paid the Complainant her expenses in attending the medical examinations, in a timely manner. In this regard, the Complainant submitted receipts on 20 September 2017 in the amount of €85.70 and receipts on 9 August 2018 in the amount of €90.85.

In its Final Response letter dated 13 March 2019, the Provider advised that it would issue these payments and offered the Complainant a customer service payment of €50 in respect of this delay.

Having reviewed the matter once again as part of this complaints process, in its response to this Office dated 30 August 2019 the Provider noted that the Complainant had since advised that it had now paid her the 2017 expenses of €85.70 twice, as it had previously paid this amount by way of cheque in October 2017. The Provider confirms that it is not seeking to reclaim this payment from the Complainant nor offset it against any other payment that it has offered or will make to her.

The Provider apologises to the Complainant for its poor service and hopes that its increased customer service payment offers will resolve this element of her complaint.

With regard to the element of her complaint relating to premium payments, the Provider wrote to the Complainant on 12 September 2017 enclosing a cheque in the amount of €330.60, representing a refund of the four monthly premiums waived for the period her claim was in payment, that is, from May to August 2017 inclusive. Whilst a policyholder is not obliged to continue paying premiums during the appeals process, the Provider notes that the policy benefits in place are valuable where the policyholder is intending to return to work.

Having reviewed the matter once again as part of this complaints process and as a further concession in view of the service provided, the Provider advised in its response to this Office dated 30 August 2019 that if she agreed that her income protection policy should now be cancelled with effect from September 2017, it will refund to the Complainant all premiums paid from that date, which it calculates to be 20 monthly premiums of €82.65 each, totalling €1,653.

The Provider notes that all offers made remain open to the Complainant to accept

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The Complaint for Adjudication

The Complainant's complaint is that the Provider wrongly or unfairly admitted and paid her income protection claim from 8 May 2017 to 3 August 2017 only, notwithstanding that she continued to be certified as unfit to work thereafter.

In addition, the Complainant also complains that the Provider provided her with a poor level of customer service throughout its handling of her income protection claim, appeal and subsequent complaint.

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.

A Preliminary Decision was issued to the parties on **8 June 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.

Following the consideration of additional submissions from the parties, the final determination of this office is set out below.

I note that the Complainant incepted an income protection insurance policy with the Provider on **1 October 2004**. She completed an income protection claim form on 24 May 2017 stating that she last worked on [date redacted] as she was suffering with *"Anxiety"*. In addition, the Complainant's GP completed a GP Claim Form on 24 April 2017, wherein she stated that the Complainant had been first diagnosed and certified as unfit for work on [date redacted], as follows:

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*"**Symptoms:** Anxious, poor sleep (varying levels of sleep disturbance), irritability, poor/decreased concentration, low mood, sad, occasionally tearful, feeling of loss & lack of value/respect …*
***Diagnosis:** Anxiety/Depression in relation to work stress …*
What treatment, if any, is the patient currently receiving?
Psychotherapy [Ms N. H]*, Consultant Psychotherapist*
[Dr J.]*, Consultant Psychiatry*
Night sedation".

Income protection policies, like all insurance policies, do not provide cover for every eventuality; rather the cover will be subject to the terms, conditions, endorsements and exclusions set out in the policy documentation.

Section 4, '**Making a claim and claim payments'**, of the applicable Income Protection Plan – Individual Policy Conditions booklet provides, *inter alia*, at pg. 9:

*"**1. Disability Benefit***

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

(a) The Insured, in the opinion of [the Provider]*, having regard to all of the information available to it, is no longer suffering a Period of Disability …*

2. Proportionate Benefit

The Insured may be entitled to a Proportionate Benefit in a situation where he does not qualify for Disability Benefit because:

(a) The Insured is not totally disabled by reason of sickness or accident to fully carry to his Normal Occupation and is able to do part of his Normal Occupation resulting in a loss of income".

In order for a disability benefit to be payable, a claimant must satisfy the policy definition of period of disability. In this regard, Section 1, '**Contract and definitions'**, of the Policy Conditions booklet provides, *inter alia*, at pg. 2, as follows:

*"**Period of Disability***

A period throughout which the Insured is totally unable to carry out his Normal Occupation due to a recognised illness or accident and during which the Insured 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."

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I note that as part of its assessment of her claim, the Provider wrote to the Complainant's treating Consultant Psychiatrist Dr J. on 1 June 2017 seeking a contemporaneous medical report. I note that the Provider subsequently received a Report from Dr J. dated **24 June 2017**, when he advised, as follows:

> *"*[The Complainant] *first attended me for psychiatric assessment and treatment at the request of her family doctor on the 7th December 2016. She has attended me on eight further occasions since then, Her next appointment is on July 1, 2017.*
>
> *She suffers from major depressive illness with severe symptoms of anxiety and stress resulting to stress in the work place. She presented as an appropriately dressed woman of above average intelligence. She was fully orientated for place, time and person. Her mood was objectively and subjectively depressed. There was no evidence of any organic brain disease or trauma. She was able to give a full logical coherent account of her problems and life history. She appeared to be an honest and trustworthy person who did not exaggerate her symptoms in any way.* [The Complainant] *is suffering from Major Depressive Illness with severe anxiety and stress. She was subjectively and objectively depressed. She complained of disturbance of her sleep, loss of drive and energy, poor concentration, lack of confidence and self-esteem, anxiety and tension, all of which rendered* [her] *unfit to work.*
>
> *Her treatment consisted of appropriate antidepressant medication, dietary supplements and Cognitive Behavioural Therapy (CBT), exercise, breathing and relation exercise and mindfulness.* [The Complainant] *has at all times been fully compliant with her treatment regimen. She has improved slowly over the time I have known her but has not made a full recovery as yet. It would not be in her best interest to return to the toxic work situation which was the cause of her depression.*
>
> *Her past medical history and her personal history show no element of psychiatric illness or any other disability relevant to her current problems. She is currently unfit to return to work and in any case has retired from her post in the* [employer] *on grounds of ill health.*
>
> *I expect that in the fullness of time* [the Complainant] *will make a complete recovery though her illness may follow a course of relapse and partial remission"*.

I note from the documentary evidence before me that the Provider referred this Report to its Chief Medical Officer for review, who in the CMO Referral dated 4 July 2017 advised,

> *"I note psych report. Psych is not in a position to Ix* [investigate]*/validate workplace concerns per comment on work environment as he has …"*

It was recommended that the Complainant attend for a psychiatric independent medical examination.

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In this regard, Section 4, '**Making a claim and claim payments'**, of the Policy Conditions booklet provides, *inter alia*, at pg. 10:

> *"**5. Medical Evidence***
>
> *The liability of* [the Provider] *will at all times be subject to production by the Insured of such reasonable information and evidence satisfactory to* [the Provider] *as* [the Provider] *at its absolute direction may require. This will include, as often as* [the Provider] *may require, …*
>
> *(b) the attendance of the Insured at any medical doctor, consultant, occupational therapist or other relevant professional person nominated by* [the Provider]*;*
>
> *(c) reports or statements from any of those persons relating to the state of health or disability of the Insured"*.

The Provider arranged for the Complainant to attend with Consultant Psychiatrist Dr F. on 3 August 2017 and provided him with the claim file, which included a copy of the Report from the Complainant's treating Consultant Psychiatrist Dr J. dated 24 June 2017. I note that in his ensuing Report dated 3 August 2017, Dr F. advised, *inter alia*, as follows:

> *"**Background***
>
> [The Complainant] *last worked in her profession as a* [job description]*…in [date redacted]. She told me that she has worked for* [her employer] *since 1980.*
>
> *The condition preventing her from working is reported as "anxiety" in the initial claim form.*
>
> [The Complainant] *told me that she took a redundancy package which came into effect on [month redacted] 2017. She said, "I felt that for myself it was the best option …*
>
> ***History of illness***
>
> [The Complainant] *referred to notes in a folder during the assessment. She said she was afraid that poor concentration would prevent her from providing me with relevant information.*
>
> [The Complainant] *told me that her problems started in the second half of 2013 when she developed physical symptoms. She had pain in her neck and shoulders. She developed joint pain, particularly in her knees. X-rays were normal. She took anti-inflammatory medication and this helped.*
>
> *She said she had always been a very outgoing person who loved her work. She said she used ot take everything in her stride. She began to notice that she was not handling things like she used to. She was worrying about things and was nervous in*

/Cont'd…

herself. She was worried about normal things that should not have caused her worry. She was doubting her ability sometimes. Concentration was impaired and there was increasing forgetfulness. She said, "The smallest of things bothered me… Things you should do without thinking… I could see obstacles… I could see myself having to put in effort".

She said she was anxious and had a knot in her stomach. She was worrying and nervous. She lost confidence. She said she was not dealing with things as they arose.

A redundancy package became available and she decided about 15 to 18 months before it came into effect to take it. Thus, she made the decision to take the redundancy package, before she went on sick leave in May 2016.

Current symptoms

[The Complainant] *told me that since she has been off work feelings of worry and anxiety continue. She feels lethargic. She said she worries about what is around the corner. She said that she feels unsure and uncertain on many days. She said that some days are better than other days.*

She identifies sleep as a major problem. She said that she has a bad day after a poor night's sleep. She finds it hard to get up after she has had a bad night. She described initial and middle insomnia occurring on four nights, followed by a couple of nights of reasonable sleep. She has been prescribed the hypnotic zopiclone by her GP but she does not like to take it, fearing addiction.

She said that her appetite is variable and sometimes it is too good. Her weight is stable. At one point she was comfort eating.

Energy levels are lower than normal and she described herself as lethargic. She said she is not motivated.

She gets great enjoyment out of cooking. She keeps her garden well and she said it is therapeutic to do gardening.

She said she finds it hard to relax. She said, "I'm telling myself to relax… And in my mind I'm not… I know I should be more relaxed than I am".

Treatment

[The Complainant] *told me that she has been attending* [Dr J.]*, Consultant Psychiatrist, since December 2016. Her last appointment was on 17/07/2017 and her next will be at the end of August. From the background documents, I note that* [Dr J.] *has diagnosed major depressive disorder with anxiety and stress.*

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[The Complainant] *has not been prescribed an antidepressant. She said that this was discussed with* [Dr J.] *but he decided to hold off on medication. The only psychotropic medication she has been prescribed is the sleeping tablet zopiclone.*

She has been having [Cognitive Behavioural Therapy] *with* [Dr J.]. *He has also done breathing and relaxation with her and mindfulness.*

She had further successions of psychotherapy with [Ms N.] *between June and December 2016 …*

Work / occupational issues

[The Complainant] *has now retired. She took a redundancy package which came into effect in April 2017.*

She told me that she loved her work with [employer]. *She had good relationships with colleagues and management.*

She said that she feels she would never be able to go back to doing the same kind of work. She said she would not be able for it and would not be able to face it. She said, "I feel like my whole self has been given a battering".

She said that she would like to be occupied but she is unsure if she would be able for a managerial role like she had previously. She said this is because her confidence is less than it was. She said that she would worry too much about it. She said she would want to feel better being able to consider any type of work in the future …

Montgomery-Åsberg depression rating scale (MADRS)

The Montgomery-Åsberg depression rating scale is a clinician-rated instrument that assesses the range of symptoms that are most frequently observed in patients with major depression. It is completed based on a comprehensive psychiatric interview. It is not a diagnostic instrument but is considered a measure of illness severity.

The MADRS score for [the Complainant]*, based on the psychiatric interview on 03/08/2017, was in the mild severity range.*

Hamilton Anxiety Rating Scale (HAM-A)

The Hamilton Anxiety Rating Scale is a clinician rated instrument that measures the severity of anxiety symptoms. It is completed based on a comprehensive psychiatric interview. It is not in itself a diagnostic instrument for anxiety and a diagnosis should not be made based on the scoring in the HAM-A alone.

The HAM-A score for [the Complainant]*, based on the psychiatric interview on 03/08/2017, was in the mild severity range.*

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SIMS questionnaire

This is a 75-item multiaxial self-administered screening measure, which may help in determining if there is symptom overstatement. It was completed by [the Complainant] *as part of the psychiatric assessment on 03/08/2017.*

Her total score of 21 was elevated above the recommended cut-off score (14) for the identification of possible symptom overstatement. His scores on four of the five scales within the SIMS were elevated. She endorsed a high frequency of symptoms that are atypical in patients with genuine psychiatric disorders, raising the possibility of symptom overstatement.

On the Affective Disorders scale she endorsed 10 of 15 possible symptoms. On the Neurologic Impairment scale she endorsed five symptoms (cut-off >2).
On the Low Intelligence scale she endorsed three symptoms (cut-off >2). On the Psychosis scale she endorsed two symptoms of psychosis that are bizarre or unusual.

Rey Test

The Rey 15 item memory test comprises five sets of three items which the patient is instructed to remember when shown for 20 seconds. Although apparently a complex memory task, it is in fact easy to remember and reproduce the items. Scores of less than nine in the absence of specific brain dysfunction may be of clinical significance.

[The Complainant] *scored 12 in this test.*

Mental state examination on 03/08/2017

[The Complainant] *was appropriately dressed and there was no evidence of self-neglect. She was well groomed.*

She engaged well in the interview and good rapport was established. Her behaviour was within normal parameters during the assessment.

There was no objective evidence of depression of mood of any significance. She was normally interactive and spontaneous during the assessment. Affect was not restricted. There was no evidence of anxiety, agitation or tension. There was no evidence of negative or depressive cognitions.

There was no abnormality of the form or stream of thoughts. There was no evidence of psychosis.

There was no evidence of memory or concentration difficulties in the assessment.

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Conclusions / Opinion

[The Complainant] *has been diagnosed with major depressive disorder and anxiety by her treating consultant* [Dr J.]. *Currently there is evidence of mild symptoms and therefore one has to assume that there has been significant improvement since the initial diagnosis …*

[The Complainant] *first became physically unwell in late 2013. Following this she developed anxiety symptoms which ultimately led to her going on sick leave …*

Any symptoms present are mild in severity. There appears to have been significant remission …

There is no evidence that [the Complainant] *is disabled in activities of normal living …*

[The Complainant] *continues to attend a consultant psychiatrist, with whom she is having* [Cognitive Behavioural Therapy] *and psychological therapy. I note that she has not been treated with antidepressant medication …*

There is no objective evidence of depression of significance at this time. There was no restriction of affect.

[The Complainant] *has not set any goals towards a return to work as she has taken redundancy and has retired.*

[The Complainant] *feels that she is currently unfit to do any kind of work …*

In my opinion [the Complainant] *is currently fit to carry out her normal occupation if it was available to her. There is no objective evidence of disabling psychiatric illness that would prevent her from performing the material and substantial duties of her normal occupation. Any residual symptoms are not disabling in nature.*

It is reasonable to return to work when there are residual symptoms of psychiatric illness because work and achievement of occupational functioning have therapeutic benefits. Occupational functioning is recognised to be an integral and essential part of recovery from psychiatric illness.

The prognosis is reasonable given the response to treatment and the good premorbid functioning".

I note that the Provider referred this Report to its Chief Medical Officer for review, who in the CMO Referral dated 29 August 2017 then advised:

"Att. per date psych IME – fit for work currently."

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In this regard, I am of the opinion that it was reasonable for the Provider in August 2017, to conclude from the objective medical evidence before it that the Complainant was at that time, fit to carry out her normal occupation. Nevertheless, the Provider took the decision to admit the Complainant's income protection claim from the end of the policy deferred period, to the date of her independent medical examination with Dr F., when he deemed her at that time fit to carry out her normal occupation, that is, to admit the claim from 8 May to 3 August 2017. I am satisfied that this was a generous approach for the Provider to adopt, given the objective medical evidence before it.

I note that in her email dated 25 November 2019, the Complainant submits, *inter alia*, as follows:

> *"The Provider has stated that benefit was paid 'up to the date of the IME Report, dated 3.8.2017, which was a reasonable action in the circumstances'. This was the first opportunity the Provider had to assess my condition with an IME. It was not possible to retrospectively deny me benefit due to their own admin time in arranging the IME."*

In this regard, its letter dated 4 February 2020, I note that the Provider submits, as follows:

> *"The payment of three months benefit…was a reasonable and fair decision in the circumstances. The other option was to make no payment based on the medical file presented".*

I note that the Complainant repeatedly refers to a *"period of administration"* throughout her complaint submissions and which in her letter dated 12 February 2020, she defines, as follows:

> *"… the period /length of time between the end of the deferred period (9.5.17) up to the date of my medical assessment with* [Dr F.]*, (3.8.17), i.e. circa three months. This period of time is <u>solely</u> within the control of the Provider's administration, i.e. it can be shorter or longer depending on the Provider's ability to schedule a medical. The relevant issue here is that the medical is the first opportunity to assess the claim at a point in time and thus, payment can be backdated to the start date as normally warranted".*

I note that the Provider, having received a Claim Form completed by the Complainant and another from her GP, sought and obtained a Report from her treating Consultant Psychiatrist and then referred all three documents to its Chief Medical Officer for review. I am of the opinion that this review constituted the first assessment of the Complainant's claim.

In this regard, I note that following the first assessment by its Chief Medical Officer, insurers can and do admit income protection claims when the claim evidence furnished by or on behalf of the policyholder at the outset indicates to the satisfaction of the insurer that the policy definition of disability is satisfied, without the need for the policyholder to attend for an independent medical examination at that time.

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However, in this case, upon review of the claim papers, the Chief Medical Officer recommended that the Complainant attend for a psychiatric independent medical examination and she attended with Consultant Psychiatrist Dr F. on 3 August 2017, who concluded that she was *"currently fit to carry out her normal occupation"*.

I am of the opinion that it was reasonable for the Provider to conclude from the objective medical evidence before it in August 2017, which I have cited from at length, that the Complainant was at that time fit to carry out her normal occupation. I therefore take the view that it was open to the Provider to decline her income protection claim at that time. In this regard, the Complainant is mistaken when she suggests that the Provider was in any way obligated to admit her claim into payment from the end of the policy deferred period until the date of her independent medical examination.

I note that the Provider acknowledges that the Complainant did have a medical condition but it maintains that at the time of her independent medical examination with Dr F. on 3 August 2017, this condition was not at a level of severity to meet the "Period of disability" policy definition and therefore a valid income protection claim under the policy terms from that date onward, was not supported by the balance of the medical evidence available.

In its letter dated 4 February 2020, I note that the Provider submitted as follows:

> *"The level of severity of a medical condition is a key component in the medical assessment of Income Protection claims. For example, a person could be diagnosed with a back or mental health condition, however the diagnosis alone does* [not] *mean a person is suffering a period of disability. There is a wide variation of symptoms within each condition which determine the impact on a person's daily activities, ranging from no treatment necessary to the severe cases requiring hospitalisation.*
>
> *Our claims assessors take all medical evidence into account including the view from our CMO when determining severity and impact on a person's ability to perform their normal occupation"*.

In this regard, in her letter dated 12 February 2020, the Complainant noted, as follows:

> *"My policy does not explicitly state that "a level of severity" is a key criteria in relation to the payment of benefit"*.

I note that Section 1, 'Contract and definitions', of the Policy Conditions booklet provides, *inter alia*, at pg. 2, as follows:

> *"**Period of Disability***
>
> *A period throughout which the Insured is **totally unable** to carry out his Normal Occupation due to a recognised illness or accident …"*
>
> ***[Emphasis added]***

/Cont'd…

The purpose of income protection is to support employees who experience work disability supported by the objective medical evidence. Income protection insurance decisions are based on objective medical evidence and the job demands of the occupation, to ascertain whether the claimant meets the policy definition for a valid claim.

The diagnosis of a medical condition is not, in and of itself, sufficient to determine claim validity, nor does it automatically equate to work disability; consequently, the weight of the objective medical evidence must clearly indicate whether a claimant satisfies the policy criteria, in this instance being *"**totally unable**"* to carry out his or her occupation. It is in determining whether this standard is met that the severity of the medical condition is relevant.

I note that the Provider has never disputed that the Complainant had a medical condition. Indeed if it had done so it would not have made the decision to admit her income protection claim for a period. Instead, I note that the Provider concluded from the objective medical evidence before it, that the severity of her condition at the time of her independent medical examination on 3 August 2017 was such that it did not render her totally unable to carry out her normal occupation and that whilst she had residual symptoms at that time, the independent examiner advised that these were not disabling in nature.

The Complainant appealed the Provider's decision to cease payment of her claim by way of furnishing it with a Report from her treating Consultant Psychiatrist Dr J. dated 10 December 2017, by email on 11 January 2018, which stated, as follows:

> *"*[The Complainant] *first attended me for psychiatric assessment and treatment at the request of her family doctor on the 7th December 2016. Since then I have seen her on numerous occasions to date. She suffers from major depressive illness with severe symptoms of anxiety as a result of problems at work. Her treatment consisted of appropriate antidepressant medication, dietary supplements and Cognitive Behavioural Therapy (CBT), exercise, breathing and relaxation exercise and mindfulness.* [The Complainant] *has at all times been fully compliant with her treatment regimen. As a result of her illness she has retired form work on grounds of ill health. Her response to treatment to date has not led as yet to full recovery as yet and she remains unfit for work. She will need to continue on treatment as outlined above indefinitely"*.

As part of its appeal process, I note that the Provider arranged for the Complainant to attend for an independent medical examination with Consultant Psychiatrist Dr M. on 8 August 2018 and it provided him with, *inter alia*, a copy of the Report from Dr J. dated 10 December 2017. I note that in his ensuing Report, Dr M. advised as follows:

> *"*[The Complainant] *is a [age redacted] woman who was with* [her employer] *for [length of service redacted]. She actually retired at the end of [date redacted].*
>
> *She feels that she is not fit to return to work. She says that she would like to work but that she would not be able to discharge her management job that entails a particular level of responsibility.*

/Cont'd…

This was a job that she was able to acquit herself of without any great difficulty. Although there were often stressors within the job essentially she was able to cope with these.

What happened to her is that she started to develop some physical symptoms in terms of joint pains and pains in her neck and shoulders, which were variously investigated but essentially evolved into anxiety and depression.

This was diagnosed by [Dr J.]*, a Consultant Psychiatrist, whom she saw and was treated with cognitive behavioural therapy and general measures to promote wellbeing. An example of interventions here would be around avoidance that she had developed when unwell.* [Dr J.] *retired in December 2017 and she has not gone to see anybody else since. This is for a number of reasons.*
Firstly she did not want to have to go through everything again having established a good therapeutic relationship with [Dr J.]*. Secondly there is a financial aspect in that she has no income as she is below the retirement age from the [occupation redacted] as well. Lastly, she decided to implement the recovery programme that she had developed with* [Dr J.] *which consisted of exercise which she has increased, self-scrutiny and challenging of avoidance in addition to getting involved in more activities. She never took antidepressants despite them being discussed as she was wary about taking medication but did take Zopiclone briefly because of her sleep.*

In terms of how she is now she would say that she is a lot better than she was even this time last year. However she says that her motivation is missing which she would have taken for granted previously. Additionally, her energy is not as good and she tends to doubt herself and be hesitant to do things. Her tendency still is to avoid and she gave an example of recently being asked to go away with some friends. Her first thought was how she could not go away but in fact she is going to be going away in September …

… she says that she can be upset easily and is more sensitive than she was in the past. She is disappointed at herself in not finishing out her career as she would have envisaged …

In terms of pre-morbid personality she would describe herself as being an extrovert and somebody who would like to take the lead on things. She would also be very organised, meticulous and perfectionistic and would be described as being overly tidy.

She presents as a neatly dressed middle aged woman who was cooperative and pleasant and brought some notes to which she was able to refer to during the course of the interview. She was initially quite anxious but settled well during the course of the interview and spoke in a fluent and articulate manner. She was mildly anxious, affect appropriate and there is no suicidal ideation. Her mood is euthymic, there are no psychotic features, she is alert and orientated and has insight.

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> [The Complainant] *is a fifty-nine year old woman who has a long history of working in* [employer] *and who developed an episode of anxiety and depression which has now largely remitted. The occurrence of this episode of anxiety and depression has led to an undermining of the confidence in her wellbeing which she always took for granted. However, despite this she has recovered well. She is a conscientious and truthful woman who has experienced an episode of recovery. At this point I think she is well enough to be able to return to work or at least be able to make a decision as to whether she wants to return to her previous role or not"*.

I note that the Provider wrote to the Complainant on **4 January 2019** to advise that it was affirming its previous decision to limit payment of her income protection claim to the period up to August 2017.

The Complainant does not accept the findings of the medical examinations nor the decisions of the Provider in relation to her claim, as she submits she was still too ill to return to work at that time and that her GP continued to certify her as unfit for work until 10 September 2019. The Complainant is keen to point out that Dr. M's conclusion in August 2018, that her condition had largely remitted, was 13 months after the report of Dr. F.

In this regard, I note that the Complainant submits in her Complaint Form, as follows:

> *"Under* [section 4.1] *of my policy I was covered for payment of Disability Benefit, which is defined as being unable to fully carry out my normal occupation, i.e. as a Customer Service Manager. In my appeal I sought payment from 3.8.2016 to 8.8.2017 in this regard, which has been refused.*
>
> *Under* [section 4.2] *of the policy I was covered for Proportionate Benefit for any period of sick leave when Disability Benefit is not payable. A second medical on 8.8.2017, arranged by* [the Provider]*, provides a snapshot on that date, which confirms my improved condition. I would expect payment, described as 'Proportionate Benefit' under the policy conditions, from that date to present* (it is noted that the Complainant has since been certified as fit for work from 10 September 2019)*. The* [Provider] *has refused to pay either benefit"*.

Having considered the weight of the objective evidence available to the Provider, which included the reports from Consultant Psychiatrists Dr F., dated 3 August 2017 and from Dr M. dated 8 August 2018 and which I have cited from at length, I am satisfied that it was reasonable for the Provider to conclude that the Complainant was at both those times, fit to carry out her normal occupation and that she therefore did not satisfy the policy conditions for either a disability benefit or a proportionate benefit from 3 August 2017 onwards, as set out in the applicable Income Protection Plan – Individual Policy Conditions booklet.

I am of the opinion therefore, that the Provider ceased payment of the Complainant's income protection claim in accordance with its entitlement pursuant to the terms and conditions of her income protection policy.

/Cont'd…

In its letter dated 1 November 2019, I note that the Provider offered to pay the Complainant an ex-gratia payment of three months benefit, that is, €5,560.49 taxable gross, as follows:

> *"The medical assessment of this claim is conclusive, in my view, however we would be prepared on an ex-gratia basis to pay an additional three months benefit to assist in resolving this dispute. I hope this gesture is looked upon favourably".*

In this regard, in her letter dated 9 December 2019, I note that the Complainant submits, *inter alia*, as follows:

> *"… The Provider also needs to acknowledge that their proposal to pay an additional three months Benefit while, at the same time, claiming that the Policy criteria are not being met is not consistent. One needs to ask – what 3 month period is the offer for?*
>
> *… I either meet the Policy criteria or I don't".*

It is unfortunate that the Provider framed its offer in terms of paying an amount by reference to a number of months' additional benefit. It is understandable that this has caused some confusion for the Complainant. I consider that it would have been more appropriate for the Provider, in its efforts to resolve this dispute, to have offered the Complainant a standalone sum of money if it wished to do so. I note indeed from the Complainant's recent submission that the tax implications to her are very different, depending on whether the payment constitutes a goodwill gesture, or alternatively, 3 months of income protection benefit payments.

Nevertheless, given that I am satisfied that the Provider ceased payment of the Complainant's income protection claim, in accordance with the terms and conditions of her income protection policy, I consider this offer, to be a generous attempt by the Provider to resolve this element of the Complainant's complaint. It is clear from the Provider's very recent submission to this office in July 2020, that its offer to make this payment has been revised to constitute an ex gratia payment; in such circumstances it will be a matter for the Complainant to advise the Provider directly, whether she now wishes to accept or decline this offer.

With regard to the element of her complaint relating to the location of her examination with Consultant Psychiatrist Dr F. on 3 August 2017, I note that in her correspondence dated 24 February 2020, the Complainant states, *inter alia*, as follows:

> *"I wish to point out that this assessment was undertaken in an environment in which I felt unsafe"*.

In this regard, in her email on 19 March 2019, the Complainant submits, as follows:

> *"At request of* [Provider] *I attended medical with* [Dr F.] *on 3.8.2017. I was expecting to attend in a usual consultation environment, i.e. to see a Private Consultant in private rooms. This was not the case and I was immediately taken aback as the medical took place in a secure psychiatric area in* [Named] *Public Hospital.*

/Cont'd…

I found the experience both disturbing, unnerving and much more stressful than it ought to have been."

In addition, in her letter dated 16 October 2019, the Complainant submits, *"the location of my IME with* [Dr F.] *had a material bearing on the outcome of the medical"* and for that reason, in her letter dated 9 December 2019, she considers that the Provider should *"set aside"* the findings of Dr F. as his examination was *"held in an unsafe environment"*.

I note that the Provider sought the views of Dr F. in relation to this matter, who in his letter dated 27 August 2019 advised, as follows:

"The assessment of [the Complainant] *on 03/08/2017 took place in my office in the Department of Psychiatry of* [Named] *University Hospital. The office located in an administrative corridor just off the reception area of the Department of Psychiatry. Access to the corridor is by swipe card, as is access to other administrative corridors throughout the hospital. This is the office which I see private patients and patients attending for occupational assessments, as well as outpatients and relatives of patients.*

The Department of Psychiatry is an acute treatment unit for patients with significant psychiatric illness. Persons who are disabled from working because of psychiatric illness also have significant psychiatric illness, so are no different from the patients being treated in an acute psychiatry setting.

The Department of Psychiatry is not a secure unit. Access to the wards in the Department is controlled by porters, the main reason for this access control being to ensure that visiting hours are adhered to so that the therapeutic programmes can run effectively in the wards. Occasionally if the porters are understaffed or are on break a member of security staff replaces them for a period.

I regret that [the Complainant] *found her experience in the Department disturbing, unnerving and stressful.*

I have reviewed my contemporaneous notes from the assessment of [the Complainant]*. I did not make any note of* [the Complainant] *having expressed concern about the area in which she was being seen, as I would have done if she had expressed such concern at the time of the assessment. I note that her appointment was at 16.30h but that the assessment started at 15.55h, so she had obviously arrived early and I was able to start early, which would have reduced her waiting time in the reception area.*

I also note that in the mental state examination, her affect did not reflect anxiety or distress".

/Cont'd…

In this regard, in her letter dated 16 September 2019, I note that the Complainant submits, *inter alia*, as follows:

> *"I continue to find it unacceptable that the venue was not at his private consulting rooms. Whilst* [Dr F.] *makes reference to my not having raised this 'concern' on the day, the fact remains that I attended at that venue which was a secure, lock-up area. I had travelled a three hour drive from* [Location]*, had had to prepare myself for the medical at a time when I was feeling unwell which turned out be a cold, chilling and frightening experience and, at which I believe I did not articulate myself well as a result, I might add that it took me some time to recover afterwards."*

It would have been helpful of the Complainant to have advised Dr F. at that time of her concerns in relation to the location of the examination and how she felt about that, to see if it was possible to carry out the examination at a different location at that time or at another time convenient to both parties. It seems however that Dr. F. was unaware of the Complainant's sentiments in that respect.

In any event, I am of the opinion that there is no reasonable basis upon which it would be appropriate for this office to direct that the Provider set aside the Report of Dr F., due to the location of the examination, as has been suggested by the Complainant. I suggest nevertheless that the Provider should take into account the Complainant's comments, for any future medical appointments to be scheduled, whether for this lady, or for any other person; it will be in the interests of both parties that the individual attending has an appropriate level of comfort in which to discuss sensitive medical issues with the medical assessor.

Whilst the Provider first put the Complainant's views on this matter to Dr F. on 23 August 2019, I note that it had previously incorrectly advised her in its letter dated 13 March 2019 that it had at that time already done so. In its letter to this Office dated 4 October 2019, I see that the Provider submitted, *"I do apologise for this and appreciate in the circumstances that it is not assisting matters"* and offered the Complainant a customer service payment of €300 in respect of this error.

I am satisfied, given the circumstances, that this offer of a customer service payment of €300, for the incorrect information given to the Complainant, was fair and reasonable. I consider it a matter for the Complainant to advise the Provider directly whether she now wishes to accept or decline this offer.

With regard to the element of her complaint relating to the level of customer service provided by the Provider throughout its handling of her claim, appeal and subsequent complaint, I note from the documentary evidence that the Provider did not arrange for the Complainant to attend for a medical examination as part of its assessment of her appeal until August 2018, some seven months after she had furnished the Provider with her appeal evidence in January 2018, and that it then delayed another five months until January 2019 before informing her of the outcome of her appeal.

/Cont'd…

I note that the Provider acknowledges that these two periods of delay were outside the service levels that one would normally expect in a claims assessment process.

In this regard, the first delay took place from April to August 2018. The Provider had sought information from the Complainant's treating Consultant Psychiatrist Dr J. on 23 January 2018, with reminders send on 21 February and 26 March 2018.

Whilst it then learnt in April 2018 that it was likely that Dr J. had retired, it was not until 1 August 2018 that the Provider arranged for the Complainant to attend for an independent medical examination on 8 August 2018. I note that the Provider acknowledges that this should have taken 10 working days at most to arrange and not four months and it has now offered the Complainant a customer service payment of €500 for this delay, which I believe is fair and reasonable and I consider it a matter for the Complainant to advise the Provider directly whether she now wishes to accept or decline this offer.

The second delay took place from August 2018 to January 2019. In this regard, whilst the Provider had received the Report from Consultant Psychiatrist Dr J. on 14 August 2018, it did not inform the Complainant until 4 January 2019 of its appeal decision. I note that the Provider acknowledges that its assessment, including a review by the Chief Medical Officer and the Claims Manager, should have taken four weeks at most to complete and not 4½ months and it has now offered the Complainant a customer service payment of €650 for this delay, which I believe is fair and reasonable and I consider it a matter for the Complainant to advise the Provider directly whether she now wishes to accept or decline this offer.

With regard to the element of her complaint relating to the failure of the Provider to reimburse her in a timely manner for her expenses for attending the medical examination on 8 August 2018, I note that the Complainant furnished receipts in the amount of €90.85 to the Provider on 9 August 2018 and submits in her Complaint Form, as follows:

> *"Expenses for attendance at first medical* [Dr F. on 3 August 2017] *were paid to me, however those in respect of the second medical* [with Dr M. on 8 August 2018] *remain outstanding for payment. I now seek payment of this small sum."*

I note that the Provider acknowledges that the Complainant submitted receipts on 20 September 2017 totalling €85.70 and receipts on 9 August 2018 totalling €90.85. In its Final Response letter dated 13 March 2019, the Provider advised that it would issue these payments and offered the Complainant a customer service payment of €50 for this delay.

Having reviewed the matter once again as part of this complaints process, the Provider noted in its response to this Office dated 30 August 2019 that the Complainant had since advised that it had now paid her the 2017 expenses of €85.70 twice, as it had previously paid this amount to her by way of cheque in October 2017. The Provider confirmed that it is not seeking to reclaim this payment from the Complainant nor offset it against any other payment that it has offered or will make to her.

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I am satisfied given the circumstances, this offer of a customer service payment of €50 is fair and reasonable and I consider it a matter for the Complainant to advise the Provider directly whether she now wishes to accept or decline this offer.

With regard to the element of her complaint relating to premium payments, I note that the Complainant submits in her Complaint Form, as follows:

> *"I continued to pay monthly premia, on a voluntary basis during the appeal, on the advice of my Broker, based on information he received from* [the Provider] *when I queried this matter. I seek return of all premia paid for that period"*.

I see from the documentary evidence before me that the Provider wrote to the Complainant on 12 September 2017 enclosing a cheque in the amount of €330.60, representing a refund of the four monthly premiums which the Provider waived for the period during which her income protection claim had been in payment, that is, from May to August 2017 inclusive.

I note that the Complainant continued to pay premiums for a period thereafter. Whilst a policyholder is not obliged to continue paying premiums during the appeals process, I note the Provider's suggestion that the policy benefits in place are valuable where the policyholder is intending to return to work. In addition, I note from the documentary evidence that the Provider informed the Complainant, via email to the Broker on 12 January 2018, as follows:

> *"The appeal will be consider*[ed] *whether the premiums are paid or not as the policy was in force at the time of the claim.*
>
> *If the premiums are not paid the policy will cease and would be subject to the usual reinstatement requirements.*
>
> *If the appeal is successful and the claim is paid for any period of time the premium would be covered under the waiver of premium condition."*

Having reviewed the matter once again as part of this complaints process and as a further concession in view of the service provided, I note that the Provider advised in its response to this Office dated 30 August 2019 that if the Complainant agrees that her income protection policy should now be cancelled with effect from September 2017, it will refund all premiums paid from that date, which it calculates to be 20 monthly premiums of €82.65, totalling €1,653 (as indexation was removed from the policy on 1 October 2017 at the Complainant's request).

I am satisfied, given the circumstances, that this offer to retrospectively cancel her income protection policy from September 2017 and refund all premiums paid since that date is fair and reasonable and I consider it a matter for the Complainant to advise the Provider directly whether she now wishes to accept or decline this offer.

/Cont'd…

In conclusion, I am satisfied that the Provider ceased payment of the Complainant's claim on 3 August 2017, in accordance with the terms and conditions of her income protection policy. In addition, whilst I acknowledge that the level of customer service that the Complainant received was at times unacceptable and fell short of what she ought reasonably be entitled to expect from the Provider, I am mindful that the Provider has made a number of genuine and generous offers to the Complainant in an effort to resolve these matters and I am satisfied, given the circumstances, that these offers are fair and reasonable.

I consider it a matter for the Complainant to advise the Provider directly whether she now wishes to accept or decline these offers which for ease and clarity I list, as follows:

- An ex gratia payment of €5,560.49, made as a goodwill gesture in response to the Complainant's complaint that the Provider's wrongfully ceased payment of her income protection claim from 3 August 2017.

- €300, made in relation to the element of her complaint relating to the Provider's error in advising the Complainant that it had forwarded details of her concerns relating to the venue of her medical examination to Dr F. in its letter dated 13 March 2019, (when in fact it did not do so until 23 August 2019).

- €500, made in relation to the Provider's delay from April to August 2018 in progressing the Complainant's appeal.

- €650, made in relation to the Provider's delay from August 2018 to January 2019 in advising the Complainant of the outcome of her appeal.

- €50, made in relation to the Provider's delay in reimbursing the Complainant for her expenses for attending the medical examination with Dr M. on 8 August 2018. In addition, the Provider is not seeking to reclaim the overpayment it made to the Complainant in the amount of €85.70 in relation to her expenses for attending the medical examination with Dr F. on 3 August 2017.

- €1,653, if the Complainant is satisfied to confirm the retrospective cancellation of her income protection policy from September 2017, this amount representing a refund of all premiums paid since that date.

On the basis that these offers by the Provider remain open to the Complainant for acceptance, it is my Decision, on the evidence before me that it is not necessary or appropriate to uphold this complaint.

To reiterate, I consider that it is a matter for the Complainant to advise the Provider directly whether she now wishes to accept or decline those offers. If she wishes to accept any or all of those offers, she should communicate expeditiously in that regard with the Provider, as it cannot be expected to hold such offers open for acceptance, indefinitely.

/Cont'd…

Conclusion

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

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

MARYROSE MCGOVERN
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

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