An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0298
Sector:	Insurance
Product / Service:	Payment Protection
Conduct(s) complained of:	Rejection of claim - did not meet policy definition of disability
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant was accepted as a member of a trade union Income Continuation Plan provided by the Provider in **December 2014**. The Provider received a claim from the Complainant in **January 2017**. The Provider allowed the Complainant's claim up to **20 April 2017**. However, the Complainant wished to return to work on **1 June 2017** and believed her claim should have been allowed to **31 May 2017**.

The Complainant's Case

The Complainant set out her complaint in the Complaint Form as follows:

> *"1. letter sent on 7th February 2017 to [the neurophysiologist] not received by [the neurophysiologist], as I double checked with his secretary.*
>
> *2. I clearly stated to [the Provider] by phone that no decision was to be made without his report.*
>
> *3. The Occupational Consultant I attended had not seen a case like mine before.*
>
> *4. Deemed fit to return to work on April 20th but not informed until May 19th. Even though all my consultants deemed me fit for a partial return to work in Sept 2017.*

5. When I finally got the report from [the neurophysiologist] in June 2017, he informed me that [the Provider] were 'aggressive' in their approach with him. This affected our patient/Consultant relationship."

In resolution of this complaint, the Complainant advised this Office by email dated **27 September 2019** that she is seeking compensation in the amount of €3,000 *"… as this is my basic wage for one month."* The Complainant also stated that *"I want it noted that I have only this year returned to fulltime employment from Sept 2019 …… even though [the Provider] deemed me fit to return to full-time in employed in April 20th 2016."*

The Provider's Case

The Provider explains that the Complainant is a member of trade union income continuation plan. The Complainant joined the plan on **10 December 2014**. The Provider advises that in order for a claim for income protection to be admitted, a member's condition must meet the definition of *disability* as set out in the policy conditions. The Provider has cited this definition in its submission.

The Complainant stopped working on **25 August 2016** and was granted 6 months full pay and 6 months half pay by her employer. The Complainant's claim was admitted under the policy from **24 February 2017**, the date on which the Complainant's salary reduced to half pay and was ultimately paid until **31 May 2017**, the day before the Complainant returned to work.

The First Claim

The Provider states the Complainant completed a claim form on **23 December 2016**. The Complainant advised she was suffering from [details of illness redacted] and had been unable to perform the duties of her occupation as a [occupation redacted] since **June 2016**. The Complainant also advised that she had been under the care of her GP, a neurologist, a neurophysiologist, and a consultant physician in relation to her condition.

A completed claim form was emailed to the Provider by the Plan Administrator on **5 January 2017**. On **19 January 2017**, the Provider wrote to the Complainant's GP to obtain a Private Medical Attendance Report (**PMAR**). The Provider also wrote to the neurologist on the same day to request a report in relation to the Complainant's condition. A completed PMAR was received from the Complainant's GP on **25 January 2017**.

The Complainant telephoned the Provider on **7 February 2017** to discuss her claim. The Provider states that during this call, the Complainant advised that her neurophysiologist had become her primary treating physician and that she was happy for the Provider to request a report from him. The Provider wrote to this individual the same day asking a number of questions regarding the Complainant's condition. A letter was also issued to the Complainant's neurologist to cancel his report.

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On **20 March 2017**, the Plan Administrator confirmed that the Complainant's employer had approved her for Critical Illness Protocol (**CIP**). This is an additional period of sick pay that certain public sector employees can apply for if they are unable to return to work for a time due to illness. In the Complainant's case, this had the effect of increasing her sick pay entitlement from 3 months full pay and 3 months half pay to 6 months full pay and 6 months half pay. The Plan Administrator advised the Provider that they had requested details of the revised half pay and off pay dates from the Complainant's employer. The Provider was also informed that the Complainant had attended her neurophysiologist the previous week and she understood that neither he nor his secretary knew anything about the letter issued on **7 February 2017**.

The Provider contacted the neurophysiologist's secretary on **27 March 2017** in relation to the outstanding report. The neurophysiologist's secretary was unavailable and a temporary secretary requested a call back the following day. A call was made to the neurophysiologist the following day and a voicemail was left. The call was followed by an email to the neurophysiologist's clinic attaching a copy of the letter of **7 February 2017**.

A call was made to the Complainant on **28 March 2017** to update her on the claim assessment and to ask for an update on her condition. The Complainant confirmed that she felt 85% back to normal and that it was her wish to return to work before the end of the school term to avail of full pay for the summer. The Complainant was informed that the neurophysiologist's report remained outstanding and to help expedite the process an Independent Medical Examination (**IME**) would be arranged with an occupational health physician. It was also confirmed that further attempts would be made to contact the neurophysiologist. The Complainant was happy for the Provider to do so. The Complainant was informed that further information was awaited from her employer and the Plan Administrator was liaising with her employer.

The IME was arranged for **20 April 2017**. The Provider wrote to the Complainant on **4 April 2017** to confirm the appointment details and wrote to the consultant occupational physician on **5 April 2017** to outline the reasons for the report. The IME report was received on **4 May 2017**. The Provider has cited three passages from the report which advises that the Complainant was fit to return to normal duties. The Provider emailed the Plan Administrator on **4 May 2017** to confirm, having assessed the medical information, that the Complainant was medically unfit for work at the date her salary reduced to half pay on **24 February 2017**. However, she was medically fit for her work duties by the date of the IME on **20 April 2017**. Therefore, the claim was medically valid from **24 February 2017** to **20 April 2017**. The Provider states that it did not receive the neurophysiologist's report, despite reminders.

The Plan Administrator received the information requested from the Complainant's employer on **11 May 2017**.

The Appeal

On **19 May 2017**, the Plan Administrator, having discussed matters with the Complainant, emailed the Provider to advise that the Complainant was not happy with the decision and that she had made plans to return to work on **1 June 2017**.

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At the request of the Plan Administrator, the Provider reviewed the Complainant's file on **19 May 2017** and emailed the Plan Administrator advising that it remained satisfied with its decision. The Provider also wrote to the Complainant the same day. The Provider has cited passages from these letters in its submission.

The letter issued to the Complainant invited her to discuss the matter with her treating doctors and advised that it was open to her to submit additional evidence in support of her claim. The Provider refers to further email correspondence with the Plan Administrator. The Complainant confirmed to the Plan Administrator that she would be attending the neurophysiologist in early **June 2017** and that she would remind him to forward his report.

On **31 May 2017**, the Complainant emailed the Provider to confirm *'I think my issue is sorted. [the Occupational Health Service] want me signed off until September so management are now dealing with this. I will be in touch regarding my payment protection payment.'* The Plan Administrator emailed the Provider on **6 June 2017** to confirm that the Complainant had returned to work on **1 June 2017**, that the neurophysiologist would be sending a report to confirm the position and that the Complainant wished for her claim to be admitted to **1 June 2017**. The Provider states that the report was not received and the Plan Administrator was informed of this on **12 June 2017**.

On **29 August 2017**, the Plan Administrator emailed a copy of the neurophysiologist's report to the Provider. It was also stated that the Complainant did not want the Provider to contact the neurophysiologist again as he was getting *'frustrated with all the requests for information.'* The Provider states that it hopes it can be seen from their submission and file of papers that it only asked the neurophysiologist to complete and return one report in **February 2017**. The reminders in the interim were sent with the consent of the Complainant and with a view to finalising the assessment of the claim. The Provider submits that requests for medical reports from treating doctors are a normal part of the claim assessment process. The neurophysiologist was paid a fee for his report.

The Provider explains that while the neurophysiologist's report was dated **26 June 2017**, it was not issued at that time. This was subsequently confirmed by his secretary over the telephone on **5 September 2017**. The Provider states that it appears the fee note raised by the neurophysiologist to be paid before the report was released was sent to an incorrect address for the Provider.

The Provider advises that while the report was dated **26 June 2017**, the information provided by the neurophysiologist related to the Complainant's condition in **February 2017** and not **June 2017** as would be expected given the date of the report and the Plan Administrator's email of **6 June 2017**.

The Provider notes the results enclosed in the report were from tests carried out in **January 2017**. The neurophysiologist also indicated a return to work was expected in a 3/6 month timeframe even though the Complainant had returned to work on **1 June 2017**, 4 weeks prior to the date of the report.

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It is explained that while the Provider was conscious the Complainant had asked it to refrain from contacting the neurophysiologist, in light of the above, one further call was placed to his clinic to seek some clarifications. The neurophysiologist indicated that he had a busy clinic and was frustrated with the questions being asked by the Provider. The neurophysiologist asked for and was provided with the names of its Chief Medical Officer (**CMO**) who he knew and who he said could contact him to provide the requested information. The CMO made two attempts to contact the neurophysiologist's clinic on **11** and **15 September 2017** but the neurophysiologist did not return his calls.

The Provider submits that it did not continually ask the neurophysiologist for information. The Provider also explains that for data protection reasons, recordings of the telephone conversations with the neurophysiologist and his clinic have not been provided but if necessary for the purposes of this adjudication, the Provider can seek the consent of the relevant parties.

A formal complaint was made by the Complainant on **19 September 2017**. The Provider responded on **22 September 2017**, outlining that on receipt of the neurophysiologist's report it required confirmation of the date of the Complainant's last attendance prior to the completion of the report and was required to give a full understanding to the Complainant's appeal.

A short time later, the Complainant provided a number of receipts she received following her attendances with the neurophysiologist. These were reviewed and it was noted that the last attendance was on **6 June 2017**. With a view to bringing the matter to a close, and notwithstanding the medical evidence obtained to that point indicated the Complainant was fit to return to work by **20 April 2017**, the Provider agreed to accept the receipts from the Complainant in good faith and the claim was admitted for the period **21 April 2017** to **31 May 2017**. The Provider wrote to the Complainant on **5 October 2017** to confirm this.

The Provider submits there is no evidence to indicate that the Complainant stated that no decision was to be made in respect of her claim until the Provider received a report from her neurophysiologist. The Provider advises that if this was the case then an assessment of the claim would not have been made until the report was received in **August 2017** and no benefits would have been payable until then. The IME was arranged so that the assessment of the Complainant's claim could be expedited. The Provider states it advised the Complainant that it would be happy to assess the neurophysiologist's report at a later date.

The Second Claim

In early **September 2017**, the Provider was notified that the Complainant had gone on sick leave. In the initial complaint response dated **22 September 2017**, the Provider advised it would assess a partial claim as the Complainant had returned to work on a part-time or phased basis. The Provider set out the information required and that an IME was necessary. The letter also referred to the Complainant's position regarding not wanting to attend a further assessment.

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The Complainant indicated her willingness to attend an IME provided it was with an identified doctor, however, this individual was also the Provider's CMO. Therefore, it was not possible for him to carry out the IME. This was confirmed to the Plan Administrator on **26 September 2017**. The Complainant confirmed later that day that she was not willing to attend any further IMEs.

In a letter dated **5 October 2017**, it was also confirmed to the Complainant that without details of her current treating doctors or attending an IME, the Provider could not progress its assessment of the partial claim. On **24 October 2017**, the Complainant confirmed she was attending the same doctors. She also confirmed she would attend an IME.

The Provider requested a PAMR from the Complainant's consultant physician on **7 November 2017** which was received in late **November 2017**. An IME was also arranged for **30 November 2017** with a consultant occupational physician. Before the IME was due to take place, the Plan Administrator advised by telephone on **23 November 2017** that the claim would not be proceeding as the Complainant had been granted extended sick leave entitlements from her employer. The IME was cancelled and the claim assessment was discontinued.

The Complaints for Adjudication

The complaints are that the Provider:

1. Failed to consider the neurophysiologist's report before reaching a decision on the Complainant's claim contrary to her express instruction;

2. Wrongfully and/or unreasonably refused to allow the Complainant's claim to **1 June 2017**;

3. Delayed in informing the Complainant of the date on which she was deemed medically fit for work;

4. Deemed the Complainant fit for work in **April 2017** despite all of her consultants deeming her fit for a partial return to work in **September 2017**;

5. Communicated with the Complainant's neurophysiologist in an *aggressive* manner.

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.

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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 19 August 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.

In the absence of additional submissions from the parties, within the period permitted, I set out below my final determination.

It is important to emphasise that, for the purpose of assessing this complaint, it is not my role to comment on or form an opinion as to the nature or severity of the Complainant's illness or condition. It is my role to establish whether, on the basis of an objective assessment of the medical evidence submitted, the Provider has adequately assessed the Complainant's claim and whether it was reasonably entitled to arrive at the decision it did following its assessment of the medical evidence submitted.

The Policy Conditions

The recital to the policy conditions states that the Provider will:

> *"… subject to … receipt of evidence satisfactory to the Company of*
>
> *(a) the occurrence of the event upon which Benefit is expressed to be payable and*
>
> *(b) the title of the person claiming Benefit*
>
> *(c) …*
>
> *the Company shall pay at its Registered Office the benefits as stated in the Policy."*

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The policy conditions contain the following definitions:

> *""Disability"*
>
> *A[n] Insured Person is suffering from a Disability if he is, in the opinion of our Chief Medical Officer,*
>
> *(i) totally unable, due to illness or injury, to carry out the duties of his/her Normal Occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted; and*
>
> *(ii) is not engaging in any other occupation or activity whether part-time or fulltime, in any capacity, for payment, profit or reward whatsoever.*
>
> *Disabled shall have a corresponding meaning.*
> *…*
>
> *"Normal Occupation"*
>
> *In respect of an Insured Person his occupation as a teacher or lecturer as proposed to and accepted by the Company.*
> *…*
>
> *"Period of Disability"*
>
> *Any continuous period arising after the Commencement Date during which an Insured Person is Disabled and ending on the earlier of the cessation of Disability and the Expiry Date."*

The Second Schedule of the policy sets out the requirements for proving a claim. I note the following sections:

> *"1.2 You and the Insured Person/Employee shall, within such time as we shall deem reasonable, provide us with all such data, information and evidence as we may reasonably require upon or with regard to the happening of any event affecting or relating to any assurance under the Policy …*
>
> *1.3 If any data, information or evidence [is not supplied]:*
>
> *…*
>
> *We may at our absolute discretion:*
>
> *(a) decline a request for assurance of Benefit;*
>
> *(b) defer the acceptance of a request for such assurance;*

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(c) accept a request for assurance, subject to such exclusions, limits and terms and conditions …;

(d) alter the amount of or the terms applicable to, or withhold or cease payment of, any Benefit payable under this Policy;

…

1.4 Payment of Benefit is conditional upon:-

(i) …
(ii) …
(iii) Proof of commencement of a Period of Disability and it continuance …"

The Claim

The Complainant submitted a claim under the plan by way of claim form dated **23 December 2016**. On this form the Complainant stated that she last worked in **June 2016** as she was suffering from [details of illness redacted].

The Provider wrote to the Complainant's neurologist and GP on **19 January 2017** requesting reports, and various information and records regarding the Complainant's condition/claim.

The Complainant's GP provided a PMAR dated **24 January 2017**. I note this report advised that the Complainant could resume work on either a part time or full time basis in 3 months and a full recovery would be likely in 6 months. Amongst the medical records submitted by the Complainant's GP was a letter from the Complainant's neurologist dated **1 September 2016**. In relation to the Complainant's symptoms, it is noted that *"Generally one would expect such symptoms to completely recover but often this takes a very considerable period of time, perhaps over three to six months."*

By email dated **7 February 2017**, the Provider informed the Plan Administrator it had received a report from the Complainant's GP and that, having spoken with the Complainant that day, she advised that she was primarily under the care of her neurophysiologist.

The Neurophysiologist

The Provider wrote to the Complainant's neurophysiologist on **7 February 2017** requesting that he provide a report regarding the Complainant's condition. By letter of the same date, the Provider wrote to the Complainant's neurologist advising that his repot was no longer required.

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The Provider advised the Plan Administrator by email on **22 February 2017**, in response to a request for an update on the Complainant's claim, that it was still waiting for a report from the Complainant's neurophysiologist.

The Plan Administrator advised the Provider by email dated **20 March 2017**, amongst other things, that the Complainant had attended her neurophysiologist the previous week and neither he nor his secretary knew anything about the Provider's request for a medical report.

On **28 March 2017**, the Provider wrote to the neurophysiologist's secretary by email:

> *"I left a voicemail for you this morning. Please see attached a copy of our request to [the neurophysiologist] from 7th Feb last. This password is …. Can you please ask [the neurophysiologist] to return his report at his earliest convenience?"*

Also on this date, the Provider advised the Plan Administrator of the above email and that it was arranging an IME to progress the assessment of the claim.

There was an email exchange between the neurophysiologist's secretary and the Provider on **29 March 2017** regarding the Complainant's signed consent and the neurophysiologist's fee.

The Provider has submitted a *Reminder Calls* schedule outlining the telephone contact with the neurophysiologist. This contains the following entries:

"27/3/17 [phone number]	*[Neurophysiologist]*	*Temp. sec. couldn't help – asked that I call back tomorrow.*
28/3/17 [phone number]	*[Neurophysiologist]*	*Left vm."*

The Independent Medical Examination

An IME was arranged for **20 April 2017**. The Provider advised the Complainant of the details surrounding the IME by email dated **4 April 2017** and also provided an update regarding her neurophysiologist:

> *"Also, I followed up with [the neurophysiologist's secretary].*
>
> *I think following receipt of my original letter to them, their confusion arose on the surname - they have you on their system as [name] (I think!) which I am assuming is your maiden or married name. The secretary is now aware the request for a report is in respect of you."*

The Complainant responded the same day thanking the Provider for the update and confirming her attendance at the IME.

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A report was prepared by the relevant doctor on **2 May 2017**. The evidence suggests the Provider received this report in or around **4 May 2017**. The report states:

> *"**4. Current Symptoms***
>
> *This lady stated that she can now walk normally. She has a heightened sensation of her nerves especially with changes in temperature with pins and needles which can be painful all over her body and excessive sweating in hot temperatures. She indicated that overall she is 90% better to what she was experiencing initially. …*
>
> *…*
>
> ***12. Conclusions and Recommendations***
>
> ***12.1 Diagnosis:** The assessment was in keeping with [details of illness redacted] treated with medications. It appears this lady had a delay with her diagnosis, but fortunately has made significant improvements. She has a further appointment with her specialist, and due further follow-up with regards to [details of illness redacted].*
>
> ***12.2 Fitness for work:** In my considered opinion this lady is fit for her normal duties. Fortunately, it appears that this lady had made a good recovery. Although ongoing symptoms remain they appear not to cause significant restrictions on day to day activities.*
>
> ***12.3 Suitability for insurance benefit:** In my considered opinion this lady no longer fulfils the definition of disability as required under your policy. Regrettably I am unable to support this lady's claim for further insurance benefit."*

Assessment of the Claim

The Provider wrote to the Plan Administrator on **4 May 2017** as follows:

> *"On the medical side of things, we have now finalised our assessment of the claim. We received a report from the GP in January, but unfortunately the specialist never responded to our request for a report. As you know we arranged an IME which was carried out on 20/04/2017.*
>
> *Having thoroughly assessed the medical information received, we are satisfied the claimant was medically unfit for work at the date her salary reduced to Half Pay (24/02/2017), however, the medical evidence concludes that the claimant had recovered to the extent that she was fully fit for her work duties by the date of the IME (20/04/2017). Therefore the claim is medically valid from 24/02/2017 to 20/04/2017. I note you will telephone the claimant with our decision. …"*

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Review of the Claim

The Plan Administrator wrote to the Provider on **19 May 2017** requesting that the claim be reviewed. This email states:

> *"[The Complainant] had made arrangements to return to work on the 01/06/2017 and stressed that this was told to the Medical Examiner on the 20/04/2017. She further advised that she is not 100% ready to return to work to the extent that her Neuro physician wanted her to return in September this year. The client wants to return to work at a realistic time frame and not be a further burden on either [the Provider] or ourselves.*
>
> *I had asked [the Complainant] regarding the appeal and she advised she cannot ask her Doctors/Specialists to complete more paper work on a condition that they had advised on already. She further advised that she would not like if we have to contact her Doctors for any further information either.*
>
> *[The Complainant] has expressed frustration at the length of the claim, the volume of paper work needed and feels let down. …*
>
> *[The Complainant] has expressed that she would like settlement to be paid up to the 31/05/2017. …"*

By letter dated **19 May 2017**, the Provider wrote to the Complainant as follows:

> *"Please be advised that our Claims Committee, in conjunction with our Chief Medical Officer, has given careful consideration to the medical information received from your GP … and Consultant Occupational Health Physician … whom you attended for the independent medical examination. Please be advised that we also requested a report from your own Consultant … however this has not been received.*
>
> *Your claim was assessed against the policy definition of disability …*
>
> *Based on the medical information received, our Claims Committee is of the opinion that your claim is medically valid for benefit payment from 24 February to 20 April 2017, the date your salary reduced to Half Pay to the date of the independent medical examination. The medical information received concludes you were medically fit to perform the full duties of your occupation on 20 April 2017.*
>
> *Based on the medical information received from [the IME] we note you confirmed that you were 90% recovered. The medical evidence also confirmed that your activities of daily living were unaffected …. While [the IME] acknowledged you still had residual symptoms of your condition, they were not to the extent that they caused any significant restrictions on your day-to-day living. As a result, you are no longer considered "disabled" within the meaning of the policy and we are therefore unable to consider your claim for any benefit payment beyond 20 April 2017.*

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…

If you are unhappy with our decision and wish to appeal, it is of course open to you to do so. … If there is any additional evidence, medical or otherwise, that you feel would be relevant to our claim assessment, please do forward it to me and I will arrange for our Claims Manager and Chief Medical Officer to review your claim for you. …"

In an email exchange between the Plan Administrator and the Provider on **29 August 2017**, the Plan Administrator advised the Provider the Complainant informed it that she had a copy of a letter from the neurophysiologist dated **26 June 2017**. The Plan Administrator also noted when it spoke to the Provider on **3 July 2017**, it was advised no new information had been received. In a further email on the same day, the Plan Administrator forwarded a copy of this letter to the Provider. The Provider was also advised that no further contact was to be made with the neurophysiologist as *"… he was getting frustrated with all the requests for information."*

The letter from the neurophysiologist dated **26 June 2017** states:

"…

3. On a recent consultation it appears that her symptoms were starting to improve.

…

8. She is complaining of inflamed joints as well as sensory alteration. I would say that she is not significantly limited in the activities that she is able to perform.

9. I think it would be reasonable for her re-commence in the next number of months on a part-time basis and hopefully she will be able to return to full working within 3-6 months.

10. She is due to be reviewed during the summer months and a more definitive opinion can be given at that time.

11. I would expect her to be fit to return to full work in the next 3-6 months' time.

12. I have indicated that I think in the normal course of events she should be fit to return in that timeframe.

…"

On **14 September 2017**, the Provider wrote to the Plan Administrator regarding contact with the neurophysiologist:

"[The neurophysiologist] advised that [the CMO] could call him for the outstanding information required.

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I understood the claimant didn't want us contact [the neurophysiologist] … but [the neurophysiologist] was the one that suggested our CMO call him. I assume this is all ok, but please do let me know otherwise if not."

On **26 September 2017**, the Plan Administrator wrote to the Provider advising that:

"Please see attached copies of receipts received from [the Complainant] today for you. Member also queried why the date of when she last attended [the neurophysiologist] would be deemed pertinent information in relation to her appeal?

Member has requested her case is reviewed by senior management in [the Provider] as feels there is adequate information available in order to make a decision.

[The Complainant] has stated that she will not be attending an IME by another Doctor nor will she be providing confirmation of her current treating doctors along with dates of when last attended as she feels that should be dealt with as one continuing rather than a separate claim from when she returned to work on a phased basis. …"

By letter dated **5 October 2017**, the Provider advised the Complainant that her appeal had been successful and that payments under the plan would be made to **31 May 2017**.

The First Complaint

On being made aware by the Complainant during a telephone conversation on **7 February 2017** that she was primarily under the care of her neurophysiologist, the Provider wrote to the neurophysiologist on **7 February 2017** requesting a report on the Complainant's condition and asked that he address a number of questions. By email dated **22 February 2017**, the Provider advised the Plan Administrator that a report from the Complainant's neurophysiologist was still outstanding.

The Provider was advised on **20 March 2017** that the neurophysiologist had not received any correspondence regarding the Complainant. A copy of the letter was emailed to the neurophysiologist on **28 March 2017** and the Plan Administrator was advised of this on the same day. The Provider also indicated that an IME would take place to progress the claim.

These matters were also discussed with the Complainant during a telephone call on **28 March 2017**. During this call, the Complainant asked that the Provider let her know when the neurophysiologist's report was received.

On **4 April 2017**, the Provider informed the Complainant that there appeared to have been some confusion in the neurophysiologist's clinic regarding her surname and that her maiden name or married name might have been used. The Complainant did not contradict this or seek to correct the Provider.

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Additionally, I note a letter containing details of an appointment for the Complainant with her neurophysiologist dated **28 September 2017** and a letter issued to the Complainant's address dated **August 2017**, both use the surname referred to by the Provider in its email **4 April 2017**.

Therefore, I believe it is likely that the neurophysiologist received the letter in **February 2017**; however, when it did, the Complainant's name was not recognised or associated with the Complainant. This was due to the fact that the Provider and the neurophysiologist maintained different surnames for the Complainant. This is something that the Provider cannot be expected to have been aware of and if the letter was not received, as asserted by the Complainant, this was not the fault of the Provider.

The Complainant's claim was assessed, in the absence of a report from the neurophysiologist, in or around **4 May 2017** following receipt of the IME report. The Provider took the decision to allow the Complainant's claim for the period **24 February 2017** to **20 April 2017**.

The Provider assessed the Complainant's claim on the basis of the PMAR and medical/hospital records received from the Complainant's GP (which included correspondence from the Complainant's neurologist), and the IME report. Accordingly, I accept that it was not unreasonable, even in the absence of a report from the neurophysiologist, for the Provider to make an informed decision regarding the Complainant's claim.

Furthermore, having considered the evidence, I cannot see that any instruction was given by the Complainant or the Plan Administrator, whether written or oral, to the Provider not progress its assessment of the Complainant's claim until a report was received from the neurophysiologist. Further to this, the Complainant has not stated when or by what means any such instruction was given. Accordingly, I am not satisfied this instruction was given by the Complainant or on her behalf.

I am also satisfied the Plan Administrator and/or the Complainant were aware or ought reasonably to have been aware up to at least the beginning of **April 2017** that a report had yet to be received from the neurophysiologist. Moreover, the Provider had not advised or informed the Complainant or the Plan Administrator that a report had been received. I include the Plan Administrator here because it appears to have played an important and substantial role as a conduit for communications between the Complainant and the Provider.

Notwithstanding this, I accept that the Provider was obliged to inform the Complainant that a report had not been received prior to carrying out its assessment of the claim nor am I satisfied that it was reasonable to expect the Provider to have done so. In any event, the Provider communicated its willingness to consider any further medical evidence regarding the Complainant's claim once it became available. Taking these factors into consideration, I do not accept the Provider's conduct in assessing the claim without notifying the Complainant that a report had not been received from the neurophysiologist to have been unreasonable.

/Cont'd…

The Second Complaint

In order for the Complainant's claim to be admitted she must satisfy the definition of *disability* under the policy terms. In essence, this requires the Complainant to have been *totally unable* to carry out her job as a teacher due to her illness. The medical evidence outlined above indicated that by the time the Complainant attended for the IME she had substantially recovered from her illness. This conclusion was also consistent with the prognosis contained in the PMAR completed by the Complainant's GP and the letter dated **1 September 2016** from the Complainant's neurologist.

While the neurophysiologist's report is not entirely consistent with those findings, there is ambiguity present in this report. First, from paragraph 3, it is not entirely clear when this report was prepared or what point in time it was referring to. Hence the Provider's query regarding when the neurophysiologist last assessed the Complainant. Second, paragraph 10 indicated that a further review be carried out in the summer, however, the report was dated **26 June 2017**. Furthermore, the Provider has pointed out that the Complainant was not deemed fit to return to work for 3/6 months yet she had returned to work approximately 4 weeks prior to the date of the report. Strangely, the first observation is consistent with the fact the Complainant appears to have attended with her neurophysiologist around **6 June 2017** around 3 weeks prior to the neurophysiologist's letter. However, this is also inconsistent with the second observation.

In any event, in light of my findings in the previous section, I am not satisfied this aspect of the complainant can be upheld on the basis of the Provider not having first obtained a report from the Complainant's neurophysiologist. Furthermore, I consider that it was not unreasonable of the Provider to take the view that it had sufficient evidence available to enable it to properly assess the Complainant's claim. Moreover, while the letter received from the neurophysiologist dated **26 June 2017** is not entirely consistent with the rest of the medical evidence, this does not necessarily mean the Provider acted unreasonably in forming its opinions in respect of the claim nor does it mean its decision regarding the claim was wrong or flawed. It is also important to note that the Provider raised certain queries regarding the letter which were not answered by the neurophysiologist and given the nature of the queries, may have provided clarity regarding the Complainant's condition and prognosis.

Therefore, in the context of the policy definition of *disability* and the evidence available to the Provider at the time of its assessment of the claim, I accept it was reasonable for the Provider to reach the conclusion that the Complainant was fit for work on **20 April 2017** and accordingly, allow her claim up to **20 April 2017**.

The Third Complaint

The Provider states that it received the IME report on **4 May 2017**.

/Cont'd…

The Provider then wrote to the Plan Administrator by email on the same day to advise it of its assessment of the Complainant's claim and that the medical evidence indicated the Complainant was medically fit for work by **20 April 2017**. The Provider's email also states: *"I note you will telephone the claimant with our decision."*

There is no evidence to suggest the Plan Administrator did not do communicate or the Provider was aware the Plan Administrator did not communicate, this information to the Complainant nor is there anything to suggest conveying this information through the Plan Administrator was inconsistent with the role assumed by the Plan Administrator.

I do not accept there is a specific obligation on the Provider to inform the Complainant of any opinions formed regarding the date on which it believed the Complainant was medically fit for work. However, I am satisfied that the Provider is obliged to inform the Complainant of the outcome is its assessment of her claim. Therefore, I am satisfied the Provider, by communicating its decision regarding the Complainant's claim to the Plan Administrator, informed the Complainant within a reasonable length of time of the outcome of her claim which also included its opinion as to when she was fit for work.

The Fourth Complaint

The Complainant has not identified the *consultants* who have formed this view nor has she furnished any medical reports or medical evidence from these individuals which supports her contention. The Complainant indicated during a telephone conversation on **7 February 2017** that her consultant physician considered that she would not be fit to return to work until **September 2017**. As part of the medical information provided by the Complainant's GP, there are two letters from the Complainant's consultant physician dated **12 October 2016** and **22 November 2017**. However, neither of these letters state that the Complainant would not be fit to return to work until **September 2017**. In particular, the earlier letter does not give any indication in this regard.

Therefore, in light of the above in respect of the *First Complaint* and the *Second Complaint*, I believe the evidence does not support the argument that the Provider acted unreasonably in concluding the Complainant was medially fit for work in **April 2017** within the meaning of the policy.

The Fifth Complaint

The Provider has submitted a small amount of email correspondence with the neurophysiologist and his secretary.

The Plan Administrator advised the Provider in an email dated **29 August 2017** that *"[t]he member also requested that no further requests are sent to [the neurophysiologist] for information as member advised that [the neurophysiologist] stated he was getting frustrated by all the requests for information."*

/Cont'd…

I would make a number of observations in respect of this aspect of the complaint. First, the Complainant has not elaborated on this aspect of her complaint. She has simply asserted that the Provider communicated with the neurophysiologist and his secretary in an aggressive manner. I note no statements from the neurophysiologist or his secretary have been submitted. The number and frequency of communications does not support the Complainant's position. The neurophysiologist advised the Provider that the CMO could contact him to discuss the Complainant's claim, therefore, I do not consider the two attempts by the CMO to contact the neurophysiologist in **September 2017** to be unreasonable or excessive. While the evidence suggests the neurophysiologist was becoming frustrated with requests for information, it is not entirely clear if these requests were coming from the Provider. This is particularly so given the lack of detail surrounding this aspect of the complaint.

Furthermore, even though an instruction was given to the Provider not to contact the neurophysiologist, the Provider contacted him subsequent to this instruction. However, the Provider maintains that such contact was necessary to obtain clarity on the neurophysiologist's letter received in **August 2017**. While I accept this was contrary to the Complainant's instruction, the Provider had a legitimate basis for seeking to contact the neurophysiologist. Additionally, it appears the neurophysiologist consented to the Provider's CMO contacting him in **September 2017**. However, I would have considered it reasonable for the Provider to first advise the Complainant of its intention to contact the neurophysiologist before attempting any contact after the instruction conveyed by the Plan Administrator on **29 August 2017**.

Nonetheless, I am not satisfied that the Provider communicated with the neurophysiologist in an aggressive manner.

Goodwill Gesture

The Provider states that:

> *"In relation to contacting [the neurophysiologist] following receipt of his report to clarify the information he had provided, we acknowledge that this conduct was made shortly after [the Complainant] had asked us to refrain from contacting him again.*
>
> *While we believe it was necessary for us to contact him in light of the information we required, and while [the neurophysiologist] agreed to provide that further information to us, we would like to offer [the Complainant] a goodwill gesture of €500 for any inconvenience caused. We confirm that this offer will remain open to [the Complainant] until your office has adjudicated on the complaint."*

I consider this goodwill gesture offered by the Provider to be a reasonable sum of compensation in the circumstances.

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

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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

10 September 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.