An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0358
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Rejection of claim Results of policy review/failure to notify of policy reviews
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainants held a unit-linked joint whole of life assurance policy with the Provider from 1 October 2000 to January 2016. This policy also provided serious illness cover until 1 November 2015, when this additional cover was cancelled at the Complainants' request.

The Complainants' Case

The First Complainant states that a policy review in August 2015 resulted in *"a nearly doubling of the monthly premium"* from €197.20 to €380.51. Following discussions with the Provider where *"no satisfactory explanation* [was] *provided for premium increase"*, the Complainants removed the serious illness cover from their policy and reduced the life cover benefit to €150,000 from 1 November 2015. They then later cancelled the policy in January 2016, when they replaced it with a life assurance policy that provided them with no serious illness cover.

The First Complainant had previously been referred to the Prostate Clinic in [named hospital] in 2014, as his prostate specific antigen readings were rising. A biopsy taken in March 2015 detected no cancerous cells, though atypical cells were identified.

Following a later MRI, a second targeted biopsy taken in September 2017 resulted in the First Complainant being diagnosed with prostate cancer towards the end of 2017 and he underwent a prostatectomy in early 2018.

As a result, the First Complainant wrote to the Provider on 12 June 2018 seeking for it to admit a serious illness claim in respect of his prostate cancer diagnosis under the Complainants' previous policy that they had removed serious illness cover from on 1 November 2015, as follows:

> *"Alongside a new…mortgage in 2000, my wife and I were required to arrange a Life Cover policy to protect the debt…This included a critical illness element of cover while also providing whole of life cover. It was important that both of these policy aspects were maintained for at least our working lives…For 15 years we paid all premiums as they became due while also accepted index-linked increases (5% per annum) and premium reviews (every 5 years). Invariably these increases were relatively small and we continued to pay without question.*
>
> *On the fifteenth anniversary of the policy a prohibitive premium review was notified to us (letter dated 10/08/2015). While earlier premium reviews had been affordable this virtually doubled our premium overnight…Your letter states the reason for the increase being due to "market conditions and fund performance". Despite several unsuccessful appeals to you to have this checked and verified we were left unsatisfied and with no option but allow the critical illness cover to lapse due to unaffordability. This was against our wishes. It's been suggested to me that the size of the premium increase indicated an underwriting policy to encourage policyholders to cancel their critical illness cover. Up to this point in excess of €25,000 had been paid to you in premiums. The policy was duly cancelled and replaced by…life cover only.*
>
> *In April 2015 a biopsy result indicated A Typical cells. I had understood this to be a positive outcome but a subsequent biopsy in 2017 confirmed that I was indeed suffering from prostate cancer (of an intermediate strength – Gleeson score 3+4). This had been preceded by a long period of monitoring by my GP and which began in the mid* [2000s]. *During this time my PSA was steadily rising to the point where in 2014/15 my GP referred me to the Prostate Clinic. Initial test were unable to detect the cause of the rising PSA but perseverance by my medical team resulted in the Oct. 2017 positive diagnosis. In [early] 2018, I underwent a prostatectomy in the [Dublin Hospital] and two months later my PSA level is virtually nil.*
>
> *There are two reasons why I believe* [the Provider] *should settle a claim under the critical illness section of policy [policy number redacted]:*
>
> *(1) Had it not been for an unexpected and prohibitive uplift in premiums in 2015, we would have maintained Critical Illness cover as per our intention when initiating cover in 2000.*
>
> *(2) My PSA readings (pre and post operation) indicate the presence of cancer long before it was finally diagnosed"*.

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The Provider declined the First Complainant's serious illness claim by way of letter dated 1 August 2018, as follows:

> *"According to the medical reports received from* [Dr M. G.] *the biopsy performed in April 2015 showed no invasive malignancy, with no cancer detected. We note…that a diagnosis of prostate cancer was made following a subsequent biopsy in 2017. As your diagnosis of prostate cancer was made in 2017 after your serious illness cover ceased on the 1 November 2015 we have no option but to decline your claim"*.

The Provider upheld its decision upon review, by way of letter dated 15 October 2018.

In his correspondence to this Office dated 12 December 2018, the First Complainant sets out his complaint, as follows:

> *"I was formally diagnosed with a serious illness after the date my serious illness cover was cancelled. It was a Whole of Life policy. A subsequent claim to* [the Provider] *was declined.*
>
> *I complained about this decision on the basis that:*
>
> - *I was able to provide evidence that the serious illness was developing prior to both cancellation and diagnosis. In addition the delay in diagnosis was caused by the medical approach adopted.*
> - *Cover would not have been cancelled had not a price increase intended to force cancellation being applied by* [the Provider].
>
> *I have appealed to* [the Provider] *to consider the situation holistically while considering the points above. Also to consider the length of time I had been insured with them (15 years) and the amount of premium paid (+€25,000).*
>
> *The complaint was also unsuccessful. The only justification provided for the rejection was that diagnosis was after cancellation. The response made no mention of referral to senior management for a holistic review, no escalation to a medical officer to consider the medical evidence provided in support of my claim that the condition was developing prior to cancellation, etc.*
>
> *I accept that this is not a straight forward situation and it is worth stating that I am prepared to accept a negotiated settlement"*.

As a result, the First Complainant seeks for the Provider to admit his serious illness claim in respect of his prostate cancer diagnosis.

The Complainants' complaint is that the Provider wrongly or unfairly declined the First Complainant's serious illness claim.

The Provider's Case

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Provider records indicate that the Complainants incepted a unit-linked joint whole of life assurance policy with the Provider on 1 October 2000, with additional serious illness cover. The premium and benefits were subject to annual indexation and the policy itself was subject to periodic review, in accordance with the policy terms and conditions.

By 1 October 2015, the Complainants' policy was providing them with life cover benefit in the amount of €369,589 and serious illness benefit of €187,789. Following a policy review in August 2015, the Complainants decided to remove the serious illness benefit from their policy and reduce the life cover benefit to €150,000 from 1 November 2015. A short time later, they decided to surrender the policy and replace it with a fixed term assurance policy from 27 January 2016, which provided life cover only. In this regard, the Complainants completed a Policy Cancellation/Withdrawal Form on 18 January 2016 and by signing the form they indicated, *"I understand that my new policy has **NO** serious/specified illness cover attaching to it while my existing policy does"*. The Provider confirmed by letter to the Complainants dated 30 March 2016 that the policy had been surrendered and enclosed a cheque in the amount of €2,862.52, representing the surrender value of the policy at 27 January 2016.

Provider records reflect that the First Complainant telephoned the Provider on 30 April 2018 to request a critical illness claim form in respect of the surrendered policy. The Agent advised the First Complainant that he had replaced the policy in 2016 with a different policy on a life cover basis only and that he was no longer covered for serious illness benefit. When asked for some details in relation to the claim he intended to submit under the surrendered policy, specifically the date on which he was diagnosed with the condition he intended to claim for, the First Complainant would not provide any information. A claim form was posted to the First Complainant on 1 May 2018 and following his later request by telephone on 7 June 2018, an additional copy was posted to him on 8 June 2018.

The Provider received the completed claim form on 5 July 2018, together with a letter from the First Complainant dated 12 June 2018. Some of the matters raised in his letter related to the nature of the policy and the outcome of the policy review which took place in 2015. Those matters were dealt with separately to the claim and a response issued to the Complainants in that regard on 26 July 2018.

In relation to the claim assessment (which is the subject of this complaint), the serious illness claim submitted by the First Complainant in July 2018 was in relation to prostate cancer, which he stated on the claim form that he was diagnosed with in 2015 and 2017. In addition, the First Complainant also advised that his symptoms had first commenced in 2005, that atypical cells had been detected in April 2015 and full cancerous cells had been detected in October 2017 and that he had undergone two biopsies, two MRI scans and multiple blood tests and had a full prostatectomy in February 2018.

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Whilst the First Complainant had not submitted his claim within a period of six months from the date he had stated his diagnosis was first confirmed, that is, *"2015"*, as required by the policy terms and conditions, the Provider agreed to consider the claim for payment. In order for the claim to be admitted, it was necessary for the First Complainant's diagnosis to have been made and for the condition to have met the policy definition of cancer prior to the serious illness benefit being removed from the Complainants' policy on 1 November 2015.

When the Complainants decided to replace their joint whole of life assurance policy with a fixed term life cover only assurance policy in January 2016, this replacement policy was fully medically underwritten at the time. As a result, the Provider had obtained medical reports from the First Complainant's GP and his Consultant Urologist, together with the claim form and the letter provided by the First Complainant. It states that these contained sufficient information for it to fully and fairly assess the claim. In this regard, the First Complainant's GP, Dr M. G. had completed a Private Medical Attendant's Report on 25 November 2015 and enclosed details of the First Complainant's Prostate-Specific Antigen (PSA) readings between March 2005 and December 2014. Dr M. G. also enclosed letters from the First Complainant's Consultant Urologist, Mr G. D. dated 5 March 2015, 26 March 2015 and 23 April 2015.

From the medical information obtained, it can be seen that the First Complainant attended for a biopsy in March 2015. Then, in April 2015, he attended Consultant Urologist Mr D. at [the Prostate Clinic in a named Hospital] for the histology results. In his letter to Dr G. dated 23 April 2015, Mr G. D. confirmed, as follows:

> *"This gentleman came back for the results of his biopsy. I was delighted to inform him that there was no cancer detected. There were a few atypical glands of uncertain significance. Apart from prolonged episode of hematospermia following the biopsy, he had no adverse effects. No further follow up or investigation is currently required in the prostate clinic. However, I would suggest that he have an annual PSA and DRE carried out. If you have any future concerns do not hesitate to refer him back to me for further assessment"*.

As part of the underwriting assessment of the Complainants' replacement policy application, the First Complainant was asked to have his PSA checked with his GP. This test was carried out on 11 December 2015 and the First Complainant's PSA level was 4.1. In this regard, the Provider notes that the normal PSA level for an individual under age 60 is considered to be within the range 0-4.

The First Complainant is of the view that his PSA level at that time demonstrated that he was suffering from prostate cancer. Whilst his PSA levels were somewhat elevated, the Provider submits that elevated PSA levels do not constitute a diagnosis of prostate cancer. In this regard, the Provider notes that no cancer diagnosis was made at any time prior to the removal of the serious illness benefit from the Complainants' policy on 1 November 2015. In addition, the First Complainant's Consultant Urologist Mr D. confirmed in his letter of 23 April 2015 that no cancer had been detected in the biopsy performed in March 2015.

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The Provider notes that when applying for the replacement policy with the Provider, the First Complainant responded *"No"* to the following question, *"Do you currently have or have you ever had any of the following… b) any form of cancer, malignant tumour, Hodgkin's disease or lymphoma?"*. The Complainants' replacement policy was fully medically underwritten and the underwriting process included the First Complainant attending for a PSA test in December 2015. Taking into account his PSA level of 4.1, ordinary rates were offered on the replacement policy, which was a life cover only policy and did not provide the Complainants with serious illness cover.

Following a review of the Private Medical Attendant's Report and medical reports provided by the Complainant's GP, Dr M. G. and taking into account the information provided by the First Complainant in the claim form and his letter dated 12 June 2018, the Provider wrote to the First Complainant on 1 August 2018 to decline the claim, as follows:

> *"According to the medical reports received from* [Dr M. G.] *the biopsy performed in April 2015 showed no invasive malignancy, with no cancer detected. We note from your correspondence that a diagnosis of prostate cancer was made following a subsequent biopsy in 2017. As your diagnosis of prostate cancer was made in 2017 after your serious illness cover ceased on the 1 November 2015 we have no option but to decline your claim.*
>
> *I appreciate that our denial of your critical illness claim may be very disappointing to you but I hope you will appreciate that all claims for benefits must be considered in light of the conditions under which the assurance is provided. It is of course open to you to appeal the claim decision. If there is any additional medical, or other, evidence you feel would be relevant to our claim assessment, please forward it to us and we will arrange for our Claims Manager and Chief Medical Officer to review your claim accordingly"*.

The First Complainant appealed this claim decision by way of letter dated 16 September 2018. Having reviewed the claim again, the Provider wrote to the Complainant on 15 October 2018 to advise that it was upholding its decision to decline his claim, noting *"while you had elevated PSA levels while the policy was in force you did not have your diagnosis at this time"*, as is required by the policy terms and conditions.

The Provider notes that its Chief Medical Officer has reviewed the file and informed that an elevated PSA level is not diagnostic of prostate cancer, rather a biopsy with histological confirmation of malignant and invasive cancer would be required. The Provider notes that its Claims Department has also reviewed the claim again and it states that it remains satisfied that based on the medical evidence obtained, the First Complainant's serious illness claim cannot be admitted as no diagnosis of prostate cancer was made prior to the Complainants' removing the serious illness benefit from their policy on 1 November 2015. Whilst it understands that the First Complainant may have been diagnosed with prostate cancer in 2017 and that he subsequently underwent a prostatectomy early in 2018, the Provider states that it cannot admit a claim where cover for the benefit claimed for ceased two years prior to a diagnosis being made.

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Accordingly, the Provider states that it is satisfied that it declined the First Complainant's serious illness claim in accordance with the terms and conditions of the Complainants' joint whole of life assurance policy.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainants were given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on 6 May 2020, outlining my preliminary determination in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

Following the issue of my Preliminary Decision, the First Complainant made a submission to this Office under cover of his letter dated 7 July 2020, a copy of which was transmitted to the Provider for its consideration.

The Provider, under cover of its e-mail to this Office dated 8 July 2020, advised that it had no further submission to make.

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

The Complainants' complaint is that the Provider wrongly or unfairly declined the First Complainant's serious illness claim. In this regard, the Complainants held a unit-linked joint whole of life assurance policy with the Provider from 1 October 2000 to January 2016. This policy also provided serious illness cover until 1 November 2015, when this additional cover was cancelled at the Complainants' request.

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The First Complainant states that a policy review in August 2015 resulted in *"a nearly doubling of the monthly premium"* from €197.20 to €380.51. Following discussions with the Provider where *"no satisfactory explanation* [was] *provided for premium increase"*, the Complainants removed the serious illness cover from their policy and reduced the life cover benefit to €150,000 from 1 November 2015 and then later cancelled the policy in January 2016.

I note from the documentary evidence before me that in his correspondence to the Provider dated 12 June 2018, the First Complainant submitted, among other things, as follows:

> *"On the fifteenth anniversary of the policy a prohibitive premium review was notified to us (letter dated 10/08/2015). While earlier premium reviews had been affordable this virtually doubled our premium overnight…Your letter states the reason for the increase being due to "market conditions and fund performance". Despite several unsuccessful appeals to you to have this checked and verified we were left unsatisfied and with no option but allow the critical illness cover to lapse due to unaffordability.*
>
> *This was against our wishes. It's been suggested to me that the size of the premium increase indicated an underwriting policy to encourage policyholders to cancel their critical illness cover. Up to this point in excess of €25,000 had been paid to you in premiums …*
>
> *Had it not been for an unexpected and prohibitive uplift in premiums in 2015, we would have maintained Critical Illness cover as per our intention when initiating cover in 2000"*.

In addition, in his correspondence to the Provider dated 16 September 2018, the First Complainant advised, among other things, as follows:

> *"*[Our] *policy was arranged on a "whole of life basis". It was our intention to have life and serious illness cover until we finished working. Cover was cancelled before retirement because of your 2015 (15th policy anniversary) premium review that nearly doubled our monthly premium from €197.20 to €380.51. This was out of all proportion compared with previous (5 yearly) premium reviews and despite several attempts by me to establish a satisfactory explanation, the only response was that the premium was based on "underwriting reasons""*.

Similarly, in his correspondence to this Office dated 12 December 2018, the First Complainant advised, among other things¸ as follows:

> *"Cover would not have been cancelled had not a price increase intended to force cancellation being applied by* [the Provider]*"*.

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Furthermore, in his recent letter to this Office dated 7 October 2019, the First Complainant also submits, among other things, as follows:

> *"The policy review event in 2015 which directly led to cancellation of cover is a key component of this complaint …*
>
> *This is an integral part of our complaint…*[The Provider] *do not appear to have provided evidence from 2015 that they checked the accuracy of the significant premium increase or what the outcome was.*
>
> *If a premium increase consistent with previous reviews had been notified the policy would have remained in force. The size of the excessive premium increase suggests they were forcing us to cancel cover by making the premium unaffordable"*.

As a unit-linked whole of life assurance policy, the Complainants' policy was subject to periodic reviews, in accordance with the policy terms and conditions. In this regard, Section 9, 'Regular Policy Review', of the applicable Policy Booklet provides at Page 10, as follows:

> *"9.1 We will review your policy at least once every five years. The purpose of this review is to ensure that the premiums you are paying are sufficient to meet the cost of providing your chosen benefits until the end of the period of cover.*
>
> *9.2 We will inform you of the results of the review and recommend to you any change in the premium required …*
>
> *9.3 … If you do not want to increase your premium, you must select one of the following options and inform us in writing of your selection:*
>
> - *to reduce the level of cover under the benefits on your policy …*
> - *to remove some of the benefits attaching to your policy"*.

The Complainants' policy was a unit-linked joint whole of life assurance policy. With policies of this nature, the cost of providing life cover increases according to the age of the policyholder(s). A positive policy value may be built up in the early years when the cost of the life cover is less than the premiums, but where the cost of life cover in later years becomes higher than the premium amount, the fund is used to subsidise this difference. In due course, the fund is exhausted, resulting in the need for a policy review, which recommends either an increase in premium or a reduction in life cover.

In this regard, policy reviews are an integral part of a unit-linked whole of life policy. The purpose of these reviews is to assess whether the value of the policy and the on-going premium payments will be sufficient to sustain the cost of life cover until the next policy review date.

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The premium calculation takes into account, among other things, the level of life cover and the age of the life assured, hence it may be necessary for the policyholder to make an additional provision for cover by way of an increased premium. The setting of a premium following a policy review is the prerogative of the Provider-appointed actuary and falls within the commercial discretion of the Provider. This is not something I will interfere with.

I note from the documentary evidence before me that the Complainants wrote to the Provider on 29 October 2015 with the following instructions:

> *"As discussed and for now please carry out the following cover amendments effective from the date of this letter:*
>
> - ***Remove** Serious Illness benefit for both lives*
> - ***Reduce** Life cover to €150,000 for both lives*
> - ***Term:** 20 years from policy start date.*
>
> *Please advise the revised premium in due course"*.

In this regard, I note that the Provider wrote to the Complainants on 3 November 2015, as follows:

> *"I can confirm that as requested with effect from 1 November 2015 Serious Illness benefit has been removed from this policy and Life Cover has been reduced to €150,000 on each life assured. Your revised premium is €25 per month…This premium will maintain your benefits to 2020 when your policy will be reviewed again"*.

As a result, I accept that the Provider removed the additional serious illness cover from the Complainants' whole of life assurance policy with effect from 1 November 2015, at their request.

I note that the First Complainant telephoned the Provider on 30 April 2018 to seek a claim form in respect of this cancelled serious illness cover. A recording of this telephone call was provided in evidence and I have considered its contents. I note that the Agent asked the First Complainant the date of diagnosis of his illness, explaining that such information would ascertain if the diagnosis had been made before the cover had ceased. I note that the First Complainant was unwilling to provide this information to the Agent. In this regard, I accept that it was reasonable and standard practice for an Insurer, where the intended claim is in respect of a surrendered policy, to attempt to confirm that cover was in place at the date of loss before issuing a claim form. This helps to avoid an expectation that a claim will be assessed and admitted in circumstances where it is evident that no cover was in place at the date of loss. In addition, I accept that the Agent was at all times polite and courteous in her dealings with the First Complainant throughout this telephone call.

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I note from the documentary evidence before me that the Complainants submitted a Claim Form to the Provider in July 2018, wherein the First Complainant provided the following details in relation to his illness:

> *"**Please describe fully the extent and nature of your illness***
>
> *Prostate cancer – Gleeson Score 3+4 – Intermediate. Atypical cells detected in April 2015 and full cancerous cells in Oct 2017*
>
> ***Have you undergone any tests or investigation to confirm this diagnosis? If yes, please provides details.***
>
> *2 x Biopsies and 2 x MRI scans. Multiple DRE* [digital rectal exams] *& blood tests*
>
> ***What treatment are you currently receiving?***
>
> *None following prostatectomy in Feb 2018*
>
> ***On what date did symptoms first commence?***
>
> *2005 approx.*
>
> ***On what date was your diagnosis first confirmed?***
>
> *2015 & 2017"*.

The Complainants' policy, like all insurance policies, did not provide cover for every eventuality; rather the cover was subject to the terms, conditions, endorsements and exclusions set out in the policy documentation. In this regard, Section 20, 'Living Cover Benefit' of the applicable Policy Conditions booklet provides, among other things, at Page 25, as follows:

> *"**Exclusions***
>
> *20.6 No payment will be made under this living cover benefit section if:*
>
> *(i) you do not notify us in writing within six months of the diagnosis being made"*.

In addition, Section 21, 'Serious Illness Cover Benefit' of this Policy Conditions booklet provides, among other things, at Page 28, as follows:

> *"21.2 … If an insured life is diagnosed as having one of the list of specified medical conditions you must notify us within six months of the diagnosis being made"*.

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Notwithstanding that the Complainants had removed serious illness cover from their whole of life assurance policy with effect from 1 November 2015 and that the First Complainant did not submit a claim form to the Provider until July 2018, I note that the Provider was willing to waive this six month notification requirement and assess the claim.

In this regard, Section 20, 'Living Cover Benefit' of the applicable Policy Conditions booklet provides, among other things, at Page 19, as follows:

> *"20.5.1 The full amount is paid out under this section if one of the following medical conditions is diagnosed or one of the following operations is carried out: …*
>
> *(iii) Cancer, being a malignant tumour characterised by the uncontrolled growth and spread of malignant cells and the invasion of tissue. This includes leukaemia and Hodgkin's disease but excludes non-invasive cancers in situ, tumours on the presence of HIV, skin cancer other than malignant melanoma".*

In addition, Section 21, 'Serious Illness Cover Benefit' of this Policy Conditions booklet provides, among other things, at Page 28, as follows:

> *"21.2 This benefit provides for the payment of a lump sum to you if the insured life (or lives) is diagnosed as having one of the specified medical conditions, as detailed in section C, sub-section 20.5.1."*

As the Complainants removed the serious illness cover from their policy with effect from 1 November 2015, I accept that in order for the First Complainant to have a valid claim, he must have been diagnosed with prostate cancer prior to 1 November 2015, when the Complainants' serious illness cover was still in force. In this regard, I accept that it was reasonable for the Provider to determine from the documentation before it that there is no medical evidence confirming a prostate cancer diagnosis in respect of the First Complainant prior to 1 November 2015. In any event, I also note that the First Complainant himself has confirmed that he was not diagnosed with prostate cancer until 2017.

In his letter to the Provider dated 16 September 2018, I note that the First Complainant submits, among other things, as follows:

> *"Prostate cancer progresses slowly. A common indicator of the presence of prostate cancer is a rising Prostate Specific Antigen (PSA) reading. My PSA readings were being monitored by my GP since 2005 with abnormal readings from 2010 onwards. Whilst a PSA reading is not always proof of cancer, in my case it unfortunately was.*
>
> *The common method of diagnosis is a physical biopsy of the gland when 10/12 random tissue samples are taken for examination. This is an inexact science and a biopsy not preceded by a scan is hit and miss. I learnt this only afterwards having always relied on the advice of my medical team for the procedural order.*

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My first biopsy was performed in early 2015 but was not informed by a preceding scan. As a result, the link between the PSA reading and the cancerous cells was missed. This is consistent with the medical report from [the Complainant's GP, Dr M. G.]. *My PSA continued to rise and in 2017 my urologist recommended a scan to identify a specific target area for a second biopsy. The scan highlighted such an area and this second targeted test was successful in identifying the cause of the elevated PSA and finally found and diagnosed the cancerous cells.*

Had the first biopsy in 2015 (5 years after abnormal PSA readings began) been preceded by a scan it would have been possible to target the correct area and confirm the presence of cancer (as indicated by the PSA reading) much sooner. The delay in diagnosis was therefore caused by the procedural order (i.e. no scan before biopsy number 1) rather than by the absence of cancer. The Gleeson Score (7) from this biopsy also confirms that cancer had been present for some time".

Similarly, in his letter to this Office dated 7 October 2019, I note that the First Complainant submits, among other things, as follows:

"…why my prostate cancer was not detected via the first biopsy. The first biopsy in 2015 which happened before cover was cancelled, should have been preceded by an MRI scan to help target suspect tissue. Instead it was a ransom tissue sample and missed the affected area of the prostate. When the 2017 biopsy was preceded and informed by an MRI scan, cancer was immediately diagnosed.

In fact it was evident that the cancer was well developed at that stage as it was classed as "Intermediate" and with a Gleason score of 7 …

In this case the combination of a rising PSA reading (beginning in 2005), an eventual cancer diagnosis, a Gleason score of 7, an operation to remove the cancerous prostate and the subsequent and immediately undetectable PSA readings lead only to one conclusion. This is that I was actually suffering from cancer a ***long time*** *before the eventual diagnosis. This late diagnosis is explained by the lack of an MRI scan before the first biopsy in 2015 …*

A reasonable person could conclude that cancer existed ***long before*** *eventual diagnosis"*.

In addition, in his letter to this Office dated 11 November 2019, the First Complainant further submits, among other things, as follows:

"We believe that we have made a strong case to demonstrate that cancer was present before it was eventually diagnosed in 2017 and why it was possible for it to have been missed in 2015".

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All illnesses are, to some extent, present prior to diagnosis and many will have been present for indeterminable periods of time. Nevertheless, I accept that the terms and conditions of the Complainants' policy are clear in the requirement that in order for there to be a valid serious illness claim, a claimant must, among other things, have been diagnosed with one of the listed specified illnesses and in that regard, I accept that in such cases the insurable event, is the date of diagnosis.

In this regard, I accept the Provider position as advised in its letter to this Office dated 23 October 2019, as follows:

> *"We respectfully submit that a claim for cancer under the Policy cannot be admitted until a diagnosis of cancer is made and the medical evidence confirms that the condition meets the definition of cancer contained in the Policy conditions.* [The First Complainant] *was not diagnosed with cancer prior to the serious illness benefit being removed from the* [Complainants'] *policy …*
>
> *Claims are assessed by the Company in accordance with the Policy conditions.* [The First Complainant's] *claim has been assessed on a number of occasions by the Company in conjunction with the Chief Medical Officer. As* [the First Complainant] *was not diagnosed with prostate cancer prior to cover ceasing under the Policy, we regret but we are not in a position to admit his claim.* [the First Complainant] *has referenced a different approach adopted by his treating doctors in relation to a biopsy carried out in 2017. That biopsy was performed more than two years after the benefit ceased and it is not possible for the results to be taken into account by the Company for the purposes of assessing the claim.*
>
> *If* [the First Complainant] *has concerns in relation to how his March 2015 biopsy was performed, this is not something that can be addressed by the Company"*.

As the First Complainant was not diagnosed with prostate cancer until 2017 and given that the Complainants had previously removed the serious illness cover from their whole of life assurance policy from 1 November 2015, I accept that the First Complainant's diagnosis did not occur whilst the Complainants had serious illness cover in place with the Provider. Accordingly, I must accept that the Provider declined the First Complainant's serious illness claim in accordance with the terms and conditions of the Complainants' whole of life assurance policy.

The First Complainant, in a post Preliminary Decision submission, states as follows:

> *"The preliminary decision document is lengthy and provides much information from both sides. From my reading though, the decision to reject the complaint seems to distil down to the actual diagnosis date compared with the cancellation date and what the policy document states in relation to these. This is something that I already knew and upon which* [the Provider] *based their original decline of my claim.*

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My purpose in engaging with [the Provider] *and the Ombudsman was to appeal to a higher level of fairness. To see beyond the terms and conditions, to consider the full picture, to realise that a long time policyholder had perhaps fallen foul of some unfortunate circumstances and to encourage the provider to engage with me regarding a negotiated settlement. In other words to ensure fair treatment for the customer where circumstances are not catered for by the contract wording.*

Having been a customer since 2000 and having paid in excess of €28,000 now in premiums over two policies. I would expect more engagement from the provider. Perhaps I was expecting too much from the provider or I was expecting something that is outside the scope of the Ombudsman to adjudicate on?

The complaint was not outside the scope of this Office. I understand the Complainant's wish to achieve a negotiated settlement. In many instances, complaints to this Office are resolved through our informal Dispute Resolution process through mediation where both parties arrive at an agreed outcome. However, where that does not happen, such as in this complaint, I am required to arrive at a fair and reasonable decision based on the evidence and submissions before me. Based on the evidence before me, and for the reasons set out in this Decision I do not uphold this complaint.

Conclusion

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

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

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

15 October 2020

/Cont'd…

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.