An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0082
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Rejection of claim - non-disclosure & voiding
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant incepted an income protection policy with the Provider on **7 October 2011**.

The Complainant's Case

The Complainant completed an income protection claim form to the Provider on **28 September 2017** advising that his first date of absence was **17 June 2017** due to a diagnosis of

"[Illness redacted] – chronic pain, difficulty sitting, driving, sleeping etc."

Following its assessment, the Provider wrote to the Complainant on **1 February 2018** to advise that it had declined the claim and cancelled his income protection policy *ab initio* on the basis that he had failed to answer the medical questions correctly in the policy application and failed to disclose medical information.

In addition, the Provider also advised that its underwriters had confirmed that, if it had been correctly informed of the Complainant's medical history and attendances with his GP and his referral for further investigations at the time of policy inception, it would not have been in a position to accept his income protection application.

The Complainant wrote to the Provider appealing its decision to decline his claim and cancel his income protection policy, as follows:

"… it's my belief that all of the medical information disclosed [by way of his GP attendance records sent to the Provider in October 2017] *is immaterial information and this can all be verified by my GP.*

It's important to stress that from 2007-2011 I was a keen sports man who was running 5kilometres most days, playing [sport redacted] competitively…and also a successful [sport redacted] who was still winning monthly medals back in 2011…so in relation to [the Provider's] *reports that I suffered from Gout, I was never diagnosed with Gout, I had a swollen toe from playing [sport redacted] tournaments which could go on for 5 hours.*

In relation to back pain and chest pain, this all came from sports usually after [sport redacted] tournaments, it resolved after a day's rest and I never needed any treatments or had any medical diagnoses on anything heart or back related. I wouldn't have been able to compete at a high level at sports if I had a problem in any of these areas.

[The Provider] *have an issue that I signed the* [income protection application] *form the day before a GP visit in relation to a buzzing in my ear, this again is immaterial information as it was from a root canal,* [the Provider] *also made a reference to my left tonsil been bigger, this has never been a medical condition and I have had this the same size for 20 years, why would I need to report this is beyond me.*

… [the Provider] *say I should have told* [it] *I had a small rash on my outer ear, again this is immaterial information and a prescription in relation to dental work.*

… in relation to moles, I want to state that I insisted on having these removed as a cosmetic issue and I answered "no" [in the income protection application form] *correctly as they never "bled, become painful, changed in size or colour", and all this is backed up when I had them removed.*

… I disagree with [the Provider's] *statement I had high cholesterol, I never had an issue with cholesterol, I would always have it checked as routine exams and never was I advised to go on medication, I had blood results done as part of regular check-up and my cholesterol was always under control.*

… I never had abnormalities on my kidneys and bladder. If I woke up a few nights to go to the toilet, I don't think that is a medical condition and any checks that were done back that up.

… this is the same issue with buzzing from dental work that was not a medical problem with my ears …

I want to put on record that as a Financial Advisor who has worked in this industry for over [duration redacted] and who has helped clients getting paid claims from all the other insurance companies, this is my first experience of dealing with [the

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> Provider] *and it's my first time having to claim anything personally and the way this has been handled has been a total nightmare.*
>
> *… I submitted this claim in September* [2017] *and my GP sent* [the Provider] *back the report shortly after, I was told all that* [the Provider] *were waiting for was my consultant's report which was delayed, however when it was received I was waiting nearly 2 months to get a final decision off* [the Provider]*, if this was a clear case of non-disclosure as* [the Provider] *suggest, then it would have been declined straight away.*
>
> *Finally, may I also state that I am 100% confident even now today if a Medical Officer was to look at any of the issues* [the Provider] *raised from my GP reports up until even mid-2012, there would be no problem medical with anything"*.

In this regard, the Complainant says that some of the illnesses that the Provider suggests he ought to have disclosed, when applying for his income protection policy - like a gum infection and short-term buzzing in his ear following routine dental work, or a sore toe, a sore foot, or backpain or chest pain as a result of sporting activities that typically resolved after a day of rest, or the presence of moles and lesions - were minor and immaterial, whilst others - such as high cholesterol, gout, tinnitus and stress or a nervous disorder - were illnesses that he never suffered with.

Following its review, the Provider wrote to the Complainant on **21 August 2018** to advise that it was standing over its decision to decline his claim and cancel his income protection policy. In this regard, the Complainant submits in the Complaint Form he completed, as follows:

> *"It's my honest belief that* [the Provider] *are renaging on my policy as they see me as high risk now that I have [illness redacted] and that I am now on biological medication since 2017.*
>
> *I have no problem admitting I went to the GP a few times in the last 5/10 years but nothing that would prevent me getting this policy. In fact I am 100% confident if I went for a medical today I would have no problem with anything that they are insisting was an issue for them.*
>
> *I took out an Income Protection Policy in September 2011. I answered "no" to the majority of health questions as I was never ill nor had at that time any material medical issues.* [The Provider] *are insisting I applied for the* [policy] *a day after having routine dental work that gave me a gum infection which is minor immaterial medical information and not in any way would it impact a person applying for Income Protection now or back then.*
>
> *Bottom line is* [the Provider] *accepted me at standard rates and issued the policy up until I put a claim in back in 2017 as a result of a diagnosis I got towards the end of 2012 that I was suffering from [illness redacted].*

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I NEVER had any issues previously with this condition and this can be backed up by the top Rheumatologist in the country who looks after me ([Consultant in Rheumatology & Rehabilitation Dr P.*] my symptoms in 2012 were small i.e. sacroiliac joint pain that lasted a few weeks and hence my GP referred me to* [Consultant in Rheumatology & Rehabilitation Dr P.] *my* [condition] *has since progressed to a stage where I am now on Biologics.*

[The Provider] *took around 6 months to give me a definite answer that they were not going to honour the policy due to what they describe as non-disclosure. Some examples of the non-disclosure are high cholesterol – I have made this clear and so has my GP, I never had high cholesterol, was never advised to take any medicines for this etc., also that I did not tell them I had a buzz in my ear which was as a result of dental work and went away (immaterial information), a sore foot (from playing [sport redacted] at a high level in 2011 and running 5k most days).*

To cut a long story short, [the Provider] *said they were cancelling my policy and returned me the premiums paid. I applied for life assurance in 2013 with the same* [Provider] *and disclosed that I now had [illness redacted] and they accepted me … My GP can confirm that any attendance I had with him prior to the* [illness redacted] *diagnosis was immaterial information that in no way would impact me getting the policy"*.

Similarly, in his email to the Office on **16 June 2020**, the Complainant submits, as follows:

"My whole annoyance is I've told [the Provider] *ring my GP, query anything with him, all I ever asked was that* [the Provider] *seek the answers to any queries from him, I'm pretty sure he will verify up until my diagnosis I was one of his fittest clients as I was playing [sport redacted] 5 times a week and jogging 5ks. If I had muscular aches that subsided after a few days, they were not medical injuries or conditions"*.

In this regard, the Complainant's GP Dr S. wrote to the Provider's Chief Medical Officer on **10 July 2020** to advise, as follows:

"From the medical notes the decision for referral wasn't made at that visit, that was general housekeeping notes to myself. [The Complainant] *did subsequently have an ENT referral regards tinnitus but his symptoms had resolved. He attended anyway which showed no abnormality and he was discharged …*

[The Complainant] *attended with a query minor illness of a gum infection / ear infection for 1 wk and was on treatment with antibiotic for 1 wk only.*

… regards 16/6/2010 (moles) [and] *21/3/2011* (lesion) *– These were just mentioned as an add on, they were review as normal. The 21/3/2011* (lesion) *– was removed and was benign – They had no long term consequence and have required no further follow up.*

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… regards the cardiac symptoms [the Complainant] *was assessed and had no cardiac disease and had a minorly raised* [cholesterol] *of 5.9 which was managed by dietary treatment. Only recently* [the Complainant] *has had a completely normal Stress test & Echo – which showed no evidence cardiac disease.*

… re 27/3/2007 these minor urinary symptoms settled and showed no abnormality on urine dipstick or ultrasound and required no further follow up.

…13/9/2011 as stated before [the Complainant] *was been treated for URTI – He did see ENT all normal and symptoms settled … He had simple mechanical back pain which resolved itself. The comment re gout was a differential and subsequently showed to be wrong as his uric acid was normal.*

… Both scans 2007 (ultrasound renal tract) *& 2010* (ultrasound) *were completely normal.*

[The Complainant] *has no ongoing renal issues, gout, mole or ENT/mental health issues. None of these conditions have had any long term consequences on his health. He has had a recent stress test and echo which are normal. His cholesterol is now been managed with a statin as it failed to improve with diet. I do not feel* [the Complainant] *was withholding information on his application. I feel these issues were minor and had resolved at the time and didn't require further follow up.*

I feel his case should be reviewed especially in light that these symptoms as listed above had no bearing on the issue that caused him to be ill which turned out to be [illness redacted]*".*

In addition, in his letter emailed to his Office on **9 July 2020**, the Complainant submits as follows:

"Firstly, as a Financial Advisor for 15 years I have had a substantial amount of claims paid out which total in the millions, which is a significant amount over the years. Three years prior to this, I was the Senior Broker Consultant for [a named insurer] *with direct access to underwriters on life & income protection cases, so I have every right to defend myself against a 'claims committee' that* [I] *don't even know what medical qualifications they have, yet who dragged this on for over 3 years. I know full well what immaterial medical information is and I wouldn't waste any underwriters time on the following notes:*

1) *One testicle was bigger than the other – this is not a medical condition. If I asked my GP at a regular check-up about this and was told its nothing to be concerned about, that's not material.* [The Provider] *have made an issue with GP visits. I*

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attend my GP at least twice a year for standard check-ups all my life, again nothing unusual about that, as I was always a health conscious person.

2) *If I woke up to go to the toilet a few times in 2007 and had a night sweat that never required medical attention or investigations, this again is not something that would cause a concern to an underwriter…as they are immaterial.*

3) *A swollen toe from wearing new runners playing [sport redacted] which* [the Provider] *state was 'gouty arthritis' and cleared after a few days, again that is a blatant lie as I never suffered from Gout or Arthritis and it's shameful that I have to go back to my GP to explain to* [the Provider] *what the medical definition of gout and arthritis are. Gout is the build-up of uric acid in the blood. I never had this and never had any issues with my swollen toe after this …*

4) *I had root canal and a molar extraction which got infected and gave me a buzz in my ear which vanished, again not an issue, even to this day. In 2013, well after I had taken out the policy, I actually had an MRI for peace of mind and it came out 100% (this was confirmed to* [the Provider] *in 2013 when they accepted me for €550,000* [life cover] *at healthy standard rates. I was 11.5 stone, never smoked and drank 2 units a week max, fit as a fiddle and hence accepted as healthy even in 2013 with mild* [illness redacted] *at that stage.*

5) *Pain in my chest went away after a few days, again it's a note on my file. At every check-up my GP would check my blood pressure, which was always perfect … In fact, in 2019 I had a full health check-up done and my heart was 100%. This is confirmed in my GP file … please refer to my GP response* [of 10 June 2020] *stating it was a note* [and] *not a disclosure, and his agreement it was immaterial.*

6) *Mental Nervous Disorder* – [the Provider] *are now stating I should have had an exclusion for this and to be honest I think that's an outrageous statement, I've never had a problem with my nerves, even to this day, and that's suffering with this [illness redacted], which would test anyone's nerves* – [the Provider] *are honing in on notes "anxious about left testicle", "anxious about left groin" (I can't even remember a problem with a left groin, obvious a pain from running that went after a day or two), again nothing that would warrant a material medical fact. To state I had a nervous disorder when I clearly did not is shocking, I have a lot of clients who suffer with nerves and they would all be on medication for this. I just find it hurtful in times when we are aware of people's mental health that* [the Provider] *are branding me with this, it's shameful and* [the Provider] *should be made aware of this.*

7) *My key point to all their accusations is – 'where is the medication I was on for all these conditions they state?' – there was none, because I didn't warrant any. I think that sums up everything about this case.*

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8) [The Provider] *are making a big deal about non-disclosure and believe me, I know what that* [is]*. IF I was on Prozac or anxiety meds, NSAIDS for painful back, had cortisone injections,* [atorvastatin] *for cholesterol etc. etc. and didn't disclose this, yes, I would totally agree and I wouldn't have wasted anyone's time on this but* ***I wasn't on any medication – NOTHING*** *up until my diagnosis* [at] *end of 2012 (only in 2019 was I prescribed the lowest dose statin of 10mg, 8 years after taking out the policy and this is a result of taking Enbrel which I started in 2017 for the* [illness redacted].

9) *Once clear red flag for me is* [that] *in* [the Provider's] *notes, they state they received a response from my GP on 23/09/2019, yet it clearly wasn't reviewed as the next note after that is June 2020 CMO reviewed … Another issue with this is I asked* [the Provider] *several times to ring or write to my GP and seek any queries they had as I had nothing to hide and that* [the Provider] *needed some clarity from* [my GP] *around some notes. I've since found the letter my GP sent back in November 2019 and he clearly states the obvious, that they were notes, not medical diagnosis.* [The Provider] *got a PMA in 2013. How come* [my supposed medical diagnoses] *weren't even disclosed on that report to* [the Provider]*, hence had* [the Provider] *looked for the same PMA in 2011, there wouldn't have been anything on it.*

10) *This point is critical to this case and was pointed out to me when I discussed my case with a senior underwriter with another company. I took out a policy with* [the Provider] *for life cover after my diagnosis in April 2013 for a substantial sum of life cover, €550,000,* [the Provider] *done medical underwriting on it, a doctor's report was received and…I was accepted at standard rates, so surely there's a red flag there, I wasn't even loaded and based on* [the Provider's] *reasons for declining me income protection, this totally contradicts everything they are saying. A man with a bad heart, as* [the Provider] *say, or mental nervous disorder, would not get life cover, simple as that, only a fit healthy person would get standard rates for €550,000 (I WASN'T EVEN LOADED FOR LIFE COVER WITH* [THE PROVIDER]*). Yet the income protection policy was only going to set* [the Provider] *back €45,000 for every year, had I been out sick and with* [illness redacted]*. What's that max I could have been out till, age 60?? 10 years liability perhaps??? €450,000 liability to* [the Provider]*?? But accepted at ease for €550k if I died!!!* [The Provider] *knew back then the chances of me dying were very low and the chances of me getting an illness like* [illness redacted] *were even lower, however I did get* [illness redacted] *and it's a chronic progressive illness that would cause them to pay out …*

It's also worth noting I had a previous income protection policy [with a different insurer]*, why would I change it if I had some material medical changes? I wouldn't have. The reason I went to* [the Provider] *was because they stated they were the market leaders in this product …*

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The way I have been treated, I don't want anything more to do with [the Provider]*, I have lost all trust in them, I don't want my policy reinstated at this stage, I want compensation for the manner in which* [the Provider] *have behaved, which has affected me and my family so much, and compensated for loss of earnings and future earnings … To think I had* [an income protection] *policy from 2011 to 2017 and never to question it, yet when I did go to claim on it* [the Provider] *refused it and the way they treated me … I can see now why* [the Provider] *ran scared, the treatment I'm on for* [[illness redacted]] *lowers my immune system, makes me prone to more serious infections. I've already been impacted by this twice in the last 6 months, where I have had to take considerable time off work and was recently in hospital due to the medication I'm on for* [[illness redacted]]*. My cousin also has* [[illness redacted]] *and had to give up work at 50, so I may be in that position myself, so with this policy I reckon I would have had my income covered for at least 10 years. I've already been out of work on and off since the claim, apart from a brief relief from starting the treatment, but that now has side effects re increased infections and lowered neutrophils & raised liver enzymes, mean*[ing] *I may not be able to continue taking it, my future is going to be a struggle …*

[The Provider] *put me through a personal hell, they let on to me they were going to honour the contract…they arranged a medical when I claimed on the policy to get me back to work and cancelled that medical when I returned to work. It's very clear from the file that once* [the Provider] *knew I had* [[illness redacted]] *and was on biological medication, they ran a mile …*

[[illness redacted]] *strikes healthy young men, which I was in 2011 – so it's an illness that would have caused* [the Provider] *a big pay out, if I was to be out of work, on a worse case basis, on and off for, say, 10 years,* [the Provider's] *pay-out may have been €450,000. It's strange* [the Provider] *went to the bother of communicating with my Rheumatologist and finding no fault there,* [it] *then reverted to* [some] *immaterial information to get out of this contract. If they say I had a mental disorder, let me say it once again, I never had, but I can say this with all my heart – what* [the Provider] *have put me through would test anyone's mental health.*

Finally, I've never hid anything from [the Provider]*. I told them the information was immaterial and in several emails to contact and liaise with my GP to clarify these* [GP medical attendance] *notes, but* [the Provider] *never bothered".*

Similarly, in his email to this Office on **25 August 2020**, the Complainant submits as follows:

"[The Provider] *state I would have needed a stress disorder exclusion yet I never suffered with stress or nerves and the proof is in my doctor's email* [of 10 July 2020] *…the proof is also in the PMA* [in March 2013] *where* [the Provider] *accepted me at standard rates and no mention of stress in my doctor's private medical report, so there should be a big red flag there and* [the Provider] *should really be cautioned not*

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to state people have a stress disorder when there is no medical evidence of that. The PMA was for life cover but it would have been the same PMA for income protection."

As a result, the Complainant seeks from the Provider *"payment of my claim and reinstatement of my premiums* [for the income protection policy] *and a contribution for the stress and hassle* [the Provider] *have caused me"*.

The Provider's Case

Provider records indicate that the Complainant incepted an income protection policy with the Provider on **7 October 2011**.

The Provider received an income protection claim form on **4 October 2017** that the Complainant had completed on **28 September 2017** advising that his first date of absence from work was **17 June 2017** due to a diagnosis of *"[illness redacted] – chronic pain, difficulty sitting, driving, sleeping etc."*

Following its assessment, the Provider wrote to the Complainant on **1 February 2018** to advise that it had declined his claim and was cancelling his income protection policy *ab initio* on the basis that he had failed to answer the medical questions correctly in the policy application form and to disclose medical information, as follows:

"When you completed your application for this policy in September 2011 you were asked a number of questions regarding your medical history. The Application Form was signed by you on 14.09.2011.

*As you answered "**No**" to all of the medical questions asked on the application your case was accepted at ordinary rates, in line with our underwriting procedure.*

While assessing your claim, it was noted that your first date of absence was June 2017 due to [illness redacted], however as the date of the diagnosis is 2012 and the policy was put in place in 2011, it was appropriate that we requested a copy of your medical notes from your GP, [Dr S.].

These medical notes indicated that, when completing your application you failed to provide us with full details in relation to your medical history and many attendances with your GP, between March 2007 and September 2011.

It is also [of] *note that one of these attendances was on the 13.09.2011, the day before you signed the declaration on the application form.*

*The questions we would have expected you to answered "**Yes**" to and provide further details are as follows, based on the* [medical notes from your GP] …

Question 1

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Are you due to have any check-up in the next 12 months in connection with any medical condition or symptoms, or are you waiting for the result of any medical investigation? If yes, please provide details.

GP Attendance 13/09/2011 *… c/o humming noise right ear last week …*
A - ?gum infection / right om
?tinnitus
enlarged left tonsil
P – advised, script for Amoxil 500mg tds. no allergies
topical fucidin to outer ear for few days
letter to ENT [Hospital] *– review if tinnitus persists*

Question 2
Are you taking any medicine or drugs or receiving any treatment or are you experiencing any signs of ill health or disability for which you have not yet consulted a doctor? If yes, please provide details.

GP Attendance 13/09/2011 *… c/o humming noise right ear last week …*
A - ?gum infection / right om
?tinnitus
enlarged left tonsil
P – advised, script for Amoxil 500mg tds. no allergies
topical fucidin to outer ear for few days
letter to ENT [Hospital]– review if tinnitus persists

…

Question 16
Have you ever had, or been suspected of having, or consulted anyone, for example doctors, specialists, hospitals, clinics, counsellors, osteopaths or physiotherapists, about any of the following?

Question 16 a)
Cancer or any other growth be it malignant or benign (innocent), leukaemia, lymphoma, Hodgkin's disease, brain or spinal tumour, lumps, bumps, tumours or moles, including any mole or freckles that has bled, become painful, changed colour or increased in size, whether seen by a doctor or not?

GP Attendance 16/06/2010 *… Left groin 4 moles anxious*

GP Attendance 17/07/2007 *… 2) small pigmented lesion left forearm dark pigmented*

GP Attendance 21/03/2011 *… anxious re lesion on back sore last few days*

Question 16 b)

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Any disease of the heart or circulatory system, irregular heart beat, or raised cholesterol, fainting, palpitations, undue shortness of breath, chest pain, rheumatic fever or raised blood pressure?

GP Attendance 27/02/2009 *… hx high cholesterol*

GP Attendance 07/08/2007 *… s- 1/52wk hx chest soreness all over at night*

GP Attendance 20/08/2007 *… s- 1) chest soreness settled with brufen*

GP Attendance 03/09/2007 *… s – recurrence chest pain / occurs at night / vague description / all over chest last for a few hours …*
Plan Refer cardiology assessment
Trial PPI omeprazole 20mg for 1/52wk

GP Attendance 25/02/2008 *Recurrence of central chest pain in last 3 wks …*
Third episode in last 12 mths
Referred cardiology letter faxed

Question 16 f)
Any problems or abnormalities with your kidneys or bladder, or any abnormality of your urine e.g. the presence of sugar, albumin or blood, or recurrent infections?

GP Attendance 27/03/2007 *… S-urinary frequency esp at night*

Question 16 k)
Any problem with your ears, hearing or balance?

GP Attendance 13/09/2011 *… c/o humming noise right ear last sudden onset – started tues – woke him from sleep at 3am continuous until w/e*

Question 16 n)
Back Pain, disc problem, lumbago, sciatica, arthritis, neck pain, gout or any other muscular, rheumatic, bony or other joint problem?

GP Attendance 20/08/2007 *… 2) now left low back ache no radiation …*
3) left big toe swollen red++ …
? Gout Arthritis
Plan Blood
Physio for back

GP Attendance 24/08/2007 *… Foot very sore Discussed options Trial nsids*

GP Attendance 03/09/2007 *… ongoing problems with sore foot/back undergoing tx*

/Cont'd…

Plan Refer cardiology assessment
Trial PPI omeprazole 20mg for 1/52wk

Question 16 q)
A blood test, special investigation or any surgical operation within the last 5 years?

GP Attendance 29/03/2007 … Referred Ultrasound renal tract

GP Attendance 16/07/2010 … Plan refer Ultrasound

The above GP attendances are extracts from the medical notes provided by your GP and we have provided a transcript of the full notes for your records and you can obtain a copy of the originals from your GP.

The significance of this is that our Underwriters have confirmed that, had we been correctly informed of your medical history and attendance with your GP and referral for further investigations, we would not have been in a position to accept your application.

It was highlighted to you on the documentation within the application of the importance of providing full details and all material facts, and the consequences of failing to do so, which as a Financial Adviser you would also be fully aware;

Application Form
Declarations (part 5)
I have read over the replies to all questions in the application and declare that to the best of my knowledge and belief, all information given is true and includes all material facts and I understand that failure to disclose all relevant facts, including full disclosure of my medical details and history, may delay or prevent the issue of my policy and may invalidate future claims. If you are in any doubt as to whether a fact is a material fact you should disclose it.

As a result, and in accordance with the conditions of your policy as outlined below, your policy has now been cancelled with effect from the commencement date and all premiums paid to date will be returned to you shortly.

1. Basis of the Policy
The policy consists of the Policy Schedule and these Conditions and is evidence of the contract which has been issued on the basis of the assessment by **[the Provider]** ***of the details provided on the Proposal Form and other information furnished verbally or otherwise, together with any medical evidence obtained from any Medical Practitioner or Consultant attended by the Insured at any time for treatment or advice***

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We reserve the right to declare the policy void frim inception in the event that we become aware of any non-disclosure or misrepresentation of any relevant personal information either at the time of proposal or at the time of and in the course of making and receiving a claim for benefit

27. Mis-statement and/or Non-disclosure
If, in connection with any application for Individual Income Protection or with the making of any claim for Disability or Proportionate Benefit or at any time, whether or not the Insured is in receipt of Disability or Proportionate Benefit, the Insured or anyone acting on his behalf, makes an untrue statement or omits to disclose any material fact, including but not limited to the provision of evidence or information requested under Condition 21 the insurance in respect of the Insured shall be terminated immediately. All Benefit payable shall be forfeited and any Benefit paid which in any way relied on the making of the untrue statement or the omission to disclose the material fact shall be recoverable

We understand that this decision may come as a disappointment; however we must base our decision on the medical evidence available to us…."

Following the cancellation of his income protection policy, the Provider issued the Complainant with a total premium refund of **€5,303.28** on **16 February 2018**.

The Provider says that on **3 April 2018**, the Complainant appealed this decision explaining that he had not advised the Provider of his various attendances with his GP on the policy application because in his view, these were either not relevant or were immaterial. The Provider says that following its review, it wrote to the Complainant on **21 August 2018** to advise that it was standing over its original decision to decline the claim and to cancel his income protection policy, as follows:

"You have stated that you are appealing the decision on the claim as it is your belief that all of the medical history that you did not disclose is immaterial. I must advise that we cannot agree with this and clearly set out the reason for this in our letter 01.02.2018.

I note your view that as a result of being a keen sportsman able to compete at a high level, the issues of Gout, back pain and chest pain all came from sports and resolved after rest. Please be aware that we have not made any statements regarding your medical history, diagnosis or treatments as every reference has been taken directly from your GP's notes from the attendances you had with him.

The information regarding your medical history provided to us by your GP and the significance of this is as previously stated. Our Underwriters, had they been correctly advised of your medical history, attendance with your GP and referral for further investigations, would not have been in a position to accept your application.

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We cannot accept that it was correct for you to have answered "No" to all of the medical questions asked on the application given your many GP attendances in the years prior to applying for the cover. The requirement to disclose all material facts is clearly stated on your completed declaration, and as you have already highlighted you are a Financial Advisor and as such you are fully aware of the requirement to disclose all material facts for products of this nature.

While assessing your claim, it was noted that your first date of absence due to [illness redacted] was June 2017. However, the diagnosis was then confirmed to have been made back in 2012, and as the policy was only put in place in 2011, it was appropriate that we requested a copy of your medical notes from your GP, [Dr S.] *in order to clarify your medical history.*

We have previously advised that Income Protection Policy and the Life Assurance Policy have different risk profiles and therefore different underwriting criteria applies to each product. As you have already confirmed you did disclose some details of your medical history when applying for Life Assurance Policy [in 2013]*, however you did not disclose anything on your application for Income Protection.*

Furthermore, when assessing an application for life protection, we do not re-underwrite any previous or existing policies by reference to medical information provided in any subsequent application. We instead rely upon the disclosures made in those earlier applications until such time that the specific policy is referenced and it becomes apparent, as it now has in this case, that there was evidence of material non-disclosure and / or misrepresentation.

In relation to the time taken to make a decision on the claim I can assure you every aspect of the case was considered in full, which does take time to ensure the correct decision is reached. As mentioned given the proximity of your diagnosis of [illness redacted] and the start date of your policy, it was appropriate for us to seek further information regarding your medical history and would be best practice when assessing a claim of this nature.

I trust this clarifies our current position and the reason for our decision and also concludes our internal appeals process".

The Provider says, in addition, that as part of the FSPO complaint process, it once again conducted a full review and referred the Complainant's file to its Chief Medical Officer, Specialist in Occupational Medicine Dr H., who advised on **11 June 2020**, as follows:

"There was significant non-disclosure of material facts concerning [the Complainant's] *health at proposal stage which did not afford us an opportunity at the time of that proposal to underwrite and make valid decisions concerning his application for income protection.*

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As previously advised, terms are unlikely to have been issued until we had been afforded the opportunity to underwrite the case BASED on his disclosures at the point of application and we would, had disclosures been made, sought a PMA from his GP to clarify his medical history.

By way of explanation we do apply far more stringent underwriting criteria to income protection applications and we apply exclusions to policies when underwriting where relevant to a disclosed condition that might cause future disablement. We defer accepting policies routinely until outcome of follow up and/or investigations are complete or symptom resolution has occurred or we have clarity concerning the tentative diagnosis as to the cause of symptoms".

The Provider says that it has given the Complainant's claim at least three assessments, resulting in its declinature letter dated **1 February 2018**, the appeal decision letter dated **21 August 2018** and again now, as part of this complaint process.

The Provider says that it is satisfied that the medical questions in the income protection application were clear and provided every opportunity for the Complainant to disclose the material medical information, later discovered, for the period from 2007 to 2011. Nevertheless, the Provider reiterates that the Complainant answered *"No"* to all medical questions on the income protection application.

In total, the Provider has identified 8 questions in the application form where the Complainant could and should have disclosed his medical history when applying for his income protection policy, as detailed in its declinature letter dated **1 February 2018**. The Provider is of the view that the medical history not disclosed was material information.

The Provider notes that its underwriters have viewed this as significant non-disclosure of material medical information and have advised that if such disclosure had taken place, it would have resulted in three exclusions having been placed on the Complainant's income protection policy in 2011, namely, an 'ears, hearing and balance' exclusion, a 'mental function nervous disorder' exclusion and a 'back' exclusion.

In this regard, the Provider's usual procedure is to decline any income protection proposal where three or more exclusions have been identified. In addition, even if the policy had proceeded in 2011 with these three exclusions in place, the Provider says that the claim circumstances presented by the Complainant in October 2017 would have resulted in a declined claim.

The Provider says that by not disclosing the material medical information for the period from 2007 to 2011, the Complainant denied the Provider the opportunity to query further and medically assess these conditions, potential diagnoses and investigations at the application stage in 2011 before accepting him for income protection cover. The Provider notes that this directly resulted in the retrospective new business underwriting of the income protection policy by its Chief Medical Officer, its underwriters and its risk claim assessors,

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who all concluded that there was the non-disclosure of material medical information on the application form signed by the Complainant in 2011.

As a result, the Provider says that it was left with little option but to decline the claim and void the Complainant's income protection policy.

The Provider says that it is satisfied that the income protection application provided clear notice as to the importance of disclosing material facts, as follows:

> *"**Underwriting Details***
>
> - *Please answer carefully, giving full details below.*
>
> - *When completing this application form you must disclose all Material Facts. Failure to disclose all relevant facts, including full disclosure of your medical details and history, may delay or prevent the issue of your policy and/or invalidate future claims. If you are in any doubt as to whether a fact is a Material Fact you should disclose it".*

In addition, the Provider points to **Section 6, 'Declarations'**, of the income protection application which provides as follows:

> *"I understand that this application, if partly completed online, shall consist of the declarations and consents made by me herein along with the details provided in my online application …*
>
> *I have read over the replies to all questions in this application and declare that to the best of my knowledge and belief, all information given is true and includes all material facts and I understand that failure to disclose all relevant facts, including full disclosure of my medical details and history, may delay or prevent the issue of my policy and/or may invalidate future claims. If you are in any doubt as to whether a fact is a material fact you should disclose it".*

The Provider says that it notes that the Complainant signed these declarations on **14 September 2011**.

The Provider says that it is not a matter for the person applying for income protection cover to determine what medical information he or she considers to be material for underwriting purposes. In this regard, the Provider is satisfied that the medical questions on the application form are very specific and that the notes explaining material risk were also very clear, and that the Complainant had every opportunity to ask for assistance if needed. The Provider is also conscious that the Complainant, as a Financial Advisor, should be fully aware of the basic contract principles that apply, the importance of disclosing all material facts on an application form and if in any doubt, to disclose it, as well as the consequences of a failure to declare same.

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The Provider notes that its original declinature letter dated 1 February 2018 clearly set out the medical questions that should have been answered *"Yes"*, together with reference to the specific consultations that should have been disclosed. Despite the numerous communications since, there has been no change to the fact that these consultations took place and should have been disclosed.

The Provider has not stated that the Complainant has or had a medical condition nor has it made any comment on medical conditions, and it did not make its decision to decline the claim and cancel his income protection policy based on the assumption of any diagnosis. Rather, it says that any reference to any diagnosis in its correspondence is based on an extract from the medical records provided by the Complainant's GP. As a result, the Provider respectfully submits that if the Complainant has an issue with the references within his medical records, that he should address these to his GP directly.

The Provider says that it has completed a retrospective underwriting of the information on the medical file that should have been disclosed at the policy application. The Provider says that a person having symptoms, unconfirmed conditions or a high level of consultations are valid underwriting circumstances to rate, exclude or decline cover. A person does not have to have a medically diagnosed condition to have an income protection policy exclusion. An attendance, for example, for a stress-related condition as opposed to a clinical diagnosis is something that should be disclosed and is something that would be taken into account when underwriting an income protection policy.

The Provider says that regardless of the eventual outcome of the medical investigations, the consultations should have been disclosed in order for the underwriters to determine if they would be deemed material to the risk at the time of the policy application. The retrospective underwriting is a determination of what terms, if any, would apply based upon the medical file that should have been presented at the time of application, that is, in September 2011, and the medical file at a later stage is not of any relevance in this matter.

In this case, the Provider says that it has determined that terms would not have been offered if the Complainant had disclosed his consultations at application stage. It therefore follows that no contract would have been in place and hence a refund of premium payments was made.

The Provider says, in relation to the Private Medical Attendant's Report completed by his GP Dr S. on **4 March 2013** and furnished to the Provider as part of the Complainant's application for life assurance cover at that time, an application which it accepted, that there are different underwriting criteria for a life assurance proposal, from that of an income protection proposal. For example, a back condition would have more underwriting significance on an income protection application, than on a proposal for life assurance.

Though some of his medical history was disclosed when he was applying for life assurance cover in 2013, the fact remains that the Complainant failed to disclose any medical history on his application for income protection in **September 2011**. In addition, when assessing an application for any new cover, the Provider does not re-underwrite any previous or existing policies by reference to medical information provided in any subsequent application.

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In light of the foregoing, the Provider is satisfied that it acted correctly, in accordance with the policy terms and conditions, when it declined the Complainant's claim and cancelled his income protection policy *ab initio* as a result of the non-disclosure of medical information.

In relation to the time it took to assess his income protection claim, the Provider notes that it received the Complainant's claim form on **4 October 2017** and that its declinature letter issued on **1 February 2018**. The Provider acknowledges that there were delays in the assessment of this claim but says that it was not unduly delayed, given the time awaiting medical reports, the nature of the claim itself and the fact that a declined claim for reason of the non-disclosure of material information takes more time and consideration. As a result, the Provider considers that the overall four months it took to fully assess the Complainant's income protection claim was not unusual for a claim of this nature.

The Provider says that having received the income protection claim form on 4 October 2017, the Provider received the GP notes on 17 October 2017 and the report from the Complainant's treating Consultant in Rheumatology & Rehabilitation Dr P. dated 24 November 2017, on 29 November 2017. It then took two months from the receipt of the medical evidence for the Provider to make a decision. Whilst this fell over the Christmas holiday period, the Provider accepts that it took about 3-4 weeks longer than would be expected to make its initial claim decision.

In relation to the time it took to assess his appeal, the Provider notes that it received an appeal letter from the Complainant on 3 April 2018 and that the appeal decision did not issue until 21 August 2018, some 22 weeks later. In this regard, the Provider accepts that it should manage an appeal of this nature within 4-6 weeks.

The Provider apologises for the delay of 4 weeks in making its initial claim decision and the further delay of 16 weeks in making its final appeal decision and it has offered the Complainant a compensatory payment of **€3,000** (20 weeks at €150 per week) in acknowledgement of these delays. The Provider says that this offer remains open to the Complainant to accept.

The Complaint for Adjudication

The Complainant's complaint is that the Provider wrongly or unfairly declined his claim for benefit payment and wrongfully cancelled his income protection policy *ab initio,* as a result of the suggested non-disclosure of medical information which the Complainant deems immaterial.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of

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items in evidence. The Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties. In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

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

A Preliminary Decision was issued to the parties on **12 February 2021**, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter. In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

I note that the Complainant incepted an income protection policy with the Provider on 7 October 2011. He subsequently completed and submitted an income protection claim form to the Provider on 28 September 2017 wherein he advised that his first date of absence was 17 June 2017 due to a diagnosis of *"[illness redacted] – chronic pain, difficulty sitting, driving, sleeping etc."*

I note that as part of its claim assessment, the Provider sought and obtained a copy of the Complainant's medical records from his GP. In addition, the Provider also obtained a report from the Complainant's treating Consultant in Rheumatology & Rehabilitation Dr P. dated 24 November 2017, which advised as follows:

> *"In summary;* [the Complainant] *was diagnosed in late October 2012 has having a probable early [illness redacted]. Symptoms were manageable until this year when the situation deteriorated rabidly early this year and has noted he has been started in disease modifying therapy with an anti TNF agent and we are hopeful that he will get a good response. The assumption is that he will be fit to return to work in the coming months but I cannot confirm this yet…*
>
> *Based on my exam over this year he had become extremely stiff, has limited movement in his spine was moving stiffly and in constant pain at the time of starting. It does seem to me that he was indeed unfit for work. The earlier information of the diagnosis was the MRI scan in August 2012 but the diagnosis was only made by myself on 31st October 2013"*.

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Following its assessment, I note the Provider wrote to the Complainant on 1 February 2018 to advise that it had declined the claim and cancelled his income protection policy on the basis that he had failed to answer the medical questions correctly in the policy application or to disclose medical information that was detailed in the medical records received from his GP.

I note that the Provider also advised that its underwriters had confirmed that, if it had been correctly informed of the Complainant's medical history and attendances with his GP and his referral for further investigations at the time of policy inception, it would not have been in a position to accept his income protection application in September 2011.

I note from his GP medical records dated 12 October 2017 that the Complainant attended his GP seven times in 2007 (on 27 March, 29 March, 17 July, 7 August, 20 August, 24 August and 3 September) on 25 February 2008, twice in 2009 (27 February and 18 March) three times in 2010, (19 January, 16 June and 16 July) and then again on 21 March and 13 September 2011, this last consultation taking place the day before the Complainant signed his income protection application.

I note from the documentary evidence before me that the Complainant answered *"No"* to all the medical history questions posed in the income protection application he signed on 14 September 2011.

Having examined the contents of this application form, I am satisfied that the medical history questions posed were unambiguous and specific in what was being asked and as to what information was being sought.

Given the extent of the consultations that the Complainant had with his GP in the five years preceding his application to the Provider for income protection cover, and the broad array of concerns and illnesses that he had presented with, I am of the opinion that it was reasonable for the Provider to conclude from his GP medical records that the Complainant failed to answer the medical questions correctly and disclose material medical information.

In this regard, in its claim declinature letter to the Complainant dated 1 February 2018, I note that the Provider clearly set out the questions contained on the income protection application that it had determined that the Complainant ought not to have answered *"No"* to, and it included direct extracts from his GP medical records to support its conclusions.

In so doing, I note that the Provider has not asserted that the Complainant had or had not any particular diagnosis or medical condition when he applied for the income protection policy in September 2011. Rather I accept that the Provider is asserting that the Complainant answered *"No"* to questions where the medical records provided by his own GP, indicated that he should have answered *"Yes"*.

In this regard, I accept the Provider's position that in answering *"No"* to all the medical history questions in the application form, the Complainant denied the Provider the opportunity to further query and medically assess his medical history at the application stage in 2011, before accepting him for income protection cover.

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I note that the Complainant submits that the information that the Provider has suggested that he ought to have disclosed on the income protection application, as per its declinature letter of 1 February 2018, is, in his view, not relevant or not material to his application.

I am satisfied however that the questions raised by the provider in the Application Form were such that the Complainant ought to have responded to include the information sought. It would have been prudent of the Complainant, given the extent of the consultations that he had undertaken with his GP in the five years preceding his application to the Provider for income protection cover, and the broad array of concerns and illnesses that he had presented with, to have disclosed his medical history, regardless of whether or not he considered it to be material information; he should have made the Provider aware of the information requested so that the Provider and its underwriters could determine the relevancy or otherwise of the information disclosed.

I am satisfied that the income protection application provided clear notice to the Complainant as to the importance of disclosing material facts, as follows:

> *"**Underwriting Details***
>
> - *Please answer carefully, giving full details below.*
> - *When completing this application form you must disclose all Material Facts. Failure to disclose all relevant facts, including full disclosure of your medical details and history, may delay or prevent the issue of your policy and/or invalidate future claims. If you are in any doubt as to whether a fact is a Material Fact you should disclose it*
> - *Please note: In answering the following, you do not need to disclose details relating to the following ailments: Acne, Anal fissure (single episode only), Hayfever (without asthma), Ganglion, Minor allergies, Thrush/Candidiasis, Chickenpox, Colds/Influenza, Food poisoning, Measles, Heat stroke/ Sunburn/Sunstroke, Laryngitis, Lockjaw (provided full recovery has been made), Mumps, Pharyngitis, Stomach bug (including gastroenteritis once fully recovered), Glandular fever (provided fully recovered), IGTN, Haemorrhoids/ piles, Verruca, Childhood bronchitis, Pregnancy (assuming no complication), Miscarriage (assuming no complications), Sinusitis/Nasal Polyps, Tonsillitis/ Quinsy".*

In this regard, the Complainant submits that the information that the Provider has suggested that he ought to have disclosed on the income protection application, in his personal view, was not relevant or material to his application. I note however that none of that information falls under the listed ailments in the application form, which are identified as <u>not</u> needing to be disclosed.

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Following the inception of his income protection policy on 7 October 2011, I note that the Provider wrote to the Complainant on 10 October 2011, as follows:

> *"In addition, as your application was submitted online we have enclosed a copy of the health and related questions and your answers supplied to us which you have declared as accurate.* ***Please be advised that your answers to the questions have formed the basis of our underwriting decision and you should therefore review this document carefully as failure to answer any question truthfully could lead to a claim being denied in the future****. Should there be any error in relation to your answers to these questions or anything you wish to add please notify us immediately"*.
>
> ***[Emphasis added]***

I also note that the enclosed 'Your Personal Illustration' document provided, *inter alia*, at pg. 4, as follows:

> *"**Non-disclosure***
> *If any of the information supplied in this quote is inaccurate,* [the Provider] *reserves the right to adjust the premium or benefit to reflect the true quotation basis.*
>
> *Your completed application form will form the basis of the contract between us.* ***If you inaccurately disclose or do not disclose a material fact on the application form, this may invalidate any future claims on this policy.***
>
> ***NOTE: A material fact is one which may influence the assessment and acceptance of the proposal by the Company. If you are in any doubt as to whether a fact is material, that fact should be disclosed****".*
>
> **[Emphasis added]**

In addition, the enclosed Individual Income Protection Plan Policy Conditions booklet (December 2009) provides at pg. 1, as follows:

> *"**1. Basis of the Policy***
>
> *The policy consists of the Policy Schedule and these Conditions and is evidence of the contract which has been issued on the basis of the assessment by* [the Provider] *of the details provided on the Proposal Form and other information furnished verbally or otherwise, together with any medical evidence obtained from any Medical Practitioner or Consultant attended by the Insured at any time for treatment or advice.*

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> ***We reserve the right to declare the policy void from inception in the event that we become aware of any non-disclosure or misrepresentation of any relevant personal information either at the time of proposal or at the time of and in the course of making and receiving a claim for benefit****".*
>
> **[Emphasis added]**

This Policy Conditions booklet also provides, *inter alia*, at pg. 6, as follows:

> ***"27. Mis-Statement and/or Non-disclosure***
>
> *"If, in connection with any application for Individual Income Protection or with the making of any claim for Disability or Proportionate Benefit or at any time, whether or not the Insured is in receipt of Disability or Proportionate Benefit, the Insured or anyone acting on his behalf, makes an untrue statement or omits to disclose any material fact, including but not limited to the provision of evidence or information requested under Condition 21 the Insurance in respect of the Insured shall be terminated immediately. All Benefit payable shall be forfeited and any Benefit paid which in any way relied on the making of the untrue statement or the omission to disclose the material fact shall be recoverable"*.

I note that the Provider later accepted the Complainant for life assurance cover in 2013 and that the Private Medical Attendants Report completed by his GP Dr S. on 4 March 2013 and furnished to the Provider as part of his life assurance application disclosed some details of his medical history. I am of the opinion, however, that it is not relevant to his income protection application to the Provider in September 2011 that the Complainant later disclosed some details of his medical history as part of a later life assurance application to the Provider in 2013, an insurance product which, in any event, has different underwriting criteria than those for income protection. In addition, I accept the Provider's position that it does not re-underwrite any previous or existing policies by reference to medical information provided in any subsequent application.

Insurance contracts are contracts of utmost good faith, wherein the failure to disclose information allows the insurer to void the policy from the outset and refuse or cancel cover. Once nondisclosure takes place – whether innocent, deliberate or otherwise – the legal effect of that nondisclosure can operate harshly, and it entitles an insurer to, amongst other things, refuse or to later cancel cover, as the Provider has done in this instance.

As the Complainant answered *"No"* to all of the medical history questions in the income protection application he signed on 14 September 2011, the Provider was therefore unaware of his medical history at the time when it agreed to incept the policy. I am therefore satisfied that the Complainant's income protection policy with the Provider came into being on the basis of a false premise.

This Office is aware that the courts have long considered the issues surrounding the non-disclosure of material facts. In *Aro Road and Land Vehicles Limited v. Insurance Corporation of Ireland Limited* [1986] I.R. 403, the Court determined that representations made in the course of an insurance proposal form should be construed objectively, with Henchy J stating:

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> *"*[A] *person must answer to the best of his knowledge any question put to him in a proposal form".*

In *Coleman v. New Ireland Assurance plc t/a Bank of Ireland Life* [2009] IEHC 273, Clarke J held that a party could only be subject to having his policy of insurance voided because of the manner in which they answer a proposal form if he or she failed to answer *"such questions to the best of the party's ability and truthfully"*.

I am also cognisant of the views of the High Court in *Earls v. The Financial Services Ombudsman [2014/506 MCA],* when it indicated:

> *"The duty arising for an insured in this regard is to exercise a genuine effort to achieve accuracy using all reasonably available sources".*

In my opinion, for the reasons outlined above, I am not satisfied that it would be reasonable to find that the Complainant answered the medical questions put to him in the income protection application form, to the best of his ability. I am satisfied that a prudent proposer for insurance would have disclosed additional medical details to the Provider at the time of the proposal for insurance, but the Complaint failed to do so.

As a result, I accept that when the Provider declined the Complainant's income protection claim and cancelled the cover from the inception date, it was entitled to do so and that its actions were in strict accordance with the terms and conditions of the insurance contract in place.

I note that in his appeal letter to the Provider in **April 2018**, the Complainant stated as follows:

> *"I submitted this claim in September* [2017] *and my GP sent* [the Provider] *back the report shortly after, I was told all that* [the Provider] *were waiting for was my consultant's report which was delayed, however when it was received I was waiting nearly 2 months to get a final decision off* [the Provider]*, if this was a clear case of non-disclosure as* [the Provider] *suggest, then it would have been declined straight away"*.

In this regard, the Provider received the Complainant's income protection claim form on 4 October 2017 and its declinature letter issued on 1 February 2018. I note that the Provider accepts that it took about 3-4 weeks longer than would be expected to make its initial claim decision. In addition, the Provider received the Complainant's appeal letter on 3 April 2018 and its appeal decision issued on 21 August 2018, some 22 weeks later, when the Provider accepts that it should have managed this appeal within 4-6 weeks.

The Provider has apologised for its delay of 4 weeks in making its initial claim decision and for its further delay of 16 weeks in making its final appeal decision and as a result, it has

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offered the Complainant a compensatory payment of €3,000 (calculated as 20 weeks at €150 per week), an offer that remains open for him to accept.

I am satisfied that this offer is, in the circumstances, reasonable and I consider that it is now a matter for the Complainant to advise the Provider whether he wishes to accept it, by way of resolution of this aspect of his dissatisfaction regarding the delay in assessing his claim. Indeed, I note the Complainant's recently stated intention to now accept this offer of redress for the delay, and to do so, he can communicate directly with the Provider.

Insofar as the primary complaint for adjudication is concerned however, that the Provider wrongfully declined the Complainant's income protection claim and wrongfully cancelled his policy, I am satisfied on the basis of the evidence before me that the Provider was entitled to adopt the position which it did. Accordingly, I take the view that it would not be reasonable to uphold this complaint.

Conclusion

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

7 April 2021

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.