An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0084
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Claim handling delays or issues Complaint handling (Consumer Protection Code) Lapse/cancellation of policy Disagreement regarding Medical evidence submitted Refusal to insure - failure to renew policy
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainants hold a unit-linked flexible whole of life insurance policy, hereinafter 'the policy', with the Provider on a dual life basis. The Complainants' daughter was automatically added as an insured person to the policy in early 2019, on the date of her first birthday.

The Complainants' Case

The Complainants' daughter was unwell in December 2018 and they took her to see GP Dr D. on 20 December 2018, having previously last attended her usual medical practice on 8 November 2018.

The Complainants' daughter was later admitted overnight to [Hospital 1] 3 days after her first birthday and transferred to [Hospital 2] the following day, where she was admitted until late January 2019 under the care of Consultant Paediatric Haematologist Prof A., who diagnosed the Complainants' daughter with Stage 3 acute T-cell lymphoblastic lymphoma.

The Complainants submitted both a Children's Critical Illness and a Children's Hospital Cash claim to the Provider in respect of their daughter's illness.

The Provider wrote to the Complainants on **10 April 2019** to advise that it had declined these claims because the symptoms that led to their daughter's diagnosis were present prior to the date of her first birthday.

The Provider advised in this regard, that Section 3.9, '**Children's Protection Benefits**', of the policy terms and conditions state that:

> *"No claim is payable if the claim is due to any of the following:*
>
> …
>
> *c) a medical condition, or symptoms of a condition, known to have existed before the child was 1 year old"*.

By way of letter dated **18 June 2019**, the Provider subsequently stood over its decision to decline indemnity.

The Complainants set out their complaint in the Complaint Form they completed, as follows:

> *"Our complaint is over the refusal of* [the Provider] *to cover/grant* [critical illness and] *hospital cash benefit to our daughter …* [Our daughter] *was added to our insurance policy when she was one years of age on* [date redacted] *and she was to have the same advantages and benefits as us, her parents.*
>
> [Our daughter] *was unwell in December of 2018 which resulted in her being treated in* [Hospital 3]*. She did attend two doctors at first.*
>
> *It was only until [date redacted] that a biopsy was done on* [our daughter] *which resulted in the diagnosis of cancer. This was 4 days after her first birthday which means that she should be eligible for illness cover. Anything up to that date is hearsay. It is easy to look at all the reports now in hindsight however the fact remains that* [our daughter] *was not diagnosed with cancer until* [date redacted] *and therefore should be eligible for illness cover"*.

In addition, in their email to this Office dated **14 October 2020**, the Complainants submit, as follows:

> *"Bottom line* [our daughter] *was not officially diagnosed with cancer until* [date redacted] *– 4 days after she reached her first birthday. She, as* [the Provider] *admitted, was automatically added to the insurance policy when she reached one years of age.*
>
> *All of the diagnosis and reports up to* [date redacted] *by all physicians were all speculation – no one knew for sure what the problem was and that was the case* [date redacted] *when she was officially diagnosed with cancer – 4 days after her first birthday.*
>
> [The Provider] *are basing* [its] *case/response on hindsight and back tracking in medical evidence. The fact remains* [our daughter] *was not officially diagnosed with cancer* [date redacted] *– 4 days after her first birthday"*.

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As a result, the Complainants seek for the Provider to admit and pay both the Children's Critical Illness and the Children's Hospital Cash claims in respect of their daughter's illness, *"as is her right".*

The Complainants' complaint is that in **April 2019**, the Provider wrongly or unfairly declined the Complainants' claims for Children's Critical Illness and Children's Hospital Cash benefits in respect of their daughter's illness, a decision which it stood over in **June 2019**.

The Provider's Case

Provider records indicate that the First Complainant incepted a unit-linked flexible whole of life insurance policy with the Provider on 25 January 2008 and originally covered the First Complainant.

On **27 December 2018**, the policy was amended to add the Second Complainant on a dual life basis. As at **9 September 2020**, the Complainants' policy provided the following benefits:

The First Complainant (Life 1)		**The Second Complainant (Life 2)**	
Life Cover:	€210,000	Life Cover:	€210,000
Accidental Death:	€210,000	Accidental Death:	€210,000
Critical Illness:	€62,785	Critical Illness:	€52,500
Hospital Cash:	€162.90		
Surgical Cash:	€32,579		
Accidental Injury:	€6,516		

The Provider says that for this policy, Children's Benefits are automatically made available when the child reaches the relevant age milestones, subject to the caveats in each benefit section. For example, congenital disorder or a medical condition or symptoms of a condition known to exist before the child was 1 year old, are excluded from benefit. In addition, the date at which Children's Benefits commences varies on the Benefit. For example, Children's Life Cover begins from 3 months of age, but both the Critical Illness and the Hospital Cash Benefits start from age 1.

Section 3.9, '**Children's Protection Benefits'** at pg. 20 of the applicable policy booklet outlines the criteria involved in order for the various Children's Life, Children's Critical Illness and Children's Hospital Cash benefits to apply. In addition, this section also sets out the circumstances where cover for these benefits will not apply, as follows:

> *"This benefit is subject to the same Policy Provisions as apply to the Life Assured. In addition, no claim is payable if the claim is due to any of the following:*
> *a) a congenital defect*
> *b) a medical condition, or symptoms of a condition, known to have existed before the Commencement Date of the policy*
> *c) a medical condition, or symptoms of a condition, known to have existed before the child was 1 year old or before the child was legally adopted by the Life Assured".*

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The Provider says that because children's benefits are automatically offered and not medically underwritten, insofar as no medical information or history is requested in advance of a child being added to the policy, certain rules must be applied to the benefits being provided, to ensure that the Provider does not take on a risk that was known about. For example, one such rule is that if symptoms of a condition are present before certain age milestones are reached, then cover will not be applicable.

As part of its claim assessment, the Provider sought medical reports from the Complainants' daughter's treating doctors, namely, Consultant Paediatric Haematologist Prof A. and GPs, Dr X. and Dr D. The medical evidence received was reviewed by the Provider's Chief Medical Officer Dr P., who on 9 April 2019 concluded that:

> *"When* [the Complainants' daughter] *was admitted to hospital on* [date] *she had already had a respiratory tract problem for 3 weeks. A chest X ray was done on the* [date] *which revealed a solid mass in the left lung field. This was subsequently confirmed as being a mass on a CT scan on* [date redacted].
>
> *This mediastinal mass was the lymphoma.*
>
> *There is no doubt in my mind that even though the diagnosis was not made until the* [date redacted]*, she was symptomatic from this problem for 3 weeks prior to the diagnosis"*.

In this regard, the Provider notes that the Patient Discharge Letter (GP Copy) dated late January 2019 in relation to the Complainants' daughter's overnight admission at [Hospital 1] states, *inter alia*, as follows:

> *"*[The Complainants' daughter] *was admitted for care following presentation to ED with 3/52 cough, breathing difficulty recent reduced feeding …*
>
> *CLINICAL DETAILS: UNWELL X 3 WEEKS. COUGH, BREATHLESSNESS, AFEBRILE O/E WHEEZE, REDCUED AE LEFT SIDE, CXR WHITEOUT LEFT SIDE ?SOLID MASS, DEVIATION TO MEDIASTINUM TO RT ?SOLID MASS VS PLEURAL EFFUSION COMPASRISION"*

In addition, the Provider also notes that the Medical Certificate completed by one of the Complainants' daughter's attending GPs, Dr D. indicated that the Complainants' daughter had respiratory issues requiring treatment since 20 December 2018, which ultimately led to her hospital referral in January 2019. The Provider says that it was with regret, that it had no option but to decline the Complainants' claims for Children's Critical Illness and Children's Hospital Cash benefits in respect of their daughter's illness. It says that it did so because the medical evidence received clearly indicated that from December 2018, their daughter had symptoms of acute lymphoblastic lymphoma, that was subsequently diagnosed in January 2019, following biopsy. The Provider says that because these symptoms existed before the Complainants' daughter reached age 1, the resultant condition was exempt from cover under the policy provisions.

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As a result, the Provider is satisfied that it correctly declined the Complainants' claims for Children's Critical Illness and Children's Hospital Cash benefits in respect of their daughter's illness, in accordance with the terms and conditions of the Complainants' policy.

The Complaint for Adjudication

The complaint is that in **April 2019**, the Provider wrongly or unfairly declined the Complainants' claims for Children's Critical Illness and Children's Hospital Cash benefits in respect of their daughter's illness, a decision which it stood over in **June 2019**.

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 **12 March 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.

The Complainants hold a unit-linked flexible whole of life insurance policy with the Provider on a dual life basis, and the Complainants' daughter was automatically added as an insured person to the policy on 8 January 2019, on the date of her first birthday. I note that the Complainants' daughter was unwell in December 2018 and that they took her to see GP Dr D. on 20 December 2018, where she was diagnosed with and treated for *"Bronchiolitis".* The Complainants' daughter was subsequently admitted overnight to [Hospital 1] 3 days after her first birthday in January 2019, and transferred to [Hospital 2] the following day, where she was admitted until late January 2019 under the care of Consultant Paediatric Haematologist Prof A., who diagnosed her with Stage 3 acute T-cell lymphoblastic lymphoma.

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The Complainants submitted both a Children's Critical Illness and a Children's Hospital Cash claim to the Provider in respect of their daughter's illness, but the Provider advised the Complainants by letter dated 10 April 2019 that it had declined both claims because the symptoms that led to their daughter's diagnosis were present before she reached her first birthday.

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

I note that Section 3.9, '**Children's Protection Benefits'**, of the applicable policy terms and conditions provides, *inter alia*, at pg. 20, as follows:

> *"**Children's Critical Illness Benefit***
>
> *If the Life Assured is covered for Critical Illness Benefit this benefit applies to the natural or legally adopted children of the Life Assured between the child's 1st birthday and the child's 21st birthday.*
>
> *Provided that the policy has not been made Paid Up, if a child of the Life Assured is diagnosed as suffering from a Critical Illness and survives for 14 days after suffered the Critical Illness, we will pay a benefit equal to 50% of the Life Assured's Critical Illness Benefit up to a maximum of €25,000. Where both parents are Lives Assured, we will base payment on the aggregate Critical Illness Benefit of the Lives Assured.*
>
> *Children are also covered for Surgical Prepayment Benefit and Overseas Surgery Benefit at 50% of the Life Assured's cover. The maximum amount of Critical Illness Benefit payable in respect of any child form all policies issued by the Company cannot be more than €25,000 (€6,250 for Overseas Surgery Benefit).*
>
> *This benefit is subject to the same Policy Provisions as apply to the Life Assured. In addition, no claim is payable if the claim is due to any of the following:*
>
> *a) a congenital defect*
>
> *b) a medical condition, or symptoms of a condition, known to have existed before the Commencement Date of the policy*
>
> *c) a medical condition, or symptoms of a condition, known to have existed before the child was 1 year old or before the child was legally adopted by the Life Assured.*

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Children's Hospital Cash Benefit

If the Life Assured is covered for Critical Illness Benefit this benefit applies to the natural or legally adopted children of the Life Assured between the child's 1st birthday and the child's 21st birthday.

Provided that the policy has not been made Paid Up, if a child of the Life Assured is admitted to hospital in any of the countries listed in section 4.1 (a) as an in-patient for a consecutive period of 72 hours (3 days & nights), we will pay a benefit equal to 50% of the Life Assured's Hospital Cash Benefit up to a maximum of €50 per day. Where both parents are Lives Assured, we will base payment on the aggregate Hospital Cash Benefit of the Lives Assured. The maximum daily payment in respect of any child from all policies insured by the Company cannot me more than €50.

This benefit is subject to the same Policy Provisions as apply to the Life Assured. In addition, no claim is payable if the claim is due to any of the following:

a) a congenital defect

b) a medical condition, or symptoms of a condition, known to have existed before the Commencement Date of the policy

c) a medical condition, or symptoms of a condition, known to have existed before the child was 1 year old or before the child was legally adopted by the Life Assured".

[underlining added for emphasis]

I note that in their email to this Office dated **14 October 2020**, the Complainants submit as follows:

> *"The fact remains* [our daughter] *was not officially diagnosed with cancer until* [date redacted] *– 4 days after her first birthday"*.

I accept however that the policy terms and conditions clearly state that no Children's Critical Illness benefit or Children's Hospital Cash benefit will be payable is a medical condition, or the symptoms of a medical condition, are known to have existed before the child is age 1. This is not dependent on the date of formal diagnosis.

In this regard, I note from the evidence before me that the Patient Discharge Letter (GP Copy) in late January 2019 in relation to the Complainants' daughter's overnight admission at [Hospital 1] 3 days after the little girl's first birthday, states as follows:

> *"*[The Complainants' daughter] *was admitted for care following presentation to ED with 3/52 cough, breathing difficulty recent reduced feeding. She was afebrile, no coryza, no vomiting or diarrhoea.*

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She had received 3/7 steroids in the community …

CLINICAL DETAILS: UNWELL X 3 WEEKS. COUGH, BREATHLESSNESS, AFEBRILE O/E WHEEZE, REDCUED AE LEFT SIDE, CXR WHITEOUT LEFT SIDE ?SOLID MASS, DEVIATION TO MEDIASTINUM TO RT ?SOLID MASS VS PLEURAL EFFUSION COMPASRISION"

I also note that the Medical Certificate completed by the Complainants' daughter's GP Dr D. indicated that the Complainants' daughter had respiratory issues requiring treatment since 20 December 2018, as follows:

*"**Condition***	***Date and Duration***	***Details of Treatment***
Bronchiolitis	*20/12/18*	*Prednisolone 10mg 3/7*
On-going dyspnoea	*8/1/19*	*Supportive care*
On-going dyspnoea	[date]	*Referred to* [Hospital 3]*"*.

In addition, I note that the Provider's Chief Medical Officer Dr P. reviewed all of the medical evidence received in support of the Complainants' daughter's claim and that having so do, on 9 April 2019, he concluded that:

"When [the Complainants' daughter] *was admitted to hospital on* [date] *she had already had a respiratory tract problem for 3 weeks. A chest X ray was done on* [date] *which revealed a solid mass in the left lung field. This was subsequently confirmed as being a mass on a CT scan on* [date]*.*

This mediastinal mass was the lymphoma.

There is no doubt in my mind that even though the diagnosis was not made until the [date redacted]*, she was symptomatic from this problem for 3 weeks prior to the diagnosis"*.

In light of the foregoing, I take the view that it was reasonable for the Provider to conclude from the medical evidence before it, that the symptoms which were ultimately diagnosed as being cancer, 4 days after the Complainants' daughter's first birthday, were present prior to her first birthday when cover came into effect.

In this regard, Section 3.9, '**Children's Protection Benefits'**, of the policy terms and conditions state that no Children's Critical Illness benefit or Children's Hospital Cash benefit is payable if the claim is due to:

" … a medical condition, <u>or symptoms of a condition</u>, known to have existed before the child was 1 year old".

[underlining added for emphasis]

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I note that the Second Complainant first telephoned the Provider on **22 January 2019** to advise that her daughter was in hospital and had been diagnosed with cancer. Having listened to a recording of this telephone call, I note that prior to agreeing to send out the claim forms to the Complainants, the Agent read out to the Second Complainant the complete provisions of the above 'Children's Critical illness Benefit', including the stipulation that:

> *" …no claim is payable if the claim is due to any of the following …*
>
> *a medical condition, or symptoms of a condition, known to have existed before the child was 1 year old or before the child was legally adopted by the Life Assured*".

This is a very sad situation for the Complainants, but on the basis of the evidence available, I am satisfied that the Provider was entitled to adopt the position which it did, and there is no reasonable basis upon which it would be appropriate 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 is rejected.

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

MARYROSE MCGOVERN
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

8 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.