An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0092
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Rejection of claim - non-disclosure Rejection of claim - pre-existing condition
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant took out an income protection policy with the Provider in **November 2015**. The Complainant made a claim under the policy in **February 2019**. The Provider declined the claim in **April 2019** on the basis of non-disclosure of material facts.

The Complainant's Case

The Complainant explains that he incepted an income protection policy in **November 2015** with the Provider through his broker, with the policy commencing in **December 2015**. At the time of this complaint, the Complainant explained that over the previous year he had been experiencing health issues, including high blood pressure, disrupted sleep patterns, inability to focus, and had attended his GP on a number of occasions. The Complainant advised that his GP referred him for Cognitive Behavioural Therapy and it was determined that the Complainant was suffering from severe anxiety and depression.

The Complainant states that he has been unable to work since **October 2018** and in **February 2019**, he completed a claim form in respect of his income protection policy. The Complainant says his claim was rejected on the grounds of non-disclosure of material information because the Provider maintained that the Complainant did not answer the following question on the insurance proposal form correctly:

> *"In the last 5 years have you had, or do you currently have any of the following: Mental illness or mental problems including low mood, depression, anxiety, panic attacks or persistent or recurring fatigue."*

The Complainant advises that the Provider is saying that in **March 2014**, he had presented to his GP with anxiety, had been referred for counselling, and was treated for anxiety. The Complainant states that the reason he attended his GP in **March 2014** and was subsequently referred for counselling was due to marital problems and not due to mental illness or mental problems.

The Complainant says that he was not, as claimed by the Provider, treated for anxiety. In this regard, the Complainant refers to a letter from his counsellor confirming the basis of the counselling received. The Complainant says this letter was furnished to the Provider as part of his appeal of its decision to decline his claim.

The Complainant submits he has shown that he did in fact answer the above question on the application form accurately and that he did not withhold any information.

The Provider's Case

The Provider explains that the Complainant met with his independent broker (the **Broker**) on **12 November 2015** and during this meeting a proposal form was completed with a view to taking out a Personal Income Protection Policy with the Provider.

Referring to the application, the Provider says that the material facts notice at section 5 states:

> *"You are legally obliged to inform us of all relevant information (material facts) in the application process. Material facts are those, which an insurer would regard as likely to influence the assessment and acceptance of a proposal for insurance. If you are in doubt as to whether certain facts are material, such facts should be disclosed.*
>
> *The policy may be cancelled, any claim on the policy may not be paid and you may have difficulty purchasing insurance elsewhere:*
>
> - *If you do not inform us of all material facts*
> - *If any of the information you provide is not true and complete …*
>
> *It is your responsibility to ensure that the information provided is true and complete whether the information was completed by you on or your behalf …"*

The Provider states that by signing the application form, the Complainant made a number of important declarations including that he had disclosed all material facts, that the information provided was true and complete and would form the basis of the contract between the Complainant and the Provider.

/Cont'd…

The Provider states that the Complainant completed a risk assessment questionnaire with the Broker during the sales meeting. The Provider states that the questionnaire forms part of the application form and its purpose is to ask the applicant a number of questions relating to their occupation, health and lifestyle. The Provider advises that the responses to the questions allow it to fully and fairly assess the risk. Where medical or other disclosures are made, the Provider says that further information may be requested before cover can be offered, and depending on the nature of the disclosure and the additional information obtained, it may be necessary for the Provider to offer an applicant special terms, usually in the form of a premium increase or an exclusion, which an applicant must accept before cover commences.

The Provider refers to the *reminder* contained at the top of each page of the questionnaire and the declaration at the end of the questionnaire.

The Provider advises that the application form was received through the Broker on **17 November 2015** and it was noted that the Complainant's date of birth had not been provided. The Provider states this was clarified by the Broker by email dated **19 November 2015** and the application was then underwritten. The Provider advises that because no medical or other disclosures were made, additional enquiries were not necessary and the application was accepted at the ordinary rate with no special terms.

The Provider states that the policy came into force on **10 December 2015** and policy documents were issued to the Complainant on **8 December 2015**. The Provider refers to condition A.2 of the policy conditions relating to disclosure of information.

On **2 February 2019**, the Provider says it received an income protection claim from the Complainant in which he confirmed that he ceased working on **28 September 2018** due to stress related anxiety. The Provider says that the Complainant confirmed that in the period **September 2018** to **February 2019**, he had been suffering from *'high blood pressure, difficulty concentrating, lack of focus, disturbed sleep, sick stomach.'* The Provider says the Complainant advised that he was undergoing cognitive behavioural therapy and that he was unable to carry out any aspect of his job, due to an inability to focus or concentrate.

The Provider has set out its assessment of the Complainant's claim and it refers to a conversation between a claims assessor and the Complainant on **12 February 2019**. The Provider states that during this call, the Complainant outlined that he had suffered from low self-esteem and anxiousness over a long period of time. The Provider says the Complainant stated that *'and when I say a long time, I'm talking years rather than months.'* The Complainant also stated that: *'I've always known this really if I'm honest.'*

The Provider says the Complainant outlined that he found it difficult to visit his doctor and that visiting his doctor was one of the things that would trigger his *'anxiety and panic attacks and so on.'* The Provider says the Complainant stated that he had attended his GP a few years previously and had been referred to a psychotherapist, which was not of any real benefit to him at the time.

/Cont'd…

The Provider explains that the Complainant's GP completed a Private Medical Attendant's Report (**PMAR**) dated **1 March 2019** and a follow up letter was issued to the GP on **14 March 2019** to remind the GP to forward a copy of his attendance notes. The Provider advises that in light of the information disclosed during a follow-up call with the Complainant on **12 February 2019**, relating to a long history of low self-esteem, anxiety and panic attacks, the Complainant's GP was also asked certain questions in relation to this. The Provider advises that an Independent Medical Examination (**IME**) was arranged for **16 April 2019**.

The Provider states that it received a response from the Complainant's GP on **20 March 2019** which indicated that the Complainant had attended him for anxiety in **March 2014**, that he had been referred for counselling to the Primary Care Service at the time, and that he had attended 8 counselling sessions. The Provider states that the GP indicated that the Complainant had described feeling anxious and of low mood again in **September 2018** but that the Complainant had not attended his surgery until **February 2019**.

The Provider states that one of the questions asked on the risk assessment questionnaire at the time the Complainant was proposing for the policy on **12 November 2015** was:

> *'Do you currently have or in the last 5 years have you had any of the following … (c) Mental illness or mental problems including low mood, depression, stress, anxiety, panic attacks or persistent recurring fatigue …'*

The Provider advises that the Complainant answered ***No*** to this question. Based on the contents of the GP's letter of **20 March 2019** and the Complainant's own disclosure to the claims assessor on **12 February 2019**, the Provider states its view that the Complainant should have answered ***Yes*** to this question. By answering *No*, the Provider says the Complainant did not offer the Provider an opportunity to fully and fairly assess the risk at the outset. The Provider explains that if the Complainant had disclosed his long history of low mood and anxiety, GP attendances for anxiety and counselling sessions, it would have sought additional information from the Complainant, his GP and psychotherapist. The Provider advises that cover would only have been offered subject to the following exclusion:

> *"No income protection will be payable in the event of a claim arising directly or indirectly from chronic fatigue syndrome, myalgic encephalomyelitis, fibromyalgia, anxiety state, stress, mood disorder, depression or any other mental health or functional somatic disorder."*

The Provider states that where it is identified that material information has not been disclosed by a policyholder when proposing for a policy, the policy conditions provide that the policy is void and that any premiums paid are retained by the Provider. In the Complainant's case, the Provider says it did not seek to void the policy but instead it proposed to retrospectively apply the above exclusion to the policy. The Provider explains this was to reflect the approach that would have been taken when the policy was proposed for, if the Provider had been aware of all of the facts.

/Cont'd…

As the Complainant's claim would have fallen within the above exclusion, the Provider says it was not in a position to complete the assessment of the claim and the Complainant's IME appointment was cancelled. The Provider says it wrote to the Complainant and the Broker on **16 April 2019** to explain what was happening.

On **29 April 2019**, the Provider states the Complainant appealed its decision. The Provider states the Complainant explained that he attended his GP in **2014** to talk through difficulties he was experiencing as a result of his marriage breakdown and that he attended counselling for that reason. The Complainant outlined that he was not suffering from a mental health condition. The Provider also advises that the Complainant attached a copy of a letter from his psychotherapist.

The Provider states that the Complainant's appeal was assessed and the decision to cease assessing the claim and apply the exclusion, remained unchanged. The Provider says it wrote to the Complainant on **10 May 2019** to confirm this.

The Provider states that the Complainant's attendances with his GP and psychotherapist is material information that it believes should have been disclosed when the policy was being proposed for. The Provider states that the Complainant was given the opportunity to disclose this information, in response to the risk questionnaire but he did not do so. The Provider states that the Complainant confirmed that his low mood, anxiety and panic attacks are matters that he suffered from for many years, and he had always know about them.

On **14 May 2019**, the Provider says it received a formal complaint from the Complainant and responded on **5 June 2019**. During the investigation of the complaint, the Provider says the Complainant's GP wrote to it on **4 June 2019** reiterating that the Complainant's attendance in **2014** was due to anxiousness as a result of a marriage breakdown, the Complainant's symptoms did not warrant a full mental health evaluation and he was not prescribed any medication at that time.

The Provider states that having reviewed the GP's letter in conjunction with all of the other information obtained in relation to the Complainant's mental health in **2014**, the decision to apply the retrospective exclusion and cease to assess the claim, was maintained.

The Complaint for Adjudication

The complaint is that the Provider wrongfully or unreasonably declined the Complainant's claim, and in doing so has wrongfully or unreasonably asserted that the Complainant misrepresented or failed to disclose material facts, on his application form in 2015.

/Cont'd…

Decision

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

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

A Preliminary Decision was issued to the parties on **25 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.

Application for Cover

I note that the Complainant signed a *Personal Income Protection Application* dated **15 November 2015**. Section 5 contains a *Material facts notice* and states:

> *"You are legally obliged to inform us of all relevant information (material facts) in the application process. Material facts are those, which an insurer would regard as likely to influence the assessment and acceptance of a proposal for insurance. If you are in doubt as to whether certain facts are material, such facts should be disclosed.*
>
> *The policy may be cancelled, any claim on the policy may not be paid and you may have difficulty purchasing insurance elsewhere:*
> - *If you do not inform us of all material facts*
> - *If any of the information you provide is not true and complete*
> - *…*
>
> *It is your responsibility to ensure that the information provided is true and complete whether the information was completed by you or on your behalf. All material facts in relation to the person to be covered must be provided by that person and not the policy holder.*

/Cont'd…

If you proceed with the application, the resulting policy will be based on the information provided:

- *as set out in this form containing your application details,*
- *as set out in any other form related to your application,*
- *…*
- *as set out in any questionnaire completed by you …*

…

We may not necessarily contact your doctor(s). Even if we do, you must still disclose all material facts. …"

Section 9 contains a number of declarations; in particular, the following:

*"**A.** **I declare:***
1. that in this application I have disclosed all material facts;
2. I understand that in any questionnaire signed by me … I must disclose all material facts; and
3. that to the best of my knowledge, all statements made on this application form whether in my handwriting or dictated by me are true and complete.

…

D.** **I agree that:
1. all of the statements made on this application form (which includes any statements made in Appendix 1) and other statements made by me in writing … in connection with this application shall form the basis of the contract between you and me; …"

The *Risk Assessment Questionnaire* is contained at Appendix 1 of the application form. This was signed by the Complainant and dated **15 November 2015**.

The following statement is set out in the top of <u>each page</u> of the questionnaire:

*"**Please remember that failure to answer the following questions truthfully and fully may result in a claim being declined and the policy being cancelled. If you are in doubt about whether a fact is material it should be disclosed.**"*

The questionnaire contains the following declaration which was signed by the Complainant:

"I declare that in the above Risk Assessment Questionnaire (appendix 1 of the application), which I understand forms part of the application, I have disclosed all material facts and to the best of my knowledge, all statements made are true and complete. …"

/Cont'd…

By letter dated **8 December 2015**, the Provider wrote to the Complainant confirming cover. At section A.2 of the enclosed Policy Conditions, it is stated that:

> *"… If there is any misrepresentation or failure to disclose material facts … by or on behalf of the Policy Holder or Insured, the policy is null and void; no benefit will be paid in respect of the claim and all Premiums paid will be retained by us. Material facts are those that an Insurer would regard as likely to influence the assessment and acceptance of a proposal for insurance. If you are in doubt as to whether certain facts are material, such facts should be disclosed. …"*

The Income Protection Claim

I note that a little more than 3 years after incepting the policy, the Complainant submitted an *Income Protection Claim Form* to the Provider dated **5 February 2019**. One of the Provider's claims handlers telephoned the Complainant on **12 February 2019** with certain questions in respect of his claim. During the call, the claims handler asked the Complainant to describe his symptoms. In his response to this question the Complainant told the claims handler that:

> *"… what I have been feeling over a long period of time now … is very low self-esteem and anxiousness and that has been a feature as I say for a long time. And when I say a long time, I'm talking years rather than months here. … I've always known this really if I'm honest. …"*

The Complainant then explained that one of the most difficult things he found was going to his doctor in respect of his mental health. The Complainant also explained that he attended his GP in this respect *"… a couple of years ago when I was referred to a psychotherapist and I followed through with that."*

Following receipt of a PMAR from the Complainant's GP dated **1 March 2019**, the Provider wrote to the GP on **14 March 2019** with the following questions:

> *"We would also be very grateful if you could please respond to the following:*
> - *We understand that [the Complainant] has a history of psychological difficulties going back some years. Please advise from your notes, when [the Complainant] first presented to you with psychological difficulties.*
> - *At his first presentation to you with psychological difficulties (a number of years ago) what treatment was provided to [the Complainant]?*
> - *Please advise the dates of any presentations to you in respect of psychological difficulties over the past five years.*
> - *[The Complainant] has advised that he attended a psychotherapist a number of years ago. Do you have any information in this regard? If so, please advise. …"*

/Cont'd…

By letter dated **20 March 2019**, the Complainant's GP responded, advising:

> *"… In relation to your queries [the Complainant] presented with anxiety in March 2014 and was referred to the Counselling in Primary Care Service. He attended them for a total of 8 sessions. He was not prescribed any medication. He reattended in September 2018 with hypertension. There appeared to be an anxiety component to this. He himself describes feeling that he was anxious with low mood and low motivation from September. He didn't formally present to us until February 2019. At that time he was anxious and referred to a trainee cognitive behavioural therapist working in the Practice who he is seeking weekly on an ongoing basis. Other than his previous referral to the CIPC I have no record of referral to any other Mental Health Practitioner."*

The Provider wrote to the Complainant on **16 April 2019** informing him that it was unable to accept his claim. The letter explained that:

> *"… From the information received, we are satisfied that material facts were not disclosed to us when you applied for your policy in December 2015. … The information received confirmed the following:*
>
> - *In March 2014, [the Complainant] attended his GP with anxiety and was referred for counselling in Primary Care Service. He attended them for a total of 8 sessions. He was not prescribed any medication.*
>
> *Based on this information the following question on your application form was not answered accurately:*
>
> - *Do you currently have or in the last 5 years have you had any of the following:*
>   - *Mental illness or mental problems including low mood, depression, stress, anxiety, panic attacks or persistent or recurrent fatigue?*
>
> *If we have been aware of the facts outlined above at application stage our Underwriters would have deemed it necessary to apply special terms to your policy. These special terms would have resulted in the following exclusion being applied to your Income Protection benefit as follows:*
>
> - *No Income Protection will be payable in the event of a claim arising directly or indirectly from chronic fatigue syndrome, myalgic encephalomyelitis, fibromyalgia, anxiety state, stress, mood disorder, depression or any other mental health or functional somatic disorder.*
>
> *…"*

Appeal and Formal Complaint

The Complainant indicated his wish to appeal the Provider's decision by email dated **29 April 2019**, where he explained that:

/Cont'd…

> *"… In 2014 I was in the early stages of the breakdown of my marriage, we have since separated. I attended my GP … to talk through the difficulties I was experiencing and he offered to refer me for counselling which I accepted. I had a number of sessions with [the Psychotherapist] in Sligo, again to talk through the relationship difficulties I was having.*
> *At that time, I was not suffering with any mental health condition, I was simply going through a very difficult stage in my life which I needed help with.*
> *Please find attached a letter from [the Psychotherapist] confirming the nature of my counselling.*
> *The question which I answered "no" to on my application form was answered truthfully and accurately, as I said there was no mental illness or mental problems at that time. …"*

The enclosed letter from the Complainant's Psychotherapist states:

> *"[The Complainant] attended me for counselling in April to July 2014 at the request of his GP … for marital problems and disharmony.*
>
> *It was on this basis only I saw [the Complainant] and not in relation to any mental health issue."*

By letter dated **10 May 2019**, the Provider wrote to the Complainant upholding its previous decision.

On **14 May 2019**, the Complainant made a formal complaint in respect of the Provider's decision. In the penultimate paragraph of this letter, the Complainant submitted that:

> *"… I believe I have shown that the question on the application form regarding mental illness or mental problems was answered accurately. As I have said the visit to my GP in 2014 was in relation to the breakdown of my marriage as was the counselling I received after referral by my GP. It is factually incorrect to suggest otherwise. …"*

Following this, the Complainant's GP wrote to the Provider on **4 June 2019**:

> *"… [The Complainant] attended me in March 2014. He was unfortunately undergoing a marriage breakup and was upset regarding same. He felt unhappy and was somewhat anxious regarding his situation. He requested a referral to the Counselling in Primary Care Service regarding his marital problems and disharmony. I did not think he was suffering from a mental health problem and I did not feel that his symptoms merited a classification of anxiety under the DSM classification. As such his symptoms at the time did not merit a full mental health evaluation as they did not meet the necessary threshold. He did not require any medication and outside this period he had no history of such symptoms. …"*

The Provider wrote to the Complainant by letters dated **5** and **25 June 2019**, upholding its original decision.

/Cont'd…

The Law on Material Non-Disclosure

The test for materiality has been set out by the Supreme Court in ***Chariot Inns Ltd v Assicurazioni Generali S.p.a. and Coyle Hamilton Hamilton Phillips Ltd*** [1981] I.R. 199 at 226, as follows:

> *"What is to be regarded as material to the risk against which the insurance is sought? It is not what the person seeking insurance regards as material, nor is it what the insurance company regards as material. It is a matter or circumstance which would reasonably influence the judgment of a prudent insurer in deciding whether he would take the risk, and, if so, in determining the premium which he would demand.*
> *The standard by which materiality is to be determined is objective and not subjective. In the last resort the matter has to be determined by the court: the parties to the litigation may call experts in insurance matters as witnesses to give evidence of what they would have regarded as material, but the question of materiality is not to be determined by such witnesses."*

This decision is generally accepted as the main authority relating to materiality and the duty of disclosure in Ireland.

Chariot Inns was recently recognised as the leading decision in this area by the High Court in ***Kirby v Friends First Life Assurance Company Limited*** [2018] IEHC 796. In the course of her judgment and while acknowledging the continued application of ***Chariot Inns***, Ní Raifeartaigh J. stated:

> *84. … It seems to me that the principle emerging is that a failure to disclose a material fact (materiality being judged by an objective standard) will not lead to an entitlement to repudiate if the non-disclosure arose from lack of knowledge of the piece of information on the part of the insured (such as in Keating) or a genuine and (perhaps) reasonable failure to remember it at the time of filling in the application (Coleman itself). …"*

In ***Earls v Financial Services Ombudsman*** [2015] IEHC 536, the High Court reviewed the case law on non-disclosure in insurance contracts and summarised the applicable principles as follows:

> ***"1. Utmost good faith***
>
> *(1) A contract of insurance is a contract of the utmost good faith on both sides. (Aro Road).*
>
> ***2. Disclosure of material matters***
>
> *(2) The correct answering of questions asked is not the sole duty of the insured. S/he must disclose all matters which might reasonably be thought to be material to the risk against which s/he is seeking indemnity. (Chariot, Aro Road).*

/Cont'd…

(3) The duty involves exercising a genuine effort to achieve accuracy using all reasonably available sources. (To require disclosure of all material facts may well require an impossible level of performance). (Aro Road).

(4) The form of questions asked in a proposal form may make the applicant's duty to disclose more strict than the general duty arising; it is more likely, however, that the questions will limit the duty of disclosure. The acid test is whether a reasonable person reading the proposal form would conclude that information over and above that which is in issue is required. (Kelleher).

3. Test of materiality

(5) Materiality falls to be gauged by reference to the hypothetical prudent insurer. (Chariot).

(6) Absent a question directed towards the disclosure of a particular fact, the arbiter must give consideration to what a reasonable insured would think relevant; relevance in this particular context is not determined by reference to an insurer alone. (Aro Road).

4. Over-the-counter insurance

(7) In the case of over-the-counter insurance, of the type identified in Aro Road, the insurer is not entitled, in the absence of fraud, to repudiate on grounds of non-disclosure. (Aro Road).

5. Determiner of materiality

(8) The sole and final determiner of materiality is the arbiter, not the insurer. (Chariot, Aro)."

Analysis

Section 5 of the application form required the Complainant to provide *all relevant information (material facts)*. This was followed by a definition of material facts and a statement to the effect that if the Complainant was in doubt as to whether certain facts were material, he should disclose such facts. Later in section 5, it is stated that it was the responsibility of the Complainant to ensure the information provided was *true and complete*. This duty also extended to the questionnaire.

In the questionnaire, the Complainant was reminded to answer each question *truthfully and fully*. It was further stated that if the Complainant was in any doubt about whether any fact was material that it should be disclosed. In the declaration signed by the Complainant, he confirmed that *to the best of my knowledge, all statements made are true and complete*.

/Cont'd…

Question 5(c) asks:

> *"5. Do you currently have or in the last 5 years have you had any of the following:*
> *…*
>
> *c. Mental illness or mental problems including low mood, depression, stress, anxiety, panic attacks or persistent or recurrent fatigue?"*

The Complainant answered ***No*** to this question.

Looking at question 5(c) from an objective and reasonable perspective, it is clear that this question is quite broad and does not contain any apparent limitation apart from the 5 year limit. Further to this, in light of the wording of this question and the obligation imposed on the Complainant when answering this question, I am not satisfied that in order to answer ***Yes***, the Complainant was required to have attended his GP or any other medical professional regarding the stated conditions or that he was required to have received a diagnosis or treatment for these conditions. If the Complainant simply experienced any of these conditions, I am satisfied he was required to answer ***Yes*** to question 5(c).

During the telephone conversation on **12 February 2019**, the Complainant told the claims handler that he had been suffering from low self-esteem and anxiousness for years. Following this, the Complainant's GP confirmed in a letter dated **20 March 2019** that the Complainant

> *"… presented with anxiety in March 2014 and was referred to the Counselling in Primary Care Service."*

In the course of his appeal and formal complaint, the Complainant submitted a letter from the Psychotherapist which stated that the Psychotherapist did not see the Complainant in relation to any mental health issue. The Complainant is adamant that he was not suffering from mental illness at that time. In a further letter from the Complainant's GP dated **4 June 2019**, the GP stated that:

> *"… He felt unhappy and was somewhat anxious regarding his situation. He requested a referral to the Counselling in Primary Care Service regarding his marital problems and disharmony. I did not think he was suffering from a mental health problem and I did not feel that his symptoms merited a classification of anxiety under the DSM classification. …"*

It should be noted however, that the position taken by the Provider is not that the Complainant had suffered from a mental illness in the 5 years before he signed the proposal form. The medical evidence does not disclose any such diagnosis. Rather, the position of the Provider is that, based on the Complainant's medical history, he should have answered "*Yes"* to the particular question on the proposal form, such that it would have then been alerted to pursue additional enquiries, before accepting the Complainant for cover.

/Cont'd…

Having considered the evidence and in light of the obligation imposed on the Complainant when completing his application, I am satisfied that, based on the information disclosed during the telephone conversation on **12 February 2018** alone, the Provider was entitled to form the opinion, and it was reasonable to do so, that the Complainant should have answered ***Yes*** to question 5(c).

Further to this, I accept that the correspondence received from the Complainant's GP was such that the Provider was entitled to form the opinion that the Complainant was experiencing mental health issues, when he presented to his GP during **2014**. I am also satisfied that the Complainant was aware of his mental state or ought reasonably to have been aware of this, at the time when the application form and questionnaire were completed.

As a result, I am not satisfied that the Complainant answered question 5(c) in accordance with the duty imposed on him by the application form and the questionnaire. Further to this, I am satisfied that the Complainant's history regarding mental health was *"… a matter or circumstance which would reasonably influence the judgment of a prudent insurer in deciding whether he would take the risk …."*

Therefore, on the basis of the evidence available, I accept that the Provider was entitled to decline the Complainant's claim and it is not appropriate to uphold this complaint. I accept, in the specific context of the duty imposed on the Complainant when completing the application form and questionnaire, that he failed to disclose material facts to the Provider, as a result of which, the policy came into being on the basis of a false premise.

Accordingly, I take the view that the evidence discloses no wrongdoing on the part of the Provider, and in those circumstances, I do not consider it 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

20 April 2021

/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.