An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0103
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Rejection of claim Refusal to insure - failure to renew policy
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns a Term Assurance Policy and relates to the Provider's refusal to indemnify the Complainants under the policy.

The Complainants' Case

The Complainants state that in the course of renewing their Term Assurance Policy, they disclosed to the Provider that the first Complainant had undergone surgery for a vascular condition. The Complainants submit that, as a result of the disclosure, the Provider requested a medical report which was furnished by the first Complainant's GP. The Complainants state that the Provider, on receipt of the requested medical report declined to offer cover "*based on the extent of your peripheral vascular disease*".

The Complainants explain that based on the decision not to offer a new policy, they thought that a claim under the policy's Critical Illness Benefit would be acceptable. They then submitted a claim under the policy's Critical Illness Benefit arising out of a stent that was administered in August 2017. The Provider declined the claim on the basis that the Complainant's condition was not a condition covered under the Critical Illness Benefit of the policy.

The Complainants make this complaint on the basis that the Provider has wrongfully, unreasonably and through a mistake of law or fact refused to renew their cover and failed to provide cover to the Complainant under the Critical Illness Benefit under the existing policy.

The Provider's Case

The Provider denies that it failed to renew the policy and submits that the policy in question was a Term Assurance Policy taken out by the Complainants over a 15 year term from 1 April 2004 to 31 March 2019. The Provider submits that the Term Assurance Policy was coming to an end and the Complainants applied for a new policy with the Provider and the Provider treated it as an application for this and/or serious illness cover. Accordingly, the Provider submits that it was necessary for the application to be medically underwritten. It states that based on the medical information obtained it was not possible for cover to be offered to the first Complainant.

In relation to the second aspect of the complaint, the declinature of cover under the Critical Illness Benefit of the Term Assurance Policy, the Provider submits that the first Complainant did not suffer from any of the covered illnesses in the Term Assurance Policy and therefore, it was not in a position to pay out a Critical Illness Benefit.

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.

A Preliminary Decision was issued to the parties on 4 March 2021, outlining my preliminary determination in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

Following the issue of my Preliminary Decision, the Complainants made a further submission under cover of their e-mail to this Office dated 5 March 2021, a copy of which was transmitted to the Provider for its consideration.

The Provider has not made any further submission.

The Complainants, in their post Preliminary Decision submission dated 5 March 2021, stated:

> "… [redacted] *is now unable to get insurance from any provider and felt that she would have at least been given the chance to orally put her complaint forward."*

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However, 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.

In this complaint I do not believe an Oral Hearing would have assisted to resolve the issues raised by the Complainants. Therefore, I do not propose to hold an Oral Hearing and will now proceed to outline my Decision.

It is accepted by the parties, and the documents demonstrate that the first Complainant developed and suffered from a condition in relation to her peripheral vascular disease. Medical documentation furnished show that in or around 2017, the first Complainant underwent iliac angioplasty and stent procedure.

A copy of the Term Assurance Policy documents have been provided. They show that the policy was issued on 10 March 2004 with a commencement date of 1 April 2004 and an expiry date of 31 March 2019.

In relation to the first aspect of the complaint which is that the Provider declined to renew the Term Assurance Policy on foot of the first Complainant's disclosure of the above-mentioned surgery, it is apparent and clear from the documentation that the Term Assurance Policy expired on 31 March 2019 and there was no provision for an automatic renewal when the policy expired/matured.

Close to the expiry of the Term Assurance Policy, the Complainants applied for further new life cover. The Provider's underwriting department viewed this proposal in conjunction with the updated medical information provided by the first Complainant. On the basis of the information furnished, the Provider declined to offer the product and cover to the Complainants. There has been no particular or express allegation of wrongdoing in this regard by the Complainants in the complaint form to this office and the complaint made to this office is pursuant to the Term Assurance Policy. There are no provisions within the Term Assurance Policy that would have any impact on the Complainants' right or ability to apply for a new policy. Whether or not to provide cover falls within the commercial discretion of the Provider. It is legitimate for the Provider to refuse cover if its underwriting team has assessed the application and the company medical evidence has recommended that cover not be offered to the Complainants. I have been provided with no evidence of wrongdoing on the part of the Provider in relation to this aspect of the complaint.

In relation to the second aspect of the complaint which is the declinature of the claim made under the Term Assurance Policy, a copy of the policy has been provided.

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Under the definitions in Section A – General Conditions, Critical Illness Benefit is defined as follows:

> *The amount of accelerated Critical Illness Benefit shown in the schedule as applying to a life assured, or as subsequently changed.*

In that regard, section C of the policy deals with "*Benefits*".

Clause 2 of Section C sets out and deals with the definition of a Critical Illness Benefit. It states:

> *A critical illness is the diagnosis by registered medical practitioner, and the verification by [the Provider's] chief medical officer, of the first occurrence of any of the following illnesses after the commencement date of the policy.*

The clause then goes on to list the conditions for events that are stated to be covered as a critical illness under the policy. From a close examination of these expressly listed conditions, the first Complainant's condition, namely peripheral vascular disease, is not expressly listed or identified as a critical illness under the policy.

The only cardiac related conditions are aorta graph surgery, cardiomyopathy, coronary artery surgery, heart attack and heart valve replacement or repair.

The first Complainant's condition is not captured by the above listed conditions and their definitions under the policy. The medical documentation expressly state the first Complainant's illness relates to her iliac artery which is not mentioned.

In light of all of the foregoing circumstances, where the first Complainant's condition does not come within the ambit or the definition of a *Critical Illness* as defined in the policy, while I realise it is disappointing for the Complainants, I accept that the Provider was entitled, under the terms and conditions of the Policy, to decline the claim.

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

Conclusion

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

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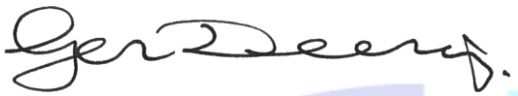
The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.



GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

21 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.