An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0164
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Rejection of claim - non-disclosure & voiding
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainants incepted a policy of insurance with the Provider in **2012**. They maintain that the Provider incorrectly and unreasonably declined a claim made by the First Complainant under the policy of insurance, and declared the policy void from the inception date.

The Complainants' Case

The Complainants state that, having experienced a loss of balance, the First Complainant was hospitalised in **April 2018**. The Complainants say that, after an investigation and having attended a neurologist, the First Complainant was diagnosed with a medical condition.

The First Complainant states that she submitted a claim to the Provider, and that the Provider *"declined my claim due to non disclosure I had attended my gp once in 2009 and 2011 for dizziness and got tablets"*. The First Complainant further states that, though she had been referred to another doctor at that time, she did not attend that appointment as she felt better.

The First Complainant contends that she was healthy in **2012** when she signed the policy documentation, and she revealed her family's history of health issues to the Provider. The First Complainant submits that she *"signed the policy in the utmost faith. It was not until 2018 that I was aware I was sick"*.

The First Complainant states that she had

> *"attended my doctor twice for dizziness which resolved itself in a short period of time. I did not in all honesty think this was a condition and did not attend the referral you mentioned as my symptoms had gone. At the time of signing the policy I had no symptoms of dizziness and signed in the utmost good faith."*

The Complainants want the Provider to restore the policy and pay the benefit claimed under the policy – a sum of €50,000.00.

The Provider's Case

The Provider refers to the Complainants' answers on the proposal form dated **6 December 2012**, specifically that the First Complainant answered "No" to the question:

> *"In the last five years have you suffered from or received treatment, advice or had investigations for any of the following:*
>
> *[...]*
>
> *(x) Other than the conditions you have already disclosed, have you sought medical advice, treatment or had investigations for any other conditions in the past 5 years (Colds, influenza and hay fever can be omitted).*
>
> *(xi) Are you awaiting the results of any tests/investigations or referral to any hospital, clinic or doctor or do you have any medical condition, pain, discomfort or other symptoms for which you have not yet sought medical advice?"*

The Provider contends that *"based on the medical evidence received during the assessment of this claim, it is apparent that the answers given to the above questions were incorrect".*

The Provider states that although the Complainant says that at the time of signing the proposal form, she *"had no symptoms of dizziness. However, at that stage your GP had felt the symptoms of dizziness that you had experienced warranted a referral to* [a specialist]*".*

The Provider submits that, while the First Complainant states she did not feel that it was necessary for her to attend a specialist,

> *"the fact remains that the specialist referral was pending at the time you completed the proposal form, and should have been confirmed in response to* [the question regarding pending referrals]."

/Cont'd…

The Provider states that

> *"had full disclosure been made at the outset of this policy and up to the issue date,* [it] *would not have been in a position to offer cover in respect of the Insured at that time."*

The Complaint for Adjudication

The complaint is that the Provider wrongfully declined the First Complainant's claim for policy benefits, following her diagnosis of multiple sclerosis in 2017, and voided the policy.

Decision

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

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

A Preliminary Decision was issued to the parties on **29 April 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 Complainants completed a proposal form for a "Dual Life Guaranteed Term Protection" policy of insurance with the Provider on **6 December 2012**. During the course of filling out the form, the First Complainant notes that she disclosed her family health history (her father had passed away after a heart attack in his mid-50s). She says that she simply did not remember her previous episodes of dizziness or did not consider it relevant. She does not believe that she would have been denied cover if she had mentioned her dizziness.

/Cont'd…

The proposal form was filled out by the Complainants with the assistance of a broker. The policy had a start date of 1 December 2012, and the cover put in place included a standalone Serious Illness Sum Insured of €50,000.00 for each life insured (ie for each Complainant).

The **Policy Document** contains the following relevant information under the heading ***Introduction,*** which is followed by a highlighted textbox:

> *The application form that you have signed, all the declarations and statements that you and the Life or Lives Insured have made, this Policy Document, and the Policy Certificate (with any Additional Benefits / Special Terms Appendix) taken together form the life insurance contract between you and [the Provider]".*
>
> *"[The Provider] will pay to you... the insurance benefits when the insured event happens, subject to the conditions contained in this policy and providing that the following requirements are met:*
>
> - *Premiums are paid as stated …*
> - *All declarations and statements you and the Life or Lives Insured have made are true*

The highlighted textbox is then followed by the information below:

> *Please note when completing the application form you and the Life (Lives) Insured must disclose all Material Facts (including any Material Facts which come to light between the day the original policy was issued and the date this policy is issued, where this policy is replacing another policy). A Material Fact is any fact about the Life Insured's health... that may increase the risk of you making a claim or influence the assessment and acceptance of your application by [the Provider]... If you fail to disclose all Material Facts or fail to provide [the Provider] with full and accurate information any subsequent claim may be rejected and your policy cancelled from the inception date. If you are in any doubt about whether a fact is material you should disclose full details".*

The **Proposal Form** contains the following information on the front page, in a colour which makes it distinctive:

> *Warning: When completing this application form you must disclose all Material Facts. A Material Fact is any fact about your health... or any other fact that may increase the risk of you making a claim or influence the assessment and acceptance of your application by [the Provider]... If you fail to disclose all Material facts or provide [the Provider] with full and accurate information any subsequent claim may be rejected and your policy cancelled from the inception date. If you are in any doubt about whether a fact is material you should disclose full details.*

/Cont'd…

I note that the importance of disclosing all material facts was also repeated at the top of page 5 of the form in a highlighted box titled "**HEALTH STATEMENT & OTHER INFORMATION.**

I note that the Complainants answered **"No"** to the following questions:

> *"**In the LAST FIVE YEARS have you suffered from or received treatment, advice or had investigations for any of the following:***
>
> *[...]*
>
> *(iii) Any form of numbness or tingling, temporary loss of muscle power or tremor, severe headaches, dizziness, seizure, fit, fainting or blackout or any symptom that may be due to a nervous system disorder?*
>
> *[...]*
>
> *(x) Other than the conditions you have already disclosed, have you sought medical advice, treatment or had investigations for any other conditions in the past 5 years (Colds, influenza and hay fever can be omitted).*
>
> *(xi) Are you awaiting the results of any tests/investigations or referral to any hospital, clinic or doctor or do you have any medical condition, pain, discomfort or other symptoms for which you have not yet sought medical advice?"*

The policy declaration at the end of the form, signed by the Complainants on 6 December 2012, states:

> *"I declare that I have read the entire application form after it was fully completed and that I am satisfied that all the answers and statement in this application are true and complete (including those completed by my Financial Advisor). I agree that this Declaration... shall form the basis of this contract of insurance.*
>
> *I understand that I must disclose **all Material Facts. A Material Fact is any fact about your health, smoking or drinking habits, occupation, pastimes or policies with other insurance companies that will increase the risk of you making a claim or any other fact that may influence the assessment and acceptance of you application by [the Provider]**. I declare that I have provided full details of all medical conditions from which I have ever suffered.*
> *…*
>
> *I understand that it I fail to disclose all material facts or provide [the Provider] with full and accurate information then any subsequent claim may be rejected and the policy cancelled from inception."*

/Cont'd…

On **9 April 2019 t**he Provider received a claim form for the Serious Illness cover contained in the policy. In this form, the First Complainant set out that she had been diagnosed with Multiple Sclerosis two years earlier, on **8 April 2017** following symptoms of *"bad vertigo and falling over with it";* loss of balance; pins and needles in her limbs and numbness along her right side. The date of onset of those symptoms is stated as being 8 April 2017.

The claim form stated that the First Complainant underwent an MRI scan on 11 April 2017 and a lumbar puncture on 18 April 2017 to confirm the diagnosis, and her treatment consisted of medication for symptoms of vertigo, nausea, and itching. In response to the question *"Have you ever previously suffered from, or received treatment for, a similar illness?"* the form stated "No".

Having received this claim, the Provider then sought information from the First Complainant's treating physicians. The Complainant's neurologist wrote to the Provider on **30 April 2019** stating:

> *"The diagnosis was confirmed in May of 2018 though she had symptoms going back further.*
>
> *She had vertigo for about ten years on and off prior to that..."*

The Complainant's GP returned a completed information document to the Provider, which provided the following relevant history:

> *"16/6/2009 Acute Vertigo Sinusitis earache"*
>
> *"4/5/11 Labarinthitis"*

However, in response to the question *"Has your patient suffered any previous episodes of this condition, or any related illness?"* the First Complainant's GP stated

> "NO".

It was noted that in May 2011, the Complainant's GP had referred the Complainant to an ENT specialist for further investigations.

Having considered the above medical history, on **19 September 2019** the Provider wrote to the Complainants informing them of its decision to decline the claim.

The Complainants, in essence, submit that:

- it did not occur to the First Complainant that her vertigo or specialist referral in 2009 / 2011 were material facts within the meaning of the policy; she filled the form out in good faith and honestly and/or

/Cont'd…

- symptoms of dizziness / vertigo are not material facts in the context of a the policy, particularly when one considers that the Provider offered her a policy even when she disclosed her family history of heart disease.

The Provider's position is that a history of vertigo / symptoms of dizziness falls within the information that must be disclosed in response to the questions on the form, and that such a history is a Material Fact in the context of the policy. It states that if the history had been fully disclosed, this would have influenced the acceptance of the proposal for this policy.

I note that Question 11(iii) on the application form, specifically included "dizziness" as one of the symptoms for which an applicant should disclose previous history, treatment, advice, or investigations (in the previous 5 year period).

I also note that Question 11(xi) asked whether the applicant was awaiting results of any tests / investigations or referral to any hospital, clinic or doctor.

The issue is whether these questions in 2012, should reasonably have been interpreted or understood by the Complainants, to encompass the First Complainant's history of vertigo / dizziness in 2009 and 2011 (and the specialist referral that was not availed of).

It appears that, in 2011 at least, in referring her to an ENT specialist the Complainant's GP was seeking to investigate issues with the First Complainant's inner ear. However, the Complainant did not attend with that specialist in 2011 because, it seems, she had begun to feel better. Had the Complainant attended with the ENT specialist, it seems possible and perhaps likely that further investigations / scans would have been recommended / carried out.

I am satisfied that the Complainant's history of vertigo / dizziness, in addition to the fact that she had been referred to a specialist in 2011 ought to have been disclosed by her in response to one or both of these questions. To find otherwise would be to ignore the plain wording of question 11(iii) – which specifically mentions dizziness – and question 11(x). I simply can't accept the Complainants' suggested alternative interpretation of those questions.

As the answer given by the First Complainant to the above statement/question was objectively incomplete, I must consider whether or not the First Complainant's history of vertigo / dizziness, and her referral to an ENT specialist, constituted Material Facts within the meaning of the policy.

A Material Fact is defined in the policy as

> *"any fact about your health, smoking or drinking habits, occupation, pastimes or policies with other insurance companies that will increase the risk of you making a claim or any other fact that may influence the assessment and acceptance of you application by [the Provider]."*

/Cont'd…

In addition to the foregoing definition, the question of whether a fact is material to the risk being insured is one which has long since been considered in detail by the Courts.

Where a customer fails to disclose a fact at inception of a policy, for whatever reason, a provider is entitled to deem the policy void ab initio if this non-disclosure relates to a material fact. A material fact is one which would have influenced a reasonable insurer had it been disclosed. Accordingly, it is not sufficient merely to establish that the particular insurer involved would have considered it material, it is also necessary to show that such a course would have been reasonable, and that a reasonable insurer would have been influenced by the information had it been disclosed.

The decision of Finlay C.J. in ***Kelleher v. Irish Life Assurance Company*** is instructive. Finlay CJ quoted the following extract from MacGillivray and Parkington on Insurance Law (8th ed., 1998):-

> *"It is more likely, however, that the questions asked will limit the duty of disclosure, in that, if the questions are asked on particular subjects and the answers to them are warranted, it may be inferred that the insurer has waived his right to information, either on the same matters but outside the scope of the questions, or on matters kindred to the subject matter of the questions. Thus, if an insurer asks, 'How many accidents have you had in the last three years?', it may well be implied that he does not want to know of accidents before that time, though these would still be material. If it were asked whether any of the proposer's parents, brothers or sisters had died of consumption or been afflicted with insanity, it might well be inferred that the insurer had waived similar information concerning more remote relatives, so that he could not avoid the policy for non-disclosure of an aunt's death of consumption or an uncle's insanity. Whether or not such waiver exists depends on a true construction of the proposal from, the test being, would a reasonable man reading the proposal form be justified in thinking that the insurer had restricted his rights to receive all material information, and consented to the omission of the particular information in issue?"*
>
> [Emphasis added]

In ***Coleman v. New Ireland***, Clarke J summarised the relevant law on disclosure in the following terms:-

> *"The requirement that a proposer for a policy of insurance must make full disclosure is more than well settled. Thus, an insurer can avoid a policy of insurance where either:-*
>
> *A. The insured fails to disclose a material fact; or*
>
> *B. The proposer makes a positive misrepresentation in the course of the negotiations.*

/Cont'd…

> *Furthermore, an insurer may be entitled to avoid a contract of insurance where there has been a breach by the proposer of a term of the contract of insurance warranting that a certain set of facts is the case. Whether, and to what extent, there has been any such warranty is a matter of construction of both the insurance policy itself together with connected documents such as any proposal form."*
>
> [Emphasis added]

Clarke J. went on to state as follows:-

> *"It is clear, therefore, that any material non-disclosure or any materially inaccurate answer to a question on the proposal form are to be judged by reference to the knowledge of the proposer, and whether answers given were to the best of the proposer's ability and truthful."*
>
> [Emphasis added]

I further note that 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).*
>
> *(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).*

Taking account of the position adopted by the Courts, I take the view on the evidence available that a reasonable person would have understood that the Provider was seeking information which would have included the First Complainant's history of dizziness or vertigo (and/or the specialist referral) in the 5 years before the policy was incepted in 2012.

/Cont'd…

I am satisfied that the answer given by the First Complainant to the particular questions, was incorrect, and that there was a breach by the Complainants of their obligations, in warranting that the information contained in the application form, was accurate.

In light of the evidence available, I cannot accept that the particular answers at issue, given on the proposal form by the Complainants, were given to the best of their knowledge or ability. I note in that regard that the specialist referral arising out of apparent vertigo/dizziness had occurred less than 18 months before their proposal for the policy and I believe that a prudent proposer for insurance would have not supplied the answer "No" to these particular questions. I also note the repeated warning advice in the proposal form and the policy documentation, as to the importance of disclosing material information

The Complainants have expressed doubt as to whether the history would have affected the Provider's decision to offer the policy. In that regard it must be noted that the Provider asked a specific question, and has stated that the answer which ought to have been given would have influenced the decision to accept the proposal for cover. I accept therefore that the medical history that was not disclosed (but was clearly covered by the plain meaning of the questions) was a material fact, which the Provider was entitled to consider in reaching its decision as to whether or not to make cover available, and in that event, the terms on which such cover would be offered.

I am satisfied that without giving the Provider access to this material information, the policy came into being on the basis of a false premise. I accept in those circumstances that the Provider was entitled to decline the claim and to void the policy from inception, and I am satisfied that its decision to do so was not unfair. For these reasons, I do not consider it appropriate to uphold this complaint.

Conclusion

My Decision on the evidence before me and 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

24 May 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.