An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0257
Sector:	Insurance
Product / Service:	Hospital Cash Plan
Conduct(s) complained of:	Rejection of claim Failure to advise on key product/service features
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns a Critical Illness policy and a claim by the Complainants for "*Standard Hospital Cash Benefit*".

The Complainant's Case

The First Complainant has submitted a copy of a proposal form for a stand-alone Critical Illness policy which the Complainants assert they have held since **1996** to the present day. It states on this document that the Second Complainant has cover for a "*Standard Hospital Cash Benefit*" of IR£50 per day and that the schedule is to be read in conjunction with the policy definitions and conditions.

The First Complainant says that the Second Complainant was referred by her General Practitioner and subsequently admitted to a psychiatric hospital for **31 days** between **19 March 2019** and **19 April 2019**. According to the First Complainant, he submitted a claim to the Provider and was *"shocked"* when the Provider informed him that

> "[it] *would not be paying this benefit, quoting* [him] *section 3. 21. 8. (v) alcohol or drugs (other than under the direction of a qualified medical practitioner)"*

The First Complainant states this means that:-

> *"hospital cash benefit is not payable if injury or illness is due to alcohol or drugs UNLESS refereed* [sic] *by a qualified medical practitioner, as was the case in* [the Complainants'] *claim*. [The Provider] *never requested any documentation regarding this medical practitioner referral".*

According to the First Complainant, the Provider told him he was issued with a *"policy schedule as well as terms and conditions"* when the policy was incepted in **1996**. The First Complainant disputes this and sets out that he has *"no record of receiving any policy Documents"* at the inception of the policy in **1996** and that he has asked the Provider for a *"proof of delivery"* of these documents to him. The Complainants assert with regard to correspondence issued by the Provider that "*all* [they] *receive is the standard letter, every year, informing* [them] *of a 5% increase in premiums"*.

The First Complainant contends that a *'cooling off'* period was not offered in **1996** and that he first became aware of this *'cooling off'* period in the Provider's letter of **20 June 2019**. The First Complainant contends that *"the fact that* [the Provider] *has introduced it* [the cooling off period]*, makes it central".*

The First Complainant says he proposes to *"exercise* [the Complainants'] *30 day cooling off period from the 20th of June 2019, when this was first brought to* [the Complainants'] *attention"*.

The Complainants want the Provider to issue *"full repayment off all premium paid"* with "*interest*" plus financial compensation for stress and anxiety.

The Provider's Case

The Provider maintains that it was entitled to decline the claim on the policy because the policy provides for an exclusion from cover, in the event that the hospital admission (in respect of which the Hospital Cash Benefit is sought) arose directly or indirectly from the consumption of alcohol.

The Provider points to the fact that the Second Complainant was admitted to a facility for the purposes of securing treatment for 'alcohol dependency syndrome'.

The Provider in its **Final Response Letter** of **20 June 2019** says that when the policy was originally put in force in **1996**, it issued policy documents to the Complainants.

The Provider says that if the Complainants were

> *"unhappy with any element of the policy* [the Complainants] *did have the option to avail of the 30 day cooling off period"*

The Provider also maintains in any event, that the facility to which the Second Complainant was admitted, does not meet the definition of a 'hospital' as set out in the policy.

The Complaint for Adjudication

The complaint is that the Provider wrongfully refused to indemnify the Complainants for a Hospital Cash Benefit claim made on their policy in **2019**.

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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 **28 June 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. Following the consideration of additional submissions from the parties, the final determination of this office is set out below.

At the time when this complaint investigation was commenced, I was highlighted by this Office to the parties, that any complaint regarding the conduct of the Provider relating to the inception of the policy in **1996**, including a complaint regarding the information given by the Provider to the Complainants, and/or the documentation supplied to them by the Provider at that time, is conduct which occurred before 2002.

As a result, any such complaint concerning the conduct of the Provider in 1996, falls outside the jurisdiction of this Office pursuant to ***Section 51(3)(a)*** of the ***Financial Services and Pensions Ombudsman Act 2017*** (as amended). Consequently, it is beyond the jurisdiction of this Office to come to any determination as to what was, or was not, given to the Complainants in terms of documentation, at the point of inception of the policy in 1996.

In that regard, the formal **Summary of Complaint** which was issued by this Office to the Provider on 26 August 2020, calling for a response to the investigation (a copy of which was shared with the Complainants on the same day) advised:

> Any conduct relating to the inception of the policy, the information given by the Provider to the Complainants at that juncture and/or the documentation furnished at that time or is conduct which occurred **before 2002** and it appears to fall outside the jurisdiction of this Office **pursuant to s51 (3) (a) of the Financial Service and Pensions Ombudsman Act 2017 (as amended).**

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For that reason, the Summary of Complaint noted that the complaint for investigation by this Office, was that the Provider had refused to indemnify the Complainants for their Hospital Cash Benefit claim in 2019.

The Complainants have argued again in recent times, that the Provider "*acted illegally*" and engaged in "*fraudulent activity*" in 1996. As previously clarified by this Office however, any complaint regarding the conduct or actions of the Provider, or indeed of any financial service provider in 1996, or at any time before 1 January 2002, falls outside the jurisdiction of this Office. Similarly, the Ombudsman has no role to play in the event of an allegation of fraud, which is a criminal matter, and does not come within the remit of this Office.

This complaint for adjudication does not therefore include any analysis of the events of 1996. Instead, the complaint for adjudication requires an analysis of the Provider's decision in **2019**, to decline the Complainants' Hospital Cash Benefit claim.

I note that the terms and conditions of the policy, under which the claim was made, provide at **Section 3 Clause 21.8** as follows:

> *Hospital Cash Benefit shall not be payable if the injury or illness in respect of which the Life Assured is admitted to Hospital arises directly or indirectly from:-*
>
> *…*
>
> *(v) alcohol or drugs (other than under the direction of a qualified medical practitioner);*

This is the exclusionary clause that the Provider has relied on, though I note that the Complainants maintain that they never received the terms and conditions of the policy in 1996, when the policy came into being.

The claim in 2019 was made, after the Second Complainant was referred to [named] Hospital by her GP. It is not in dispute between the parties that the referral was for the purposes of securing treatment for 'alcohol dependency syndrome'.

The Complainants have submitted that the proviso contained within brackets in Section 3 of Clause 21.8 subclause (v) of the policy, is activated, insofar as the policy anticipates an admission or referral "*under the direction of a qualified medical practitioner".* I do not however agree with the Complainants' interpretation of this proviso.

The Policy Condition provides as follows:-

> "*Hospital Cash Benefit shall not be payable if the injury or illness in respect of which the Life Assured is admitted to Hospital arises directly or indirectly from:-*
>
> *…*
>
> *(v) alcohol or drugs (other than under the direction of a qualified medical practitioner);*

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I am satisfied that the proviso which is contained within the brackets, relates to the circumstances in which the policyholder may be consuming alcohol or drugs. This means that an admission to a hospital arising directly or indirectly from the consumption of drugs will be covered, if the consumption of drugs was directed by a qualified medical practitioner. This wording, in my opinion, does not relate to whether or not the Policyholder was referred to hospital by a qualified medical practitioner.

In its response to this office, the Provider points out that the wording in brackets was drafted with "*the intention of excluding drugs taken under the direction of a qualified medical practitioner*". This seems to me to be both the obvious meaning of the words and a to be a reasonable carve-out within the policy. Accordingly, I take the view that the proviso was not activated in this instance and I am satisfied that the Provider was entitled to decline the Hospital Cash Benefit claim, by relying on Section 3 Clause 21.8 subclause (v).

There has been some comment as to whether the wording in brackets in Section 3 Clause 21.8 subclause (v) should or should not also be considered to apply to the word 'alcohol'. However, in my view, this argument is not hugely relevant as there is no suggestion that the Second Complainant was consuming alcohol under the direction of a qualified medical practitioner.

Bearing in mind the fact that I have found that the Provider was entitled to determine that the Complainants' claim was not covered by the policy, owing to the exclusion at Clause 21.8 subclause (v), I do not consider it necessary to determine whether the Provider was also entitled to decline the claim because the [named] Hospital did not meet the definition of a 'hospital' as set out in the policy.

It is also noted by this Office that the Complainants claim to be entitled to invoke a 'cooling off period', as and from the date of the Provider's Final Response Letter, dated **20 June 2019**. The Complainants say in that respect, that because they did not receive a cooling off notice in 1996, they should be entitled to the benefit of a fresh cooling-off period, which they propose to invoke (and thereby recoup all premium paid to-date) as and from the date of the Final Response Letter in June 2019, on the basis that this letter was the first reference made to them of the existence of any cooling-off period.

Whilst I note the Complainants' position that they were not notified in 1996, of their entitlement to a cooling-off period, it falls outside the jurisdiction of this Office to examine their complaint of the mis-selling of the policy to them in 1996, or in that context, to come to any determination as to what was, or was not, supplied to the Complainants by the Provider at the point of inception of the policy in 1996.

The Complainants' contention that they are now entitled to exercise a cooling off notice, is based on their position that they did not receive a cooling-off notice in 1996, and they first became aware of this *'cooling off'* period in the Provider's letter of **20 June 2019**.

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The Complainants maintain that the Provider is responsible for a "*failure of their legal obligation to inform us of our cooling off period in 1996",* such that the Provider has been:

> *"pilfering our money all this time and no contract exists, and all monies plus interest must be immediately returned, and we wonder how many more clients have been treated in this shabby manner?"*

Whatever may have occurred in 1996, I do not accept that the contents of the Provider's final response letter in June 2019, created a fresh entitlement for the Complainants to exercise a cooling off option from that time, to cancel the policy from inception, 23 years after it had come into being.

Since the preliminary decision of this Office was issued in **June 2021**, the Complainants have indicated their dissatisfaction with what they believe to be an error of law, that the Ombudsman did not seek to exercise his discretion to extend the time limits, in accordance with ***Section 51(2)(iii)*** of the ***Financial Service and Pensions Ombudsman Act 2017*** (as amended) ("the Act") so that their complaint of mis-selling to them in 1996 could be made within:

> *"such longer period as the Ombudsman may allow where it appears to him or her that there are reasonable grounds for requiring a longer period and that it would be just and equitable, in all the circumstances, to so extend the period."*

On the basis of the information and evidence which the parties submitted in the course of this investigation, the Ombudsman did not form the opinion that the time limit should be extended, so that the Complainants could pursue their complaint that the Provider mis-sold the policy to them in 1996. Neither however did the Ombudsman form the opinion that the time limit should not be extended on that basis. He made no determination in that regard.

Accordingly, if the Complainants believe that they can make further information available to this Office, that will lead the Ombudsman to form the opinion that there are reasonable grounds for extending the time, and that it would be just and equitable, in all the circumstances to do so, they may of course submit such additional information for consideration.

In that event, that time limit issue will then be examined in detail by the legal services team, so that a comprehensive jurisdictional determination can be undertaken, to facilitate the Ombudsman, in forming an opinion as to whether or not he should extend the time limit, in accordance with ***Section 51(2)(iii)*** of the Act, to enable the Complainants' complaint of the mis-selling to them of the policy in 1996, to be investigated by this Office.

Nothing in this decision will prohibit the Ombudsman from undertaking that consideration, because the suggested mis-sale of the policy in 1996, has not been the subject of this adjudication, which has been limited instead to the Provider's conduct, as specified above under "**The Complaint for Adjudication**".

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The Complainants are also unhappy that in the course of the investigation of their complaint that the Provider incorrectly declined their claim for policy benefit in 2019, this Office had regard to the provisions of the policy under which the claim was made:

> *"What we will not accept is that after invoking section 51(3) (a) of the Financial Services and Pensions Ombudsman Act 2017 (as amended) to prevent the truth, the then attempt to use documents , namely Policy conditions from 1996 to deny the legitimate hospital claim, falls outside your jurisdiction as its previous to 2002, and you are not legally entitled to rule on these, we will challenge this in the highest court in the land, or maybe the pay master will give you another angle to deny our legitimate claim?"*

I am satisfied that because the Complainants' claim in 2019, was made under the policy incepted in 1996, it was necessary for the Provider to assess that claim in accordance with the provisions of that policy. In addition, for the purpose of the FSPO's investigation of the Complainants' complaint that the Provider was wrong in declining that claim, I am firmly of the opinion that it was appropriate for this Office to examine the provider's conduct, in the course of that claim assessment under the 1996 policy. I note indeed in that regard, that the Complainants actively engaged in the investigation process of this Office, and they commented in detail as to how they believe those policy provisions ought to be interpreted.

On the basis of the evidence before me, I am satisfied that the Provider was entitled to rely on the policy exclusion quoted above, in order to decline the Complainants' claim. In those circumstances, and whilst I appreciate that the Complainants will be disappointed with this decision, in the absence of any evidence of wrongdoing on the part of the Provider, I do not accept that there is any reasonable basis before me 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

27 July 2021

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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.