An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0384
Sector:	Insurance
Product / Service:	Payment Protection
Conduct(s) complained of:	Rejection of claim
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant incepted a **Specified Illness Protection Plan** with the Provider on **12 September 2008**.

The Complainant's Case

The Complainant was hospitalised on in **January 2018** for almost three weeks with a diagnosis of *"Leptospirosis with Acute respiratory distress syndrome & Acute Renal failure"*.

The Complainant completed a Specified Illness Cover **Claim Form** to the Provider in **February 2018**, wherein he detailed the illness for which he was claiming as *"Weil's disease … Respiratory (lung), Kidney, liver failure"*.

Following its assessment, the Provider wrote to the Complainant on **15 March 2018** to advise that it was declining the claim as his illness did not meet the policy definition of any of the specified illnesses covered by his **Specified Illness Protection Plan**.

The Complainant's Representative later wrote to the Provider on **26 March 2019** to appeal the decision to decline the claim and submitted, among other things, that:

> *" … as a result of* [his] *condition* [the Complainant] *was put into an induced coma and fortunately for* [him] *he was able to exit the coma without permanent brain or nerve damage. However we would respectfully suggest that the fact that it was an induced coma that it was necessary for* [the Complainant] *to enter into would prove the severity of his condition and although he has not permanent neurological damage, one cannot say how the effects of the induced coma will impact on* [the Complainant] *going into the future. Furthermore we would respectfully suggest that the life support system was necessary throughout the period and accordingly* [the Complainant] *would satisfy part of the condition contained in the specified illness plan …*
>
> *…* [the Complainant] *developed respiratory and renal failure from the 7th of January 2018 up until the 14th of January 2018 and although these conditions have improved it should be acknowledged that he did suffer from these symptoms. Whilst it is acknowledged that* [the Complainant] *has made improvements under both of these headings* [he] *instructs us that he still continues to suffer from the symptoms arising from his condition in circumstances where he continues to suffer from extreme fatigue arising from his condition …*
>
> *…* [The Complainant] *had relied on the understanding that the…Specified Illness Protection Plan would give him some comfort should he suffer from a severe medical condition which he has in this case … ".*

Following its review, the Provider wrote to the Complainant's Representative on **10 May 2019** to advise that it was standing over its decision to decline the Complainant's claim.

The Complainant sets out his complaint in the **Complaint Form** he completed, as follows:

> *"Between 7/1/18 and 14/1/18 I developed respiratory and renal failure and received treatment in* [Hospital A] *+* [Hospital B]*. After my treatment I was unable to work and submitted a claim on my specified illness cover. The claim has been rejected"*.

In addition, in its letter to this Office dated **17 October 2019**, the Complainant's Representative states:

> *" … By way of background you will note…that* [the Complainant] *took out a* [Provider] *Specified Illness Protection Plan in or around September 2008 as* [he] *was single and self-employed at the time … He understood when taking out the Specified Illness Cover Policy that it would cover any illness or sickness which he suffered and owing to the fact that he was self-employed he would not be in a position to earn income owing to his inability to work …*

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> *In or around the 6th of January 2018* [the Complainant] *contacted out of hours doctors' service as he had been unwell for a period of four days with a minor respiratory problem but then became very unwell with pleuritic pain haemoptysis dyspnoea, fever and was transferred to hospital by ambulance.*
>
> [The Complainant] *was transferred from the ICU in* [Hospital A] *directly to the ICU in* [Hospital B] *on the 7th of January 2018 due to experiencing Type 1 Respiratory Failure, secondary to Acute Respiratory Distress Syndrome and Acute Renal Failure. He was subsequently diagnosed with leptospirosis and this was treated with intravenous antibiotics benzylpenicillin. During his admission in* [Hospital B] *he was intubated and ventilated on admission and he remained ventilated from the 7th of January 2018 until he was successfully extubated on the 14th of January 2018. During his ICU admission in* [Hospital B] *he was dialysed and once out of ICU he continued with intermittent haemodialysis via femoral vascath.*
>
> *Although* [the Complainant] *after his discharge from hospital continued to made gradual improvement he suffered* [anaemia] *and extreme fatigue after discharge and continued to suffer lower energy levels but these gradually increased over time. As a result of the illness suffered by* [the Complainant] *he was unable to carry out any of his work…as he no longer had the strength or energy to perform his duties. A number of months after his health started to improve* [the Complainant] *made a claim for the specified illness cover under his* [Provider] *Policy. This was investigated in full by* [the Provider] *in conjunction with obtaining medical documentation and report from* [the Complainant's] *treating general practitioner …*
>
> *Unfortunately for* [the Complainant] [the Provider] *declined his claim by way of letter of the 15th of March 2018. He subsequently instructed this office to complete an appeal for him with* [the Provider] *but unfortunately again his claim was declined on appeal by way of letter of the 10th of May 2019".*

The Complainant seeks for the Provider to admit and pay his specified illness claim in the amount of **€50,000** (fifty thousand Euro) and in this regard, he stated in the **Complaint Form** that:

> *"I am seeking payment under* [my] *cover as I was unable to work and support my business and family from a financial view point"*.

The Complainant cancelled his **Specified illness Protection Plan** with the Provider by telephone on **24 July 2018**, effective from **12 August 2018**.

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The Provider's Case

The Provider says that its records indicate that the Complainant incepted a **Specified Illness Protection Plan** with the Provider on **12 September 2008**. The policy was sold to the Complainant by a named bank and there was, at the time of the sale, a tied agency agreement between this bank and the Provider.

The Provider notes that there were a number of telephone calls received in **January 2018** enquiring as to a possible specified illness claim for the Complainant. The Provider says that on **10 January 2018**, the bank telephoned its Customer Services Team on the Complainant's behalf to advise that the Complainant was at that time in a coma. The Customer Services Agent, 'the Agent', advised that *"Coma"* was a listed illness under the Complainant's **Specified illness Protection Plan** but that permanent symptoms were required by the illness policy definition. The Provider notes that the bank did not have any detailed information and was advised to have the Complainant's wife telephone with as much information as she had, when she was in a position to do so and that this information would be passed to the Protection Claims Team, which would then contact her regarding any possible claim and talk her through the claims process.

The Provider says that on **11 January 2018**, the bank again telephoned its Customer Services Team to advise that the Complainant was in a coma and queried could a claim be made under his policy for this. The Agent read out the *"Coma – resulting in permanent symptoms"* illness policy definition. The Provider notes that the bank did not have any more details and advised that it would speak to the Complainant's wife to obtain more information.

The Provider says that on **20 January 2018**, the Complainant himself telephoned its Customer Services Team to query the process for making a specified illness claim. The Agent explained to the Complainant that a specific list of illnesses were covered under his policy and that the first step, was for him to review the **Specified Illness Protection Plan Policy Document** to see if his illness was listed.

The Agent advised that she could send a copy of the **Policy Document** to the Complainant for review or she could ask the Protection Claims Team to call him back. The Complainant agreed that he would like the **Policy Document** sent to him first. The Agent went on to explain how the specified illness claim process works, if he had a covered illness.

The Provider says that on **23 January 2018**, it posted the Complainant a copy of his **Policy Document** and on **26 January 2018**, he telephoned the Provider's Customer Services Team to request a **Claim Form** to be sent to him. The Provider notes that the Agent advised that she would send a query to the Protection Claims Team with the details, and that they would be in contact with him with regard to a claim form issuing.

The Provider says that on **3 February 2018**, a Claims Assessor telephoned the Complainant to discuss the matter. The Complainant advised during this call that following a recent diagnosis of Weil's disease he had been in a coma for 7 days in ICU and he would like a **Claim Form** for completion.

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The Claims Assessor noted that the Complainant had previously been sent a copy of his **Policy Document** and drew his attention to the *"Coma – resulting in permanent symptoms"* illness definition. The Complainant said he had not read the **Policy Document** as yet.

The Provider notes that the Claims Assessor asked the Complainant to read the *"Coma – resulting in permanent symptoms"* illness definition to familiarise himself with the stipulations that apply to the definition and the criteria that need to be met in order for a claim to be made, before completing the **Claim Form**, to ensure he was eligible to claim. The Complainant advised that he had some ongoing problems with his kidneys following his hospital admission. The Claims Assessor advised that the **Claim Form** could be completed first with all this information filled in, and that the Provider would request any additional medical information from his doctors that was required in order to ascertain if he had a claim for payment. A **Claim Form** was posted to the Complainant.

The Provider says that on **9 February 2018**, it received a **Claim Form** signed by the Complainant on **7 February 2018**, in which he detailed the illness for which he was claiming as *"Weil's disease"*. The Provider notes that Weil's disease is not one of the listed specified illnesses covered by the Complainant's policy.

The Complainant also advised in the **Claim Form** that:

> *"I spent 10 days in ICU in* [Hospital B]*, 7 of them were spent on life support and spent a total of 3 weeks in hospital. First seven days I was in a coma"*.

The Provider notes that *"Coma – resulting in permanent symptoms"* is one of the listed specified illnesses covered under the Complainant's policy and is defined at pg. 20 of the **Specified Illness Protection Plan Policy Document** as follows:

> *"A state of unconsciousness with no reaction to external stimuli or internal needs which:*
>
> - *Requires the use of life support systems for a continuous period of at least 96 hours; and*
> - *Results in permanent neurological deficit with persisting clinical symptoms.*
>
> *For the above definition, the following is not covered:*
>
> - *Coma secondary to alcohol or drug abuse.*
>
> *A person in a coma is unconscious and cannot be brought around. He or she is unlikely to respond to any form of physical stimulation or to have any control of bodily functions. Often this can occur as a result of injury to the head or a growth in the brain. It is important to realise that there are various depths of coma, measured by how an individual responds to repeated external stimuli. The coma may result in permanent neurological damage (brain damage resulting in permanent functional impairment) or the patient may recover completely.*

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> *The conditions for* [the Provider] *to pay a claim are that there must be minimal reaction to external stimuli for at least 96 hours, life support systems must be necessary throughout this period and there must be permanent brain or nerve damage (e.g. paralysis of the right or left side of the body or disturbed speech or vision)".*

In addition to his having been in a coma, the Provider also noted the Complainant's mention of *"Respiratory (lung), Kidney, liver failure"* on the **Claim Form**. As a result, the Provider says it felt it prudent to request medical information from the Complainant's GP in order to establish more details in respect of his medical condition to ascertain if he would qualify for a claim under the *"Coma – resulting in permanent symptoms"* illness criteria or any of the other specified illnesses listed in his policy.

The Provider says that the Complainant's GP completed a **Medical Certificate** on **23 February 2018** for the Provider and also supplied the Provider with a copy of his records, including hospital reports/letters in respect of the Complainant's condition and time in hospital. The Provider says it conducted a detailed assessment of the medical information provided by the GP in respect of the Complainant's condition, taking into account the information the Complainant himself provided on his **Claim Form** and the specified illnesses listed in his policy.

The Provider noted that the medical information received confirmed that the Complainant was diagnosed with a condition called Leptospirosis (a form of Weil's disease), however this condition in itself is not one of the specified illnesses listed in the Complainant's policy.

The Provider also noted that the Complainant was put into an induced coma due to this diagnoses of Leptospirosis and the complications he experienced as a result, and it therefore considered his claim against the *"Coma – resulting in permanent symptoms"* illness definition, which clearly states that:

> *"The conditions for* [the Provider] *to pay a claim are that there must be minimal reaction to external stimuli for at least 96 hours, life support systems must be necessary throughout this period and there must be permanent brain or nerve damage (e.g. paralysis of the right or left side of the body or disturbed speech or vision)".*

The Provider says that this definition includes being unable to be brought around from the coma and also the requirement for permanent neurological deficit with persisting clinical symptoms resultant from the coma. In this regard, the Provider says that the Complainant was put into an induced coma due and that a person can be brought around from an induced coma, and therefore this aspect of the illness criteria has not been satisfied.

In addition, the Provider says that the medical evidence received also provides no evidence of resultant permanent neurological deficit with persisting clinical symptoms as a result of the Complainant's induced coma, and notes that the Complainant's Representative also acknowledges in its submissions that the Complainant does not have permanent neurological damage following the coma.

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While the Provider says that it does note that the Complainant suffers with fatigue and anaemia (iron deficiency due to reduced red blood cells) nevertheless, this cannot be considered a neurological deficit.

The Provider notes the Complainant's Representative's contention that although the Complainant does not have permanent neurological damage following the coma, one is unable to determine at this point in time, how the effects of the induced coma will impact on him in the future. In this regard, the Provider says it is not reasonable to expect it to consider a possible unknown neurological deficit which may or may not present at some time in the future, to satisfy this requirement.

The Provider acknowledges that the Complainant did suffer significant respiratory and renal symptoms as a result of complications from his diagnosis of Leptospirosis, but the medical evidence it received shows that the Complainant has thankfully made a full recovery in this regard. Furthermore, the Provider says it is important to reiterate that both these acute conditions were caused by Leptospirosis, which in itself is not one of the specified illnesses listed in the Complainant's policy.

Having considered the medical information received, the Provider is satisfied that the Complainant's condition does not fulfil the policy definition of any of the specified illnesses listed in his policy.

In relation to the comments made in respect of the Complainant's home life and his ability to work, the Provider says it is important to note that the Complainant's policy is not an income protection policy. Instead, the **Specified Illness Protection Plan** will pay a lump sum settlement amount should a valid claim be made, for one of the specified illnesses listed. As a result, the Provider says the Complainant's inability to work is not a criterion which automatically qualifies him for specified illness benefit.

In relation to the comments made in respect of the Complainant's understanding that his policy would cover any illness or sickness that he might suffer, the Provider says that in accordance with the **Specified illness Protection Plan Policy Document**, the policy provides specified illness benefit for the listed specific illnesses and conditions only. The policy is called Specified Illness Protection and the benefit is called Specified Illness cover. The Provider says that the policy is named a Specified Illness Protection Plan so as to alert the customer to the fact that only *specified* illnesses are covered. The Provider notes that the criteria that needs to be met in order for a claim to be considered under each of the specified illnesses/conditions is clearly defined in the **Policy Document**. The Provider says it does not provide cover for any illness or condition which is not specifically listed (or subsequently added to the policy) or does not meet the criteria detailed within each illness definition.

The Provider says that the Complainant was furnished with a copy of the **Policy Document** on **15 September 2008**, when his cover commenced, and again by email and in hard copy when requested in **January 2018**. The Provider is satisfied that this **Policy Document** clearly explains the scope of cover, in plain English.

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In relation to the sale of the policy, the Provider says that its records indicate that the policy was sold to the Complainant by a named bank and that there was, at the time of the sale, a tied agency agreement in place between this bank and the Provider. The Provider says that it asked the bank, its agent, to respond to the comments made as to the Complainant's understanding that his policy would cover any illness or sickness that he might suffer. The Provider notes the bank's response in that regard, on its behalf, as follows:

> *"The Complainant would have been provided with details of the illness covered under the policy, both at the point of sale by the Bank's Financial Planning Consultant (FPC) who sold the policy and subsequently by the Provider when the policy documentation was issued on commencement of the policy.*
>
> *In relation to the point of sale the Bank's records show that the Complainant was referred by his branch to meet with an FPC to discuss his 'Lending Protection' needs arising from a proposed mortgage with the Bank, which had been sanctioned on 1st September 2008. The Particulars of Offer of Mortgage Loan outlined that Mortgage Protection Life Insurance was required on the life of the Complainant for a specified amount and term.*
>
> *The FPC's laptop records show that in addition to discussing the Complainant's life cover requirement related to his Home Mortgage with the Bank, the matter of critical illness cover was also discussed and the Complainant decided to avail of this cover in the sum of €50,000 over a 25 year term by way of the Specified Illness Protection Plan.*
>
> *Arising from the discussions on both the life and critical illness cover products, the FPC would have provided the Complainant with product brochures for each type of cover. The brochure for the Specified Illness Protection Plan summarized how the policy works and describes the features and benefits of and the illnesses covered by the policy. The brochure would have been accompanied by a 'Definitions Guide' which provides a full explanation of the specific illnesses that the policy covered"*.

The bank supplied this brochure and the "Definitions Guide" to the Provider which the Provider has included as part of its evidence to this Office. In addition, the Provider says that the **Policy Document** it posted out to the Complainant on **15 September 2008** also included details of the 30-day cooling-off period, which the Complainant could have availed of if he had considered the cover unsuitable at the time he took out the policy.

The Complaint for Adjudication

The complaint is that the Provider wrongly or unfairly declined the Complainant's specified illness claim, and that it failed to inform him as to the limitations of the policy.

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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 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 **21 September 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.

I note that the Complainant was hospitalised for almost three weeks in **January 2018** with a diagnosis of *"Leptospirosis with Acute respiratory distress syndrome & Acute Renal failure"*.

He completed a Specified Illness Cover **Claim Form** to the Provider on **7 February 2018** detailing the illness for which he was claiming as *"Weil's disease"*.

I note that following its assessment, the Provider wrote to the Complainant on **15 March 2018** to advise that it was declining the claim as his illness did not meet the policy definition of any of the specified illnesses covered by his **Specified Illness Protection Plan**, a decision it later stood over upon appeal on **10 May 2019**.

I note that in the **Claim Form** he completed to the Provider on **7 February 2018**, the Complainant inserted, among other things, the following information:

> *" … **Please state the illness for which you are claiming (e.g. heart attack, cancer, stroke, multiple sclerosis, kidney failure etc)***
> *Weil's disease*
>
> ***Please describe your illness fully***
> *Respiratory (lung), Kidney, liver failure …*

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I spent 10 days in ICU in [Hospital B]*, 7 of them were spent on life support and spent a total of 3 weeks in hospital. First seven days I was in a coma … "*

In the **Medical Certificate** he completed to the Provider on **23 February 2018**, I note that the Complainant's GP inserted, among other things, the following information:

*" … **Please advise if life support systems, including assisted ventilation, were required?***
Yes … From 7/1/18 to 14/1/18 – developed respiratory and renal failure …
Can you please confirm how long the claimant was in the Coma for:
… intubated & ventilated for 7 days …

Can you confirm the exact diagnosis?
Leptospirosis with Acute Resp. Distress Synd + Acute Renal Failure … "

In addition, I note that in its **Discharge Summary** dated **26 January 2018**, Hospital B states:

"[The Complainant] *was transferred from ICU in* [Hospital A] *directly to ICU in* [Hospital B] *on the* [*] *January due to experiencing Type 1 Respiratory Failure secondary to Acute Respiratory distress syndrome, and acute renal failure. He was subsequently diagnosed with Leptospirosis, this was treated with IV antibiotics, Benzylpenicillin. He was initially presented to* [Hospital A] *with flu like symptoms & haemoptysis.*

He was intubated & ventilated on admission. He remained ventilated until the [*] *January. He was successfully extubated on the* [*] *January.*

During his ICU admission he was dialysed & once out of ICU he continued with intermittent haemodialysis via femoral vascath. His last HD was on the [*] *January. His creatinine continues to improve & he has not required any further dialysis. His vascath was removed on the* [*] *January.*

[The Complainant] *was transferred from ICU to ward on the* [*] *January …*

[The Complainant] *continues to make steady progress on the ward. His energy levels are increasing & his appetite has improved significantly. We are very happy with his progress & feel he is ready for discharge home where he can continue with his physiotherapy rehab in the community".*

It is important to note that the Complainant's **Specified Illness Protection Plan**, like all insurance policies, does not provide cover for all eventualities. Instead the cover is subject to the terms, conditions, endorsements and exclusions set out in the policy documentation.

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Condition 3, 'Specified Illness Benefit', at pg. 5 of the applicable **Specified illness Protection Plan Policy Document** provides:

> *"Subject always to Conditions 9 (Medical Evidence.), 10 (Territorial Limits), 11 (Contributory Exclusions) and 12 (Claim Requirements):*
>
> 1. *If your Policy has been arranged on a Single Life basis, a Specified Illness Benefit in the amount subject to Condition 6 (Indexation Option) of the Benefit Payable shown on the Schedule will become payable under your Policy if the Life Insured suffers one of the Specified Illnesses listed in Appendix A after the Commencement Date and prior to the Cessation Date and then survives a period of 14 days after the date of diagnosis of the Specified Illness … "*
>
> [Underlining added for emphasis]

In this regard, I note that Appendix A, 'Definitions of Specified Illnesses', at pg. 14 of the **Policy Document** states:

> *"The Specified Illnesses covered under this Policy, for the purposes of Condition 3, are defined below. Subject to and in accordance with Condition 3,* [the Provider] *will pay Specified Illness Benefit only in respect of conditions or events listed and defined below and not excluded under any Special Conditions attaching. No benefit will be payable in respect of any other condition or event, whether regarded as serious or not … "*
>
> [Underlining added for emphasis]

Appendix A then lists and defines the specified illnesses covered by the policy at pgs. 15 – 28, as follows:

- Alzheimer's Disease – resulting in permanent symptoms
- Angioplasty – for coronary artery disease of specified severity
- Aorta Graft Surgery – for disease
- Aplastic Anaemia – of specified severity
- Bacterial Meningitis – resulting in permanent symptoms
- Benign Brain Tumour – resulting in permanent symptoms
- Blindness – permanent and irreversible
- Cancer – excluding less advanced cases
- Cardiomyopathy – of specified severity
- Coma - resulting in permanent symptoms
- Coronary Artery By-pass Grafts – with surgery to divide the breastbone
- Creutzfeld-Jacob Disease – resulting in permanent symptoms
- Deafness – permanent and irreversible
- Encephalitis – resulting in permanent symptoms
- Heart Attack – of specified severity
- Heart Valve Replacement or Repair – with surgery to divide the breastbone
- HIV Infection – caught from a blood transfusion, a physical assault or at work in an eligible occupation
- Kidney Failure – requiring dialysis
- Liver Failure – End Stage

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- Loss if Hands or Feet – permanent physical severance
- Loss of Speech – permanent and irreversible
- Major Organ Transplant
- Motor Neurone Disease – resulting in permanent symptoms
- Multiple Sclerosis – with persisting conditions
- Paralysis of Limbs – total and irreversible
- Parkinson's Disease – resulting in permanent symptoms
- Pre-Senile Dementia – resulting in permanent symptoms
- Progressive Supra-Nuclear Palsy – resulting in permanent symptoms
- Pulmonary Artery Replacement – with surgery to divide the breastbone
- Severe Lung Disease – of specified severity
- Stroke – resulting in permanent symptoms
- Third Degree Burns – covering 20% of the body's surface area
- Traumatic Head Injury – resulting in permanent symptoms
- Total and Permanent Disability

I am satisfied that the **Policy Document** makes it clear that it is only these specified illnesses that are covered by the **Specified illness Protection Plan**, and that a claimant's illness or condition must satisfy the policy definition of that illness or condition in order to be eligible for the specified illness benefit.

The Complainant was hospitalised for a period of weeks in **January 2018** with a diagnosis of *"Leptospirosis with Acute respiratory distress syndrome & Acute Renal failure"*. I note that Leptospirosis is not however one of the specified illnesses listed in the Complainant's policy. In addition, while the Complainant suffered *"Acute Renal failure"* as a complication of his Leptospirosis diagnosis and required dialysis, I note that *"Kidney Failure – requiring dialysis"* is defined at pg. 23 of the **Policy Document**, as follows:

> *"Chronic and <u>end stage failure of both kidneys</u> to function, as a result of which regular dialysis is necessary*
>
> *The kidneys act as filters which remove waste material from the blood. When the kidneys do not function properly, a build-up of waste products can lead to life-threatening problems. The body can function with only one kidney as the remaining kidney takes over the work of the damaged kidney. However, if both kidneys fail completely, then regular renal dialysis (kidney machine treatment) or a kidney transplant will be required. In some circumstances, it is possible for the kidneys to fail temporarily and recover after a period of dialysis. A claim may be made in the event that <u>both kidneys fail completely and permanently</u>, resulting in the need of regular long-term dialysis or a kidney transplant".*
>
> [Underlining added for emphasis]

I am satisfied that it was reasonable for the Provider to conclude from the medical evidence before it, that the Complainant's kidney failure was temporary and that he no longer required dialysis, and therefore that his condition did not satisfy the policy definition for *"Kidney Failure – requiring dialysis"*.

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Furthermore, while the Complainant was placed in an induced coma for 7 days, I note that *"Coma – resulting in permanent symptoms"* is defined at pg. 20 of the **Policy Document**, as follows:

> *"A state of unconsciousness with no reaction to external stimuli or internal needs which:*
>
> - *Requires the use of life support systems for a continuous period of at least 96 hours; and*
> - *Results in permanent neurological deficit with persisting clinical symptoms*.
>
> *For the above definition, the following is not covered:*
>
> - *Coma secondary to alcohol or drug abuse.*
>
> *A person in a coma is unconscious and cannot be brought around. He or she is unlikely to respond to any form of physical stimulation or to have any control of bodily functions. Often this can occur as a result of injury to the head or a growth in the brain. It is important to realise that there are various depths of coma, measured by how an individual responds to repeated external stimuli. The coma may result in permanent neurological damage (brain damage resulting in permanent functional impairment) or the patient may recover completely.*
>
> *The conditions for* [the Provider] *to pay a claim are that there must be minimal reaction to external stimuli for at least 96 hours, life support systems must be necessary throughout this period and there must be permanent brain or nerve damage (e.g. paralysis of the right or left side of the body or disturbed speech or vision)".*
>
> [Underlining added for emphasis]

In my opinion, it was reasonable for the Provider to conclude that the medical evidence before it, provides no evidence of resultant permanent neurological deficit to the Complainant with persisting clinical symptoms, as a result of his induced coma (and I note too that the Complainant's Representative accepts that the Complainant suffered no permanent neurological damage as a result of his being placed in an induced coma), and therefore the Complainant did not satisfy the policy definition for *"Coma – resulting in permanent symptoms"*.

As a result, I am satisfied that the Provider was entitled to decline the Complainant's specified illness claim in accordance with the policy terms and conditions, because the Complainant's illness and condition, although a serious illness, did not satisfy any of the definitions of the identified specified illnesses listed in his **Specified illness Protection Plan Policy Document**.

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I note that the Complainant's Representative submits in its letter to this Office dated **17 October 2019** that:

> *" …* [The Complainant] *understood when taking out the Specified Illness Cover Policy that it would cover any illness or sickness which he suffered … "*

In this regard, I note that the **Specified Illness Protection Plan Policy Schedule** dated 15 September 2008 that the Provider posted to the Complainant on that date states:

> *"**Benefit(s):** …*
>
> ***Specified Illness Cover***
>
> *On Diagnosis and Certification of a Specified Illness in respect of* [the Complainant] *…*
>
> *Benefit Payable €50,000 …*
>
> ***Special Conditions:***
>
> *This Policy Schedule is issued in conjunction with the* [bank] *SPECIFIED ILLNESS PROTECTION PLAN Policy Document (Ref: 2SI2)".*
>
> [Underlining added for emphasis]

I am satisfied that this **Policy Schedule** clearly stipulates that specified illness cover will only be payable *"On Diagnosis and Certification of a Specified Illness"*.

In this regard, as already referenced above, Appendix A, 'Definitions of Specified Illnesses', at pg. 14 of the **Policy Document** states, among other things, that:

> *" …No benefit will be payable in respect of any other condition or event, whether regarded as serious or not … "*

I accept too the Provider's position that the name of the Complainant's policy, a **Specified Illness Protection Plan**, indicates that cover is only provided in respect of the illnesses specified in the policy document.

I can appreciate that the Complainant has been through a very difficult time, although thankfully he was recovering well, at the time when he made his claim to the Provider.

Having regard to all of the evidence however, I am satisfied that it does not support the complaint that the Provider wrongly or unfairly declined to pay the Complainant's specified illness claim.

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Neither do I accept that the Provider failed to warn the Complainant regarding the limitations of the policy cover. I am satisfied that the brochure, the policy document and the Definitions Guide, were all designed to adequately notify the Complainant as to the very specific criteria of the identified conditions to be met, for a policyholder to pursue a claim for policy benefit in respect of one of the identified specified illnesses listed in the policy.

I note that since the preliminary decision was sued by this Office on 21 September 2021, the Complainant's legal representatives have suggested that the Provider might, as a gesture of goodwill, refund the Complainant the amount of the total premium payments that he has made for the policy cover over the years since it was incepted in 2008. In response, the Provider indicated that, on review:

> *"…we have found that we are not in a position to refund the premiums in respect of plan* [number redacted]*. We note specifically that the complainant benefited from valuable cover while the plan was in place. Had he been diagnosed with a covered condition over term of the plan, a lump sum of €50,000 would have been payable. It is for this reason that we do not believe it reasonable to refund the premiums paid on this plan."*

Any request by the Complainant for a goodwill gesture from the Provider, is a matter outside of the conduct giving rise to this complaint investigation, and the FSPO has no role to play in that regard. Insofar as the substantive complaint against the Provider is concerned however, for the reasons set out in detail above, 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

29 October 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—

/Cont'd…

(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.