An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0418
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Claim handling delays or issues Rejection of claim- non-disclosure (life)
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint concerns a Mortgage Protection Policy, taken out in **2014** by the now deceased insured. The complaint has been made by the legal personal representative of the deceased insured, and the representative will be referred to hereinafter as 'the Complainant'.

The complaint is that the Provider wrongfully or incorrectly repudiated the death benefit claim under the policy.

The Complainant's Case

The Complainant states that the deceased insured, passed away in early 2020, having suffered from a *"rare tumour"*. The Complainant submits that a claim was made on the policy for death benefit, which was declined by the Provider on the grounds of non-disclosure by the deceased insured when he proposed for insurance in **2014**.

The Complainant contends that the deceased insured disclosed *"everything relevant"* at the time of proposing, and that his cause of death was unrelated to the information the Provider states was not disclosed. The Complainant states that the deceased insured completed the proposal form *"in good faith"* and that he had fully recovered from the *"prior disease"* by **2014**. The Complainant submits that the *"claimed lack of disclosure did not in any way affect the risk on the policy"*.

The Complainant maintains that the Provider's decision to decline the claim is *"capricious and opportunistic"*.

In the Complainant's submission of **21 August 2020** it is stated that:

> *"In my opinion [the deceased insured] was not being fraudulent and acted in good faith, when he failed to disclose the peripheral vascular disease on the insurance form. He discounted this precisely because he was no longer suffering with it. He had completed treatment for this condition. It was not a disability for him. [The deceased insured] was working and living a normal life when he renewed this insurance policy and this peripheral vascular condition affected him in no way when we dealt with all our insurance matters".*

The Complainant wants the Provider to pay the claim in full.

The Provider's Case

It is the Provider's position that there was ample opportunity for the deceased insured to disclose his medical history, previous surgery, prescribed medication and ongoing specialist review in response to the application questions, however this was not done.

The Provider states that the importance of giving full and accurate information in relation to all Material Facts when answering the health questions is stressed several times throughout the application form and Policy Document.

The Provider submits that the deceased insured was made aware that the information supplied in direct response to the specific health questions on the application form would form the basis of the insurance contract. The Provider says that the importance of disclosing Material Facts, and the consequences of failing to do so, was reiterated to the applicant throughout the application form and also again in the Policy Document. The Provider states that the specific policy terms and conditions are relied upon in repudiating the claim.

The Provider says it does not require that an applicant is a medical person or require knowledge of medical terminology when completing the application form. The Provider says the onus is not on the applicant to determine what aspects of their medical history should, or should not, be disclosed and it is for this very reason the Provider has set out clear and specific questions on the Application form.

The Provider submits that it is the responsibility of the applicant to answer these questions honestly and completely. The Provider says that in turn, it is the responsibility of the Provider to make an informed decision on the risk level of the applicant, relying solely on the disclosures made by the applicant on the application form.

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The Provider states that the policy terms and conditions, as detailed on page 1 of the Policy Document, specifically state: '*if you are in any doubt about whether a fact is material you should disclose full details'.* The Provider says this point is again reiterated on the application form.

The Provider states that the deceased insured had a responsibility to disclose his medical history, previous surgery, prescribed medication and ongoing Specialist review in response to the specific questions on the application form, however this was not done. The Provider says these are material facts that the Provider's Underwriting Department would have relied upon in reaching their decision to accept or reject the insurance application.

The Provider says it fully complied with Provision 4.1 of the Consumer Protection Code 2012 by ensuring that all of the terminology used on the application form, in particular the Health Questions, were set out in clear, accurate and straightforward English. The Provider says key information was brought to the attention of the applicant through the form of the warnings and declarations contained within the application which were set out in highlighted text in order to draw further attention to these statements.

The Provider submits that the consequences of failing to make full disclosure of relevant facts, most notably the applicant's medical history, in this instance were fully explained throughout the policy documentation in line with the Provider's responsibility under Provision 4.35 of the Consumer Protection Code 2012.

The Provider states that there is a warning 'Important Information for Customers' notice contained on the first page of the application form (the Personal Declaration Form) highlighting to the applicant the importance of disclosing all Material Facts, and the consequences of failing to disclose Material Facts.

The Provider states that the deceased insured was made aware that the information supplied in direct response to the specific health questions on the application form would form the basis of the insurance contract. The importance of disclosing Material Facts, and the consequences of failing to do so, was reiterated to the applicant throughout the application form and also again in the Policy Document.

The Provider says that all contracts of insurance are subject to the duty of utmost good faith. The Provider states that under a contract of insurance, there is a duty on the part of the insured to disclose all material facts of which the insured is aware. The Provider states that it relies on an applicant answering all the questions put to them by the Insurer truthfully and to the best of their knowledge.

The Provider submits that in completing the Declaration on the Application Form, the deceased insured warranted that the answers given were honest and complete and agreed that failure to disclose any material fact may invalidate the contract. The Provider says that the definition of a material fact is clearly explained in this declaration, in particular making reference to any facts in relation to the applicant's health.

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The Provider says that the ongoing duty of disclosure was reiterated to the Financial Advisor, who submitted the application form directly to the Provider on behalf of his client, in correspondence dated **5 March 2014** stating as follows:

> *'Please note that your client(s) has a duty to disclose any material facts, which come to light between the date the proposal form is signed and the date the policy is issued. Failure to do so may result in any subsequent claim being refused'.*

The Provider states that the Policy was subsequently issued on **19 March 2014** and copy policy documentation issued directly to the deceased insured. A cooling off letter, dated **19 March 2014**, was provided to the deceased insured which again highlighted the importance of disclosing material information as follows:

> '*Your application was accepted by [the Provider] based on the answers provided by you. Please therefore check the application to ensure that all questions have been answered correctly as failure to provide full and accurate information may result in any future claim being rejected'.*

The Provider submits that a copy of the completed application form, containing the answers provided to the medical questions, was furnished to the deceased insured at the date of policy issue with a request for this to be checked and the following warning message was given:

> *"If any of the questions are incorrect or incomplete please contact us in writing immediately but no later than 10 days from the date you receive this letter'.*

The Provider rejects any suggestion that it has acted in a capricious or opportunistic manner. The Provider states that the fact of the matter is that the deceased insured did not disclose important facts relating to his health in response to specific questions directed to him on the Proposal Form.

The Provider says these questions were set out in clear, plain English and not disguised in medical terminology. The Provider submits that the importance of answering these questions correctly, and the consequences of failing to do so, were highlighted on several occasions throughout the application literature.

The Provider's states that its Underwriting Department did review this medical history retrospectively to establish if a reduced benefit payment on this claim could be considered. The Provider says that the Underwriting Department confirmed that this application would not have been accepted, under any terms, had the full medical history been disclosed and therefore it states that there can be no consideration given to a reduced payment.

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Evidence

The Provider's timeline of events

4 March 2014 - The Financial Advisor, submitted an Application Form through the Provider's online submission system. The Provider says this system is available to Financial Advisors only. This was a Guaranteed Mortgage application for the deceased insured for a 20 year single life policy with Life Cover of €120,000.00.

On the completed application form, the deceased insured confirmed he was suffering from a hip fracture - slight discomfort in his hips and had visited his GP in relation to this. No other disclosures in relation to his medical history were made.

4 March 2014 – The Financial Advisor clarified by email that the deceased insured had not suffered a hip fracture but had visited his GP in relation to a slight discomfort in his hips.

5 March 2014 - The Provider issued an 'Arthritis / Muscle / Joints Questionnaire' for completion by the deceased insured, further to the disclosure he had made on the application form.

13 March 2014 - The Financial Advisor returned the completed Medical Questionnaire, by email, to the Provider. The deceased insured provided the following details on this completed Questionnaire:

· Mild form of osteo-arthritis diagnosed May 2013 affecting hips only.
· Only symptom was of pain when walking up hills.
· No medication for this or requirement for surgery.
· Awaiting an appointment for review at [name redacted] University Hospital in respect of this condition however advised this could take up to 2 years.

19 March 2014 - The policy was issued with a cooling off letter and policy documentation provided to both the deceased insured and his Financial Advisor. The Provider to the Complainant

> *"We are pleased to enclose a copy of your policy documentation which includes our disclosure notes along with a copy of the electronic application form containing the answers to the medical and other questions you provided. Your application was accepted by [the Provider] based on the answers provided by you. Please therefore check the application to ensure that all questions have been answered correctly as failure to provide full and accurate information may result in any future claim being rejected.*
>
> *If any of the questions are incorrect or incomplete please contact us in writing immediately but no later than 10 days from the date you receive this letter. We will acknowledge receipt of your letter within 5 days. It is important that you read through your policy documentation carefully to make sure that the policy will meet your needs".*

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[date redacted] 2020 – Financial Advisor emailed the Provider advising of the death of the policyholder.

15 May 2020 - Details of the death benefit payable and the claim requirements were issued to the Advisor. In addition, the Provider requested a medical report from the deceased insured's attending GP.

28 May 2020 – The GP submitted the completed medical report to the Provider, and confirmed the cause of death was … (this was also confirmed on the submission of the Death Certificate). The GP provided shortened details of his patient's medical history which referenced a 9 day admission to [name redacted] Hospital in 2011 due to critical ischaemia of the left lower limb, in addition to a history of intermittent claudication (pain/cramping in the lower leg due to inadequate blood flow to the muscles).

18 June 2020 - The Provider requested a detailed medical history which the GP forwarded on this date. This confirmed the following in relation to the deceased insured's medical history:

· Suffered a left common iliac artery and external iliac artery aneurysm in August 2011 and underwent angioplasty in his left common iliac artery and external iliac artery and stenting of the common iliac artery.
· Subsequently developed a distal emboli which required surgical embolectomy.
· Attend for a review appointment with a Consultant General and Vascular Surgeon, Outpatients clinic on **20 March 2014** – 6 days following the policy issue.
· Was on regular medications of Aspirin and a Statin at the time of taking out the policy.

The Provider states that this medical history was referred to the Provider's Underwriting Department for full review.

02 July 2020 – Completed Underwriting Referral Sheet

> *"Arthritis of the hip is only condition disclosed on the application and was accepted with a client questionnaire.*
>
> *2011 he had a angioplasty of L common iliac artery and EIA and stenting of the CIA and then developed emboli which required an embolectomy surgery.*
>
> *This would fall into the category of severe peripheral vascular disease (surgical intervention) and in life guides in 2011 this was a decline – it is still a decline. Loadings at the time were much higher than now but it would be a decline on manual in 2011 and also current manual.*
>
> *We would not have offered terms here – note I have not factored smoking into this decision"*

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8 July 2020 - Correspondence confirming the decline of the claim, and voidance of cover, was issued to both the Financial Advisor and the Complainant.

The Complainant's Solicitors subsequently wrote to the Provider in July 2020 appealing this decision, stating that the deceased insured had honestly answered all questions on the application form.

6 August 2020 - The Provider issued a response to the Solicitors explaining the reason for the claim decision.

Further correspondence was received from the Solicitors in September 2020 enclosing letters from the Consultant Vascular Surgeon, and the GP.

The GP confirmed that the deceased insured suffered from peripheral artery disease and remained under the care of the Consultant Vascular Surgeon until his discharge in June 2016. The GP also stated that this medical history was not linked to cause of death. The Consultant Vascular Surgeon confirmed surgical intervention for significant peripheral arterial disease, affecting the blood supply to left leg, in 2011 with regular follow up until June 2016.

The decision to decline the claim remained unchanged.

A Final Response letter was issued in **September 2020**.

Policy Provisions

The policy terms and conditions are set out in the Policy Document.

At Page 1 of the Document, the 'Introduction' states as follows:

> *'The application form that you 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 Special Terms Appendix taken together form the life insurance contract between you and [the Provider] …'*
>
> *'[The Provider] will pay to you or your legal representative….the insurance benefits when the insured event happens, subject to the conditions contained in this policy and providing that the following requirements are met:*
> *(a) …..*
> *(b) All declarations and statements you and the Life or Lives Insured have made are true'*
>
> *'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*

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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'.

As stated in the Policy Document, the application form also forms the basis of the life insurance contract.

Application Form

In the Important Information for Customers' notice contained on the first page of the application form (the Personal Declaration Form) it highlights to the applicant the importance of disclosing all Material Facts, and the consequences of failing to disclose Material Facts as follows;

'You must carefully read the statements below regarding your commitment to provide honest and complete information to us together with all of the Customer Declarations…

Note that all of the information you provide in the Personal Information Form must be true and complete otherwise payment of any future benefit may be affected'.

There is a further addendum to this notice as follows:

'Your commitment to provide honest and complete information to us:

I am aware that if I do not answer all questions honestly and completely, then [the Provider] may not pay out if I need to make a claim in the future.

I understand that [the Provider] will not necessarily obtain a report from my doctor, so it is vital that I fully disclose all Material Facts (see overleaf).

I understand that [the Provider] will assess my application based on the information in this form. I understand that it is my responsibility to check that my completed application is honest and complete before submitting it to [the Provider]'.

On Page 2 of the application form there is a Policy Declaration which reiterates the applicant's declaration that all answers and statements in the form are true and complete in particular making reference to the definition of Material Facts as follows:

*'**Material Facts**: I understand that I must disclose all Material Facts. A Material Fact is any fact that may influence the assessment and acceptance of an application for insurance or may increase the possibility that you will make a claim under this policy. If you are in any doubt about whether a fact is material, you should disclose full details'.*

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A declaration is made and signed by the applicant as follows:

> *"I confirm the I have read, fully understand and agree to all parts of the above declarations ((i), (ii),(iii) and (iv)) the commitment to provide honest and complete information on page 1 and that, as policy owner I will be the beneficial owner(s) of this policy.*
>
> *I am aware that if I do not answer all questions honestly and completely, [the Provider] may decline to pay a future claim".*

The Complainant's signature and date the **03 March 2014** are then entered on the application form

When completing the application form on **3 March 2014**, the deceased insured answered **'No'** to the following Health Questions:

"Q9. Have you EVER suffered from or received treatment, advice or had investigations for any of the following:

(iv) *Disease of the arteries or veins, aortic aneurysms or poor circulation in the legs.*

Q10. In the LAST 5 YEARS have you suffered from or received treatment, advice or had investigations for any of the following:

(ix) *Other than the conditions you have already disclosed, are you taking any prescribed drugs, medicines, tablets or any other treatment at present? (Please give the name of the condition for which you are taking this treatment, not the medication).*

Q 10 (x) *Other than the conditions disclosed above have you sought medical advice, treatment or had investigations for any other condition in the past 5 years?*

The deceased insured answered **'yes'** to the above question, and advised: ***'hip fracture'*** Details: ***'slight discomfort in hips - visited GP regarding this'***

<u>The Complaint for Adjudication</u>

The complaint is that the Provider wrongfully or incorrectly repudiated the death benefit claim under 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 **11 October 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.

Analysis

My examination and adjudication of this complaint is limited to the complaint made against the Provider in relation to the repudiation of the death benefit claim. My examination and adjudication does not extend to matters pertaining to any conduct of the Independent Intermediary (the Broker who sold the policy) in relation to the advices given to the deceased insured, or in relation to the completion of the application form. The Provider would not be responsible for the actions of an Independent Intermediary.

My role is to assess whether it was reasonable for the Provider to decide that the facts relative to the deceased insured's full health history, that he is said to have not disclosed to the Provider in 2014, were material facts. The matters not disclosed were the surgical intervention for significant peripheral arterial disease, affecting the blood supply to his left leg, in 2011, with medication and regular follow up.

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In deciding this, I am mindful of the decision in *Chariot Inns Ltd v Assicurazioni Generali spa [1981] IR* 199 wherein the Supreme Court stated that the test for materiality is:

> "*...a matter or circumstance which would reasonably influence the judgment of a prudent insurer in deciding whether he would take the risk, and if so, in determining the premium which he would demand. The standard by which materiality is to be determined is objective and not subjective.*"

I am further mindful of the well accepted principle that a contract of insurance is a *"contract of utmost good faith on both sides"* and I note what Mr Justice Barrett in *Earls -v- The Financial Services Ombudsman & Anor [2015] IEHC 536* stated in relation to this duty, wherein he outlined that:

> *"The duty of utmost good faith requires a genuine effort to achieve accuracy using all available sources; to require disclosure of all material facts which are known to an insured may well require an impossible level of performance"*

With regard to my assessment of whether the information that was not disclosed was a material fact, the High Court in Earls (cited above) decided that this office should not proceed on the basis that if a material fact was not disclosed then, it would mean, there has been a breach of the duty of disclosure. Rather in the Court's opinion, this may not always be the case, as the duty arising for an insured in this regard, is to exercise a *"genuine effort to achieve accuracy using all reasonably available sources"* and on the facts of the case in Earls it was noted the proposer's *"memory and experience"* in the characterisation of the event was relevant.

Consequently, it is evident that the test for materiality is an objective one and the proposer is required to disclose every matter which a reasonable person would consider to be material to the risk against which indemnity is being sought.

Furthermore, I note this general duty may be limited in particular circumstances by reference to the form of questions asked in the proposal form. Consequently, I must consider whether the particular questions that were asked of the deceased insured on the Application Form had limited that general duty.

In this regard, it is recognised by Finlay CJ in *Kelleher v Irish Life Assurance Company [1993] 3 IR 393* Finlay CJ that the test is as follows:

> *"whether a reasonable man reading the proposal form would conclude that information over and above it which is in issue was not required"*

Consequently, the question at issue is also to be assessed by reference to the reasonable person.

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The Complainant has stated the following to support the claim for payment under the policy.

> *"I believe he disclosed everything relevant. The cause of death had nothing to do with information claimed not disclosed. .. [The deceased insured] was not a medical person and filled in forms in good faith. He was not being fraudulent when he failed to disclose about prior disease. I believe he fully believed at the time that it was irrelevant, and it was too, as he had by 2014 recovered from it".*

Having examined the Application Form in relation to the policy that gives rise to this complaint, I accept that, a **"material fact"** was correctly defined in the application form and the consequence of a non-disclosure of a material fact was also set out, that is: *payment of any future benefit may be affected'.*

The obligation placed on the deceased insured was to answer questions on the application form fully and it was specifically set out on the application form that if in doubt whether a fact was material such facts were to be disclosed. The deceased Insured declared by his signature on the application form, that the answers he gave were *honest and complete information*.

I accept that the questions on the Application Form, were clear and straightforward. They were not ambiguous or open-ended, and the particular question was clear with regard to whether the deceased insured had ever suffered from or received treatment, advice or had investigations for a disease of the arteries or veins, aortic aneurysms or poor circulation in the legs. I note that the Provider when asking this question placed emphasis on the word "ever" by setting the word out in capital letters "EVER".

Having regard to the medical evidence, I accept that this question was not answered fully and /or correctly on the application form.

In the above regard, I note from a letter dated **27 July 2020** that the Consultant Vascular Surgeon gave the history of the undisclosed medical condition as follows:

> *"[The deceased Insured] was treated by me in 2011 for significant peripheral arterial disease affecting the blood supply to his left leg. He underwent surgical intervention at that time which was successful in terms of restoring good blood supply to his left leg. He underwent follow up review post operatively on regular intervals, at yearly intervals until June 2016 ...".*

The medical evidence shows that the Complainant was also taking medication for the condition at the time of the application for cover.

While it may be that the cause of death was not linked to the undisclosed medical history, I accept that the application for insurance cover would not have been considered by the Provider had this health history been disclosed to the Provider at proposal stage.

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As I accept that the material facts not disclosed by the deceased Insured would have reasonably operated on the mind of a prudent insurer assessing and accepting the risk, I accept that the Provider did not act unreasonably or outside the terms and conditions of the policy in arriving at its decision in relation to the death benefit claim. Therefore, 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***.***

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

11 November 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

ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.