Decision Ref:	2021-0448
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Rejection of claim - non-disclosure Failure to provide correct information
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainants incepted a **Life Home Cover Policy** with the Provider on **25 August 2005**, which provided them with accelerated life and specified illness cover in respect of both lives. This complaint concerns the Provider's decision to decline the First Complainant's specified illness claim.

The Complainants' Case

The First Complainant was diagnosed with Multiple Sclerosis in **October 2013**.

The First Complainant later completed a Specified Illness Cover **Claim Form** to the Provider on **8 June 2018**.

Following its assessment, the Provider wrote to the Complainants on **18 October 2018** to advise that it was retrospectively excluding Multiple Sclerosis from the First Complainant's cover and declining her specified illness claim, due to the nondisclosure of material facts, in particular that her mother had been diagnosed with Multiple Sclerosis [age redacted] but the First Complainant had, on **4 April 2015**, answered *"No"* in response to the following health question asked on the policy application form:

> *"**15.** Have your parents or any of your brothers or sisters suffered or died from heart disease including cardiomyopathy, stroke, kidney disease, cancer, multiple sclerosis, Huntington's chorea, polycystic kidneys, polyposis of the colon or other hereditary disorder before age 60? Note: If you are adopted please answer 'No' to this question"*

The Complainants had met with one of the Provider's Financial Advisers on **4 April 2005** to apply for the policy, and the First Complainant says she informed the Adviser during this meeting that her mother had been diagnosed with multiple sclerosis.

In addition, the Complainants say the page of the **Underwriting details for [the First Complainant]** document that contained Question 15 and the First Complainant's recorded answer of *"No"* was missing from the policy documents that the Provider had posted to them in 2005. As a result, the Complainants say it was not possible for the First Complainant to learn that her answer to Question 15 had been recorded incorrectly and to notify the Provider of this error.

The Complainants wrote to the Provider in **November 2018** to appeal its decision to decline the claim, however following its review the Provider wrote to the Complainants on **13 December 2018** to advise that it was standing over its decision to retrospectively exclude Multiple Sclerosis from the First Complainant's cover.

The First Complainant sets out the Complainants' complaint in the **Complaint Form** they signed, as follows:

> *"I was diagnosed with M.S. (Multiple Sclerosis) in [Date Redacted] . At an insurance meeting in 2018, I discovered I was covered for M.S. on life insurance I took out with my mortgage back in 2005. On my application for illness cover, I informed* [the Provider] *that my mother suffered from M.S.* [The Provider] *later informed me that my claim was rejected because my mother illness was not disclosed on Q15 of* [the] *form for insurance cover back in 2005. When I checked my copy of the insurance application form from 2005, Q15 was not part of the form I was given, denying me any change of spotting and rectifying any errors and in doing so not to be able to apply for cover at higher cost".*

Similarly, in her undated letter to this Office, the First Complainant submits:

> *"In [Date Redacted] I was diagnosed with Multiple Sclerosis, and at an off the cuff meeting with an insurance agent in 2018 I found out Multiple Sclerosis was on my cover.*
>
> *On my claim form I informed* [the Provider] *that my mother suffered from Multiple Sclerosis.* [The Provider] *refused my claim for* [it] *said this information was not recorded on the Q15 of family history section of my application form back in 2005.*
>
> *I put in an appeal, for when I checked my application form Q15 was not among the package I was given back in 2005, and thereby I was unable to notify* [the Provider] *of any error on the application form. I was notified that had* [the Provider] *had the information* [it] *would have excluded Multiple Sclerosis from my cover.*
>
> *I made it known to* [the Provider] *that I found this to be unfair to be completely excluded from Multiple Sclerosis without opportunity to get cover at a high premium".*

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The Complainants seek for the Provider to reinstate cover for Multiple Sclerosis in respect of the First Complainant and admit the specified illness claim relating to her Multiple Sclerosis diagnosis, which at the date of diagnosis in [Date Redacted] would have been in the amount of **€161,839** (one hundred and sixty-one thousand, eight hundred and thirty-nine Euro).

The Provider's Case

Provider records indicate that the Complainants incepted a **Life Home Cover Policy** with the Provider on **25 August 2005**. The Provider notes that this policy provides the Complainants with accelerated life and specified illness policy cover in respect of both lives, initially in the amount of **€185,000**. This sum assured reduces on an annual basis in line with a decreasing mortgage loan against which the policy provides security. The Provider notes that upon the death of either life assured, or should either by diagnosed with and fulfil the definition of a covered specified illness, the sum assured on the date of death or diagnosis of the illness would be paid to the mortgage provider, in its capacity as the policy owner, and the policy would cease.

On **11 June 2018**, the Provider received a Specified Illness Cover **Claim Form** completed by the First Complainant on **8 June 2018**, wherein she advised that she had been diagnosed with Multiple Sclerosis in [Date Redacted]. An enclosed letter from her GP dated **6 June 2018** confirmed the Complainant had been diagnosed with Multiple Sclerosis in 2013.

The Provider notes that the First Complainant advised in the **Claim Form** that her mother had been diagnosed with Multiple Sclerosis in [Date Redacted] , when she was [Age redacted]. The Provider says this was the first it had been made aware of her family history of Multiple Sclerosis, in that the First Complainant had not disclosed this information when applying for the policy in 2005.

In that regard, the Provider says the Complainants met with one of its Financial Advisers on **4 April 2005**. During this meeting, the Adviser verbally asked the Complainants the questions on the application form and recorded the information they provided on the online application form, which was then sent electronically to the Provider. The Adviser's role was also to inform the Complainants as to the importance of disclosing all material facts and the potential consequences of not doing so. The Provider notes that during this meeting, the Complainants signed a **Declaration** in which they acknowledged that they understood their application for cover was based on the information provided by them, their obligation to inform the Provider about all material facts and the potential consequences of not doing so.

The Provider says the online application record indicates that the First Complainant had, on **4 April 2005**, answered *"No"* in response to the following health question asked on the policy application form:

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"15. *Have your parents or any of your brothers or sisters suffered or died from heart disease including cardiomyopathy, stroke, kidney disease, cancer, multiple sclerosis, Huntington's chorea, polycystic kidneys, polyposis of the colon or other hereditary disorder before age 60? Note: If you are adopted please answer 'No' to this question"*

The Provider says it posted the Complainants the **Record of Conversation**, a copy of the online proposal/application form, on **5 April 2005**, the day after their meeting with the Financial Adviser, and this included a copy of both the health questions asked by the Adviser, and the answers provided by the Complainants during the online application process. The cover letter advised:

" …Our decision on whether to accept your application, and if so on what terms, is based on the information you provided in answer to the questions asked in the online application form. Therefore, please carefully review your answers to ensure that they are true and complete. I would again draw your attention to the note on Material Facts …"

The Provider says that, on inception of the policy, it also posted a **Welcome Park** to the Complainants on **25 August 2005**, and this again included a copy of both the health questions asked by the Adviser and the answers provided by the Complainants during the online application process. The cover letter advised:

"You must carefully review your answers to the health questions to make sure they are correct;

If any recorded details are incorrect or if there has been a change in the health of the lives covered between the date you applied for cover and now, you must let us know immediately …"

In relation to the First Complainant's comments that *"when I checked my application form Q15 was not among the package I was given back in 2005, and thereby I was unable to notify* [the Provider] *of any error on the application"* and *"I checked my copy of the insurance application form from 2005, Q15 was not part of the Form I was given, denying me any chance of spotting and rectifying any errors"*, the Provider says it can find no reason why a copy of the full application was not received by the Complainants on two separate occasions.

The Provider says it does not believe that a very relevant page from the **Underwriting details for [the First Complainant]** document in either communication was omitted, and it certainly cannot accept that this occurred on two separate occasions, when it issued the Complainants the **Record of Conversation o**n **5 April 2005** and the **Welcome Pack** on **25 August 2005**. In that regard, the Provider says it finds it impossible to accept that an identical error occurred on two different print runs, months apart. In addition, the Provider is not aware of a similar issue being raised by any other customers.

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In relation to the First Complainant's comments that the missing page *"*[denied] *me any chance of spotting and rectifying any errors and in doing so not able to apply for cover at higher cost"* and that she *"found this to be unfair to be completely excluded from Multiple Sclerosis* [cover] *without opportunity to get cover at a high premium"*, the Provider confirms that if it had been advised of her family history of Multiple Sclerosis, it would not have offered the First Complainant cover for Multiple Sclerosis for a higher premium, due to an unacceptably high risk of multiple sclerosis being inherited from mother to daughter.

The Provider says that to be clear, if the First Complainant had informed it of her family history of Multiple Sclerosis, it would not have allowed her cover for this condition under any circumstances and the Complainants' policy would not have been put in place without a signed indemnity excluding Multiple Sclerosis from the First Complainant's cover. The Provider understands the First Complainant considers this to be unfair, but it says it is bound by strict underwriting rules in this regard that cannot be deviated from.

Following its claims assessment, the Provider wrote to the Complainants on **18 October 2018** to advise that it was retrospectively excluding Multiple Sclerosis from the First Complainant's cover and declining her specified illness claim due to the nondisclosure of material facts, in particular that her mother had been diagnosed with Multiple Sclerosis at the age of [age redacted] but the First Complainant had, on **4 April 2005**, answered *"No"* in response to Question 15 of the health questions asked on the policy application form.

The Provider says that if it had been made aware of the First Complainant's mother's diagnosis of Multiple Sclerosis, cover for this condition would not have been given to the First Complainant or if after the start date of cover, it would have been removed retrospectively. By removing cover for multiple sclerosis retrospectively, the Provider says it has put the Complainants in the position they would have been in, had the Provider been aware of the First Complainant's full medical history at the point of application.

In addition, the Provider noted in its letter of **18 October 2018** that the First Complainant had stopped smoking in **January 2005** but that she had, on **4 April 2005**, also answered *"No"* in response to the following health question asked on the policy application form:

> *"***2.** *Have you smoked tobacco of any kind in the past 12 months or do you intend to smoke in the future?"*

As a result, the Provider advised that Complainants that it had recalculated their policy benefit to €103,061, this being the amount of cover their premium would have purchased had this premium included the increased charge, due to the First Complainant's smoking.

The Provider received a letter from the First Complainant on **12 November 2018** appealing its decision. Following its review, the Provider wrote to the Complainants on **13 December 2018** to advise that it was standing over its decision to retrospectively exclude Multiple Sclerosis from the First Complainant's cover.

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However, despite receiving information from both the First Complainant and her treating medical practitioners stating that she had smoked tobacco within 12 months of completing the online application in **April 2005**, the Provider accepted her explanation for this as provided in her letter of appeal of 12 November 2018, and it reversed its decision to retrospectively apply smoking rates to the First Complainant's cover, thereby allowing her cover to continue at non-smoker rates. The Provider says it believes that it has treated the Complainants fairly in this matter.

The Complaint for Adjudication

The complaint is that the Provider wrongfully or unfairly declined the First Complainant's specified illness claim.

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 **1 November 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 First Complainant, having been previously diagnosed with Multiple Sclerosis in **October 2013**, completed a Specified Illness Cover **Claim Form** to the Provider on **8 June 2018**.

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I note that following its claims assessment, the Provider wrote to the Complainants on **18 October 2018** to advise that it was retrospectively excluding Multiple Sclerosis from the First Complainant's cover and declining her specified illness claim due to the non-disclosure of material facts, in particular that her mother had been diagnosed with Multiple Sclerosis at the age of [Age Redacted] but the First Complainant had, on **4 April 2015**, answered *"No"* in response to the following health question asked on the policy application form:

> *"**15.** Have your parents or any of your brothers or sisters suffered or died from heart disease including cardiomyopathy, stroke, kidney disease, cancer, multiple sclerosis, Huntington's chorea, polycystic kidneys, polyposis of the colon or other hereditary disorder before age 60? Note: If you are adopted please answer 'No' to this question"*

I note the Provider wrote to the Complainants on **13 December 2018** to advise that following its appeal review, it was standing over its decision to retrospectively exclude Multiple Sclerosis from the First Complainant's cover.

The Complainants had met with one of the Provider's Financial Advisers on **4 April 2005** to apply for the policy, and I note the First Complainant says she informed the Adviser during this meeting, that her mother had been diagnosed with multiple sclerosis.

I note from the documentary evidence before me that the Provider posted the Complainants the **Record of Conversation**, a copy of the online proposal/application form, on **5 April 2005**, the day after their meeting with the Financial Adviser, and that this included a copy of both the health questions asked by the Adviser and the answers provided by the Complainants during the online application process. I note the cover letter advised, among other things, that:

> *"… The purpose of this letter is to provide you with details of the cover you applied for along with a copy of the online application form questions and your answers for your own records …*
>
> *… Our decision on whether to accept your application, and if so on what terms, is based on the information you provided in answer to the questions asked in the online application form. Therefore, please carefully review your answers to ensure that they are true and complete. I would again draw your attention to the note on Material Facts …"*

In that regard, the 'Important Notes' section at page 4 provided:

> ***"Telling* [the Provider] *about Material Facts***
>
> *Please remember that you must tell us everything relevant in answer to all of the questions on the application form. If you do not, or if any of the answers to these questions are not true and complete,* [the Provider] *could treat the plan as void. If this happens there will be no cover under the plan and we will not refund the payments. In these circumstances we will not pay a claim.*

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A material fact (relevant information) includes anything that a reputable insurer would regard as likely to influence the assessment and acceptance of an application for insurance. If you are not sure whether something is relevant, you should tell us anyway. As this as automated process we can only regard information recorded on the system as having been disclosed. Any acceptance terms are invalid if hand written information is subsequently added".

In addition, I note the Provider also some 4 months later, on inception of the policy, posted a **Welcome Park** to the Complainants on **25 August 2005**, and that this too included a copy of both the health questions asked by the Adviser, and the answers provided by the Complainants during the online application process. I note the cover letter advised, among other things, that:

"… Your welcome pack contains important information about your plan and we recommend you study these documents carefully to make sure the type and amount of cover are in line with your expectations. This pack includes the following: …

- *A copy of the **health questions and your answers** to these questions are enclosed.*

Your health details

Our decision to accept you for cover is based on the information you provided in either your paper or online application form. It is important that you take note of the following:

- *It is important that you have told us all relevant information that is likely to influence the assessment and acceptance of your application.*
- *You must carefully review your answers to the health questions to make sure they are correct.*
- *If any recorded details are incorrect…you must let us know immediately …*

<u>If any of this information is not correct or if we have not received all relevant information, we may end your cover and refuse to pay any claim</u>. If this happens you will lose all rights under the plan and we will not refund your payments. Therefore if your details are incorrect or you feel there is further information we should be aware of, please do not hesitate to contact our Customer Service Team immediately on [telephone number redacted] *…"*

[Underlining added for emphasis]

I note that this **Welcome Pack** again included the '**Telling [the Provider] about Material Facts'** note.

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The Complainants say that the page of the **Underwriting details for [the First Complainant]** document that contained Question 15 and the First Complainant's recorded answer of *"No"* was missing from the policy documents that the Provider had posted to them in 2005. As a result, the Complainants say it was not possible for the First Complainant to learn that her answer to Question 15 had been recorded incorrectly, and to notify the Provider of this error.

If it were the case that the relevant page had been omitted from the **Underwriting details for [the First Complainant]** document that the Provider posted to the Complainants along with the application documents on **5 April 2005**, and again omitted for the second time from the set of policy documents it posted to them on **25 August 2015** - though it is important to note that there is no evidence before me indicating that this is what happened - I take the view that having read the documentation, then the First Complainant ought reasonably to have noticed that Question 15 regarding her family's medical history and which specifically referenced Multiple Sclerosis, along with the specific information regarding her mother's diagnosis which she says she had provided in response to that question, were not enclosed, and to have then contacted the Provider to advise of this omission.

In posting the **Underwriting details for [the First Complainant]** document to the Complainants along with all the application documents on **5 April 2005** and again with all the policy documents on **25 August 2015**, I am of the opinion that the onus was then on the First Complainant to ensure that all of the information she had provided to the Financial Adviser during the policy application process on **4 April 2005** in response to the health questions, were recorded correctly and fully therein. In this regard, I am satisfied that the cover letters appropriately advised the Complainants to carefully review the enclosed documents and to contact the Provider if any details were incorrect. This correspondence also advised them of the importance of disclosing material facts and of the serious consequences of the Provider ending their cover, in the event of any failure to do so.

It must be noted in that regard that the Complainants were clearly placed on notice within the "**Important Notes**" section of the letter sent to then on 4 April 2005 of how important it was for them to tell the Provider "*everything relevant in answer to all of the questions on the application form.*"

The "***Material Facts***" warning clearly warned the Complainants that:-

> "*If you do not, or if any of the answers to these questions are not true and complete*, [Provider] *could treat the plan as void. If this happens there will be no cover under the plan and we will not refund the payments. In these circumstances, we will not pay a claim."*

I am conscious that the Material Facts warning went on to explain that a material fact was "*relevant information*" which "*includes anything that a reputable insurer would regard as likely to influence the assessment and acceptance of an application for insurance*".

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The Complainants' case is that the First Complainant had at all times intended to and believed she had disclosed her mother's medical history. On that basis, I am satisfied that the Complainants clearly understood that this information was material medical information. In circumstances however, where the policy incepted in **2005** came into existence without this information coming to the Provider's attention, I am satisfied that the policy came into being on the basis of a false premise and, in those circumstances, the Provider was strictly speaking entitled to void the policy in accordance with the contractual arrangements which the Complainants had agreed to in 2005.

It is notable that, in this instance, the Provider elected not to void the policy from inception, which would have resulted in both Complainants having no specified illness or life cover whatsoever. I take the view that the Provider's approach to this unfortunate situation has been more than reasonable, bearing in mind that it could simply have voided the policy in accordance with the Terms and Conditions agreed.

It is also important for the Complainants to understand that if, as she believed, the First Complainant had disclosed her mother's diagnosis of Multiple Sclerosis during the policy application and if this disclosure had been captured on the policy application, the Provider would not then have offered the First Complainant cover in respect of that condition, at any premium level. The Provider has explained that with a family history of that nature, the risk is considered by the Provider to be too high to accept, irrespective of the premium level.

As a result, I accept the Provider's position that by retrospectively removing cover for the First Complainant for multiple sclerosis, that the Provider put the Complainants in the position they would have been in, had the Provider been aware of the First Complainant's full medical history at the point of application. Rather than standing over its strict entitlement to void the policy, thereby removing all cover from both Complainants, I am satisfied that the Provider treated the Complainants very fairly and subsequently amended cover to a level which ought to have been put in place when the policy was incepted in 2005, on the basis of the Complainant's full medical history which it seems she believed she had disclosed to the Provider.

Having regard to all of the above, I am satisfied that the evidence does not support the Complainants' complaint that the Provider wrongfully or unfairly declined the First Complainant's specified illness claim.

It is my Decision therefore, on the evidence before me that this complaint cannot reasonably be upheld.

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Conclusion

This complaint is rejected pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***.

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

25 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

(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.