An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0547
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Mis-selling (insurance)
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns an Income Protection policy. The Provider, against which this complaint is made, is the Broker that sold the policy.

The Complainant's Case

The Complainant submits that she first took out an Income Protection policy in November 2015. The Complainant states that prior to taking out the policy, she disclosed a "*previous depressive episode*". The Complainant acknowledges that a "*Mental Health exclusion*", was included on the policy.

The Complainant contends that she was advised by the Provider that, should she suffer from the same mental illness again, she would not be covered in the event of a claim.

> *"I am aware there was a Mental Health exclusion that was applied to the policy, however the way in which this was explained to me by the provider, was that I would not be covered if I suffered from the same sort of depression again, which I have not."*

The Complainant submits that in 2018, she was "*signed off work by my GP*" and, subsequently, the Complainant has had cause to make a claim under the policy due to being diagnosed with "*reactive depression*", being unable to return to work at the time.

This claim was repudiated by the Underwriters of the policy due to the "*Mental Health Exclusion".*
The Underwriters stated:

> *"No Benefit will be payable under this policy for any illness or disability consisting of or arising directly or indirectly from any mental or behavioural disorder".*

As the policy was purchased through a broker, the Complainant was referred to make an enquiry to the Provider by the Underwriters.

The Complainant was also informed of this by the Provider in its Final Response Letter.

The Complainant contends that on this basis, she was mis-sold the policy by the Provider.

The Complainant is seeking payment of the benefit in full, or "*at the very least a refund of the payments to date*".

The Provider's Case

The Provider, in its response, acknowledged the complaint and reiterated the position of the Underwriters, namely that the claim was invalid due to the exclusion. The Provider contends that the Complainant signed documents agreeing to this at the inception of the policy and has stated:

> "*As we informed you of the exclusion and you accepted the terms, unfortunately we cannot accept that the policy was 'mis-sold'*".

The Complaints for Adjudication

The complaint is that the Provider mis-sold the policy to the Complainant, resulting in her claim under the policy being repudiated by the Underwriters.

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.

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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 June 2021, outlining my preliminary determination 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 issue of my Preliminary Decision, the Complainant made a submission under cover of her e-mail and attachments to this Office dated 7 July 2021, a copy of which was transmitted to the Provider for its consideration.

The Provider, under cover of its e-mail to this Office dated 15 July 2021 advised that it had no further submission to make.

Having considered the Complainant's additional submission and all submissions and evidence furnished by both parties to this Office, I set out below my final determination.

The Complainant has, as part of her post Preliminary Decision submission, detailed her dissatisfaction that "*to* [the Complainant's] *surprise, the* [Preliminary Decision] *neither mentions that the* [the Provider], *failed to provide responses within the time limits set out by the FSPO on numerous occasions in 2020*".

While it is indeed disappointing that the Provider did not meet deadlines set by this Office, I note that the Provider has previously offered explanations regarding delays experienced during the investigation of the complaint by this Office.

Prior to considering the substance of the complaint, it will be useful to set out the relevant terms and conditions of the policy.

Terms and Conditions of the Policy

The underwriter, in declining the claim, relied upon the 'Mental Health Exclusion' which was set out as the first of four 'Special Conditions' to the policy, all of which are reproduced below:

> ***Special Conditions**:*
>
> *No benefit will be payable under this policy for any illness or disability consisting of or arising directly or indirectly from any mental or behavioural disorder (as defined by the World Health Organisation using the International Classification of Diseases*

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(ICD10 or subsequent revision(s) thereof)) including (but not exhaustively) anxiety, depression, bipolar disorder, stress, schizophrenia and schizoaffective disorders, or mental or behavioural disorder due to alcohol or substance use or misuse or any functional somatic symptoms (also known as medically unexplained symptoms) including (but not exhaustively) chronic fatigue, chronic pain, or irritable bowel syndromes or myalgic encephalo-myelitis/-pathy (ME).

This Policy has been accepted on Special Terms

This Application has been rated due to Medical Reasons

Life 1 is rated.

The above Special Conditions, including the 'Mental Health Exclusion', were set out in a stand-alone two-page document entitled 'Special Acceptance Terms' which was enclosed with a letter from the underwriter dated 1 December 2015. That letter noted that the Complainant's application had been "*rated due to medical reasons*" and that the Complainant would need to sign and return the 'Special Acceptance Terms' before the policy would take effect. The 'Special Acceptance Terms' were signed by the Complainant on 16 December 2015 with a stamp and returned to the underwriter.

Analysis

This is a complaint of mis-selling of an income protection policy. Essentially, the Complainant contends that the policy sold to her by the Provider was not fit for purpose on the basis that it did not provide cover to her when she sought to rely on it. Specifically, in 2018, when the Complainant was signed off work by her GP with a diagnosis of reactive depression as a result of bullying in the workplace, the underwriters of the policy declined cover citing the 'Mental Health Exclusion' included on 'Special Acceptance Terms' signed by the Complainant.

The Complainant articulates her complaint in the following terms:

I received a letter dated 11th December, advising me that I was not covered under the exclusion on my policy … I was shocked and very upset on receiving this letter as I know that I was advised by [the Provider] *on numerous occasions while trying to get me to take out the insurance that if I was unfortunate enough to be unwell for more than 6-months, I would be able to claim on this policy which at the very least would pay my mortgage. I was aware there was a Mental Health exclusion that was applied to the policy, however the way in which this was explained to me by* [the Provider] *was that I would not be covered if I suffered from the same sort of depression again, which I have not.*

The Complainant maintains that she was advised orally that the Mental Health Exclusion (of which she was aware) would only apply in respect of a recurrence of an illness or type of illness previously suffered.

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The Provider disputes this and maintains, on the contrary, that the detail of the Mental Health Exclusion was explained to the Complainant. There is thus a dispute as to fact between the parties. I am satisfied however that I can resolve this complaint without coming to any determination on this dispute.

It is common case that the Complainant received, reviewed and signed the 'Special Acceptance Terms'. An email from the Complainant to the Provider of 16 December 2015 confirms that the Complainant had *"reviewed the document*" and that she would "*sign the doc now with the special condition*". The 'Special Acceptance Terms' is a short document. There are four Special Conditions with only the Mental Health Exclusion running to more than nine words. I am satisfied that in referring to the 'special condition' in the singular in her email of 16 December 2015, the Complainant was referring to the Mental Health Exclusion.

The Special Acceptance Terms document appears to have been furnished to the Complainant no later than 3 December 2015 and was signed by her on 16 December 2015. The relevant terms of this document are concise and unequivocal in excluding cover consisting of or arising from various ailments including depression. There is no reference at any point to previous illnesses suffered; cover is plainly excluded in respect of all mentioned ailments regardless as to whether a future episode is a first occurrence or a recurrence. The Mental Health Exclusion is very clear and any review of it by the Complainant ought to have rendered clear the cover on offer.

The Complainant has, as part of her post Preliminary Decision submission, stated:

> "*in the* [Preliminary Decision] *it is advised that full evidence was provided. This is not accurate. At no point is it mentioned that the* [Provider]*, failed to provide key evidence, that is, copies of numerous calls made to me by the provider advising me wrongly on the policy and what I was and was not covered for especially since I repeatedly asked for the clause to be explained, to which I was assured I was covered on repeated occasions".*

The Complainant further comments that:

> "*In the [Preliminary Decision], it is also stated:*
>
> *"The Mental Health Exclusion is very clear and any review of it by the Complainant ought to have rendered clear the cover on offer.*
>
> *As discussed with the [Provider's] representative in November and December 2015, the exclusion was not 100% clear to me, hence why I therefore requested it to be explained by the broker which were selling it, which I trusted it was, during calls made to me by the [Provider].*

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> *My purchase of this policy was based on this explanation and assurance from the [the Provider] which I later found was mis-sold as it did not cover what they repeatedly advised it would".*

It should be noted that throughout the investigation and adjudication of the complaint reference has been made by the Complainant in relation to the call recordings in question and the Provider's inability to submit these in evidence.

While I note that the Provider has stated it has attempted to retrieve these call recordings from a previous telecom provider, it is most disappointing that the Provider has been unable to retrieve the call recordings. In the absence of the recordings, the Provider has supplied system/call notes regarding contact with the Complainant and its explanation on why the calls failed to be retrieved.

My decision has been reached based off a full review of complaint and the documentary evidence available to me during my adjudication. In consideration of the above and as in my view the Mental Health Exclusion remains very clear and any review of it ought to have rendered clear the extent of the cover on offer.

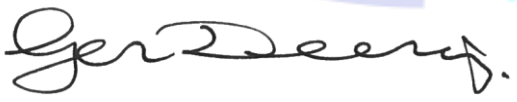
It remains my view that in furnishing the 'Special Acceptance Terms' to the Complainant, and separate from any consideration of any oral communications, the Provider plainly advised the Complainant of the existence and content of the Mental Health Exclusion. On the basis of this, and though I understand the difficulty this poses for the Complainant, it would not be reasonable to uphold this complaint.

For the reasons set out in this Decision, 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.



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FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

21 December 2021

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Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that—

(a) ensures that—

(i) a complainant shall not be identified by name, address or otherwise,

(ii) a provider shall not be identified by name or address, and

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