Decision Ref:	2021-0563
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Maladministration Dissatisfaction with customer service
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint concerns a life assurance policy, which was arranged by the Provider, against which this complaint is made, in its capacity as '*broker*'. The Provider acted as an Independent Intermediary when arranging the life policy for the Complainants, with the Underwriter.

The Complainants' Case

The Complainants state that they met with a representative of the Provider, in their home in or around **23/24 August 2016** in relation to the provision and recommendation of a life assurance policy with critical illness benefits. The First Complainant states that this meeting was organised by the Second Complainant and that the meeting lasted *"approximately 1 minute"* as he had to go to visit a close relative in hospital who was gravely ill. The First Complainant contends that during this brief conversation he was asked some lifestyle questions, including whether he had any health problems which *he answered correctly as being 'no'*. The First Complainant further contends that the Provider *"produced numerous forms and pointed where to sign"* and he (the First Complainant) subsequently left the house, and he never met the representative again.

The First Complainant states that he made a serious illness claim on the policy on **8 March 2018** which was later declined by the Underwriter on **28 June 2018**, citing one of the reasons as *'non-medical disclosure'* in relation to a family history of a central nervous system disease which was not noted on the medical questionnaire of the application. The First Complainant further states that *"I do recall signing the customer consent and*

declaration form in ***August 2016*** *but only when the agent called to my house to finalise the application"* which he says he did before being called away urgently. The First Complainant says that it appears that the questionnaire was completed in the presence of his new partner, the Second Complainant, who would have had "*no prior knowledge of either my medical history or my family medical history".* The First Complainant states in his letter of complaint dated **17 October 2018** that he did not receive a copy of the medical questionnaire upon the issue of the life cover as stated by the Provider in its response letter(s) but does submit in his email to the Financial Services and Pensions Ombudsman office on **28 December 2019** that *"I think my partner may of received it and filed it".* The First Complainant further asserts that the fact that he did not review the questionnaire and was not consulted when the questionnaire was completed ultimately resulted in the declinature of the claim.

The Complainants states that the representative's entire creating of this policy is flawed, that the representative has admitted in his response to postdating documents, and the Complainants question how many documents he post-dated.

The First Complainant states he has found so many inconsistencies including his own date of birth, the spelling of his son's name, posting of forms, and dates on forms. The Complainants state if it was one or two things a person could be forgiven, but *the facts are the facts* and he says the representative's story is untrue.

The Complainants want the Provider to reimburse them with €25,000.00, the amount of cover attached to the life policy.

The Provider's Case

In its response letter dated **19 September 2018**, the Provider states that, having reviewed the file, it was satisfied that throughout the process its representative endeavoured to make the Complainants aware of the importance of disclosing all material facts in relation to the personal medical history and that of immediate family members, and that through no fault of the Provider this information was not disclosed.

The Provider states that following the issue the life cover policy to the Complainants a full copy of the medical questionnaire was posted to the Complainants by the Underwriter on **8 September 2016**, the purpose of which was to give the Complainants an opportunity to review the accuracy of the information recorded and to *"correct any inconsistencies".* The Provider asserts that neither the Provider nor the Underwriter received any communication from the Complainants in relation to this document or its contents. The Provider says that on two further occasions that additional disclosure documentations were signed by the Complainants which highlight the importance of disclosing all relevant medical information. The Provider states that it is satisfied that it acted in good faith upon collecting all relevant important medical information.

The Provider submits that it contacted the Underwriter in relation to the repudiated claim whereupon it was noted that the rejected claim did not fit the exact definition of the

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specific illness covered, and that this may have been the primary reason as to its denial. The Provider states that the Underwriter can only furnish limited information to the Provider in its capacity of intermediary due to sensitivity of the data and suggests that the Complainants make contact with the Underwriter to explore its stance.

The Provider states that based on its representative's account and the documented evidence, the Provider is confident that the following events took place.

- The meeting with both Complainants took place as outlined.
- The health questions were asked of both Complainants and the answers as given were recorded.
- The Complainants were sent both a copy of the online declaration and the cooling off notice, by the Underwriter directly, both of which highlighted the request to check both documents to ensure that the information given was correct.
- The 'Important Note on Completion' and the 'Declaration of Health' are internal Provider documents for the sole purpose of making customers aware of the importance of full disclosure both when the application is being completed and at cover commencement date. These were completed and signed by the Complainants.

The Provider states that despite its representative's endeavours, non-disclosure of material facts from applicants for insurance can still occur on occasion as appears to be the case with the Complainants.

The Provider states that it appears that First Complainant's claim was rejected based on the fact that it did not fit the criteria of the terms and conditions of the policy as laid out by the Underwriter, rather than the claim being denied due to non-disclosure of material facts. The Provider says therefore it fails to see where its role lies in the Complainants' grievance. The Provider says the claim would have been rejected regardless of the information provided or collected at the time of completing the form.

The Provider says that the Complainants also cancelled the policy at their own request rather than it being withdrawn due to non-disclosure. The Provider states it had no role to play in the policy being cancelled. The Provider says it is also very satisfied that its representative on behalf of the Provider, acted with the client's best interest throughout their engagement.

Evidence

13 October 2018 – The Underwriter to the Provider

"The claim itself has been declined as the medical evidence received did not confirm that the Insured had suffered any of the listed illnesses covered by the policy.

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In addition, during the assessment of this claim, the medical evidence confirmed that the Insured had not correctly disclosed a family history (which underwriting have advised would have impacted on the terms offered at policy outset)".

13 November 2018 – The Underwriter to the Provider

"Our Chief medical officer and reinsurers have reviewed this case again and unfortunately we have no option but to continue to decline this claim. The evidence we have received does not confirm that the policy criteria required for a valid serious illness claim to be met, has been satisfied and that the Critical Event occurred following policy issue date. … In addition I note we are still outstanding the signed special terms letter. If your client does not wish to sign this we will have no option but to remove serious illness from the plan".

13 November 2018 – The Underwriter to the Provider

"An exclusion is to be applied to one of the listed conditions under the Serious Illness benefit – we are currently awaiting the return of a signed Special Terms Letter. This exclusion will have no impact on the policy premium. The client will have full details of this exclusion. Should you contact him".

The Complaints for Adjudication

The complaint referred to this office, by the Complainants, is in relation to the Provider's role as an independent intermediary. This office is not investigating the Underwriter's repudiation of the serious illness claim or its application of an exclusion on the policy.

Therefore, the complaint for adjudication is that the Provider proffered poor customer service by:

- Not acting with due care and diligence in the best interests of the Complainants when furnishing medical information to the Underwriter at the inception of the life policy;
- Not completing the medical questionnaire with the First Complainant resulting in the omission of critical medical information.

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.

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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 **22 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.

A Submissions dated **14 December 2021** from the Complainant and submission dated **14 December 2021** from the Provider, were received after I issued my Preliminary Decision to the parties. These submissions were exchanged between the parties. I have considered the contents of these additional submissions, and all the submissions and evidence, for the purpose of setting out my final determination below.

Analysis

In the Complainants' post Preliminary Decision submission dated **14 December 2021** the Complainants furnished a letter from their General Practitioner advising that the First Complainant did not have a brain infraction between 2014 and 2017. The Complainants state that this is new evidence which proves he did not in fact have an *'old stroke'* prior to the policy being taken out with the underwriter, as it is maintaining.

In the Provider's response of **14 December 2021** to the Complainants' post Preliminary Decision submission, it states the Complainants' new evidence appears to challenge the Insurer's reasons for the decline of the claim which is between the Complainants and the Insurer.

The evidence shows that in **August 2016**, the Complainants made the first approaches to the Provider (an Independent Intermediary) to obtain suitable life and serious illness cover. The Provider duly arranged cover, by having an application form completed and a number of declarations signed by the Complainants.

The evidence also shows that it was not the most appropriate time for the First Complainant to give his full attention to such matters, and he appears to have left it to his partner (the Second Complainant) to commence and complete the application process. The First Complainant's close relative was not well at this time, and he had to be with him. The First Complainant's close relative sadly died on or about the time of the completion of the application for cover.

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The evidence shows that both Complainants signed the application form and declarations.

In **March 2018** the First Complainant made a serious illness claim to the Underwriter of the policy, in respect of his health condition. The evidence shows that the Underwriter of the policy turned down the claim on the basis that the First Complainant's medical condition did not meet the policy criteria for payment. The Underwriter also noted that there was a non-disclosure in relation to the First Complainant's medical history.

It is important to note that the Underwriter did not reject the First Complainant's claim due to the non-disclosure. It was rejected because his medical condition did not meet the Underwriter's criteria for payment for the medical condition in question. It is also noted that the Underwriter did not void the policy. The Underwriter merely applied an exclusion in respect of the First Complainant to take account of his non-disclosed family health history. The Underwriter did not increase the premium that was being paid by the Complainants.

I accept that other than the application of the exclusion on the policy by the Underwriter (which would have most probably applied from the outset had the Underwriter been made aware of the First Complainant's family health history), the policy met the Complainants' requirement for life cover and serious illness cover. As with any insurance policy, a claim has to meet the Underwriter's criteria for cover, before a payment is made. I have not investigated whether the Underwriter was justified in rejecting the claim. It is important to note that an independent intermediary would not be responsible where an underwriter turns down a claim in respect of a claimant not meeting the underwriter's policy criteria.

That said, I accept that in relation to the Provider's role: the Provider's representative should not have post-dated or pre-dated documentation in relation to the policy application. The Provider accepts that such post-dating and pre-dating occurred. The Provider advises that the following items were dated on the day that they were being administered in the office (**31 August 2016**) rather than on the date of the meeting **25 August 2016**; the "Terms of Business acknowledgement", the "Factfind", the "Application Form", and the "Important Note on Completion". The Provider's representative also says that as he did not have an agreed date for the initial face to face meeting with the Complainants, he future dated the Statement of Suitability for **29 August 2016**.

I accept that in all the circumstances of this complaint, the Provider's representative should have preferably postponed the finalisation of the application process until both Complainants were in a position to give the fullest attention required for that process. The Provider has stated that when the representative meets customers to complete an application, he normally prepopulates documentation with the information he would have received up to that point and this would only ever include: Names, Address, Phone Numbers, Date of Birth(s). In the particular circumstances I accept that the representative should not have recorded the answers to either medical or personal questions on the application form relating to the First Complainant, as given to him by the Second Complainant, without having the First Complainant later review those answers to confirm if they were correct.

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It was the Second Complainant who had supplied the above information, that was pre-populated on the application form. Here it is evidenced that the First Complainant's birth date, and his son's name was incorrectly recorded by the representative, which supports the First Complainant's position that he did not give those answers directly to the Provider.

In the above regard, the Provider says the Complainants were sent both a copy of the online declaration and the cooling off notice, by the Underwriter directly, both of which highlighted the request to check both documents to ensure that the information given was correct. The First Complainant had initially stated that they did not receive either of these documents, but later stated that his partner, the Second Complainant may have received the online declaration. I accept that had the Complainants received those documents, they could have had an opportunity to correct the inaccuracies recorded by the representative. However, the issue of whether these documents were or were not sent/received would primarily relate to any complaint against the Underwriter (the sender of those documents), not the Provider against which this complaint is made.

To conclude, I accept that the Provider cannot be held responsible for the Underwriter's turning down of the First Complainant's serious illness claim. I accept that the Complainants were not adversely affected by the non disclosed information, that is, the policy was not cancelled by the Underwriter, nor were the premiums increased by the Underwriter. Therefore, I accept that the direction sought by the Complainant against the Provider, for the payment of the claim amount of €25,000, or the return of premiums that were paid, is not merited here. That said, I do accept that a payment is merited for the above highlighted failings by the Provider in relation to the application process.

I accept that it is reasonable of a customer to expect that the application process is correctly carried out, and that the inaccuracies identified above could have caused the Complainants here to lose their trust in that process. Therefore, as I believe the Provider's conduct was unreasonable I partially uphold this complaint and direct that the Provider pay the Complainants compensation of €750 (seven hundred and fifty euro) for the inconvenience caused.

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially upheld, on the grounds prescribed in ***Section 60(2)(b)*** *the conduct complained of was unreasonable.*

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider make a compensatory payment to the Complainants in the sum of €750, to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants to the Provider.

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- I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

- The Provider is also required to comply with ***Section 60(8)(b)*** 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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

22 December 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.