An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0007
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Rejection of claim - did not meet policy definition of illness
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Policyholder incepted a Term Assurance Policy with the Provider on **22 May 2007** which provided her with life cover in the amount of **€100,000.00** and accelerated critical illness cover in the amount of **€25,000.00**, for a term of 19 years.

This complaint relates to (i) a critical illness claim the Policyholder made in **October 2015** and the Provider's declinature of that claim in **July 2016**, and (ii) a second critical illness claim the Policyholder's Solicitor made on her behalf in **September 2016** and the Provider's failure to process that claim prior to the Policyholder's death on **9 October 2016**. The Complainants are the Executors of the late Policyholder's Estate.

The Complainants' Case

The Complainants say the late Policyholder lived and worked in Ireland and was a mother of four, with two of her children residing in Ireland and two resident in [Asian Country] her country of origin. The Complainants say the late Policyholder was visiting her two children abroad in **September 2015** when she was admitted to hospital on **15 September 2015** and shortly after diagnosed with Systemic Lupus Erythematosus.

The Policyholder competed a Critical Illness **Claim Form** to the Provider on **1 October 2015**, advising that she had been diagnosed with Systemic Lupus Erythematosus on **20 September 2015**, having first developed symptoms on **29 August 2015**.

The Complainants say the Provider would not accept the medical reports from the hospital in [Asian Country] confirming the late Policyholder's diagnosis. They say the Provider advised the late Policyholder that if she returned to Ireland and had her diagnosis confirmed by a consultant physician in Ireland, then her critical illness claim would be admitted. As a result, the Policyholder returned to Ireland and supplied the Provider with medical reports from a Consultant Rheumatologist in Dublin.

Following its assessment, the Provider wrote to the Policyholder on **4 July 2016** to advise that it was declining her critical illness claim as her diagnosis did not satisfy the policy definition of Systemic Lupus Erythematosus, as follows:

> *"The unequivocal diagnosis by a consultant physician of Systemic Lupus Erythematosus with cardiac, central nervous system or renal impairment. Discoid lupus is specifically excluded".*

The Policyholder's condition then deteriorated and she was admitted as an in-patient to a hospital in Dublin on **30 August 2016** with no anticipated date of discharge, at that time. Her Solicitor made a second critical illness claim to the Provider on her behalf on **1 September 2016**.

The Policyholder died shortly after, on **9 October 2016**, before the Provider had completed its assessment of this second critical illness claim. The Complainants say they had asked the Provider on a number of occasions throughout **September 2015** to expediate the processing of this claim, given the late Policyholder's rapidly deteriorating condition.

In its letter to the Provider dated **21 November 2018**, the Solicitor for both the late Policyholder and the Complainants advises, as follows:

> *"When the Deceased received her diagnosis, although she was not informed of her estimated life span, she believed that she had less than a year to live because of the severity of the symptoms she was suffering…We are instructed that the Deceased's wish was to remain in* [Asian Country] *to live out her last months, where she could be cared for by her family where she had a home.*
>
> *At the time of the diagnosis, the Deceased was experiencing severe financial difficulties which were made worse by the costs arising on her admittance into hospital. The Deceased did not have accommodation available to her in Ireland…The Deceased was anxious to repay her daughter and to make provision for her family before her death, out of the proceeds of the* [critical illness benefit]*.*
>
> *Soon after the Deceased received her diagnosis, she contacted* [the Provider]*, from [Asian Country] with a view to ascertaining her entitlements under the Policy…During a telephone call between the Deceased and a member of staff at the Claims Department…the Deceased was informed in no uncertain terms that she would be entitled to* [critical illness benefit] *on receipt of a medical report setting out her condition. It was on this basis that the Deceased commissioned the medical report of* [a hospital in Asian Country] *and forwarded it to* [the Provider]*.*

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By letter dated 7 October 2015 [the Provider's] *claims department responded to the Deceased indicating that* [the medical report from the hospital in Asian Country] *was deficient and that the Deceased's diagnosis will need to be confirmed by a consultant physician registered in the Approved Territories specified in the Policy, which did not include* [Asian Country]*. By letter dated 21 October 2017 after the Deceased had forwarded an additional report,* [the Provider] *indicated that the Deceased was required to return to Ireland for the diagnosis to be confirmed by a consultant physician registered in one of the permitted territories under the Policy. The relevant section of* [the Provider's] *letter states as follows:-*

> *"Please let us know when you intend to return to Ireland".*

At no point did [the Provider] *notify* [the Policyholder] *that her diagnosis was not sufficiently severe to warrant payment under the* [critical illness benefit].

Between October 2015 and November 2015, numerous telephone calls ensued between the Deceased and [one of the Complainants] *of the one part and* [Mr G.] of [the Provider] *of the other part and eventually it was decided that the Deceased would return to Dublin to be assessed by a medical practitioner here in Ireland, which she did.* [The Complainants] *say that* [Mr G.] *made it clear to* [this Complainant] *in no uncertain terms that if the Deceased's medical condition was confirmed by a medical practitioner registered in Ireland the funds the subject of the* [critical illness benefit] *would be available to her immediately. It was only on 6 July 2016, after the Deceased had returned to Ireland (where no accommodation was available to her) when* [the Provider] *confirmed that the Deceased's condition was not sufficiently serious to merit the payment of* [critical illness benefit] *…*

In summary, on 16 December 2015 [a hospital in Dublin] *wrote to* [the Policyholder's] *GP…and confirmed the Deceased was admitted to the Rheumatology Department for symptoms relating to* [Systemic Lupus Erythematosus] *and that she was prescribed a course of steroids to treat same.* [One of the Complainants] *instructs us that he contacted* [the Provider] *several times requesting* [it] *to process the Deceased's claim for* [critical illness benefit] *quickly and he met with* [Mr G.] *at one point.*

By fax 27 May 2016, [the hospital in Dublin] *wrote to* [the Provider] *enclosing a Specialist Medical Report, completed by* [a Consultant Rheumatologist]*, enclosing the Deceased's medical records. One report enclosed…Radiology Report dated 18 November 2015, shows a finding of "Moderate cardiomegaly [enlargement of the heart] with some upper lobe venous diversion". The Preliminary Discharge Summary dated 22 February 2016 confirms that "There is cardiac enlargement and upper lobe pulmonary venous hypertension"*.

By letter dated 4 July 2016, [the Provider] *responded to the Deceased rejecting her claim …*

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> *In the meantime, the Deceased was bedridden for most of the days on which she was not in hospital or attending doctors being treated for the symptoms of* [Systemic Lupus Erythematosus]*".*

The Complainants submit that the late Policyholder qualified for critical illness benefit on **20 September 2015** when she was first diagnosed with Systemic Lupus Erythematosus or in any event, that she qualified for this benefit no later than **18 November 2015**, when a Radiology Report from the hospital in Dublin confirmed a finding of *"Moderate cardiomegaly [enlargement of the heart] with some upper lobe venous diversion".*

The Solicitor further advises in his letter to the Provider of **21 November 2018** that:

> *"On 30th August 2016, the Deceased was admitted to the Intensive Care Unit in* [the hospital in Dublin]*.*
>
> *By letter dated 1 September 2016* [the Solicitor] *wrote to* [the Provider] *confirming that the Deceased was taken into hospital as an in-patient, providing an additional report dated 8 August 2016 from* [a Consultant Rheumatologist at the hospital in Dublin] *confirming the Deceased had an "elevated troponin level" which it is suggested, is evidence of cardiac impairment.*
>
> *A considerable amount of telephone calls and correspondence…between* [the Solicitor] *and* [the Provider's] *claims department took place between 1 September 2016 and the Deceased's death on 9 October 2016 but no substantive response was received from* [the Provider] *and indeed the Deceased's claim was not processed before her death.*
>
> *The Deceased passed away on 9 October 2016 and her remains were repatriated to* [Asian Country]*.*
>
> [The Complainants'] *position is that the stress of the situation exacerbated the Deceased's condition and reduced the length of time she had to enjoy with her family.*

In her letter to this Office sent by email on **26 June 2020**, one of the Complainants submits:

> *"Several opportunities were missed* [by the Provider] *to provide sufficient clarity to* [the late Policyholder] *to enable her to make well informed decisions about how to proceed after her discharge* [from the hospital abroad]*, following an* [Systemic Lupus Erythematosus] *flare.*
>
> *It was insufficient to simply inform* [the late Policyholder] *that her claim cannot be considered without a diagnosis from an approved territory (the exclusion of* [Asian Country] *seems somewhat arbitrary). Had she been told that an identical diagnosis would result in a rejection of her claim, she might have reconsidered her return to Ireland.*

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NB: The 'no Protections Benefit' clause for being resident outside an [approved territory] *for more than 13 weeks is unfair and not enforceable under the Consumer Contracts Regulations 1995.*

The consultant rheumatologist [at the hospital in Dublin] *sent two sets of detailed letters and information (firstly in December, 2015 and again in February, 2016), which were rejected and further information was requested. This was unnecessary prevarication, during which time* [the late Policyholder] *become* (sic) *ever more distressed while remaining hopeful that her claim would be successful.*

Had the claim been rejected at that point, again [the late Policyholder] *would have been able to reconsider her options, having not yet reached the state of health she was in by the time she received the rejection sent* [by the Provider] *on 4th July, 2016.*

[The Provider] *received a letter from* [the Solicitor] *on 1st September, 2016 stating that* [the late Policyholder] *was back in hospital with no discharge date in sight, providing details of the extent of her illness, and providing an accompanying letter from* [the Consultant Rheumatologist at the hospital in Dublin]*, dated 8th August, 2016, which provides various vital information about* [the late Policyholder's] *condition, including the following (note cardiac, one of* [the Provider's] *stipulated conditions):*

> *"During* [the Policyholder's] *admission to* [hospital in Dublin] *back in November* [2015] *a coronary angiogram was performed because of symptoms of chest pain and an elevated troponin level which sternly suggested that the chest pain was of cardiac origin". Late in the letter,* [the Consultant Rheumatologist] *goes on to say:*
>
> *The most recent blood tests confirm a diagnosis of* [Systemic Lupus Erythematosus] *but also confirm that the lupus is active…" and goes on to mention five lupus features:*
>
> *"Reynaud's phenomenon, arthritis and arthralgia, non-specific interstitial pneumonitis and chest pain with an elevated troponin level".*

This information should have been sufficient for [the Provider] *to recognise the urgency of* [the late Policyholder's] *situation, the criticality of her illness and that acceleration of the critical illness part of her policy could now be expedited. But instead, again* [the Provider] *prevaricated – not replying until 23rd September* [2016] *(a full three weeks later), saying they had written to* [the Consultant Rheumatologist] *for yet another assessment, while completely ignoring the information they had already received from him to date.*

Another letter on 3rd October [2016] *was written saying* [the Provider] *were now writing to* [another doctor] *after hearing from a letter sent by* [the Solicitor] *on 28th September that* [the late Policyholder] *had moved to his care, again further prevaricating.*

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A further letter was sent on 6th October [2016] *confirming that* [the late Policyholder] *was in ICU with multiple organ failure (i.e. on death's door) and on 7th October* [2016], [the Solicitor] *sent a letter requesting immediate transfer of the €25,000 critical illness accelerated amount. How convenient for* [the Provider] *that they did not receive these letters until after* [the late Policyholder's] *death on 9th October* [2016] *without a cent of assistance to this family.*

The rejection from [the Provider] *sent on 4th July, 2016 in response to the explanation of* [the late Policyholder] *have* (sic) *mixed connective tissue disease with Lupus features being considered insufficient to meet the* [policy] *definition of* [Systemic Lupus Erythematosus] *is unfair, given the confirmation that the illness included Lupus features. It was not a simple* [mixed connective tissue disease] *diagnosis. Furthermore, it is highly debateable as to whether such a thing as an unequivocal definition of* [Systemic Lupus Erythematosus] *exists, given its many ways of manifestation, as noted in* [the Consultant Rheumatologist's] *letter of 21st January, 2019 …*

[The late Policyholder] *died, at the age of 47 years old, for which her death certificate states cause of death as:*

> *"Septicaemia due to methicillin resistant staphylococcus aureus*
> *Mixed connective tissue disease with predominant features of lupus erythematosus*
> *Coronary atherosclerosis".*

So septicaemia resulted from complications, which arose out of [the late Complainant's] *Lupus. The last cause, coronary atherosclerosis, again is clearly cardiac, again one of the conditions in* [the policy] *definition.*

In conclusion, [the Provider] *made it impossible for* [the late Policyholder] *to obtain the critical illness payment at the time of greatest need.* [The late Policyholder] *lived her life from October 2015 until her death in October 2016…moving from hope to despair and distress, as her financial means dwindled to the extent, that her survival became dependent on her sons…and the charity of others.* [The Complainants] *witnessed* [the late Policyholder] *in tears throughout her dying hours (notwithstanding her distress in the months beforehand), knowing that she was unable to provide for her children in the immediate future.*

While the children did eventually receive the [€100,000.00 life cover] *policy funds early in 2019, it is a cruel irony that €25,000 of those funds had been withheld at a time when needed most, denying* [the late Policyholder] *peace of mind in her dying moments, and her children the means to pay for the repatriation of their mother's body to* [Asia], *discharge outstanding loans to* [the hospital in Asia] *and pay for subsequent accommodation. This was only achieved through the charity of others".*

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In addition, in her letter to this Office dated **28 December 2020**, this Complainant also submits that:

> *" … This is such a harrowing case – the endless delays and periods of waiting; the surprise revelation about the definition of* [Systemic Lupus Erythematosus] *that* [the Provider] *uses and its overly narrow nature when* [the late Policyholder] *was clearly critically ill; the fact that the outcome of the claim was so late in coming,* [the late Policyholder] *had only 3 months left to liv and little time to appeal, and ended up dying in Ireland when she wanted to die in* [Asia] *in her daughter's house (this would have saved her family from going through the stress of having her remains repatriated), where cost of living would have been much cheaper for her in her last months than in Ireland; the fact that the insurance money would be released anyway with the possibility that 25% that could, in theory, have been released before her death, and yet was withheld when it was really, desperately needed by the distrait family, while she was dying …"*

In her letter to this Office dated **18 January 2021**, this Complainant further submits:

> *"…I cannot accept that* [the Provider] *could not have known something of the difficulties of the situation, given what was said in the telephone conversations* [between the late Policyholder and the Provider]*. As early as 13th November 2016,* (sic) [the late Policyholder] *already said she was distressed, vulnerable and really ill. On 27th November,* [she] s*aid she was running out of money for her medication. On 23rd March,* [the late Policyholder] *explained that she is not doing anything [working], that she cannot buy anything, that she has no hair now and is horrible looking. She said "I have nothing here – what am I doing here". On 25th May,* [the late Policyholder] *said she was crying every day. On 1st July, she said "this is the end of the work for me". On 4th July, she said she was feeling suicidal, she had no food.*
>
> *It is not enough to say that the definition is in the original paperwork for the policy. It is important that clients are reminded of such information rather than insurers simply hiding behind the small print and then dumping on the* [late Policyholder] *as justification of refusing her claim, so many months later, especially given that English is not* [her] *first language. In listening to the* [recordings of the] *phone calls, at no point until the phone calls in July 2016, was this definition referred to. This really is not fair … especially as they are already contending with such dire news that they have a terminal illness and, in fact, feeling very sick. There was an opportunity to remind* [the Policyholder] *of the definition of* [Systemic Lupus Erythematosus] *at the very beginning when she said on 22nd October, "I want to know – am I entitled or not?" followed by "so, I have to come back there [to Dublin] before I know if I am eligible?" Had she been referred to the* [policy] *definition at that point, she could have then discussed it with her doctor in [Asia], and she could have had the opportunity to make a more informed decision about whether or not to proceed with the claim. Surely this is basic customer care.*

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I understand the amount was eventually paid out, but that cannot compensate for the horror of what the family went through in [the late Policyholder's] *last months, which could have been avoided, had a more considerate approach been taken … "*

In its letter to the Provider dated **21 November 2018**, the Complainants' Solicitor sets out the Complainants' complaint, as follows:

"[The Complainants'] *grievances are as follows:-*

1. *That* [the Provider] *should not have encouraged the Deceased to return to Dublin in circumstances where it was not certain whether or not the Deceased would qualify for Critical Illness Benefit.*

2. *That* [the Provider] *should have identified an issue with the Deceased's diagnosis for the purposes of processing the* [critical illness benefit] *claim when they received the* [report from the hospital in Asia] *in September 2015 and not on 6 July 2016, after the Deceased returned to Ireland.*

3. *That* [the Provider] *should have accepted the Deceased's* [critical illness benefit] *claim on foot of the* [report from the hospital in Asia].

4. *That the request by* [the Provider] *for further information and documentation was arbitrary and unnecessary and only served to unduly delay and obstruct the processing of the Deceased's* [critical illness benefit] *claim.*

5. *That* [the Provider] *did not communicate* [its] *decision on the* [critical illness benefit] *claim to the Deceased or her dependents in a timely fashion or treat them with dignity and respect.*

6. *If it is found that* [the Provider] *was justified in* [point 3] *above, that* [the Provider] *should have accepted the Deceased's claim for* [critical illness benefit] *on 1st September 2016 after having received the report dated 8 August* [2016] *from* [the Consultant Rheumatologist at the hospital in Dublin] *indicating an increased troponin level and the admittance of the Deceased as an in-patient.*

7. *That* [the Provider] *should have acted expeditiously in processing the Deceased's 'second claim' for* [critical illness benefit]*, contained in* [the Solicitor's] *letter of 1 September 2016.*

8. *That if the Deceased's diagnosis of…September 2015 and 8 August 2016 did not come within the definition of* [Systemic Lupus Erythematosus] *in the Policy, that policy is defective in its definition.*

9. *That the Policy is defective and arbitrary in that it fails to acknowledge medical practitioners registered in* [Asia].

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10. *That if the Policy is not defective* [in failing to acknowledge medical practitioners registered in Asia]*, the fact this point should have been made clear to the Deceased at the time she purchased the Policy, her being domiciled in* [Asian Country] *and having the express intention of returning there permanently".*

In this letter, the Solicitor advises that the Complainants are seeking from the Provider the sum of **€23,900 (twenty-three thousand and nine hundred Euro)**, as follows:

"1. Cost of flights for the Deceased to Dublin	*€900.00*
2. Cost of repatriation of remains to [Asia]	*€3,000.00*
3. Compensation	*€20,000.00*
	€23,900.00*".*

The Provider's Case

The Provider says that the late Policyholder incepted a Term Assurance Policy on **22 May 2007** for a term of 19 years. This policy provided her with life cover in the amount of **€100,000.00** and accelerated critical illness cover in the amount of **€25,000.00**; 'accelerated' means that any payment of the critical illness benefit would reduce any life cover remaining payable, by that amount.

The Provider says it received by email on **2 October 2015** a Critical Illness **Claim Form** completed by the Policyholder detailing that she had been diagnosed with Systemic Lupus Erythematosus on **20 September 2015** while visiting family abroad. A Clinical Summary from the hospital in [Asia] was also attached.

The Provider wrote to the Policyholder on **7 October 2015** confirming that her claim was being assessed and that it had written to her GP in Ireland and her treating doctor in [Asia]for information to assess her claim fully and fairly. This letter highlighted the fact that it can take some time for medical reports to be returned and that the diagnosis would need to be confirmed by a consultant physician in one of the approved territories, the full list of which was set out in the letter and which did not include [Asian Country].

In that regard, the Provider says it will only accept a diagnosis by a medical practitioner who is registered in any of the approved territories listed in the applicable **Policy Conditions**. The Provider says this list is quite extensive and consists of Austria, Australia, Belgium, Canada, Channel Islands, Czech Republic, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Isle of Man, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, New Zealand, Norway, Poland, Portugal, Spain, South Africa, Sweden, Slovakia, Slovenia, Switzerland, United Kingdom and the United States of America. Further, the Provider confirms that at the time of her policy application in 2007, the Policyholder could not have availed of a policy from the Provider without this particular condition, being in place. It says that similar stipulations apply in its policies available today.

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The Provider says that on **6 October** and **9 October 2015**, the Policyholder's daughter emailed the Provider medical reports which she confirmed were prepared by the Policyholder's treating doctors abroad. The Provider says the Policyholder's daughter was informed that it would be necessary to verify that these reports did come from the treating doctors, as is usual practice in such circumstances.

The Provider wrote to the Policyholder on **22 October 2015** advising that the diagnosis must be made by a medical practitioner registered in one of the approved territories and because [Asian Country] is not an approved territory, it advised that:

> *" … we will require the diagnosis to be confirmed by a consultant physician in Ireland. Please let us know when you intend to return to Ireland".*

In addition, during a telephone call with the Policyholder on **22 October 2015**, the Provider requested that she inform the Provider when she intended to return to Ireland. In that regard, the Provider says it did not require the Policyholder to return to Ireland but rather it enquired when she was intending to return. The Provider says that because the Policyholder was an Irish resident who lived, worked and had family in Ireland, and was on holidays in [Asian Country] when she first became ill, that it was not unreasonable to have expected that she would be returning to Ireland, at which time her diagnosis could be formally confirmed by an Irish medical practitioner.

The Provider says the Policyholder's treating Specialist in [Asia] emailed it the medical reports on **23 October 2015** that the Complainant's daughter had previously emailed to the Provider, thereby confirming the veracity of these reports. The Provider says it wrote to the Policyholder's GP in Ireland on **8 October 2015** and received back a report on **30 October 2015**, dated 26 October 2015. It wrote to the GP on **25 November 2015** seeking further medical information and received this additional medical information on **11 December 2015**, dated 9 December 2015.

The Provider says the Policyholder telephoned on **6 November 2015** to confirm that she had returned to Ireland and was aware that she would need to have her condition verified by an Irish specialist. On **20 November 2015**, the Provider informed the Policyholder by telephone that it would need to write directly to her Specialist in Ireland to request a medical report. The Policyholder telephoned on **23 November 2015** with the name of her Specialist (and she later, in **January 2016,** furnished the Provider with medical reports from the hospital she attended in Dublin).

The Provider wrote to the Policyholder's Specialist in Ireland on **25 November 2015** seeking a medical report and it says it sent reminders on **30 November**, **9 December** and **16 December 2015** and on **6 January** and **11 January 2016** regarding the outstanding medical report, which it ultimately received on **29 January 2016**. As this report did not provide all the information required to enable it to determine if the Policyholder's illness met the policy definition of Systemic Lupus Erythematosus, the Provider wrote to the Consultant Rheumatologist again on **4 February 2016** seeking additional information.

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The Provider says it received a response on **30 May 2016** which confirmed that Systemic Lupus Erythematosus was not the primary diagnosis, but rather the diagnosis was that of mixed connective tissue disease with some Systemic Lupus Erythematosus features.

Following its assessment of all the information received, the Provider wrote to the Policyholder on **4 July 2016** to advise that it had declined her claim, as follows:

> *"In order for a claim to be paid under your Critical Illness benefit, the condition must exactly meet one of the definition as outlined in the policy conditions. Your claim was assessed under the Systemic Lupus Erythematosus definition.*
>
> *Please note that the definition for Systemic Lupus Erythematosus under your policy is as follows:*
>
> > *The unequivocal diagnosis by a consultant physician of Systemic Lupus Erythematosus with cardiac, central nervous system or renal impairment. Discoid lupus is specifically excluded.*
>
> *Our Chief Medical Officer has carefully assessed the medical information received from your doctor in [Asia] and your GP & Specialist in Ireland …*
>
> *We must unfortunately advise that your claim cannot be admitted for payment. While* [your specialist] *has confirmed a diagnosis of "mixed connective tissue disease with Lupus features", there is no evidence of cardiac, central nervous system or renal impairment which is a requirement of the above definition. Therefore, your condition does not meet the severity criteria for payment as outlined in the above definition … "*

The Provider says that in order for it to assess a claim for critical illness benefit, it needs to obtain medical information from a policyholder and his or her treating doctors to confirm the diagnosis and to confirm whether the illness suffered meets the relevant definition contained in the policy conditions. The Provider says it can take some time for hospital consultants to review and respond to a request for medical information, and that regretfully it cannot make a final decision until all of the required information has been received.

In this case, while the claim assessment commenced in **October 2015**, the Provider notes that all of the medical information it had requested was not obtained until **June 2016**. Having assessed the information it received, the Provider says that while the diagnosis abroad in **September 2015** was that the Policyholder was suffering from Systemic Lupus Erythematosus, by **June 2016** her treating consultants in Ireland had confirmed that her condition had improved and though there were some features of Systemic Lupus Erythematosus, the primary diagnosis was that of mixed connective tissue disease, with the medical reports confirming that there was no cardiac, central nervous system or renal impairment.

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The Provider wrote to the Policyholder on **11 July 2016** to advise that it was open to her to appeal its claim decision and that her claim could be reviewed if her condition deteriorated in the future.

The Provider says that on **1 September 2016**, it received a letter from the Policyholder's Solicitor making a renewed claim for critical illness benefit, as her condition had deteriorated. Enclosed was a letter of authority signed by the Policyholder on 26 July 2016 and a copy of a letter from her treating Consultant Rheumatologist dated 8 August 2016. The Provider received follow-up letters from the Solicitor on **8 September** and **21 September 2016**.

The Provider says that on **23 September 2016**, it wrote to the Solicitor to advise that its Chief Medical Officer had written to the Policyholder's Consultant Rheumatologist for information to assess the claim.

The Provider says that on **28 September 2016**, it received a letter from the Solicitor advising that the Policyholder was now under the care of a different Consultant Rheumatologist. As a result, the Provider wrote to this Consultant Rheumatologist for information on **3 October 2016**, and confirmed this to the Solicitor in its correspondence of the same date.

The Provider says that on **7 October 2016**, it received a letter from the Solicitor enclosing a medical letter from a hospital in Dublin dated 6 October 2016 advising:

> *"*[The Policyholder] *is currently an inpatient in the Intensive Care Unit.* [The Policyholder]*, who has* [Systemic Lupus Erythematosus]*, is critically ill and has multiple organ failure"*.

The Provider says that the Policyholder died on **9 October 2016**.

The Provider says that while it had been asked by the Solicitor to reconsider the Policyholder's critical illness benefit claim in **September 2016** when her condition had begun to deteriorate, regretfully the information it then requested from her treating doctors was not received in time to allow the claim assessment to be finalised prior to her sudden death.

The Provider says that it wrote to the Solicitor on **19 October 2016** setting out the requirements for processing a death claim.

On **16 February 2017**, the Provider received a letter from the Solicitor enclosing a copy of the death certificate and an extract from the will and requesting confirmation relating to the payment of the life cover benefit following the extraction of the Grant of Probate.

The Provider responded to the Solicitor on **23 February 2017** setting out the requirements for the life cover benefit to be paid, with a follow-up letter issued a year later, on **27 February 2018**.

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The Provider says that on **17 September 2018**, it received a letter from the Solicitor enclosing the relevant documents enabling the Provider to process payment of the life cover benefit. The Provider wrote to the Solicitor on **4 October 2018** confirming that the life cover benefit claim had been paid and the sum of **€100,000.00 (one hundred thousand Euro)** had been transferred to their bank account.

The Provider says that it was not suggested to the Policyholder that her critical illness benefit claim was valid but rather it was explained what was required for a claim to be paid. As [Asian Country] is not an approved territory per the policy conditions, the Provider says it did explain that information from an Irish medical practitioner would be required, in the expectation that the Policyholder would be returning to Ireland after her vacation in Asia.

The Provider says it is authorised to sell life and pension products only to persons who are habitually resident in the Republic of Ireland and when assessing the risk it is taking on, at the time of application, this is a factor that is taken into account. At the time of her application, the Policyholder was residing in Ireland and was an Irish citizen. While the Provider accepts medical records from an extensive list of territories, regrettably [Asian Country] is not one of the approved territories and thus additional information is sought to support medical information received from [Asian Country].

The Provider says that features of a policy are discussed with the applicant at the time of sale and in addition, when the **Policy Conditions** are issued, it invites policyholders to carefully read these conditions and reminds them that they have a cooling-off period during which they may cancel the policy.

In response to the Complainants' comment that *"The 'no Protections Benefit' clause for being resident outside an* [approved territory] *for more than 13 weeks is unfair and not enforceable under the Consumer Contracts Regulations 1995"*, the Provider does not agree that the relevant provision (relating to the exclusion of the payment of protection benefits where the policyholder is resident outside the approved territories for more than 13 weeks in any one year) is an unfair term.

The Provider says that it is authorised to sell life assurance to persons who are habitually resident in Ireland and in determining the risk it is taking on and arriving at a premium, it is on the basis that persons habitually resident in Ireland are not based in unapproved territories for more than 13 weeks in any year as set out in the policy conditions.

The Provider addresses the Complainants' comment that any request *"for further information and documentation was arbitrary and unnecessary and only served to unduly delay and obstruct the processing of the Deceased's* [critical illness benefit] *claim"*. The Provider says that it does not agree with this assertion. Where a claim is submitted by a policyholder for one of the critical illnesses covered by the policy, in this case Systemic Lupus Erythematosus, the **Policy Conditions** provide that *"the medical diagnosis supporting the claim must be made by a medical practitioner registered in the Approved Territories"*.

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The Provider says it is also necessary for it to obtain medical information from treating doctors to confirm the diagnosis and to confirm if the illness suffered, meets the policy definition. The Provider notes that it can take some time for it to receive this information before it can conclude its claim assessment. Based on the medical information provided at the time the initial critical illness claim was declined, the Provider says the policy definition of Systemic Lupus Erythematosus had not been met.

In response to the Complainants' comment that the Provider *"did not communicate* [its] *decision on the* [critical illness benefit] *claim to the Deceased or her dependents in a timely fashion or treat them with dignity and respect"*, the Provider says it believes it assessed the claim and communicated in a professional and courteous manner at all times.

In response to the Complainants' comment that the policy *"is defective and arbitrary in that it fails to acknowledge medical practitioners registered in* [Asian Country]*",* the Provider says that the policy is not defective and that the **Policy Conditions** clearly set out the territories that are approved, for the purposes of the policy and that this is just one of the policy terms. The Provider says that as it is authorised to sell life assurance to persons who are habitually resident in Ireland and to provide insurance to those persons only that it is quite usual for an insurer to impose some restrictions for policyholders who travel abroad.

While it is very sympathetic to the late Policyholder's family, the Provider believes it administered her Term Assurance Policy in accordance with its terms and conditions. The definition of Systemic Lupus Erythematosus in the **Policy Conditions** had not been met and the initial critical illness claim had to be declined. The Provider says that in the interest of fairness to all it policyholders, its claims must be administered in accordance with the policy terms and conditions.

The Provider was considering the second critical illness claim when regrettably the Policyholder passed away. The Provider says it is very saddened by the outcome but hopes it can be understood that it had no knowledge what the eventual outcome would be, and that any additional information requested was additional information it required at the time to enable it assess the claim and that steps taken by it were taken in light of the information it had to hand at that time.

The Provider says that upon receipt of the information required, it paid the full life cover benefit of **€100,000.00 (one hundred thousand Euro)** in accordance with the policy conditions and it notes that this is the maximum total benefit amount that was payable under the policy.

The Complaint for Adjudication

The complaint is that the Provider wrongly and unfairly assessed and declined the late Policyholder's critical illness claim in that:

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1. the Provider wrongfully encouraged the Policyholder to return to Dublin in circumstances where it was not certain whether or not she would qualify for critical illness benefit;

2. the Provider failed to identify an issue with the Policyholder's diagnosis for the purposes of processing the critical illness claim when it received the medical report from the hospital in [Asian Country]in September 2015 and (not after the Policyholder had returned to Ireland);

3. the Provider failed to accept the Policyholder's critical illness claim on foot of the medical report from the hospital in [Asian Country];

4. the request by the Provider for further information and documentation was arbitrary and unnecessary and only served to unduly delay and obstruct the processing of the Policyholder's critical illness claim;

5. the Provider failed communicate the claim decision to the Policyholder or her dependents in a timely fashion or treat them with dignity and respect;

6. if it is found that the Provider was correct in not accepting the Policyholder's critical illness claim on foot of the medical report from the hospital abroad, then the Provider should have accepted her claim on 1 September 2016 after having received the report dated 8 August 2016 from the Consultant Rheumatologist at the hospital in Dublin which indicated an increased troponin level and the admission of the Policyholder as an in-patient;

7. the Provider should have acted expeditiously in processing the Policyholder's 'second claim' for critical illness, as presented by the Solicitor in its letter of 1 September 2016;

8. if the Policyholder's diagnosis on 20 September 2015 in [Asia] and/or on 8 August 2016 in Ireland did not meet the policy definition of Systemic Lupus Erythematosus, then the policy is defective in its definition;

9. the Policy is defective and arbitrary in that it fails to acknowledge medical practitioners registered in [Asian Country]; and

10. if the Policy is not defective and arbitrary in failing to acknowledge medical practitioners registered in [Asia], then the fact the policy does not acknowledge medical practitioners registered abroad should have been made clear to the Policyholder at the time she purchased the policy, she being domiciled in [Asian Country] and having the express intention of ultimately returning there permanently.

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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 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 **10 December 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 late Policyholder was visiting her two children in [Asian Country] in **September 2015** when she was admitted to hospital on **15 September 2015**. Two weeks later, she competed a Critical Illness **Claim Form** to the Provider on **1 October 2015**, wherein she advised that she had been diagnosed with Systemic Lupus Erythematosus on **20 September 2015**, having first developed symptoms on **29 August 2015**.

The Provider advised the Policyholder that it could not assess her critical illness claim unless the diagnosis was confirmed by a consultant physician in one of its approved territories, the full list of which was set out in the **Policy Conditions** booklet and which did not include [Asian Country]. As a result, the Policyholder returned to Ireland and then supplied the Provider with medical reports from a Consultant Rheumatologist in Dublin.

Following its assessment, the Provider wrote to the Policyholder on **4 July 2016** to advise that it was declining her critical illness claim because her diagnosis did not satisfy the policy definition of Systemic Lupus Erythematosus, as follows:

> *"The unequivocal diagnosis by a consultant physician of Systemic Lupus Erythematosus with cardiac, central nervous system or renal impairment. Discoid lupus is specifically excluded".*

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Subsequently, the Policyholder's condition deteriorated and she was admitted as an in-patient to a hospital in Dublin on **30 August 2016,** with no anticipated date of discharge given at that time. Her Solicitor then made a second critical illness claim to the Provider on her behalf on **1 September 2016**. I note that, sadly, the Policyholder died on **9 October 2016**, before the Provider had completed its assessment of this second claim.

It is not the role of this Office to adjudicate in conflicts of medical evidence. Rather, it is the role of this Office to examine the totality of the medical evidence which was before the Provider at the time to determine whether the decision made by the Provider in **July 2016** to decline the late Policyholder's critical illness claim was a reasonable decision based upon the medical evidence that was available to the Provider at that time, as this is the decision now complained of by the Complainants.

I am satisfied that this is in accordance with the views of the High Court in ***Baskaran v. Financial Services and Pensions Ombudsman*** *[2016/149MCA]*, where the Court confirmed that:

> *"The function of the* [Financial Services and Pensions Ombudsman] *in considering the…complaint was, in general terms, to assess whether or not* [the Provider] *acted reasonably, properly and lawfully in declining the claim of the Appellant"*.

There are a number of elements to the Complainants' complaint and I shall now address each of these elements separately.

1. The complaint that the Provider should not have encouraged the Policyholder to have returned to Dublin in circumstances where it was not certain whether or not she would qualify for critical illness benefit:

I have considered the recordings of the telephone calls that have been supplied in evidence. In particular, I note from the recording of the telephone call that took place between the late Policyholder and the Provider on **22 October 2015** the following relevant exchanges:

Agent: *Are you returning to Ireland soon? …*

Do you know when you will be coming back to Ireland? …

… What we'll probably have to do is get your condition verified by a medical consultant, a relevant consultant, in Ireland …

… but we will need your condition to be verified by a consultant in Ireland, I assume when you return to Ireland that for ongoing kind of management of your condition that you'll have, you'll have to start attending a specialist? …

… we'll need your condition to be verified by a doctor in Ireland …

/Cont'd…

Policyholder: *… and now I want to know, if I am entitled to this or not?*

Agent: *Ok, well before we confirm anything we'd need to have your condition verified by a relevant consultant in Ireland –*

Policyholder: *You mean I have to come back there before I know if I will be, I will be –*

Agent: *Yes. Yes … Well, I think when you return to Ireland you'll probably, you know, start attending a specialist over here, and then once you do that we'd write to that specialist for confirmation of your, of your condition …*

… there isn't a doubt from the information, it's just a part of the policy conditions that we would need your condition verified by a relevant medical practitioner in, in the approved territories and [Asian Country] *isn't,* [Asian Country] *isn't included in that. So, in all these cases, we'd, if you're returning to Ireland, we'd need your condition verified by a doctor in Ireland …*

… Basically we'd need your condition verified by a consultant over here, ok? So I suppose it's up to you to kind of register with a consultant …

… when you know when you're coming back to Ireland, you might let us know also …

I note Section D, '**Claim Procedures and Exclusions'**, at pg. 13 of the applicable **Policy Conditions** booklet states:

> *"Where the conditions require the diagnosis of a registered medical practitioner, he or she must be registered as a medical practitioner in one of the following territories: Austria, Australia, Belgium, Canada, Channel Islands, Czech Republic, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Isle of Man, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, New Zealand, Norway, Poland, Portugal, Spain, South Africa, Sweden, Slovakia, Slovenia, Switzerland, United Kingdom and the United States of America".*

I am satisfied that the Agent was correct in advising the Policyholder throughout the telephone call on **22 October 2015** that in order to progress her critical illness claim, her medical condition would need to be verified by a relevant medical practitioner in one of the approved territories, the full list of which was set out in the **Policy Conditions** booklet and which did not include [Asian Country]. It seems from the audio evidence that the Agent assumed that the Complainant would be returning to Ireland

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I note when the Policyholder asked the Agent whether she was entitled to the critical illness benefit, he clearly responded that:

> *"Ok, well before we confirm anything we'd need to have your condition verified by a relevant consultant in Ireland".*
>
> [underlining added for emphasis]

In that regard, I am satisfied that the Agent did not suggest or confirm that the Policyholder's critical illness claim would automatically be admitted once she returned to Ireland and attended a relevant medical consultant. Instead, he explained that having the condition verified was a step that had to be taken before a claim decision could be confirmed.

I am also satisfied that the Agent was not in a position to advise the Complainant that her claim would be unsuccessful or otherwise, because a claim decision could not be made by the Provider until such time as a relevant medical consultant in one of the approved territories had confirmed the Policyholder's diagnosis.

In addition, I accept the Provider's position that its Agent did not encourage the Policyholder to return to Ireland. In that regard, as her policy postal address was an Irish address and as she was an Irish citizen as well as a citizen of [Asian Country], and as she was hospitalised and diagnosed whilst holidaying in [Asian Country], I am of the opinion that it was reasonable for the Agent to believe, in the absence of her advising otherwise, that she would be returning to Ireland, once she was fit to travel.

2. The complaint that the Provider should have identified an issue with the Policyholder's diagnosis for the purposes of processing the critical illness claim when it received the medical report from the hospital in [Asian Country] in September 2015 and not after the Policyholder had returned to Ireland:

I am satisfied that in accordance with the policy terms and conditions, a fundamental element of the claim assessment process is that the Policyholder's medical condition needed to be verified by a registered medical practitioner in one of the approved territories, the full list of which was set out in the **Policy Conditions** booklet, and which did not include [Asian Country].

As a result, I take the view that the Provider could not carry out a full assessment of the Policyholder's critical illness claim until such time that her medical condition had been confirmed by a relevant medical consultant registered in one of the approved territories. In my opinion, it would have been completely inappropriate for the Provider to have suggested to the Policyholder the outcome of the claim assessment, based solely on the medical reports it had received in September 2015 from her treating doctors who were not in the approved territories.

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3. The complaint that the Provider should have accepted the Policyholder's critical illness claim on foot of the medical report from the hospital in [Asian Country]:

The Policyholder's Term Assurance Policy, like all insurance policies, did not provide cover for every eventuality; rather the cover was subject to the terms, conditions, endorsements and exclusions set out in the policy documentation.

I note that Section D, 'Claim Procedures and Exclusions', at pg. 13 of the applicable **Policy Conditions** states that:

> *"Where the conditions require the diagnosis of a registered medical practitioner, he or she must be registered as a medical practitioner in one of the following territories: Austria, Australia, Belgium, Canada, Channel Islands, Czech Republic, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Isle of Man, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, New Zealand, Norway, Poland, Portugal, Spain, South Africa, Sweden, Slovakia, Slovenia, Switzerland, United Kingdom and the United States of America".*

As [Asian Country] is not listed as one of the approved territories, I am satisfied that the Provider, in accordance with the policy terms and conditions, could not assess the Policyholder's claim based on the medical reports it had received from her treating doctors in that country.

4. The complaint that the request by the Provider for further information and documentation was arbitrary and unnecessary and only served to unduly delay and obstruct the processing of the Policyholder's critical illness claim:

The Policyholder competed a Critical Illness **Claim Form** to the Provider on **1 October 2015**, advising that she had been diagnosed with Systemic Lupus Erythematosus on **20 September 2015**.

In order for a critical illness claim to be admitted, I am satisfied that in accordance with the policy terms and conditions, the diagnosis must exactly meet one of the critical illness definitions as defined in the **Policy Conditions** booklet.

In that regard, Section 2, 'Critical Illness Benefit', of 'Section C - Benefits', at pgs. 7 and 10 of the **Policy Conditions** booklet provides that:

> *"A critical illness is the diagnosis by a registered medical practitioner, and the verification by* [the Provider's] *chief medical officer, of the first occurrence of any of the following illnesses after the policy commencement date …*
> *…*
> ***Systemic Lupus Erythematosus***
> *The unequivocal diagnosis by a consultant physician of Systemic Lupus Erythematosus with cardiac, central nervous system or renal impairment. Discoid lupus is specifically excluded".*

/Cont'd…

I am satisfied that in order for it to assess her critical illness claim fully and fairly, the Provider needed to obtain medical information from the Policyholder's treating doctors in an approved territory to confirm the diagnosis and to confirm whether the illness suffered satisfied the policy definition of Systemic Lupus Erythematosus.

In that regard, I accept that in the course of a claim assessment, the Provider may have cause to write to a consultant on a number of occasions in order to ascertain if the illness suffered satisfies the policy definition of the critical illness being claimed for.

I also accept the Provider's position that it can take some time for hospital consultants to review and respond to requests for medical information and that it cannot make a final claim decision until all of the required information has been received and the Provider's Chief Medical Officer has confirmed whether the policy definition of the critical illness in question has been met.

I note from the documentary evidence before me that the Provider wrote to the Policyholder's Consultant Rheumatologist in Ireland on **25 November 2015** seeking a medical report and it says it sent reminders on **30 November**, **9 December** and **16 December 2015** and on **6 January** and **11 January 2016** regarding the outstanding medical report, which it subsequently received on **29 January 2016**.

I note the Provider advises that because this report did not provide all the information required to enable it to determine if the Policyholder's illness met the policy definition of Systemic Lupus Erythematosus, the Provider wrote to the Consultant Rheumatologist again on **4 February 2016** seeking additional information. I am satisfied that it was in order for the Provider to press for the information it required, and I note the Provider received a response on **30 May 2016**, dated **27 May 2016**, which confirmed:

> *"…*[The Policyholder] *has a diagnosis of mixed connective tissue disorder with Lupus features, Raynaud's phenomenon and non-specific interstitial pneumonitis…".*

5. The complaint that the Provider did not communicate the claim decision to the Policyholder or her dependents in a timely fashion or treat them with dignity and respect:

I note from the documentary evidence before me that the Policyholder's Consultant Rheumatologist wrote to the Provider on **27 May 2016**, setting out her diagnosis as:

> *"…*[The Policyholder] *has a diagnosis of mixed connective tissue disorder with Lupus features, Raynaud's phenomenon and non-specific interstitial pneumonitis…"*

Following its assessment of all the medical information before it, I note the Provider advised the Policyholder by telephone on **1 July 2016** and in writing on **4 July 2016** that it was declining her critical illness claim because her diagnosis did not satisfy the policy definition of Systemic Lupus Erythematosus.

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I do not consider the period of 24 working days between **30 May 2016**, the date the Provider received confirmation of the Policyholder's diagnosis from her treating Consultant Rheumatologist (dated **27 May 2016**) and **1 July 2016**, when the Provider told the Policyholder by telephone of its claim decision, to represent an undue delay on the Provider's part in communicating its claim decision.

In addition, I have listened to the recordings of the telephone calls that have been furnished in evidence and I am satisfied that the different Agents who dealt with the late Policyholder and her children, made great efforts to keep them informed of the progress of the claim assessment and were at all time courteous and treated each of them with dignity and respect.

6. The complaint that if it is found that the Provider was correct in not accepting the Policyholder's critical illness claim on foot of the medical report from the hospital in [Asian Country] then the Provider should nevertheless have accepted her claim on 1 September 2016 after having received the report dated 8 August 2016 from the Consultant Rheumatologist at the hospital in Dublin because it indicated an increased troponin level and the admission of the Policyholder as an in-patient:

The late Policyholder's Solicitor wrote to the Provider on **1 September 2016** to make a renewed claim for critical illness benefit, as the Policyholder's condition had deteriorated.

Enclosed was a copy of a letter from the Policyholder's treating Consultant Rheumatologist to the Solicitor dated **8 August 2016** which advised, among other things, that:

> *"I can confirm that* [the Policyholder] *has a mixed connective tissue disease with predominantly features of systemic lupus erythematosus…She had a recent admission to* [hospital in Dublin] *with a severe drop in her white cells (neutropenia) secondary to the drug Imuran which was discontinued. Her white cells have since recovered.*
>
> *During* [the Policyholder's] *admission to* [hospital in Dublin] *back in November* [2015] *a coronary angiogram was performed because of symptoms of chest pain and an elevated troponin which strongly suggested that the chest pain was of cardiac origin. Apart from minor atheroma in the right coronary artery fortunately the coronary angiogram was unremarkable. On further evaluation* [the Policyholder] *had a high resolution CT scan of thorax which showed a pattern of pulmonary inflammatory changes in keeping with non specific intrastitial* (sic) *pneumonitis most likely related to the underlying* [Systemic Lupus Erythematosus].
>
> *The most recent blood tests confirm a diagnosis of* [Systemic Lupus Erythematosus] *but also confirm that the lupus is very active with an* [erythrocyte sedimentation rate] *of 45. Alkaline Phosphatase and Gamma GT are both extremely elevated at 250 and 335 respectively.* [The Policyholder] *has been commenced on a trial of treatment with Cellcept.*

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> *In summary* [the Policyholder] *has a diagnosis of mixed connective tissue disease with predominantly lupus type features. Her features include: Raynaud's phenomenon, arthritis and arthralgia, non specific interstitial pneumonitis and chest pain with an elevated troponin level. She had just been commenced on a trial of treatment with Cellcept in addition to Prednisolone"*.

In assessing the Policyholder's second critical illness claim and in light of the contents of the letter from her treating Consultant Rheumatologist to the Solicitor dated **8 August 2016** (as cited from above) I am satisfied that it was reasonable and in accordance with the policy terms and conditions for the Provider to write to the Consultant seeking additional information in order to ascertain whether the severity of the illness the Policyholder was suffering with, at that time, satisfied the policy definition of Systemic Lupus Erythematosus.

In that regard, I note from the documentary evidence before me that the Provider's Chief Medical Officer states in her ***Review*** dated 14 January 2019 that:

> *"…**Letter in August 2016 mentioned raised troponin. We requested an up to date specialist report in respect of this** …*
>
> *Again this letter does not confirm* [the Policyholder] *meets our severity criteria which requires renal cardiac or central nervous system involvement.*
>
> *(Coronary artery disease is not a linked diagnosis to* [Systemic Lupus Erythematosus]*).*
>
> *We were absolutely correct to seek an up to date report after the issue of raised troponin was alluded to, as we would then seek to check if* [the Policyholder] *has any myocardial infarction or some other* [Systemic Lupus Erythematosus] *related complications …*
>
> *… No response to our further letter…ever received by the time of* [the Policyholder's] *death"*.

7. The complaint that the Provider should have acted expeditiously in processing the Policyholder's 'second claim' for critical illness, as presented by the Solicitor in its letter of 1 September 2016

I accept that the Provider must assess each critical illness claim in accordance with the policy terms and conditions.

In light of the contents of the letter from her treating Consultant Rheumatologist to the Solicitor dated **8 August 2016** (as cited from above) I am satisfied that it was reasonable and in accordance with the policy terms and conditions for the Provider, in assessing the Policyholder's second critical illness claim, to write to the Consultant seeking additional information in order to ascertain whether the severity of the illness the Policyholder was suffering with at that time, satisfied the policy definition of Systemic Lupus Erythematosus.

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I note from the documentary evidence before me that the Provider's Chief Medical Officer states in her ***Review*** dated 14 January 2019 that:

> *"… No response to our further letter…ever received by the time of* [the Policyholder's] *death"*.

As a result, I am satisfied that the Provider was not in a position in **September 2016** to complete its assessment of the Policyholder's second claim for critical illness.

8. The complaint that if the Policyholder's diagnosis on 20 September 2015 in [Asian Country] and/or on 8 August 2016 in Ireland did not meet the policy definition of Systemic Lupus Erythematosus, then the policy is defective in its definition:

Section 2, 'Critical Illness Benefit', of 'Section C - Benefits', at pg. 10 of the **Policy Conditions** defines Systemic Lupus Erythematosus as follows:

> *"The unequivocal diagnosis by a consultant physician of Systemic Lupus Erythematosus with cardiac, central nervous system or renal impairment. Discoid lupus is specifically excluded".*

In her letter to this Office sent by email on **26 June 2020**, one of the Complainants submits, among other things, that:

> *" … it is highly debateable as to whether such a thing as an unequivocal definition of* [Systemic Lupus Erythematosus] *exists, given its many ways of manifestation, as noted in* [the Consultant Rheumatologist's] *letter of 21st January, 2019 …*

In that regard, in his letter to the Complainants' Solicitor dated **21 January 2019**, the late Policyholder's Consultant Rheumatologist advised, as follows:

> *" … While I would certainly argue that* [the late Policyholder] *had likely cardiac involvement to her systemic lupus erythematosus, I would also be of the view that the particular definition used by* [the Policyholder] *for severity in system lupus erythematosus does not take into account the other ways in which systemic lupus erythematosus can be life-threatening. The* [Provider] *definition talks about "an unequivocal diagnosis by a consultant physician of systemic lupus erythematosus with cardiac, central nervous system or renal impairment". This definition does not include for example those patients with lupus who may have severe haematological complications which may result in either significant infection with septicaemia or possibly severe haemorrhage, both capable of causing death. In the case of* [the late Policyholder] *she had evidence of interstitial pneumonitis, in other words pulmonary inflammatory changes indicating very significant lung involvement related to her systemic lupus erythematosus. Significant pulmonary involvement such as this should be included in the* [Provider] *definition of severity in systemic lupus erythematosus."*

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I am satisfied that the Policyholder's Term Assurance Policy is a contract like any other. It is based on the legal principles of offer, acceptance, and consideration. The Provider may offer terms, and these terms can be accepted by those seeking insurance, who then elect to pay the premium requested, which represents the consideration for the contract.

It is a matter for the Provider to decide the terms of the cover it is willing to offer and in so doing, it is entitled to set the definition for each of the critical illnesses that it is willing to cover.

When defining a critical illness, the Provider may attach certain medical criteria that need to be satisfied in order for a valid claim to arise. The **Policy Conditions** booklet clearly defines Systemic Lupus Erythematosus as:

> *"The unequivocal diagnosis by a consultant physician of Systemic Lupus Erythematosus with cardiac, central nervous system or renal impairment. Discoid lupus is specifically excluded".*

This is the contractual definition which the Policyholder agreed to at the inception of the policy. This included all the terms and conditions set out in the **Policy Conditions** booklet, including the definition of the critical illnesses listed therein.

9. The complaint that the Policy is defective and arbitrary in that it fails to acknowledge medical practitioners registered in [Asian Country]

Section D, 'Claim Procedures and Exclusions', at pg. 13 of the applicable **Policy Conditions** states that:

> *"Where the conditions require the diagnosis of a registered medical practitioner, he or she must be registered as a medical practitioner in one of the following territories: Austria, Australia, Belgium, Canada, Channel Islands, Czech Republic, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Isle of Man, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, New Zealand, Norway, Poland, Portugal, Spain, South Africa, Sweden, Slovakia, Slovenia, Switzerland, United Kingdom and the United States of America".*

[Asian Country] is not listed as one of the approved territories for the purposes of the policy.

As noted above, the Policyholder's Term Assurance Policy is a contract like any other, it is based on the legal principles of offer, acceptance, and consideration. The Provider offers terms, and these terms can be accepted by those seeking insurance, who then elect to pay the premium requested, representing the consideration for the contract. These are the terms which the Policyholder agreed to in the **Policy Conditions** booklet, including the territories that are approved for the purposes of the policy, when she agreed to incept the cover.

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In addition, I accept the Provider's position that where an insurer is authorised to sell life assurance to persons, who are habitually resident in Ireland and to provide insurance only to those persons, that it is not unusual for that insurer to impose certain restrictions for policyholders who travel abroad.

10. The complaint that (if the Policy is not defective and arbitrary in failing to acknowledge medical practitioners registered in [Asian Country]) then the fact the policy does not acknowledge medical practitioners registered in [Asian Country] should have been made clear to the Policyholder at the time when she purchased the policy, given that she was domiciled in [Asian Country] and had the express intention of returning there permanently.

I note that the Provider wrote to the Complainant on **10 May 2007** enclosing the policy documents for her records. I note that the enclosed ***Important information specific to your Term Assurance Policy*** documents provided, among other things, that:

> *"**Make sure the policy meets your needs!** …*
>
> ***If you have second thoughts***
> *If, when you receive your Term Assurance Policy, you feel that it is not suitable for your needs then you may cancel it by instructing us in writing and returning the policy documents to us. The policy will terminate immediately on receipt of this instruction at* [the Provider's] *Head Office. If it is received not later than 30 days after the date of issue of the policy documents then any regular premiums remitted to* [the Provider] *will be refunded in full"*.

If the Policyholder, having read the **Policy Conditions** booklet, was dissatisfied that [Asian Country] was not listed as one of the approved territories, it was open to her to cancel her policy and receive a refund. She did not however, do so.

In addition, I note the Policyholder incepted her Term Assurance Policy with the Provider on **22 May 2007** and did so using an Irish address. In addition, I note the Policyholder was an Irish citizen as well as a citizen of [Asian Country] and as a result, I do not accept that she was necessarily "*domiciled in* [Asian Country]*"* at the time when she took out her policy. There is no adequate evidence before me indicating that she informed the Provider in her policy application that she would be *"returning there permanently"*.

In any event, Section D, 'Claim Procedures and Exclusions', at pg. 13 of the applicable **Policy Conditions** states that:

> *"**2. Exclusions***
>
> *There are a number of circumstances in which a claim for payment of a Protection Benefit or a Children's Protection Benefit will not be admitted. These exclusions, and the protection benefits to which they apply, are as follows:*

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- *No Protection Benefits (except for a Life Cover Benefit or Children's Life Cover Benefit) are payable if a Life Insured or where relevant the child of a Life Insured is resident outside the Approved Territories for more than 13 weeks in any year.*

  Where a claim is made for a Protection Benefit the medical diagnosis supporting the claim must be made by a medical practitioner registered in the Approved Territories.

  For the purposes of this Policy, "Approved Territories" means Austria, Australia, Belgium, Canada, Channel Islands, Czech Republic, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Isle of Man, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, New Zealand, Norway, Poland, Portugal, Spain, South Africa, Sweden, Slovakia, Slovenia, Switzerland, United Kingdom and the United States of America".

I note that in her letter to this Office sent by email on **26 June 2020**, one of the Complainants submits that:

> *"… The 'no Protections Benefit' clause for being resident outside an* [Approved Territory] *for more than 13 weeks is unfair and not enforceable under the Consumer Contracts Regulations 1995 … "*

I do not accept this Complainant's assertion that the exclusion of the payment of critical illness benefit where the policyholder is resident outside the approved territories for more than 13 weeks in any one year, is an unfair or unenforceable term. In paying the policy premium, I am satisfied the Policyholder agreed to the terms and conditions set out in the **Policy Conditions** booklet, including this term.

Accordingly, whilst one must have every sympathy for the Complainants in respect of the very sad and untimely death of the late Policyholder, I am of the opinion that, given the evidence made available by the parties, there is no reasonable basis upon which it would be appropriate to uphold this complaint.

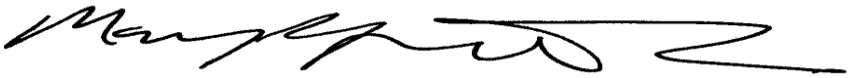
I note that the benefits payable under the policy were promptly paid by the Provider, once the appropriate documentation was supplied by the Complainants, 2 years after the late policyholder's death. Accordingly, I do not accept that there has been any wrongdoing by the Provider in relation to the policy in question and consequently, on the evidence before me that this complaint cannot be upheld.

Conclusion

My Decision, pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is rejected.

/Cont'd…

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

6 January 2022

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.