An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0039
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Claim handling delays or issues Disagreement regarding Medical evidence submitted
Outcome:	Substantially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The complaint concerns the declinature of the Complainant's mortgage payment protection insurance claims.

The Complainant's Case

The Complainant has provided a timeline of events and a written submission outlining her complaint with her Complaint Form. The Complainant says she purchased an insurance product from her Lender in conjunction with a mortgage loan in **February 2002** and a top-up loan in **October 2005**. At that time, the Complainant says the insurance products were underwritten by an insurance provider. However, to the Complainant's surprise, she says she found out on the day of her claim that the insurance provider was no longer the insurer and this was now the Provider.

The Complainant says she submitted a claim to the Provider under her mortgage payment protection policy on **3 October 2017** due to sickness which resulted in an operation. The Complainant advises that the operation proved extremely difficult to recuperate from and, as it became apparent that she was going to be out of work for an extended period of time, she submitted a claim to the Provider.

On **12 October 2017**, the Complainant says the Provider sent a request to her GP seeking further information for the periods **17 February 2002** to **17 February 2005** and from **2 May 2017** to the date of the letter sent to her GP. On **7 December 2017**, the Complainant says, based on the information provided, the Provider denied her claim on the basis that she was first diagnosed with adhesions in **2002** prior to the purchase of the policy. The Complainant says this was not the case as she was not diagnosed with adhesions until **2015** when she had a hysterectomy and the adhesions were discovered.

After submitting her claim, the Complainant says she experienced additional complications, explaining that she was incapacitated for weeks on end and that her daughter had to take care of her and assist with the care of her son who has special needs. The Complainant says she was attending her GP, physio and acupuncturist for stress, worry and pain management. The Complainant says her mood was very low and this was only made worse by the Provider and the frustration of dealing with the Lender over accruing arrears.

On **20 December 2017**, the Complainant says she rang the Provider about submitting supporting documentation from her consultant. The Complainant says she was advised to submit a letter of appeal with documentation from her consultants. At this juncture, the Complainant says she began to realise that the Provider processed and denied her claim without ever seeking any detailed clarification or any medical details from her consultants. The Complainant submits that it should have been clear to the Provider that her care had been passed from her GP to the medical consultant who examined her, assessed her medical condition and arrived at the clinical diagnosis. The consultant, therefore, was the only medical professional who could possibly provide appropriate and accurate details of her medical condition.

On **21 December 2017**, the Complainant says she was sent to a urological specialist who wrote to the Provider stating there was no way her current situation could be linked to **2002**. The Complainant says this consultation led to another operation in **January 2018** to investigate any potential damage that might have been caused from the previous operation and to rule out any underlying sinister causes like cancer. The Complainant says the consultant who performed the surgery in **August 2017** also provided a letter to the Provider stating that in no way could the pain that led to her incapacitation be linked to **2002** and was most likely a result of her hysterectomy preformed in **2015** and therefore impossible to link to an operation the Complainant had in **1985**.

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The Complainant says she spent most of **December 2017** in bed with chronic pain and it became increasingly difficult to deal with the Provider and the Lender. As a result, the Complainant says she had to employ another staff member to replace her in her [business] on a long term basis.

On **5 February 2018**, the Complainant says she telephoned the Provider for an update on her claim to be told that the appeal had not been dealt with but had been *'actioned off'*. The Complainant says she was informed that her medical documentation had been left on someone's desk for over a month but had not been reviewed. Later the same day, the Complainant says she received a call where she was advised that the Provider's medical team had reviewed the file and denied the claim but the Provider could not give a reason for this. The Complainant says she lodged a complaint with the Provider and requested that a supervisor call her back. The Complainant says she also lodged a complaint with the Lender as the Lender was the broker for the policy.

On **8 February 2018**, the Complainant says a supervisor contacted her. The Complainant says she became very upset because the supervisor seemed to be under the impression that the review did not include the information from her consultations. The Complainant says the information the supervisor had was inconsistent and it seemed that the Provider had made an error on the file. The Complainant says the supervisor said there seemed to be gaps in the file but could not expand on what was missing and assured the Complainant that if the Provider needed any more letters from her consultants, the Provider would pay for this. The Complainant says the previous two letters cost €300.00.

On **28 February 2018**, the Complainant says she received a letter denying her claim due to lack of evidence of urinary tract infection from **May 2017**. The Complainant says as this complication came about after her first surgery, she fails to see the relevance of this.

The Complainant says she was attending physiotherapy, acupuncture, GPs and consultants for stress, exhaustion, severe pain and very low mood, and that matters seemed to be further exacerbated by her dealings with the Provider. The Complainant says phone calls with the Provider often left her in tears for hours and often ended in a relapse at the prospect of losing her house due to the accumulation of arrears on the mortgage.

On **6 March 2018**, the Complainant says she received a phone call from a Provider agent who said they were dealing with the Complainant's complaint but that the Complainant's file was missing letters from her consultant. The Complainant says the Provider's agent looked for further information like proof of staff employed in her absence and a work diary.

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The Complainant says she was unclear as to what this was and asked the Provider's agent to send her an email with details of the requested information. The Complainant says it appeared that the Provider was now calling into question her employment status in attempting to develop the level of detail being sought. The Complainant says it was quite clear the Provider did not accept that running her business did not extend beyond 18 hours per week. The Complainant says it should be clear that if her [business] opens in the hours stated that all other work required to be completed does not get done until the second half of the day which includes staff meetings, training, business affairs management, book keeping, compliance management, and health and safety management.

Later that day, the Complainant says she received an email which denied her claim, again with vague details outlining the reasons for the denial. The Complainant says the Provider offered to pay her claim as a goodwill gesture if she could provide further information but did not clearly state what was needed to provide support for the appeal. The Complainant says this email was very distressing and left her disturbed and upset for the rest of the week. The Complainant says she responded to the email looking for clarity and requested access to all data the Provider held.

On **13 March 2018**, the Complainant says she received an email denying her claim. On **15 March 2018**, the Complainant says she phoned the Provider as she had received a letter from the Lender stating that an account liaison person had been appointed to deal with her case. When the Complainant sought to speak with the relevant individual, the Complainant says she was told that this person no longer took calls and when the Complainant asked to speak with a supervisor, she was told a similar story. The Complainant says she became distraught on this call because the Provider's agent refused to speak to her as a final response had been sent to the Complainant and that the claim and complaint were closed. The Complainant says the Provider was not going to answer any of her questions, then or now. The Complainant says she was told to *'take a breath and try to find my words'*. The Complainant says she was outraged, deeply wounded and highly offended at these overtures. The Complainant says she tried to explain her distress and shock as she had not yet received any letters from the Provider. Later that day, the Complainant says she received a letter closing her file and closing the complaint.

In the penultimate paragraph of her submission, the Complainant outlines the impact of the Provider's conduct, as follows:

> *"To say I am disillusioned and frustrated at this process is an understatement. Each week that turns into a month I get further into debt with little hope of any resolution.*

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> *I am already sick and struggling to manage, this process is causing me an undue amount of stress in my life. It has become increasingly upsetting and frustrating; it occupies an unrealistic amount of my energy and time. Every phone call about this either to* [the Lender] *or* [the Provider] *ends in tears and a relapse of my condition. This process has put a strain on my health and all my relationships including my extended family and my son who has special needs."*

The Complainant says arrears are accumulating on her mortgage loan and she is unable to meet these commitments. The Complainant says the Lender's arrears department are in the process of declaring her loan unsustainable and commencing legal proceedings to re-possess or sell her property. The Complainant says the Lender is aware of the problems with the Provider but unfortunately, the process with the Provider could take longer than the Lender is willing to wait.

In resolution of this complaint, the Complainant wants the Provider to admit and pay her claim(s) in full.

The Provider's Case

The Provider says there are two claims: claim reference ending 821 in respect of loan account ending 081 with a policy start date of **23 October 2002** and claim reference ending 820 in respect of loan account ending 572 with a policy start date of **17 February 2005**. The Provider has set out a timeline in respect of each claim reference, beginning with the receipt of a claim form on **5 October 2017**.

The Provider says an automatically generated 'chase letter' issued on **6 December 2017** and that it wrote to the Complainant on **7 December 2017** to advise it had received medical records and these were being reviewed. The Provider says the decision from the Medical Team was received on the same day and the decline letter issued subsequent to this. The Provider says it does not have any record of a medical report from the Complainant's consultant.

On the original claim form completed by the Complainant's GP, the Provider says it was stated that the reason for the Complainant being unable to work was *"Abdominal pain due to adhesions"*. In the following section where the form asks if the Complainant suffered from more than one condition, the Provider says the GP stated: *"Urinary Tract Infections and Hiatus Hernia"*. The Provider says these conditions are assessed separately.

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In the terms and conditions of the policy for **2002**, the Provider says 'Disability' is defined as:

> *"A state of incapacity due to accidental bodily injury or illness as certified by a registered medical practitioner in consequence of which the insured person is totally disabled from attending to the occupation at which s/he was gainfully employed immediately prior to or any occupation for which s/he is fitted by knowledge or training."*

In the terms and conditions of the policy for **2005**, the Provider says 'Disability' is defined as:

> *"disability means any accident, sickness, disease, condition or injury which stops you from doing any paid work. If you are self-employed, a disability must stop you from helping, managing or carrying out any part of the day-to-day running of a business."*

The Provider says that as the Complainant was self-employed, she was asked to provide evidence that she had employed someone to take care of the business for her while she was incapacitated. The Provider says the 'hours worked' were requested on the original claim form and as the Complainant had completed the employer's section herself, the Provider says the form was returned to her to be completed by her accountant or tax office. The Provider says the Complainant's accountant confirmed that she was working 15 hours per week.

The Provider says the Complainant's medical records show that she consulted with her GP in **May 2002** for abdominal pain and a laparoscopy was performed on **18 December 2002** which concluded the existence of adhesion.

Regarding the correspondence from the urological specialist, the Provider says this is from a Consultant Urologist who reviewed the Complainant for recurrent urinary tract infections ("UTI") and that the Complainant's claim was not declined based on the information about UTIs. The Provider says this consultant confirmed that recurrent infections were related to the Complainant's early induced post-menopausal status post hysterectomy. The Provider says the presence of adhesions which was the subject of the Complainant's claim had been consulted for in **2002**, prior to the inception of the policies. The Provider says the claim was declined based on the medical records showing that she consulted with her GP in **May 2002** for abdominal pain and subsequent laparoscopy on **18 December 2002** which confirmed adhesion.

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The Provider says a telephone call took place on **5 February 2018** to advise the Complainant that medical records were reviewed and that the claim was declined. The Provider says the decline was not based on an operation which took place 30 years ago but based on the fact that there was no consultation on **2 May 2017** for UTI and nothing related to UTI until **15 June 2017**. The Provider says at this stage the Complainant was not found to have a UTI and there was no evidence of any UTI until **28 July 201[7]**. The Provider says the Complainant was certified unfit for work with abdominal paid due to adhesions on **2 May 2017** and the GP noted UTI and Hiatus Hernia as secondary conditions, however, the medial records did not confirm a consultation for UTI until **28 July 2017**. The Provider says the decline letter was sent on **6 February 2018**.

The Provider says the claim for UTI would have been validated from **28 July 2017** subject to evidence of ongoing consultations and treatment for the condition. The Provider says this would have continued for a maximum of 12 months or up to when the Complainant returned to work – whichever happens first.

In respect of documentation received relating to the Complainant's appeal, the Provider says that *"*[d]*ue to a user error, records received on 11.02.2018 were completed without being reviewed."* When this was raised during a telephone call on **5 February 2018**, the Provider says the records were referred to its Medical Team and reviewed the same day with the decline letter being issued on **6 February 2018**. The Provider advises that feedback was provided to the relevant agent regarding their mistake.

Regarding a telephone conversation which took place on **6 March 2018**, the Provider says its agent called the Complainant following on from the complaint that was logged. The Provider says its agent did not say that medical information was missing. The agent confirmed what was required in order to validate the claim. The Provider says the Complainant requested that an email be sent to her outlining the Provider's request which was sent on **6 March 2018**. The Provider says the information requested on **6 March 2018** has not been provided and the offer remains in place on validation of the requested information.

The Provider says its agent attempted to assist the Complainant as best they could on **15 March 2018**. When the Complainant became upset, the Provider says its agent suggested that the Complainant take a moment and was not offensive. The Provider says the Complainant called to speak to a Client Relationship Manager whose name had been given by the Lender. However, the complaint from the Lender had already been referred to the Provider's claims team and the agent advised the Complainant of this.

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The Provider says its agent advised that if the Complainant was unhappy with the Final Response that she had the right to refer her complaint to this Office. The Provider says itS agent attempted to engage with the Complainant, however, she was too upset to continue the call.

The Complaint for Adjudication

The complaint is that the Provider wrongfully or unreasonably declined the Complainant's mortgage payment protection insurance claims.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision, I have carefully considered the evidence and submissions put forward by the parties to the complaint.

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on 25 November 2021, outlining my preliminary determination in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

Following the issue of my Preliminary Decision the parties made further submissions, copies of which were exchanged between the parties.

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Having considered the additional submissions and all submissions and evidence furnished by both parties to this office, I set out below my final determination.

In addition to this complaint, a complaint was also received by this Office in respect of the Lender's conduct surrounding the level of assistance provided to the Complainant in respect of her claims ("the Linked Complaint"). In these circumstances, this Office wrote to the Complainant's Representative by letter dated **20 December 2019** requesting consent to the sharing of the evidence in respect of each complaint with the Respondent Provider to the linked complaint. The Complainant's Representative indicated her consent, on behalf of the Complainant, to the sharing of evidence by email dated **23 January 2020**.

This Office wrote to the Provider on **15 February 2021** to inform it of the Complainant's agreement to the sharing of evidence with the Respondent Provider to the linked complaint. This letter enclosed all documentation received in respect of the Linked Complaint up to **17 August 2020**. By email dated **23 February 2021**, the Provider advised this Office that the information was being reviewed. By email dated **10 March 2021**, the Provider advised this Office that it had nothing further to add.

In so far as concerns the Provider's assessment of the Complainant's illness or conditions and its assessment of the medical evidence, it is important to emphasise that it is not the role of this Office to comment on or form an opinion as to the nature or severity of the Complainant's illness or condition. It is the duty of this Office to establish whether, on the basis of an objective assessment of the medical evidence submitted, the Provider has adequately assessed the Complainant's claim and whether it was reasonably entitled to arrive at the decision it did following its assessment of the medical evidence submitted.

Background

The Provider received a 'Disability Claim Form' from the Complainant around **5 October 2017**. The claim form quoted the Complainant's mortgage loan account numbers ending 081 and 573. Section C of the claim form contains a 'Doctors Statement' which states, as follows:

> *"3. Please provide details of sickness or accident*
> *If accident, please give the cause*
>
> *Abdominal pain due to adhesion*
>
> *4. If your patient suffers from more than one sickness or injury, please list them putting the most serious first*

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Urinary tract infections
Hiatus hernia

5. *First date your patient consulted you for this condition* *02 05 17*

6. *First date you certified the patient unfit for work* *02 05 17*

[…]

11. *Please advise us whether your patient has suffered from this or a related condition before?*

[Answer – Yes]

If yes please give details below.

Dates	*Details*
[Day and month redacted]	*Removal of ovarian cyst*
[Day and month redacted]	*Hysterectomy*
[Day and month redacted]	*Laparoscopy with division of adhesions*

[…]"

The claim form also provided details of the Complainant's hospital attendance in **August 2017** and the name of her consultant.

The Provider wrote to the Complainant on **12 October 2017** (in respect of claim reference 820) advising that it had received her claim form in respect of her sickness claim. The letter requested that the enclosed copy of the claim form be completed by her accountant or tax office as the Complainant was self-employed. The letter also advised that once the Provider received this information it would assess the claim against the terms and conditions of the Complainant's cover (which would take 14 days) and inform the Complainant as to whether her claim would be admitted or declined.

By letter of the same date, the Provider wrote to the Complainant's GP (in respect of claim reference 820) requesting the following information:

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"Copies of your patients medical records from 17.02.2004 - 17.02.2005 and 02.05.2017 - to date

Copies of all of the clinical consultation/surgery notes including details of consultation referrals, outpatient appointments, treatments and repeat prescriptions.

Details of any further surgery planned.

When in your opinion will your patient be fit to return to work"

The Provider wrote to the Complainant on **22 November 2017** (in respect of claim reference 821), stating that it had not received a reply to its last letter asking for additional information and indicated that the Provider looked forward to receiving the relevant information in the next 30 days, failing which, it would need to close the claim. The letter also advised that it was to be disregarded if the reply had been sent.

By letter dated **11 November 2017**, the Complainant's GP wrote to the Provider enclosing the Complainant's medical records. It appears this documentation was received by the Provider around **1 December 2017**. In the GP's letter, the GP advised, as follows:

"Question 3 – Details of any future surgery

- awaiting appointment with urology [for] *UTI.*

Question 4
I am unable at present to give a date of fitness to return to work"

The Complainant's accountant completed Section D of the claim form and dated it as **3 November 2017**. The Complainant's accountant also drafted a letter dated **13 November 2017** regarding the Complainant's absence from work. These documents appear to have been sent by the Complainant to the Provider under cover of letter dated **27 November 2017** and received by the Provider around **1 December 2017**. In a submission dated **14 May 2019**, the Provider says this documentation was processed on **7 December 2017**.

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At Section D, the Complainant's accountant stated the number of hours worked by the Complainant per week as 15 hours and her first absence from work due to sickness as **2 May 2017**.

The Provider wrote to the Complainant on **6 December 2017** (in respect of claim reference 820) advising that it had received a completed claim form and that it had written to her GP requesting medical records. By way of a further letter dated **6 December 2017**, the Provider wrote to the Complainant (in respect of claim reference 820) stating that it had not received a reply to its last letter asking for additional information and indicated that the Provider looked forward to receiving the relevant information in the next 30 days failing which, it would need to close the claim. The letter also advised that it was to be disregarded if the reply had been sent. In its Complaint Response, the Provider says another of these letters issued on **7 December 2017**. However, this letter issued in error as medical records had already been received.

An internal Provider email dated **7 December 2017** regarding the Complainant's claim states:

> *"On review of the claim form the doctor identified that the claimant had pre-existing problems.*
>
> *On review of the records this lady has a very long problem of abdominal pain and has undergone numerous investigations.*
>
> *Adhesions were identified in 2002. These were operated on in 2008.*
>
> *I think we should decline the claim due to the fact that ongoing abdominal pain is a long-standing and pre-existing issue. Adhesions were diagnosed prior to the policy and she was aware of these issues during pre-x period."*

The Provider acknowledged receipt of the Complainant's medical records in respect of claim reference 820 by letter dated **7 December 2017** and advised that its medial team was currently reviewing these records. By way of a further letter dated **7 December 2017**, the Provider wrote to the Complainant advising her of its decision to decline claim reference 820, as follows:

> *"Upon review of the circumstances and supporting documentation you have provided us, we are unable to pay your claim.*

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*The following **condition/s** of the insurance policy **has/have** not been met:*

This means:

If you know you have a pre-existing condition or major injury/critical illness at the start date/restart date, or you have seen or arranged to see a doctor about a pre-existing condition during the 12 months immediately before the start date/restart date, we may still insure you. However we will not pay any claims directly relating to that pre-existing condition or major injury/critical illness.

You are claiming for abdominal pain due to adhesions. We note from your medical records the adhesions were first identified in 2002. Unfortunately this is prior you (sic) *when your* [Lender] *payment protection commenced on the 17th February 2005.*

If you check your policy documents you will find the Sickness requirements detailed in the terms & conditions section.

*If you or **your doctor** are able to provide new documented evidence to meet this condition, please send this to us* […]*. When we receive this, we will re-assess your claim based on this new information provided.*

Our reassessment may take a further 14 days, after which we will write to you with our final decision. […]

If you disagree with the final decision you may lodge a complaint […]*."*

The Complainant telephoned the Provider on **20 December 2017** to enquire about the appeals process as she had *"further information"*. The Provider's agent explained the relevant process to the Complainant. The Complainant then asked the Provider's agent for the reason why her claim was declined. In response, the Provider's agent explained that it was because of a pre-existing condition. The Provider's agent advised the Complainant that she could email a copy of this letter to her.

The Provider wrote to the Complainant by letter dated **3 January 2018** (in respect of claim reference 821) stating that it had not received a reply to its last correspondence asking for additional information and indicated that the Provider looked forward to receiving the relevant information in the next 30 days failing which, it would need to close the claim. The letter also advised that it was to be disregarded if a reply had been sent.

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Under cover of letter dated **8 January 2018**, the Complainant forwarded a letter from her Consultant Urologist to the Provider. The Consultant Urologist's letter is dated **14 December 2017** and states:

> *"There is a clinical picture of recurrent urinary infections particularly frequent in the last year. She has typical irritative bladder symptoms and can have haematuria. She's had multiple antibiotics and just finished Ciproxin recently.*
>
> *I note past history ovarian cyst aged fifteen two pregnancies/deliveries, total abdominal hysterectomy and unilateral oophorectomy 2015 and subsequent menopause. She had further surgery for abdominal adhesions 2017.*
>
> *Otherwise history is non-contributory she cannot tolerate Nitrofurantoin. Examination today is non-specific.*
>
> *I reassured this lady that infections are likely innocent but troublesome and related to her early induced post-menopausal status post hysterectomy.*
>
> *I have arranged for repeat urine test an ultrasound renal tract/pelvis and cystoscopy. In the meantime I went through the usual measures of which she was already aware.* […]
>
> *Finally copied this letter to* [the Complainant] *as there was an insurance issue. Her medical condition does not relate to any longstanding complaints."*

The Provider's system notes indicate that medical information was received on **11 January 2018**. The Provider's notes state this information was *"reviewed at this time these were sent to IME to review on the 05.02.2018"*.

The Complainant telephoned the Provider for an update regarding her claim (claim reference 821) on **5 February 2018**. Having looked into the matter, the Provider's agent acknowledged that the Complainant had sent information to the Provider in **January 2018** and advised that she was referring this information to the Provider's medical team for review as it had not been assessed yet. The Provider's agent told the Complainant that *"it looks like it was actioned off I think by error"*. The Provider's agent apologised to the Complainant for this. The Provider's agent advised that she did not know how this error occurred and that the matter would have to be looked into. The Provider's agent advised that she would log a complaint. The Complainant also requested a call back from the Provider.

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An internal Provider email dated **5 February 2018**, regarding claim reference 821 states that:

> *"I have reviewed the medical records on this claim.*
>
> *There is no evidence of a consultation on May 2nd.*
>
> *There is no consultation for anything related to her urinary tract on this claim until 15/06/2017 which is 6 weeks after the insured was certified off sick.*
>
> *At this stage she was not found to have a urinary tract infection and indeed there was no evidence of any urinary tract infection until 28/07 which is over 12 weeks from the date she was first certified and the first findings of a UTI.*
>
> *There is no evidence of a valid claim here.* […]*"*

The Provider telephoned the Complainant later the same day to advise that its medical team had reviewed the medical information provided and that the claim was not accepted. The Provider's agent explained the reason for the Provider's decision was that there was no evidence of a consultation on **2 May 2017** in respect of the urinary tract aspect of the Complainant's claim. The Complainant explained there was a letter from her surgeon to say that she had an operation. The Complainant then said she had a hospital admission which led to an operation and this gave rise to a further operation, all of which the Complainant provided proof of. Following further brief discussion, the Complainant requested that a manager contact her. The Provider's agent explained there was a 24 hour call around time for a call back. The Provider's agent advised she would include the Provider's decision to decline the claim as part of the earlier complaint.

In a further internal email dated **5 February 2018**, it states that:

> *"The insured has now changed the reason for disability so the notes below would also apply.*
> *She cannot be certified for two different conditions for the same period."*

By letter dated **5 February 2018**, the Provider wrote to the Complainant in respect of claim reference 821 declining her claim, as follows:

> *"Upon review of the circumstances and supporting documentation you have provided to us, we are unable to pay your claim.*

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*The following **condition/s** of the insurance policy **has/have** not been met:*

This means:

"A state of incapacity due to accidental bodily injury as certified by a registered medical practitioner in consequence of which the insured person is totally disabled from attending to the occupation at which he/she was gainfully employed immediately prior to disability or any other occupation for which he/she is fitted by knowledge or training".

There is no evidence of a consultation when you were first certified unfit for work on the 02nd May 2017 for your urinary tract infection until 28th July 2017.

If you check your policy documents you will find the Sickness requirements detailed in the terms & conditions section.

*If you or **your doctor** are able to provide new documented evidence to meet this condition, please send this to us* […]*. When we receive this, we will re-assess your claim based on this new information provided.*

Our reassessment may take a further 14 days, after which we will write to you with our final decision. […]

If you disagree with the final decision you may lodge a complaint […]*."*

The Provider acknowledged the complaint by letter dated **6 February 2018**.

One of the Provider's agents telephoned the Complainant on **6 February 2018** in response to her request for a supervisor call back. The Provider has furnished recordings of two telephone calls placed to the Complainant on this day, and on each occasion, the Provider's agent was directed to the Complainant's voicemail.

The Complainant telephoned the Provider on **8 February 2018** to speak to a named supervisor ('M'). However, this individual was not available at that time and a call back was arranged.

The Provider's agent, M, telephoned the Complainant on **8 February 2018** in relation to her request for a supervisor call back. During this conversation, the Complainant explained that she was unhappy that the agent she spoke to regarding the declinature of her claim was unable to explain why the claim was declined.

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The Complainant also advised she was unhappy that her claim was left on someone's desk for a period of time without action. The Complainant stated that she wanted someone to explain to her why her claim was declined. In response to this, the Provider's agent asked the Complainant to confirm whether the number of hours she worked each week was 15 hours. The Complainant queried why this was relevant. The Provider's agent explained that in order to make a claim, the Complainant was required to be working 18 hours or more per week. In response to this, the Complainant advised that the opening hours of her [business] were 'different'. The Complainant then said: *"I'm not getting into that at the moment"*. The Complainant queried why the Provider declined her claim in circumstances where she was under the care of two consultants and the Provider had two consultant letters.

The Provider's agent explained there was no evidence of a GP consultation as the Complainant was first certified as unfit for work on **2 May 2017** and the Complainant did not 'consult' again until **28 July 2017**. The Provider's agent explained there was no evidence of a consultation for a UTI until **15 June 2017**, which was six weeks after the Complainant was certified off as sick, and there was no evidence of a UTI until **28 July 2017**.

Shortly after this, the Provider's agent advised the Complainant that if there were gaps in the information that she could send updated records to the Provider. Later into the conversation, the Provider's agent explained that this discussion related to the claim reference 821 and that claim reference 820 was a separate decline. The Provider's agent explained there were two different claims because there were two different policies. The Complainant advised the Provider's agent that she had one policy which she was paying in two parts because she had two mortgage loans – a mortgage loan and a top up loan. The Complainant said it was the same policy. The Complainant set out her medical history and referred to the documentation submitted to the Provider, including consultant correspondence. The Provider's agent indicated that she would refer both claims back to the medical team for assessment.

In relation to the number of hours worked each week, the Provider's agent explained this was a matter she discovered when looking at the Complainant's claim. The Complainant explained that she worked more than 15 hours, stating that she did after school work. The Provider's agent asked how many hours this was, to which the Complainant responded 'all day'. The Provider's agent indicated that the Complainant worked a 40 hour week. The Provider's agent stated that if further information was required, the Provider would request this in light of the expense already incurred by the Complainant.

/Cont'd…

By letter dated **26 February 2018**, the Provider issued an update to the Complainant in respect of her complaint.

An entry in the Provider's records indicate that a telephone conversation may have taken place with the Complainant around **28 February 2018**, but a recording of this conversation does not appear to have been furnished.

On **5 March 2018**, the Complainant telephoned the Provider wishing to speak to a named supervisor, M. The person in question was not available and a call back was arranged.

The Provider's Complaints Department telephoned the Complainant on **6 March 2018** regarding her complaint. The Provider's agent ('F') explained to the Complainant that the Provider required certain information regarding her hours of work. The Provider's agent explained that under the terms of her policy, the Complainant needed to show she was working 18 hours or more per week at the time she was unfit to work at **28 July 2017**. The Provider's agent explained this could be done by way of an accountant's letter. The Provider's agent also explained it required confirmation that the Complainant employed someone to work in her business while she was out sick. The Provider's agent asked if the Complainant hired someone while she was absent from work.

The Complainant responded that she did. The Provider's agent then asked if the Complainant could provide something to prove this. The Complainant queried what she could provide. The Provider's agent stated that it could be something to show that the Complainant hired someone. The Provider's agent said this could come from the Complainant's accountant. The Complainant then discussed the information previously furnished to the Provider. The Complainant asked that the Provider email her the information that was required and she would get her accountant to send it to the Provider.

Following this conversation, the Provider's agent wrote to the Complainant in respect of claim reference 821 by email dated **6 March 2018**, as follows:

> *"*[…] *your claims were declined due to the pre-existing nature and also that there was no evidence of ongoing clinical consultations.*
>
> *From reviewing your file and as a gesture of goodwill on this occasion only, we have made a decision to validate your claim from the 28/07/2017 as this is the first date that we can see you were certified unfit for work with a urinary tract infection, provided that you can submit confirmation from your accountant that you were working 18 hours per week prior to this date and that you were not contributing to your business at any point from the 28/07/2017 to date.*

/Cont'd…

I note from our conversation today that you confirmed you are still unable to work due to illness.

Please provide confirmation of this also from your accountant to advise of same.

The request for information as above can be in the form of a letter on headed paper from your Accountant confirming the requested information, a copy of work diary and registration of employee to the Inland Revenue Office as this would confirm the identified employee was employed by your business during this time.

At present, we have ongoing medical evidence on file from July to November. Therefore, we would require further up to date medical information from your GP from November to date. […]*."*

The Complainant responded to this email the same day, as follows:

"I am outraged and very upset at your email as it is not what we discussed on the phone. You did not discuss 80% of this information on the phone to me today.

You never said anything about denying my claim. You said you were only ringing because I rang yesterday. And implied you were only dealing with my complaint which was separate to my claim. In fact you said the medical team were looking at those details and you were not going to discuss. No one notified me that my appeal to claim had been denied. Your email does not clarify matters either.

Am I to believe from reading you (sic) *email below you are denying my appeal. And for what reason?*

But you are paying?

I was assured by a supervisor [Provider agent, M] *that she would look into all aspects of the case. And that she had received letters from my consultants in January. How is it possible that after three surgeries all verified by consultants that you can still say you need more proof. I explained all that to* [M] *on 8.2.18. She assured me that if there were gaps relating to information they would find them and they would pay for any more consultant letters.*

I am outraged at your treatment of me and your email. I'm very upset that it has come to this. And it is quiet obvious to me case (sic) *you are unaware, one consultant is in Cork and the other in Clane and another in Autevin.*

/Cont'd…

I've been out of work, unable to drive until recently and unable to pay mortgage hence my claim. Someone has to drive me and take time off work.

I am more than happy to gather any information necessary to support this claim but it is very obvious from recent calls, with each new person on my case a new piece of information is requested. Only to totally disregard ever (sic) *piece of information you looked for.*

Further to this you want a copy of my work diary? What is a work diary in this instance and why would you need this to verify a medical claim?

Just to clarify you now want me to replace the letters from my three consultants about my surgeries - because you lost everything from November.

A letter from my GP - stating what exactly - that you lost all the information they took two months to compile. Which [the Provider] *paid €300 towards cost.*

A letter from my accountant -
Stating I'm out of work?

Proof from revenue of an employee? From when to when?

Can you clarify in writing what exactly you are looking for and why? […]*"*

A Final Response Letter issued by the Provider on **7 March 2018** in respect of both claim references, which states, as follows:

"Upon review of your disability claims, I note your medical records were received on the 11th January 2018. Unfortunately, these were not reviewed at this time and I would like to offer our sincere apologies as this was an oversight on our behalf.

I understand you spoke with our office on the 05th February 2018 and your medical records were reviewed by our medical department on this date. You received letters from our office in relation to both your claims being unsuccessful.

I wish to outline the reason for your claims being unsuccessful. Upon reviewing your disability claim form the main condition you are claiming for is abdominal pain due to adhesions from 02 May 2017. Your GP did mention that you also had urinary tract infection from the 28th July 2017.

/Cont'd…

I have reviewed both your disability claims and note the main condition you are claiming for is abdominal pain due to adhesions. The medical information we received into our office (sic) it was noted the adhesions were first identified in 2002.

Unfortunately, this condition was diagnosed prior to when your [Lender] *payment protection insurance commenced on the 17th February 2005 for you mortgage account* [ending 573] *and the other account* [ending 081] *which commenced on the 23rd October 2002.*

I would like to draw your attention to the terms and conditions of your policy which are pertinent to the assessment of your claim for account [ending 573]*.*

- *Pre-existing condition means any condition, injury, disease or related condition or symptoms which you knew about or should reasonably have known about at the start date or restart date, or had seen or arranged to see a doctor about during the 12 months immediately prior to the start date or restart date.*

Furthermore, I would also like to draw your attention to the terms and conditions of your policy which are pertinent to the assessment of your claim for account [ending 081]*.*

- *Disability or redundancy resulting from any physical or mental defects infirmity or recurring disease for which the insured person has received treatment or advice (which includes regular or routine examination or consultation to monitor the condition) of which the person was aware in the 12 months immediately preceding the effective date of the insurance.*

I wish to clarify, we have no confirmation for your [Lender] *account* [ending 081] *which commenced on the 23rd October 2002 that you were working 16 hours per week prior to becoming ill. We also have no confirmation that you were working 18 hours for* [Lender] *account* [ending 573] *which commenced on the 17th February 2005.*

As outlined in the terms of your policy:

- *Is in permanent gainful employment (16 hours or more per week) including self-employment and has been so employed continuously for the 6 months immediately prior to such date – this relates to account* [ending 081]*.*

/Cont'd…

- *Self-employed means working for at least 18 hours a week for profit in a profession or business, either alone or with others* […]. *This relates to account* [ending 573].

I am aware on the 06th March 2017 you spoke with one of our consumer specialists. They sent you an email to clarify, as a gesture of goodwill on this occasion only, [the Provider] *have made a decision to validate your claim from the 28th July 2017 for your urinary tract infection.*

This is the date we note from the medial information we received into our office that you were certified unfit to work for this condition. I understand you are still unable to work due to your illness and you did employ someone to take your position while you have been unfit to work.

We have advised you that we require confirmation from your accountant for the following:

- *A letter from your Accountant on headed paper confirming the hours you worked prior to the 28th July 2017 and a copy of your work diary if you are unable to provide this*
- *Registration of said employee to the Inland Revenue Office to confirm the identified employee was employed by your business during this time.*
- *We have medical information from July 2017 to November 2017. We require further medical evidence from your GP from November 2017 to date.*

[…].*"*

The Provider responded to the Complainant's **6 March 2018** email on **13 March 2018**, as follows:

"The reason we have requested information from your accountant and yourself surrounding your employment and querying if you had a person working in your place during the period of sickness is because when a person is employed as a PAYE customer we request the employer to complete the form and in self-employed cases, the accountant. Furthermore, a self-employed person cannot be contributing to their business at any point during their period of illness as outlined in the terms of your policy.

/Cont'd…

The reason you were not fully advised of the information on the call was because you were quite busy on the day in question and we put all the information into an e-mail for your records once the file had been reviewed and we had made our findings.

We have issued a final response letter to you outlining our position and providing you with your Financial Services and Pension Ombudsman Rights and you will receive this shortly.

The supervisor reviewed this with management and unfortunately, it took some time to come to a decision and this information was requested below as per the e-mail from the 06/03/2018."

The Complainant telephoned the Provider on **15 March 2018** requesting to speak with a named individual, 'NB'. The Provider's agent advised the Complainant that this individual did not take calls anymore. The Provider's agent further explained that this individual used to be a Client Relationship Manager but no longer occupied that position. The Provider's agent asked the Complainant if there was anything she could help with. In response to this, the Complainant explained that it was the named individual with whom she needed to speak as she had been sent an official letter from the Lender stating that this was the person she needed to speak to. The Complainant stated that she would only speak to this person. The Provider's agent explained that the Lender had initially contacted the Client Relationship Manager who passed the matter to that agent's department. It was further explained that a Final Response Letter had been issued and that if the Complainant needed to discuss the matter further she was required to refer the matter to this Office. The Provider's agent advised that if the Complainant had a query, she would be happy to discuss it but if the Complainant was unhappy with the Final Response Letter she could go to this Office. The Complainant discussed the matter further stating that the Provider did not answer any of her questions. The Complainant became upset at this point. The Provider's agent explained she would try to help the Complainant with her query.

The Provider's agent advised the Complainant to take a moment. The Complainant became more upset following this, explaining her frustration at the Provider not answering the questions she had raised.

The Provider wrote to the Complainant's GP on **18 April 2018** requesting the GP's consent to the release of the Complainant's medical records, which appears to have been given on **2 May 2018**.

/Cont'd…

The Provider wrote to the Complainant on **9 May 2018** in respect of both claim references, following contact from the Lender, as follows:

> *"We have today spoken with* [the Lender] *who have requested that we send a follow up letter to you outlining the information required to validate your claim.*
>
> *As outlined in the final response letter we require the following:*
>
> *- A letter from your Accountant on headed paper confirming the hours you worked prior to 28th July 2017 and a copy of your work diary.*
> *- A letter from the Inland Revenue Office detailing the registration of the employee who was employed to cover your position at the time you were sick*
> *- Medical evidence from November 2017 to date.*
>
> *Upon receipt of this information, we will be in a better position to validate your claim further.*
>
> *Alternatively, as per our letter dated the 07/03/2018, you may refer your complaint to the Financial Services and Pensions Ombudsman.* […]*."*

The Provider wrote to the Complainant on **27 June 2018** (in respect of claim reference 821), stating that it had not received a reply to its last letter asking for additional information and indicated that the Provider looked forward to receiving the relevant information in the next 30 days, failing which, it would need to close the claim. The letter also advised that it was to be disregarded if a reply had been sent.

Vulnerable consumer

In a submission dated **8 April 2019**, the Complainant's Representative states that:

> *"As per the CPC the Complainant can be clearly identifiable as a **Level 1 Vulnerable Customer** due to the fact that she was suffering from illness, low income, dependable child with disability, and under financial pressure from the bank."*

/Cont'd…

Provision 3.1 of the ***Consumer Protection Code 2012*** ("the Code") states the following in respect of vulnerable consumers:

> *"Where a **regulated entity** has identified that a **personal consumer** is a **vulnerable consumer**, the **regulated entity** must ensure that the **vulnerable consumer** is provided with such reasonable arrangements and/or assistance that may be necessary to facilitate him or her in his or her dealings with the **regulated entity**."*

Chapter 12 of the Code defines a vulnerable consumer as follows:

> *"a natural person who:*
>
> *a) has the capacity to make his or her own decisions but who, because of individual circumstances, may require assistance to do so (for example, hearing impairment or visually impaired persons); and/or*
>
> *b) has limited capacity to make his or her own decisions and who requires assistance to do so (for example, persons with intellectual disabilities or mental health difficulties)."*

The grounds advanced for the Complainant being a vulnerable consumer are her illness, income level, a dependent child with a disability and financial pressure from the Lender.

In my Preliminary Decision I stated that while these factors may have been the source of stress or concern for the Complainant, these factors, either individually or in combination did not of themselves mean that the Complainant was a vulnerable consumer such that required the Provider to put in place certain arrangements or provide certain assistance to the Complainant in her dealings with the Provider.

The Complainant's Representative has, as part of a post Preliminary Decision submission, disputed this conclusion. The Complainant's Representative details that "[the Complainant's] *financial advisor and myself worked endlessly on this because* [the Complainant] *was unable to deal with this because she had **limited capacity to make his or her own decisions due to mental health difficulties…".*** The Complainant's Representative's submission continues and states "*How did* [the Ombudsman] *come to the conclusion that* [the Complainant] ***does not have** mental health issues, when on numerous calls and correspondences it was stated clearly that* [the Complainant's] *mental health was suffering as a direct result of the pressure the bank,* [the Provider] *and later* [the Ombudsman's] *office put on her. While you have a team of people to work on this complaint* [the Complainant] *was not in the same position and was not afforded the common courtesy of accurate or consistent information*".

/Cont'd…

I would point out that I have not *"come to the conclusion that* [the Complainant] *does not have mental health issues",* as suggested by the Complainant's Representative. I make no comment or finding in relation to the Complainant's health. I am neither qualified nor required to do so. My role is to decide, based on the evidence before me, whether the Provider was required to treat the Complainant as a vulnerable consumer, in accordance with the Code based on the information available to it at the time of the conduct complained of. I remain of the view that based on the information available to the Provider at the time of the conduct complained it wasn't unreasonable of the Provider not to treat the Complainant as a vulnerable consumer as defined in the Code, based on the information available to it.

I note that no medical documentation has been submitted by the parties that demonstrate the Complainant was suffering from any mental health difficulties that would impair her capacity to make her own decisions.

Furthermore, I can find no evidence to support the Complainant's Representative's assertion that this Office put pressure on the Complainant. I therefore do not accept this assertion.

Applicable policy terms

In **October 2017**, the Complainant submitted a Disability Claim Form to the Provider on the apparent understanding that she held a single mortgage payment protection policy with the Provider. It appears to be the Provider's position that two policies were incepted by the Complainant, one in respect of each loan. It also appears from the Provider's assessment of the Complainant's claims and its response to this complaint that the Provider assessed claim reference 821 (loan account 081) by reference to policy terms dated **February 2002** and that it assessed claim reference 820 (loan account 573) by reference to policy terms dated **January 2012**.

The Complainant completed a Lender loan application form dated **3 September 2002** in respect of loan account 081. A Lender arranged mortgage protection policy was taken out in respect of this loan with cover effective from **23 October 2002**. The Complainant completed a further Lender loan application form dated **11 February 2005** in respect of loan account 573 and Provider arranged mortgage protection cover was put in place in respect of this loan with cover effective from **17 February 2005**.

The policy documents relating to the policy incepted by the Complainant in **October 2002** appear to comprise a 'Mortgage Protection Plan Certificate of Insurance' ("the Certificate of Insurance") and accompanying terms dated **February 2002**.

/Cont'd…

Although further mortgage protection cover was arranged for the Complainant in **February 2005**, the Provider has not provided any such similar certificate of insurance showing the inception of a new or separate policy, offering cover on terms separate and distinct from the terms on which the **October 2002** cover was incepted. It is also important to note at this juncture that there appears to be only one policy number (ending 980) which was used by the Provider in respect of both claim references.

Leading on from this, I note that when the Provider wrote to the Complainant and her GP on **12 October 2017** in respect of claim reference 820, it cited the policy number as 980. When the Provider wrote to the Complainant on **22 November 2017** in respect of claim reference 821, it cited the policy number as 980. The Provider wrote to the Complainant

in respect of both claim reference 820 and 821 on **9 May 2018**, citing the policy number as 980. On reviewing the correspondence issued by the Provider in respect of each claim reference, I note that the same policy number was used by the Provider throughout.

In circumstances where the Provider considers there to be two separate policies, I would expect to see separate policy numbers and separate certificates of insurance for example. However, the available evidence does not show the existence of separate policies in respect of the mortgage protection cover incepted by the Complainant in respect of loan accounts 081 and 573 nor has any documentation been submitted to demonstrate that two distinct policies were incepted by the Complainant. It appears to me that the policy arranged in **October 2002** in respect of loan account 081 was extended to include the Complainant's later loan, loan account 573, without incepting a new policy.

The Certificate of Insurance states that the cover offered by the policy was underwritten by a particular financial services provider ("the First Insurer"). In documentation furnished by the Lender. I note that correspondence appears to have issued to policyholders in **May 2003** (dated **2 May 2003**) advising that the underwriter of the policy was changing to another financial services provider, the Second Insurer, with effect from **1 June 2003**.

While this letter states that the *"terms, conditions, amount of cover and your monthly premium remain unchanged"*, it appears that policy terms dated **April 2003** in the name of the Second Insurer issued in respect of the Second Insurer's policies. Therefore, it is not clear whether it was the **October 2002** policy terms or the **April 2003** policy terms which remained unchanged, as stated in the **2 May 2003** letter.

I note that the **April 2003** policy document appears to have been replaced by a number of subsequent and updated versions.

/Cont'd…

The Provider's position appears to be that the **February 2002** policy terms applied to loan account 081 and remained unchanged. Therefore, these were the applicable policy terms for the assessment of the Complainant's claim in respect of this loan account. However, in light of the foregoing analysis, I am not sufficiently satisfied that these were the appropriate terms on which to assess the Complainant's claim.

In terms of loan account 573, I note the cover arranged in respect of this loan was effective from **February 2005**. As part of its response to this complaint, the Provider has furnished a copy of the policy terms which it relied on in the assessment of the claim in respect of loan account 573, which are dated **January 2012**.

It is not clear whether the Complainant holds a single policy or two separate policies.

If it is the case that one policy was incepted, then both claims should be assessed by reference to the same policy terms. However, it is not clear whether the **February 2002** terms continue to apply and remain unchanged.

If it is the case that two polices were incepted, one in respect of each loan, it would still remain unclear as to which policy terms apply to each account. For loan account 081, this is because it is unclear as to whether the **February 2002** policy terms were unaltered. As no policy inception documentation has been submitted for loan account 573 (such as a certificate of insurance) it is not clear what policy terms were applicable to this policy when incepted and how these policy terms changed over time.

A further difficulty is the fact that only one policy number appears to be in existence. As a result, it is difficult to comprehend two different sets of policy terms applying to a single policy number.

Claims assessment

As noted above, it appears the Complainant understood that she held a single policy with the Provider and was therefore making a single claim when submitting her claim form in **October 2017**. The Provider wrote to the Complainant on **12 October 2017** to acknowledge receipt of her claim form. In this letter, the Provider cited a single claim reference (820) and advised that certain documentation was required to complete the assessment of the claim.

/Cont'd…

However, no such correspondence appears to have issued in respect of claim reference 821, whether to acknowledge this claim, notify the Complainant of the existence of a second claim or provide the Complainant with a claim reference number.

It appears the first correspondence that issued in respect of claim reference 821 was a letter dated **22 November 2017**. In this letter, which the Provider describes as an 'Automatic chase letter' in its timeline for this claim reference, it is stated that the Provider had not received a response to a previous letter requesting additional information. However, it is not clear why, or what caused, this letter to issue as no request for information in respect of claim reference 821 had been made prior to this.

In circumstances where two claims were registered by the Provider (both on **12 October 2017**), it is my opinion that it was reasonable to expect the Provider to have written to the Complainant to acknowledge not only receipt of the claim form, but also to advise/acknowledge that two claims were registered and provide the claim reference numbers in respect of these claims.

It appears the first indication that two claims were in being was the Provider's letter of **22 November 2017**, but only one claim was acknowledged in the Provider's letter of **12 October 2017**.

It appears from the evidence that claim reference 820 was assessed around **7 December 2017** and a letter issued by the Provider the same day declining the claim. However, it is not clear why the Provider did not assess claim reference 821 at the same time as claim reference 820. In this respect, I note there is no evidence to suggest that the Provider required any additional or particular information to allow it to complete its assessment of claim reference 821 nor has the Provider offered an explanation was to why it did not assess both claims simultaneously. While the Provider's declinature of claim reference 820 was followed by further correspondence between the parties and the provision of additional information, it is my opinion that the Provider unreasonably delayed in assessing claim reference 821.

The Complainant queried the declinature of claim reference 820 on **20 December 2017** and provided further information *"in support of my application"*, under cover of letter dated **8 January 2018**. Disappointingly, the evidence shows that the information provided by the Complainant was *"actioned off"* by the Provider which, I accept, resulted in an unreasonable delay in this information being reviewed and, in turn, caused a delay in the assessment of both claims.

While the Complainant sent additional information to the Provider in **December 2017**, this information does not appear to have been assessed in respect of claim reference 820.

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Although correspondence issued to the Complainant in respect of claim reference 821 in **January 2018** and the months that followed, there is no evidence to show that the Complainant's additional information was reviewed by the Provider in the context of claim reference 820.

In particular, I note that during a telephone conversation on **8 February 2018**, the Provider's agent stated that the conversation only concerned claim reference 821 and that claim reference 820 was a separate matter. In circumstances where both claim references were treated by the Provider as separate matters and as being subject to separate policy terms, it is my opinion that the Provider should have assessed the information provided by the Complainant in **December 2017** in respect of each claim. However, there is no evidence to show that this occurred. In this respect, the Provider does not appear to have issued correspondence to the Complainant demonstrating its consideration of this additional information in respect of claim reference 820 until its Final Response Letter dated **7 March 2018**.

Declinature of claim reference 820

Claim reference 820 was declined by letter dated **7 December 2017** due to the pre-existence of 'adhesions' from **2002**. In declining this claim, the Provider noted that adhesions were first identified in **2002**, prior to payment protection cover commencing on **17 February 2005**.

In this respect, section 2 of the **January 2012** policy terms state (on page 5 of the policy document), as follows:

> *"**Important Information***
>
> - *If **you** are aware of any **pre-existing condition**, any **critical illness** or any impending **hospitalisation** at the **start date**, or the **restart date**, **we** may still insure **you**, however, **we** will not pay any claims directly relating to any **pre-existing condition**, any, **critical illness** or any impending **hospitalisation**."*

Disability cover is provided for at section 3.1. On page 7 of the policy document, it states, as follows:

> *"**Disability cover exclusions***
>
> ***We** will not pay **you** a **monthly benefit** for any **disability** caused by or resulting from:*

/Cont'd…

- *any **pre-existing condition**;* […]*"*

The term 'pre-existing condition' is defined at section 1, on page 4, as follows:

> *"any condition, injury, disease or related condition or symptoms which **you** knew about or should reasonably have known about at the **start date** or **restart date**, or had seen or arranged to see a **doctor** about during the 12 months immediately prior to the **start date** or **restart date**".*

On the claim form, the sickness/condition the Complainant was seeking to claim benefit payment for was abdominal pain due to adhesion. It appears from the Complainant's GP medical records that an entry dated **18 December 2002** states, on the fourth line of this entry, as follows:

> *"Hospital – laparoscopy – adhesion"*

On considering the above definition of pre-existing condition, I accept that it was reasonable for the Provider to decide that the Complainant was aware or should reasonably have been aware of the existence of adhesion(s) from **December 2002**. I also accept that adhesion(s) comes within the broad policy definition of pre-existing condition, which covers *"any condition, injury, disease or related condition or symptoms"* and does not necessarily require a medical diagnosis.

Accordingly, I accept that based on the available medical evidence, the Provider was reasonably entitled to decline claim reference 820 for a claim relating to abdominal pain due to adhesion as this was a pre-existing condition at the commencement of cover in respect of loan account 573.

In the submission accompanying her Complaint Form, the Complainant says she realised during a telephone conversation with one of the Provider's agents on **20 December 2017** that the Provider assessed her claim without seeking any clarification or medical information from her consultants. However, as the Provider was reasonably entitled to decline claim reference 820 on the basis of there being a pre-existing condition. For this reason, I do not accept that the Provider was required to obtain further information from the Complainant's consultants.

Declinature of claim reference 821

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Claim reference 821 was declined by letter dated **5 February 2018**. As noted above, the sickness/condition on which the Complainant's claim was based was abdominal paid due to adhesion.

I also note that secondary conditions of urinary tract infections and hiatus hernia were noted on the claim form. The Provider's letter of **5 February 2018** declined the Complainant's claim by reference to the policy definition of disability, as follows:

> *"There is no evidence of a consultation when you were first certified unfit for work on the 02nd May 2017 for your urinary tract infection until 28th July 2017."*

Thus, it appears the Provider assessed claim reference 821 on the basis of urinary tract infections (UTIs). However, the claim, as originally made, was in respect of abdominal pain due to adhesion. Yet there is no evidence that the Provider assessed or declined claim reference 821 on basis of a sickness/condition of abdominal pain due to adhesion. It seems to be the case that as the Provider declined claim reference 820 on the basis of a claim for abdominal paid due to adhesion, it proceeded to assess claim reference 821 by reference to one, but for some reason not both, of the secondary conditions identified on the claim form.

In circumstances where the Provider considered the Complainant to hold two separate policies, I do not consider it was appropriate or correct to take this course of action. As can be seen, the Provider considered that separate policy terms applied to each claim reference. As such, the Provider should have assessed each claim separately, by reference to what it considered to be the policy terms applicable to each claim.

However, there is no evidence of the Provider assessing a claim for abdominal pain due to adhesion by reference to the policy terms applicable to claim reference 821, the **February 2002** terms. Accordingly, I am satisfied that the Provider failed to assess the Complainant's claim for abdominal paid due to adhesion in respect of claim reference 821.

It appears that it was not until the Final Response Letter of **7 March 2018** that the Provider sought to decline a claim for abdominal pain due to adhesion in respect of claim reference 821. This is discussed further below.

Assessment of secondary conditions

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In terms of the assessment of the Complainant's secondary conditions, as the Provider considered the Complainant to hold two separate policies, it is not clear why it only assessed a claim for UTI in respect of the cover applying to claim reference 821 and not to the cover provided by both policies. This seems to be a rather arbitrary approach to take to the assessment of the Complainant's claims. Further to this, it is not clear why the Provider chose only one of the secondary conditions noted on the claim form and not both.

If the Provider decided to assess the Complainant's secondary conditions, I consider it reasonable to expect the Provider to have assessed both secondary conditions and under both claim references.

The Provider assessed claim reference 821 based on a claim for UTIs and declined this claim as there was no evidence of a consultation certifying the Complainant as unfit for work on **2 May 2017** based on a sickness/condition for UITs. It is my opinion, having regard to the definition of 'disability' in the **February 2002** policy terms set out below, that the Complainant must be unable to work by virtue of a sickness/condition that has been certified by a registered medical practitioner. On considering the evidence, I note the Complainant was certified as unfit for work on **2 May 2017** due to abdominal pain associated with adhesion. However, I note there is no evidence to show the Complainant was certified unfit for work on this date due to UTI.

It appears from the Complainant's medical records that the first occasion (proximate to the date the Complainant was certified as unfit for work) on which urinary related complaints were noted was **28 July 2017**, and some form of medical referral noting UTIs was made by the Complainant's GP on **8 August 2017**, both of which occurred after the date on which the Complainant was certified unfit for work. Accordingly, the available evidence does not support the assertion that the Complainant was medically certified as unfit for work due to UTIs on **2 May 2017**.

Assessment based on a single policy

The above discussion regarding the Provider's assessment of each claim reference is based on there being two separate policies.

However, in light of my analysis in respect of whether the Complainant holds a single policy or two separate policies, I will now consider the assessment of the Complainant's claims from the perspective of there being a single policy.

In this respect, I note the following exclusions at section 6.F) of the **February 2002** policy terms:

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> *"Disability or redundancy resulting from any physical or mental defects infirmity or recurring disease for which the insured person has received treatment or advice (which includes regular or routine examination or consultation to monitor the condition) of which the insured person was aware in the 12 months immediately preceding the effective date of the insurance".*

The term 'disability' is defined as:

> *"A state of incapacity due to accidental bodily injury or illness as certified by a registered medical practitioner in consequence of which the insured person is totally disabled from attending to the occupation at which he/she was gainfully employed immediately prior to disability or any occupation for which he/she is fitted by knowledge or training."*

The term 'redundancy' is defined as:

> *"A period during which the insured person is redundant under the terms of the Redundancy Payments Act 1967 and any amendments thereto"*

The Complainant's cover first commenced in **October 2002**. The Complainant's GP records indicate a laparoscopy in respect of adhesion was carried out in **December 2002**, which post-dates the commencement of cover. While the Provider notes that the Complainant consulted her GP for abdominal pain in **May 2002**, on reviewing the entries in the GP records for **May 2002**, I am unable to discern (due to the legibility of the writing) whether the Complainant consulted for abdominal pain in **May 2002**.

In the Final Response Letter, the Provider states that adhesions were *diagnosed* prior to the commencement of cover in respect of loan account 081 on **23 October 2002**. However, on considering the available evidence, I am not satisfied that any reference to abdominal pain in **May 2002** (even in conjunction with the reference to adhesions in **December 2002**) is sufficient to reasonably allow the Provider to conclude that the Complainant was *diagnosed* with adhesions prior to **October 2002**.

I am not satisfied that there was any pre-existing condition, based on the available medical evidence, of adhesion when the policy was incepted in **October 2002**.

Furthermore, the exclusion at section 6.F) requires there to be 'disability' or 'redundancy' arising from the pre-existing condition, with these terms being defined in the policy. On considering the available evidence, I do not accept that there was sufficient evidence

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which would have reasonable allowed the Provider to conclude that the Complainant was suffering from disability or redundancy associated with adhesion(s) prior to **October 2002**.

In these circumstances, it would appear based on the **February 2002** policy terms, a claim for abdominal pain due to adhesion should not have been declined in the Final Response Letter.

Accordingly, it is imperative to ascertain the precise terms that were applicable to claim reference 821 and whether these were amended over time.

Medical information/documentation

When the Provider declined the claims on **7 December 2017** and **5 February 2018**, it stated that if the Complainant provided further medical evidence to meet the relevant policy terms, the Provider would re-assess each of the claims. Although the Provider offered to re-assess the claims if the Complainant provided further medical information, I do not consider that the Provider was necessarily required to specify the precise type of medical information required.

It is my opinion that the Complainant was required to furnish sufficient medical information/documentation to demonstrate that she satisfied the relevant policy definitions of 'disability'.

On **6 March 2018**, the Provider emailed the Complainant setting out certain information required to validate a claim for UTIs, which included up-to-date medical information from the Complainant's GP as the Provider only had medical evidence for the period **July** to **November 2017**.

In circumstances where the Provider was in the process of assessing a claim for UTIs, I consider it was reasonable for the Provider, in order to properly assess this claim, to seek up-to-date medical records from the Complainant's GP.

It appears from the evidence that the Complainant forwarded a letter from a Consultant Urologist to the Provider on **8 January 2018**. During a telephone conversation on **5 February 2018**, the Complainant referred to a surgeon's letter in respect of an operation she had undergone which had been furnished to the Provider.

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During a telephone conversation on **6 March 2018**, the Complainant stated that the Provider had *"proof of letters from consultants past September.* [I/you] *got them in January."* In an email to the Provider dated **6 March 2018**, the Complainant stated that:

> *"Just to clarify you now want me to replace the letters from my three consultants about my surgeries - because you lost everything from November."*

On considering the evidence, it is not entirely clear what letters the Complainant is referring to when she references 'three consultants'. From the documentation provided, I can see a letter from a Consultant Physician dated **1 April 2004** and a letter from a Consultant Urologist dated **14 December 2017**.

In my Preliminary Decision I had stated "*however, the Complainant does not appear to have provided this Office with copies of the letters she is referring to*".

The Complainant's Representative has, as part of a post Preliminary Decision submission, submitted a number of medical letters, including the above referenced **14 December 2017** letter from the Consultant Urologist.

In the Complainant's letter of **8 January 2018**, she refers to additional information from her consultant:

> *"Please find additional information from my consultant in support of my application."*

The term 'consultant' is used in a singular sense and there is no mention of information being provided from more than one consultant.

In the timeline accompanying the Complainant's Complaint Form, the following is stated in respect of information sent directly to the Provider by Professor R, a surgeon:

> *"31/12/2017 – Professor* [R] *Surgeon sent letter directly to* [the Provider] *outlining reasons for operation in August stating they were not linked to operation in 1985 but had arose from Hysterectomy in 2015."*

It does not appear that this letter was received by the Provider. Further to this, the Complainant has not demonstrated that a letter of this date was in fact sent to the Provider by Professor R. As the Provider does not have a record of receiving this letter, I am not satisfied that any failure to consider this medical information was the fault of the Provider.

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The Complainant's Representative has, as part of the Post Preliminary Decision submission, stated that "*If the said letter from Professor* [R] *has gone missing but is discussed many times and if the entirety of the claim lays solely on this letter. Why was this not mentioned during our correspondence previously? Why has your team not included the letter and addressed this point before this point. We referred to this letter many times and have included it again with this submission".*

It should be noted that a letter dated **31 December 2017** has not been submitted, however a letter from Professor R address to the Provider **21 December 2017** has been submitted.

In this correspondence dated 21 December 2017 it states:

> *"To whom it may concern*
>
> *This lady had surgery under my care on* [dates redacted] *2017 for adhesiolysis and excision of a small ovarian cyst. She was having significant abdominal pain at the moment and was referred to me for that reason. I undertook the surgery for her using laparoscopic technique. She did indeed have adhesions primarily between the abdominal wall and the small bowel. We divided these for her and excised the cyst which was benign. She is making slow but steady progress post-operatively but still has significant pain. I note that she is due for your logical investigation in January and I wish her well in relation to this. In my view, it is very reasonable to assume that her previous hysterectomy would have been the cause of these adhesions as adhesion formation is frequently associated with hysterectomy in my experience. I wish* [the Complainant] *well and I hope that she eventually makes a full recovery".*

It is important to again point out that it is not the role of this Office to comment on or form an opinion as to the nature or severity of the Complainant's illness or condition. Nor is it the role of this office to comment on the content of medical reports or letters. It is the duty of this Office to establish whether, on the basis of an objective assessment of the medical evidence submitted, the Provider has adequately assessed the Complainant's claim and whether it was reasonably entitled to arrive at the decision it did following its assessment of the medical evidence submitted.

Hours worked requirement – claim reference 821

During a telephone conversation on **8 February 2018**, the Provider's agent told the Complainant that in order to make a claim she was required to be working 18 hours or more per week. The Provider's agent explained that this requirement was discovered when this agent was looking into the claim.

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The Provider's agent also stated that the claim the subject of the conversation was claim reference 821. In this respect, the policy terms relied on by the Provider when assessing claim reference 821 were the **February 2002** policy terms. However, I note that there is no requirement that the Complainant work 18 hours or more per week in these policy terms.

At section 1, the term 'employment' is defined, as follows:

> *"Active, permanent, gainful employment (16 hours or more per week) including self employment"*

Section 2(ii) states:

> *"is in permanent gainful employment (16 hours or more per week) including self-employment* […]*."*

It can be seen that the reference to an hours-worked requirement in the **February 2002** policy terms is 16 hours, not 18 hours as (incorrectly) stated by the Provider's agent on **8 February 2018**. An 18 hour requirement is stated in the **January 2012** policy terms. Therefore, the Provider's agent appears to have been confused as to which policy terms applied to this claim.

The incorrect hours-worked requirement was communicated to the Complainant again during the telephone conversation on **6 March 2018** where the Provider's agent also referred to an 18 hour requirement. Similarly, it appears the Provider incorrectly stated the hours-worked requirement as 18 hours in its email of **6 March 2018**. It appears that it was not until the Final Response Letter of **7 March 2018** that the 16 hour requirement was identified in respect of loan account 081.

In terms of there being an hours-worked requirement in the **February 2002** policy terms, I note that the 'Insurance Benefits' are set out at section 3.

In particular, section 3.A) states, as follows:

> *"**A) Disability and Redundancy benefit***
>
> *If the insured person suffers disability commencing after the effective date of the cover for a period of more than 30 consecutive days a monthly benefit shall be payable by the insurer on the 31st day of disability."*

On considering the benefit provided by section 3.A), I cannot see any requirement that the Complainant work a minimum number of hours per week before benefit becomes payable.

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However, I note that section 2 sets out the following eligibility criteria:

> *"**2. TERMS AND CONDITIONS OF ELIGIBILITY***
>
> *A borrower is eligible for this insurance provided that on the effective date of the insurance, such borrower*
>
> *(i) is aged over 18 and under 61 years*
>
> *(ii) is in permanent gainful employment (16 hours or more per week) including self-employment and has been so employed continuously for the 6 months immediately prior to such date*
>
> *(iii) is permanently residing in the Republic of Ireland*
>
> *(iv) is not aware of any impending redundancy not of any impending hospital treatment or tests* […]*"*

The term 'Insured Persons(s)' is defined as:

> *"The borrower or borrowers named in the certificate of insurance provided such borrower or borrowers meet the terms and conditions of eligibility and pay the appropriate premium"*

The term 'Effective Date' is defined as:

> *"The legal completion date of the mortgage"*

Having considered the **February 2002** policy terms, it is my opinion that to be eligible for the insurance provided by the policy, the Complainant had to satisfy the conditions contained in section 2 *on the effective date*, being the date of her mortgage.

Section 2(ii) contains an hours-worked requirement, but this relates to employment *immediately prior to such date*, being the effective date (the completion date of the mortgage). Further to this, section 3.A) states that the benefit under this section applies when the *insured person* suffers disability. As can be seen from the above definition of insured person, this means the borrower named in the certificate of insurance *provided such borrower or borrowers meet the terms and conditions of eligibility*, being the conditions at section 2.

It is my view that the conditions set out at section 2 were required to be satisfied at the inception of the policy but were not required to be satisfied as part of the Complainant's

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claim. However, I note that the Provider cited the provisions of section 2(ii) in its Final Response Letter. As such, it appears the Provider wrongly relied on the provisions of section 2(ii) of the **February 2002** policy terms as the basis for the hours-worked requirement.

However, having regard to the definition of 'disability' (cited above), I accept that the Provider was entitled request that the Complainant verify *"the occupation at which he/she was gainfully employed immediately prior to disability"*.

Furthermore, the above definition of the term 'Employment' includes the term 'gainful employment' and also references a 16 hour or more per week work requirement. In light of this and on considering the policy as a whole, I accept that there is a basis on which the Provider could reasonably rely in requiring the Complainant to demonstrate that she worked 16 hours or more per week in respect of claim reference 821.

Hours worked requirement – claim reference 820

In respect of disability cover, the **January 2012** policy terms state at section 3.1, as follows:

> *"If **you** are **working** or on statutory maternity leave (not any extended leave provided by **your** employer), and **you** become **disabled** during the **insured term** for at least 90 days in a row, **you** will be entitled to make a claim.*
>
> […]
>
> ***We** will consider the first day of **disability** as the day a **doctor** confirms that **you** are **disabled** and are not able to **work**. **We** will only pay **you disability** benefit if a **doctor** is regularly treating **you** for the **accident**, disease, illness, condition or injury causing **your disability**."*

A number of definitions are set out at section 1. In particular, I note the following definitions.

'Disability' is defined as:

> *"any **accident**, sickness, disease, condition, injury which stops **you** from doing any paid **work**. If **you** are **self-employed**, a **disability** must stop **you** from helping, managing or carrying out any part of the day-to-day running of a business."*

'Self-employed' is defined as:

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> *"**working** for at least 18 hours a week for profit in a profession or business, either alone or with others and paying the appropriate class of Pay Related Social Insurance contributions and being liable to pay income tax."*

'Work' and 'Working' are defined together as:

> *"being in **full-time employment**."*

'Full-time employment' is defined as:

> *"**working** for at least 18 hours a week in the Republic of Ireland either under a contract of employment or as a **self-employed** person.* […]*."*

Having considered the basis on which disability cover is provided under section 3.1 and having regard to the above definitions, it is my opinion that the Complainant was required to have been working for at least 18 hours per week at the date she was certified as unfit for work. Therefore, I accept that the Provider was reasonably entitled to seek to verify the number of hours the Complainant worked in its Final Response Letter in respect of claim reference 820.

Work Diary

Following a telephone conversation with the Complainant on **6 March 2018**, the Provider emailed the Complainant setting out certain information required to validate a claim for UTIs. In particular, the Provider mentioned a 'work diary'. Responding the same day, the Complainant queried what a work diary was and why this was required to verify a medical claim.

It appears the Provider responded to this email five business days later on **13 March 2018**. During the conversation on **6 March 2018** and in this email, the Provider explained why work related information was required. However, the Provider did not respond to the specific query as to what a 'work diary' was. In circumstances where the Provider was seeking a work diary, I consider it reasonable to require the Provider to have explained what it considered such a document to be and the form it should take. However, I am satisfied that arising from the above telephone conversation and email, the type of information being sought by the Provider was reasonably clear.

Verification of hours worked

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As the Provider declined claim reference 820 on the basis that the Complainant's adhesion(s) were pre-existing and claim reference 821 on the basis that there was no evidence that the Complainant was certified unfit for work due to UTI on **2 May 2017**, I do not believe that the hours-worked requirement was necessarily something that had to be brought to the Complainant's attention in **December 2017** or **February 2018**, when the claims were declined.

During the telephone calls on **8 February** and **6 March 2018**, the Provider's agents discussed the 18 hour work requirement in the context of a claim for UTIs. In an email dated **6 March 2018** and the Final Response Letter dated **7 March 2018**, the Provider set out further detail regarding this requirement, stating that the Complainant could provide one of the following:

- An accountant's letter
- A work diary
- Employee registration details from the Inland Revenue Office

Having considered the matter, I accept that the Provider was reasonably entitled to request the above documentation to assess a claim for UTIs.

I am of the view that such information/documentation would enable the Provider to verify the Complainant's employment status and whether anyone was hired to replace the Complainant during her absence from work.

Telephone contact with the Provider

The Complainant has referred to a number of telephone conversations with the Provider in her submissions.

In respect of the second telephone conversation which took place **5 February 2018**, the Complainant says the Provider's agent could not provide a reason for the declinature of her claim. On reviewing the recording of this telephone conversation, I note the Provider's agent explained to the Complainant that the reason for the Provider's decision was that there was no evidence of a consultation for a UTI on **2 May 2017**. Therefore, I accept that the Complainant was given a reason for the declinature of her claim during this telephone conversation.

In respect of the telephone conversation which took place on **6 March 2018**, the Complainant says the Provider appeared to be calling into question her employment status in an attempt to develop the level of detail sought in respect of her claim. On reviewing

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the recording of this conversation, I note that the parties discussed the 18 hour work requirement and that the Complainant would need to show that she employed someone while she was absent from work. As noted above, in circumstances where the Provider declined claim reference 820 on the basis that this claim related to a pre-existing condition and claim reference 821 on the basis that the Complainant did not satisfy the policy definition of disability, the Provider was not necessarily required to seek this type of information from the Complainant unless the claims were being assessed further.

In terms of claim reference 820, as the Provider considered there to be a pre-existing condition, the point was never reached where the claim was required to be assessed by reference to the policy definition of disability. In terms of claim reference 821, as the Provider considered that the Complainant was not certified as unfit for work on **2 May 2017** due to UTI, it was not necessary to continue the assessment of this claim. In each instance, it appears that if each claim was assessed further by the Provider, then the hours worked requirement would have been an issue for consideration.

It appears that it was at the time of this call that the Provider was proposing to admit a claim in respect of UTI once certain information was provided by the Complainant, which included information regarding the number of hours worked per week. Therefore, I do not believe that the Provider sought to call the Complainant's employment status into question.

Rather, in line with the definition of disability in the **February 2002** policy terms, the Provider was seeking to verify the Complainant's employment status, which I am satisfied it was reasonably entitled to do. However, in this instance and as discussed above, the particular policy terms relied on by the Provider as the basis for its entitlement to seek this information from the Complainant were not the appropriate terms on which to rely. Although, I do consider there to be a legitimate basis for seeking this information which is consistent with the **February 2002** policy terms.

In respect of the telephone conversation which took place on **15 March 2018**, the Complainant says she requested to speak with NB as advised by the Lender but was told NB no longer took calls. The Complainant also says the Provider's agent refused to speak to her as a final response had been issued and that the claim and complaint were closed. The Complainant says she was told to *'take a breath and try to find my words'*. The Complainant says she was outraged, deeply wounded and highly offended at these comments.

I have reviewed the recording of this conversation and outlined this above. On considering the matter, while it is unfortunate that NB was no longer occupying a position as Client Relationship Manager when the Complainant telephoned to speak with her, I do not

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accept that the Provider was required to put the Complainant in contact with NB. It is normal that staff members in organisations change roles and as part of their new role they may no longer carry out the same functions or duties and may not be involved in the same type of work as in their previous position, such as taking customer calls. In this instance, it was explained to the Complainant that the matter had been passed to this particular agent's department to deal with. This agent also offered to assist the Complainant with whatever matter she wished to discuss. This seems perfectly reasonable to me.
I note the Complainant was advised that if she wished to discuss the Final Response Letter further she would have to refer a complaint to this Office. In this respect, it is important to note that a final response letter is a financial service provider's final response to a complaint. If a complainant is dissatisfied with this response, they have the right to refer a complaint to this Office. In such circumstances, a financial services provider is not necessarily required to engage with a complainant any further in respect of the complaint. In this instance, I accept that the Provider's agent was reasonably entitled to refer the Complainant to this Office if she wished to pursue the Final Response Letter further. However, I also note that the Provider's agent advised that she could discuss any query the Complainant had outside the Final Response Letter. Therefore, the evidence does not support the assertion that the Provider's agent refused to speak with the Complainant due to the fact a final response had been issued and the claim and complaint were closed.

When the Complainant became upset during this call the Provider's agent advised the Complainant to *"take a moment"*. However, the Provider's agent does not appear to have told the Complainant to *'take a breath and try to find my words'*. On considering this part of the conversation, I am satisfied that the Provider's agent spoke to the Complainant in a professional and courteous manner.

Having considered the submissions and evidence, I substantially uphold this complaint. In doing so, I make the following directions.

I direct that the Provider write to the Complainant within 21 days of my Legally Binding Decision clarifying the mortgage payment protection insurance in place in respect of loan account 081 and loan account 573 beginning in **October 2002**. In particular, the Provider should address whether single or separate mortgage payment protection insurance policies were incepted.

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I direct that the Provider write to the Complainant within 21 days of my Legally Binding Decision in respect of the mortgage payment protection insurance relating to loan account 081 with details (and supporting policy documentation) of the following:

(i) The date the cover in respect of this loan account was incepted
(ii) The policy terms in effect at the date of inception
(iii) Any amendments to the policy terms from the date of inception to date of her claim in **October 2017**

I direct that the Provider write to the Complainant within 21 days of my Legally Binding Decision in respect of the mortgage payment protection insurance relating to loan account 573 with details (and supporting policy documentation) of the following:

(i) The date the cover in respect of this loan account was incepted

(ii) The policy terms in effect at the date of inception
(iii) Any amendments to the policy terms from the date of inception to date of her claim in **October 2017**

I direct that the Provider re-assess claim reference 820 by reference to the applicable policy terms in respect of a claim for:

(i) Abdominal pain due to adhesion
(ii) Urinary tract infection(s)
(iii) Hiatus hernia

as at the date the Complainant was medically certified unfit for work on **2 May 2017**.

In my Preliminary Decision I indicated my intention to direct that the Provider re-assess claim reference 821 by reference to the applicable policy terms in respect of a claim for:

(i) Abdominal pain due to adhesion
(ii) Urinary tract infection(s)
(iii) Hiatus hernia

as at the date the Complainant was medically certified unfit for work on **2 May 2017**.

In the event that the above assessments for urinary tract infection(s) are declined in respect of claim reference 820 and claim reference 821, I direct that the Provider further assess a claim for urinary tract infection(s) in respect of the cover in place for loan account 081 and 573 as at **28 July 2017**.

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In addition to the above direction, I also indicated my intention to direct that the Provider pay compensation in the amount of €5,000 to the Complainant.

I note the submission made by the Provider to this office dated **27 January 2022,** in which the Provider notified this office that it has "*agreed to accept claim XXXX821. Based on the medical evidence we have on file, we have made a payment to cover from 01.06.2017 to 27.11.2017*" and that with "*regards to the €5,000 compensation,* [it] *had contacted the* [Complainant] *for her account details of where we can send this payment to and we are awaiting her reply".*

While I welcome the above actions I would point out, for the avoidance of doubt, that the other directions issued by me to the Provider, as part of this Decision, will still be expected to be completed in full.

Conclusion

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

Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to:

write to the Complainant within 21 days of my Legally Binding Decision clarifying the mortgage payment protection insurance in place in respect of loan account 081 and loan account 573 beginning in **October 2002**. In particular, the Provider should address whether single or separate mortgage payment protection insurance policies were incepted;

write to the Complainant within 21 days of my Legally Binding Decision in respect of the mortgage payment protection insurance relating to loan account 081 with details (and supporting policy documentation) of the following:

(i) The date the cover in respect of this loan account was incepted
(ii) The policy terms in effect at the date of inception
(iii) Any amendments to the policy terms from the date of inception to date of her claim in **October 2017**

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write to the Complainant within 21 days of my Legally Binding Decision in respect of the mortgage payment protection insurance relating to loan account 573 with details (and supporting policy documentation) of the following:

(i) The date the cover in respect of this loan account was incepted
(ii) The policy terms in effect at the date of inception
(iii) Any amendments to the policy terms from the date of inception to date of her claim in **October 2017**

I direct that the Provider re-assess claim reference 820 by reference to the applicable policy terms in respect of a claim for:

(i) Abdominal pain due to adhesion
(ii) Urinary tract infection(s)
(iii) Hiatus hernia

as at the date the Complainant was medically certified unfit for work on **2 May 2017**.

I also direct that the Provider re-assess claim reference 821 by reference to the applicable policy terms in respect of a claim for:

(i) Abdominal pain due to adhesion
(ii) Urinary tract infection(s)
(iii) Hiatus hernia

as at the date the Complainant was medically certified unfit for work on **2 May 2017**.

I also direct the Provider to make a compensatory payment to the Complainant in the sum of €5,000, to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the Provider.

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.***

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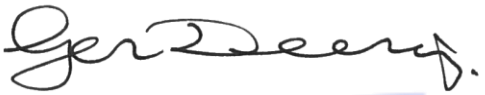
The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.



GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

31 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.