An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0053
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Rejection of claim
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant holds a Guaranteed Term Protection Policy with the Provider. This complaint concerns a claim for Personal Accident Income Benefit that the Complainant made under her policy, and the Provider's decision to decline this claim.

The Complainant's Case

The Complainant states she suffered an injury to her neck and back on **19 November 2018** when pushing a heavy trolley in her workplace.

The Complainant subsequently submitted a Personal Accident Income Benefit **Claim Form** to the Provider in **April 2019**, as follows:

> *"… **Please describe your injury/incapacity.***
> *Back and neck pain …*
>
> ***If your injury/incapacity is the result of an accident, please describe in detail the circumstances surrounding this accident.***
> *Back and neck pain following pushing overloaded trolley at work place …"*

Following its assessment, the Provider wrote to the Complainant on **18 April 2019** to advise that it had declined the claim, as follows:

> *"… We note from your claim form both you and your GP…advise your injury was the result of pushing an overloaded trolley. Unfortunately, we are unable to consider this claim as this does not meet the* [policy] *definition* [of 'temporarily disabled'] *and the information provided on the Claim Form confirms no evidence of an accident as required under the policy terms. We have no option but to decline this claim …"*

The Complainant, by email to the Provider of **28 April 2019**, appealed its decision to decline her claim, as follows:

> *"… this injury has been caused due to accident that happened in work. I work in the online department but what you need to understand is that when an order is made, I have to gather the products and transport them to the correct area via trolley. The accident happened as I was PUSHING an overloaded trolley on the back of orders made online. How is this not considered as not meeting the definition and information provided in my policy?*
>
> *You have been supplied with separate reports from different doctors advising you that this injury has impacted my ability to perform my job which has cut my income as I am not getting paid any sick leave from work …"*

In addition, in noting that the policy definition of 'temporarily disabled' excluded *"disability which occurs as a result of lifting, twisting turning or bending"*, the Complainant questioned where in this definition did it exclude disability as a result of pushing.

The Provider emailed the Complainant on **8 May 2019** to advise that it was standing over its decision to decline indemnity in this matter, as follows:

> *"… While we are not disputing the fact that you have suffered an injury which has impacted on your ability to carry out your occupational duties, this incapacity does not meet the criteria required to be considered a medically valid Personal Accident Claim. Therefore, the decision to decline this claim remains unchanged …"*

The Complainant, by email of **13 May 2019**, made a formal complaint to the Provider regarding its decision to decline her claim, in which she advised that she was willing to attend and be assessed by a doctor of the Provider's choosing, if it wanted her to, in order to confirm her inability to work. The Provider issued the Complainant with its **Final Response Letter** on **28 May 2019**, again setting out its reason for declining her claim.

The Complainant sets out her complaint in the **Complaint Form** she completed, as follows:

> *" … I work in* [redacted]*, in the online department which includes me receiving the orders and physically loading them onto a trolley … I had an accident in work while I was pushing an overloaded trolley and have been unable to work since which is over 7 months. I have been paying for physiotherapy and doctors appointment regularly.*

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My job does not pay me sick leave so I've had a significant reduction in income. I have spoke[n] *to different agents in* [the Provider] *and have been misinformed on many occasions …*

My complaint was sent in [to the Provider] *on 13/05/2019 and the first acknowledgement I received was on 28/05/2019 which was the final response letter. I never received the 5 day acknowledgement as per* [the Central Bank of Ireland's **Consumer Protection Code 2012 (as amended)**] *when a customer is making a complaint. I contacted a phone number that was provided to me and asked to speak to the claims agent…as I was awaiting for an update or a response to my complaint. I was passed around for 30 minutes and ended up leaving a voicemail for her to which she did not follow up and contact me back.*

This has caused me nothing but stress affecting me both physically and mentally. I took out an insurance policy to make sure I was covered for any incident that may occur especially that my job does not cover loss of income during an accident. I have asked [the Provider] *what does my policy cover if not this and once again they left the question unanswered …"*

In his letter dated **29 June 2019**, the Complainant's treating Orthopaedic and Trauma Specialist advised that:

"[The Complainant] *should refrain from heavy lifting, heavy carrying, heavy pushing and pulling, frequent bending forward, kneeling and squatting activities, long time sitting due to her neck, low back and Lt knee condition"*.

In addition, in his letter dated **8 May 2020**, this Specialist also advised that:

"[The Complainant] *is under my care due to chronic low back pain with recurrent Lt sided sciatica. Her symptoms have become more intrusive in course of pregnancy. Her* [expected due date] *is 18/04/2020. Her low back treatment was partially suspended for pregnancy period and based only on physiotherapy at the beginning of pregnancy and on home exercises. She is planned for lumbar spine MRI scan and further treatment after delivery. Basing on so far symptoms I believe that her long term prognosis is promising, but recovery time is difficult to predict. Her another* (sic) *orthopaedic issue is Lt knee chronic pain after an injury on 21/08/2017. She was planned for Lt knee hyaluronic acid intra-articular injection, but it was also suspended due to pregnancy. It will be continued after the delivery".*

The Complainant seeks for the Provider to admit her Personal Accident Income Benefit claim which she calculates to be in the amount of **€120.00** (one hundred and twenty Euro) per week, payable in respect of each week she has been absent from work due to her injury.

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The Provider's Case

The Provider says that the Complainant completed and sent a Personal Accident Income Benefit **Claim Form** to the Provider on **26 March 2019**, in which she provided the following details:

> *"… **Please describe your injury/incapacity.***
> *Back and neck pain …*
>
> ***If your injury/incapacity is the result of an accident, please describe in detail the circumstances surrounding this accident.***
> *Back and neck pain following pushing overloaded trolley at work place.*
>
> ***What date did this accident occur?***
> *19/11/2018"*

In addition, the Complainant's GP also advised in this **Claim Form** that the Complainant had suffered a *"low back overloading injury at work when pushing heavy trolley".*

The Provider notes that Section 14, 'Personal Accident Benefit', at pg. 24 of the **Policy Document** states that:

> *"… On proof that a Life Insured in respect of whom Personal Accident Benefit applies has become temporarily disabled as a result of an accident, that occurs after the Policy Issue Date in Ireland or the United Kingdom,* [the Provider] *will pay the Personal Accident benefit applicable to that Life Insured.*
>
> *For the purposes of Personal Accident Benefit, temporarily disabled means being completely physically unable to follow the occupation the Life Insured was following as described in the application for insurance, directly as a result of an accident caused by external violent and visible means. Disability which occurs as a result of lifting, twisting, turning or bending cannot be considered as having occurred as a result of external, violent and visible means and therefore cannot be considered under this benefit …"*

The Provider says that following its assessment, it wrote to the Compliant on **18 April 2019** advising that it had declined the claim, as follows:

> *"… We note from your claim form both you and your GP…advise your injury was the result of pushing an overloaded trolley. Unfortunately, we are unable to consider this claim as this does not meet the* [policy] *definition* [of 'temporarily disabled'] *and the information provided on the Claim Form confirms no evidence of an accident as required under the policy terms. We have no option but to decline this claim …"*

The Provider says that it is not disputing that the Complainant suffered an incapacity. However, it says that as there was nothing 'violent' about the incident described in the **Claim**

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Form, in that her incapacity occurred as a result of the physical exertion of pushing a heavy trolley, and therefore her claim does not fall within the policy terms. The Provider thus refused the claim as the Complainant's incapacity was not the result of an "accident" within the meaning of the policy provisions, because there was no external violent and visible means.

The Provider says that reading Section 14, '**Personal Accident Benefit'**, of the **Policy Document** as a whole, it is clear from the context that the use of *"lifting, twisting, turning or bending"* is not intended to be an exhaustive list and is included by way of example of the types of accidents which would not be covered and which would not be considered as having been caused by *"external violent and visible means"*. In that regard, the Provider says that the absence of any reference in Section 14 to 'pushing' does not change its position, as the key point is that the temporary disablement in the Complainant's case, did not arise as a result of an accident caused by *"external violent and visible means"*.

Accordingly, the Provider is satisfied that it declined the Complainant's Personal Accident Income Benefit Claim in accordance with the terms and conditions of her policy.

In addition to Personal Accident benefit, the Complainant's policy also provides her with, amongst other things, **Serious Illness Cover** and **Hospital Cash**. The Provider says there is no claim to be considered under Serious Illness Cover, because the Complainant is not suffering from any of the medical conditions listed in the policy. Further, as there is no indication that the Complainant was hospitalised, no claim can be paid under the Hospital Cash benefit, as this is only payable where the insured is hospitalised for a period of 72 hours or more.

The Provider says in response to the Complainant's contention that its staff mistreated and misinformed her by telephone on a number of occasions, that it carried out an extensive search of its customer service telephone records, using the mobile number provided by the Complainant, over the course of a 3 month period from March to May 2019 and found a record of only 1 call having been received from this number, and this was on **24 April 2019**.

The Provider confirms that its Customer Services Representative acted correctly during the course of this call and at no point misinformed or mistreated the Complainant. It says however, that if the Complainant is able to provide any further information in relation to the telephone calls that she refers to, such as the date the calls were made or the number she rang from, the Provider says it will carry out a further search of its call logs.

The Complaint for Adjudication

The complaint is that in 2019, the Provider wrongfully or unfairly declined the Complainant's Personal Accident Income Benefit claim.

Decision

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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 **10 December 2021**, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter. Following the consideration of additional submissions from the parties, the final determination of this office is set out below.

I note that the Complainant states she suffered an injury to her neck and back on **19 November 2018** when she was pushing a heavy trolley in her workplace. She submitted a Personal Accident Income Benefit **Claim Form** to the Provider in **April 2019**, but following its assessment, the Provider wrote to the Complainant on **18 April 2019** to advise that it had declined the claim. The Complainant appealed this outcome by email on **28 April 2019**, and the Provider responded to the Complainant by email on **8 May 2019** to advise that it was standing over its decision to decline indemnity.

The Complainant's insurance policy, like all insurance policies, does not provide cover for every eventuality; rather the cover will be subject to the terms, conditions, endorsements and exclusions set out in the policy documentation.

I note that Section 14, 'Personal Accident Benefit', at pg. 24 of the **Policy Document** states that:

> *"… On proof that a Life Insured in respect of whom Personal Accident Benefit applies has become temporarily disabled as a result of an accident, that occurs after the Policy Issue Date in Ireland or the United Kingdom,* [the Provider] *will pay the Personal Accident benefit applicable to that Life Insured.*

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> *For the purposes of Personal Accident Benefit, temporarily disabled means being completely physically unable to follow the occupation the Life Insured was following as described in the application for insurance, directly as a result of an accident caused by external violent and visible means. Disability which occurs as a result of lifting, twisting, turning or bending cannot be considered as having occurred as a result of external, violent and visible means and therefore cannot be considered under this benefit … "*
>
> [My emphasis]

As a result, I note that in order to be eligible for Personal Accident Income Benefit, the Insured must be:

> *"… completely physically unable to follow the occupation the Life Insured was following as described in the application for insurance, directly as a result of an accident caused by external violent and visible means".*

I note in the Personal Accident Income Benefit **Claim Form** the Complainant sent to the Provider on **26 March 2019**, she advised of the circumstances of her injury as follows:

> "*Back and neck pain following pushing overloaded trolley at work place …"*

In addition, I note the Complainant's GP advised in the **Claim Form** that the Complainant had suffered a *"low back overloading injury at work when pushing heavy trolley".*

I am satisfied that it was reasonable for the Provider to conclude that the Complainant's injury was not *"directly as a result of an accident caused by external violent and visible means"*, as required by the policy, in order to meet the criteria for a valid Personal Accident Income Benefit claim.

In that regard, while the Complainant may have been incapacitated and unable to perform her normal working duties, I take the view that the circumstances resulting in her incapacity, insofar as the Complainant hurt her neck and back while pushing an overloaded trolley at work, is not an injury that can be said to have been caused by external violent and visible means.

In my opinion, an injury sustained by pushing a trolley falls into the same category of injuries sustained by lifting, twisting, turning or bending, as anticipated by the policy exclusionary clause. However, even if I am incorrect in that respect, there is no evidence available that the Complainant's incapacity was the result of an accident caused by external violent and visible means. As a result, I am satisfied the Provider was entitled to decline the Complainant's Personal Accident Income Benefit claim in accordance with the terms and conditions of her policy.

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I note the Complainant's comments in her **Complaint Form** that:

> *"…I have spoke*[n] *to different agents in* [the Provider] *and have been misinformed on many occasions …"*

The Provider says that it has identified a record of only one telephone call received from the Complainant, and this was on **24 April 2019**. A recording of this telephone call has been furnished in evidence and I have considered the contents of this call. I am satisfied that the Customer Service Representative was at all times courteous to the Complainant, and explained to her fully and correctly why her policy did not provide cover for her injury.

I note the Complainant says that the Provider failed to comply with its obligations under Provision 10.9 (a) of Chapter 10, 'Errors and Complainants Resolution', at pg. 67 of the Central Bank of Ireland's **Consumer Protection Code 2012 (as amended)**, which states that:

> *"the regulated entity must acknowledge each complaint on paper or on another durable medium within five business days of the complaint being received".*

In this regard, the Complainant states in her **Complaint Form** that:

> *"My complaint was sent in* [to the Provider] *on 13/05/2019 and the first acknowledgement I received was on 28/05/2019 which was the final response letter. I never received the 5 day acknowledgement as per* [the Central Bank of Ireland's **Consumer Protection Code 2012 (as amended)**] *when a customer is making a complaint".*

I am satisfied that the documentary evidence before me, demonstrates that the Complainant emailed her complaint to the Provider on **Monday 13 May 2019** and that the Provider issued a complaint acknowledgement letter to her on **Monday 20 May 2019**, which I am satisfied is in accordance with its obligations under the Code. Further, I note the Provider issued the Complainant with its **Final response Letter** on **28 May 2019**, which was well within the timeframe permitted by the Code.

Having regard to all of the above, I am satisfied that the evidence does not support the complaint that the Provider wrongfully or unfairly declined the Complainant's Personal Accident Income Benefit claim.

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

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Conclusion

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

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

MARYROSE MCGOVERN
FINANCIAL SERVICES AND PENSIONS ONMUDSMAN(ACTING)

9 February 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.