An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0138
Sector:	Insurance
Product / Service:	Payment Protection
Conduct(s) complained of:	Claim handling delays or issues Complaint handling (Consumer Protection Code) Dissatisfaction with customer service Rejection of claim - fit to return to work
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint arises from the refusal of the Provider to admit and pay a claim made for 'Total Disability' on the Complainant's sickness income policy.

The Complainant's Case

The Complainant holds a sickness income policy with the Provider.

In **April 2017**, the Complainant became seriously ill and was hospitalised. In a letter to this office, received on **2 March 2021**, the Complainant submitted that he was "*very ill for all of that year and most of the following year*".

On **15 April 2017**, the Complainant made a claim to the Provider for 'Total Disability' payment. The Provider made payments on this claim until **September 2017**, at which point it sought additional medical records from the Complainant. The Complainant provided this documentation on a number of occasions.

The Complainant states that the Provider used incorrect terminology in correspondence with him regarding the policy. He states that he was referred to as '*not economically*

viable' or '*not economically active'*. He noted that these terms were not included in his policy.

The Complainant submitted that on **29 May 2018** and **16 November 2018** he asked the Provider to explain what his policy coverage was. He did not receive a response to either query. He stated that the Provider continued to take direct debit payments from his account.

The Complainant argued that he is entitled to 12 months' disability payment, as per his policy, and that the Provider owes him the balance of **213** days of payment.

The Provider's Case

In an email to this office of **1 October 2020**, the Provider stated that the Complainant's claim was received in **May 2017**. This claim asserted that the Complainant was a self-employed builder who was unable to work due to his medical condition, and this was assessed and accepted "*on face value*".

Three payments were made to the Complainant, covering the period of **15 April 2017** to **10 September 2017**, totalling €2,251.67 (two thousand, two hundred and fifty-one Euro and sixty-seven Cent). The Provider noted that each payment was accompanied by a letter to the Complainant, which set out that liability was accepted only for that period, and further payments would be subject to further evidence.

The Provider received the Complainant's 'continuation form' on **21 November 2017**. A different Agent of the Provider assessed this claim, and noted that the Complainant's prior claim with the Provider had been assessed on the basis that he was retired. As a result of this, the Provider arranged for an independent nurse from the Health Claims Bureau to assess the Complainant's condition. This assessment took place on **6 December 2017**, and the report noted that the Complainant had been unable to do any physical work since **2014**. The Provider noted that this report outlined that the Complainant was able to do some, but not all, of his daily activities. As a result of this report, the Provider concluded that the Complainant's claim should be assessed on the basis that he is retired.

On **3 January 2018**, the Provider wrote to the Complainant with an offer of €222.20 (two hundred and twenty-two Euro and twenty Cent), as the maximum benefit for 'Partial Disability' in settlement of the claim. The Provider submitted that "*as you are able to carry out administrative tasks relating to your business we can only now consider partial Disability in settlement of your claim*."

/Cont'd…

This offer was rejected on **15 February 2018**, and the Complainant provided further information to the Provider. The Provider reviewed this correspondence and confirmed its decision that the Complainant should be offered Partial Disability, as a retired person.

In a letter to the Complainant of **9 March 2018**, the Provider stated that the Complainant had previously made claims to the Provider for a total of 2890 days, in which he had claimed to be unable to work. The Provider further submitted that this was "*60% of this thirteen-year period*" with an average of four months between each claim. It referred to a letter from the Complainant's consultant orthopaedic surgeon of **5 November 2015**, which implied that the Complainant was no longer working. Based on that letter and the Complainant's claim history, the Provider reiterated that it was assessing the Complainant's claim on the basis that he is retired.

In its formal response to this Office, dated **27 April 2021**, the Provider acknowledged that it should not have used the terminology '*economically viable*' and '*economically active*' in correspondence with the Complainant.

The Provider was asked by this Office if it was satisfied that it had complied with General Requirement 3.3 of the ***Consumer Protection Code 2012*** (CPC), in relation to the requests made for information made by the Complainant on **29 May 2018** and **16 November 2018**. The Provider stated that it did reply to the first letter on **7 June 2018**, advising the Complainant to contact the Customer Service Department for details on his cover.

In relation to the second request, the Provider noted that a letter of **19 October 2018** from the Complainant was received on **16 November 2018**. The Provider submitted that it cannot trace a specific response to this request, and apologised for the omission. The Provider noted that it did send annual benefit statements to the Complainant on **19 June 2018** and **9 April 2019**, which set out a summary of his policies and a cover letter, with full details of his cover.

The Provider noted that:

> *"We issued annual benefit statements in 2018, 2019 and 2020 giving him a summary of his cover and referring him to his terms and conditions, and also how to contact us if he had any questions. There is no evidence he did this so we were unaware that he felt this way. We were also not afforded the opportunity to investigate this as an aspect of his complaint as he didn't contact us about it."*

The Provider further stated that the Complainant has made a claim for Total Disability benefits since this matter, and this indicates that he is aware that his policy continues to provide cover.

/Cont'd…

The Provider submits that it is satisfied that it has acted in compliance with General Principles 2.1 and 2.2 of CPC. It has accepted the claim on face value, and thereafter sought to continually validate the claim to ensure that it met the terms and conditions of the policy. The Provider also submits that it complied with General Requirement 4.1 CPC to require clear, accurate and up to date information.

The Complaint for Adjudication

The complaint is that the Provider terminated benefit payments under the Complainant's sickness income policy in September 2017 and has failed to explain to the Complainant what his current monthly premium payments cover him for. The Complainant wants the Provider to:

- Pay him the balance of the 12 months of payments he says he is entitled to, €3,154.53 (three thousand, one hundred and fifty-four Euro and fifty-three Cent); and
- Provide an explanation as to what the monthly premiums of €84.36 (eighty-four Euro and thirty-six Cent) cover the Complainant for.

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 **4 January 2022**, 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

/Cont'd…

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.

Evidence

I note that the Complainant's **Sickness Income Policy** with the Provider states:

"DEFINITION OF TERMS

…

"Totally Disabled"	*Means the Insured is unable to perform each and every duty of the Insured's business or occupation (or usual activities if not employed).*
"Partially Disabled"	*Means the Insured is unable to perform one or more, but not all of the important duties of the Insured's business or occupation (or usual activities if not employed)."*

In the **Sickness claim form** received by the Provider on **15 May 2017**, the Complainant stated:

"1.7 What is your job or occupation (e.g. plumber, courier)

S/e builder

Please tell us any other jobs that you are paid for

----------"

I have also noted the contents of the **Assessment Visit Report** of the independent nurse from the Health Claims Bureau, dated **12 December 2017**, following a visit on **6 December 2017**.

The Report states as follows:

*"**3.1 The claimant Economically Active at Commencement of Incapacity.***

…

d. Main Job title (Actual)

/Cont'd…

Electrician by trade, however, also working doing maintenance/handyman

…

f. Has the occupation changed in any way since the Policy commenced?

No, however, since 2014 he has not been able to do any physical work. He had been maintaining his own properties but has to employ tradesmen now to do any necessary maintenance or repairs.

g. Does the claimant undertake/have any other form of remunerative activity? If so, please give full details.

Rental income from his properties.

…

4. Summary of Medical Position

…

f. And what can the claimant still do? If the claimant can still do anything, from when could he/she do it? Can the claimant assist, supervise or administrative any part of their original activities?

He has rental properties and is able to do the paperwork associated with the properties.

…

k. Please describe the claimant's activities on a typical day.

…His daily activities consist of waking at 7 or 8am. His sleep is poor therefore he wakes on and off during the night. When he wakes in the morning he watches television for a couple of hours. Around 11am he will start to get up by sitting on the edge of the bed, get dressed sometimes has a shower. He occupies a 2 storey house but lives in the downstairs area therefore avoids the stairs. He will prepare breakfast, tea and toast. He walks about 50 yards to the local shop for the paper, return home and rest while reading the paper. For lunch he will drive to town which is a short distance from his house. He spends his spare time reading and visiting friends. He generally goes to bed around 10pm."

In his letter of **29 May 2018** to the Provider, the Complainant stated:

/Cont'd…

> *"If my policy does not cover me for this disability, I wonder what it does cover me for???"*

In a letter to the Provider dated **19 October 2018**, the Complainant also stated:

> *"Finally, as [Provider] continue to take monthly payments from my account yet they offer no future cover. Please clarify"*

Analysis

The Complainant asserts that he is owed the balance of 12 months of Total Disability benefit under his policy, for his claim in **April 2017**. The Provider asserts that the Complainant is only entitled to Partial Disability benefit. The Provider has submitted in that regard that the Complainant is retired, and therefore his ability to perform his "*usual activities*" must be analysed. As he is able to complete some of the usual activities of a retired person, he does not meet the definition of 'Totally Disabled'.

I note that the Provider has based its conclusion that the Complainant is retired on the independent nurse's report, and the claim history of the Complainant. The Provider asked the Complainant on multiple occasions to provide evidence that he had worked since **2014**. This was not provided by the Complainant, who I note is in his late 70s.

In the claim form, the Complainant stated that he was a self-employed builder. In the independent nurse's assessment, he stated that he had not been able to do physical work since 2014. In the absence of further information from the Complainant on this issue, I believe that it was reasonable for the Provider to conclude that the Complainant was retired. As the Complainant is able to complete some of the activities of a retired person, it was also reasonable, in my opinion, for the Provider to conclude that he met the definition of 'Partially Disabled'.

However, the Complainant refutes that he is retired, and he has specifically submitted that he manages rental properties. The Provider has also relied in that respect on the independent nurse report, which states that the Complainant was able to complete administrative tasks for his rental properties. On that basis, the Provider submits that the Complainant cannot meet the definition of 'Totally Disabled'.

In the claim form and the continuation forms, the Complainant did not provide any information on the activities or duties that he found himself unable to perform. On the basis of the Complainant being considered a self-employed property manager or landlord,

/Cont'd…

I accept that paperwork and administrative tasks form a part of the important duties of those roles. As a result, I am satisfied that the Provider was entitled to take the view that the Complainant was 'Partially Disabled' and not 'Totally Disabled'.

I am in no doubt that the Complainant was very ill, and indeed the medical details are clear as to his illness at the time, but the purpose of the policy is to provide for benefit payments to be made, on the basis of whether he was totally disabled or partially disabled from undertaking his usual employment. Therefore, regardless of whether the Complainant is assessed as retired or as self-employed, I accept that the Provider was entitled to form the opinion that he did not meet the definition of 'Totally Disabled' under his policy.

In relation to the Complainant's requests for information, I note that the first letter of **29 May 2018** was responded to by the Provider. Although the Provider did not specifically answer the Complainant's direct question in its response, in my opinion, the question could well have been interpreted as an exasperated comment, rather than as a request for policy documentation or explanation.

In relation to the second request for information, I note that the Provider has accepted that it did not respond to the Complainant's letter. General Requirement 3.3 CPC states:

> *"3.3 A regulated entity must ensure that all instructions from or on behalf of a consumer are processed properly and promptly."*

The Provider's failure to process and respond to the second request for information was mitigated by the fact that annual statements with the Complainant's policy coverage were sent to the Complainant.

Additionally, I note the Provider's submission that the Complainant has since made a further claim to the Provider for Total Disability benefit. Consequently, there has been little evidence presented of the impact on the Complainant of the Provider's technical breach of Provision 3.3 CPC.

Having regard to the above, I do not accept that the Provider failed to make appropriate payments to the Complainant on his sickness income policy claim. I am satisfied however, that the Complainant's requests for explanation of policy cover were not responded to appropriately by the Provider and this was unreasonable, in my opinion, within the meaning of ***Section 60(2)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017***. Accordingly, taking account of this failure, and other errors that have been the subject of further commentary in the parties' submissions since the preliminary decision was issued

/Cont'd…

in January 2022, I consider it appropriate to partially uphold this complaint and to direct the Provider to make the compensatory payment referred to below.

Conclusion

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

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainant in the sum of €250 (two hundred and fifty Euros) 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.***

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 Ombudsman (Acting)

21 April 2022

PUBLICATION

Complaints about the conduct of financial service providers

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—

/Cont'd…

(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.

Complaints about the conduct of pension providers

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will **publish case studies** in relation to complaints concerning pension 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.