An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

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| **Decision Ref:** | 2022-0223 |
| **Sector:** | Insurance |
| **Product / Service:** | Employers Liability |
| **Conduct(s) complained of:** | Lapse/cancellation of policy<br>Rejection of claim - non-disclosure |
| **Outcome:** | Rejected |

## LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint arises from an **Executive Income Protection Plan** incepted with the Provider on **6 March 2012**. The Complainant was not the policyholder, but she makes this complaint in her capacity as an actual or potential beneficiary of a *"long-term financial service"* within the meaning of the ***Financial Services and Pensions Ombudsman Act 2017***. The Policyholder was the Complainant's employer. The Complainant, as the life assured, completed the application for cover through an Insurance Intermediary ('the broker'). The Provider was the Insurer, responsible for underwriting the applications for cover and assessing claims.

This complaint concerns the Provider's decision in **July 2018** to decline the Complainant's income protection claim and to cancel the policy from inception, on the basis that she had failed to disclose her full medical history when applying for the cover.

### The Complainant's Case

The Complainant completed and submitted an income protection **Claim Form** to the Provider on **28 May 2018**, wherein she advised that she had not attended worked since **22 May 2018** due to *"Stress, lack of sleep, stress, anxiety".*

Following its claim assessment, the Provider wrote to the Complainant on **23 July 2018** to advise that she had failed to disclose her full medical history when applying for cover and that its underwriters had confirmed that if it had been aware of such information, when considering her policy application, it would not have been in a position to offer terms of cover. As a result, the Provider declined the Complainant's income protection claim and

voided the **Executive Income Protection Plan** from inception, and it refunded to the Policyholder all premiums paid since the commencement of the policy.
The Complainant wrote to the Provider on **13 September 2018** to appeal its decision to decline her income protection claim and void the policy from inception, as follows:

> *" … I feel my initial application form was rushed and not given the due time needed, and my Nurse Medical was loosely carried out and the Nurse made some grave errors in completing the application form by giving incorrect answers. I am disputing the way the Nurse Medical was carried out, for example, "Have all "Yes" questions been fully answered = YES". This should have been a "No" answer. Of course the Nurse Medical would not have expected me to remember/know all the dates/years of the scans/x-ray's etc, but the Nurse should have requested this information from my GP especially as I answered "yes" which covered all parts of the question, not just Bloods.*
>
> *In my original application I consented for a PMA* [(GP Report)] *to be completed but this was never done. I have been blessed with good health all of my life, I can occasionally be forgetful when I am very busy (managing a* [place of employment] *with 50 staff with a €3 million turnover), as can be verified in my Medical Notes where I complained of worrying about poor memory over the years. There was never a question on either the application form or the nurse medical to ask me about poor memory. I did attend for an MRI due to my concerns regarding my memory loss and this came back clear. My GP advised me at the time it was nothing more than a busy mind trying to retain everything.*
>
> *I think that it is unreasonable and unfair that a PMA was not done as I gave full permission for this on my application form. It was never explained to me at the time of the nurse medical that any omissions would make this application invalid, and as per the Nurse Medical I was never encouraged to pursue any additional medical advice and more importantly when the nurse medical was finished I was not given the opportunity by the nurse to scroll back and review the questions from the start, I had answered before I signed, as these were all on the nurses laptop. If that had been done, mistakes would have been spotted then in 2012 and corrected immediately. Receiving this information in July 2018 was far too late to review and correct. I was simply asked to sign the form by the nurse. I feel there was/is a duty of care by the Nurse to go through what I had completed.*
>
> *To the best of my knowledge for all current Income Protection Applications, the client is now afforded the opportunity to review all questions answered before the application is fully submitted to the Life Company, therein removing the margin for error.*
>
> *I would plead with you not to reject my claim/application. I have worked from inception date of the policy in 2012 to the current time 2018 without every* (sic) *have* (sic) *any claim on my policy. I need the assurance going forward that I am protected for the remainder of my working life as it is my full intention to work on for another number of years".*

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The Complainant enclosed additional correspondence to the Provider in support of her appeal.

In that regard, in the enclosed **Report** dated **23 July 2018**, the Complainant's GP stated that:

> *"*[The Complainant] *aged* (sic) *is 60yrs. She finds herself currently in a very stressful situation and has severe difficulty with anxiety as a direct result. She is unable to sleep and is anxious, emotional and distressed. She is suffering panic attacks and is unable to concentrate. She never felt like this in the past. I have advised against work as her job is extremely stressful. I have commenced her on medication and advised counselling. This is completely different to any situation she ever encountered in the past.*
>
> *I wish to clarify her past medical history.* [The Complainant] *attended me in 2004 with a bereavement reaction of tiredness and low mood which I documented in her notes as such. She needed to work as she was in a busy job and indeed she did and was fit to do so. I treated her for a very short time (my notes show a period of 5 weeks only) with a low dose SSRI* [selective serotonin reuptake inhibitor] *to help her to get on with her busy life. She has been a regular patient since that time over 14 years and did not require any further treatment for mood.* [The Complainant] *had not considered this of any consequence.*
>
> *In 2012 she embarked on an insurance policy. There was no PMA requested and if there had been it would have included her brief sadness reaction in 2004. I wonder why this was not requested. I also insist that she dis* (sic) *not suffer any mental health issues for over 16 years.*
>
> *Mild depression is not anxiety and* [the Complainant] *never suffered anxiety in the past. I concur strongly with her assertion that she did not suffer from any mental health issues at any time in the past but a natural response to a personal loss in the dim distant past that bears no relationship to her current anxiety disorder.* ***Further should I have been given the opportunity to provide a PMA report the current situation would not have arisen****"*.

In the enclosed **Report** dated **9 August 2018**, the Complainant's treating Occupational Physician stated that:

> *"*[The Complainant] *has asked me to write this report in support for her appeal against* [the Provider's] *decision to decline/terminate her claim. In addition to her own history she has provided me with documents from* [the Provider] *outlining its reasons for terminating her claim.*
>
> *My first impression on reading your documentation, is that some clerk was asked to find every possible thing in the doctors PMA that could suggest withholding of material information, and provided a comprehensive list, all of which are not factually correct.*

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*It beggars belief that this information was not requested in 2012 when the policy was first taken out, given the patient's age at the time, the fact that the nurse questionnaire revealed that she had a significant past medical history, and that the applicant had signed an authority to do so.*

*There is an assertion that the applicant wilfully withheld information in responding to the questionnaires. It is well recognized, that reliance on questionnaires only, either in pre-employment medicals or in completion of life insurance forms is hazardous, as there may be a significant number of omissions. People have difficulty recalling details of their medical history where there have been no adverse outcomes.*

*The fact that patient was complaining of difficulty in remembering things in 2012 highlights this fact.*

*There is much made of the fact that patient apparently had an episode of depression in 2004. This occurred after the death of a close personal friend due to a rapidly advancing cancer. As the episode lasted five weeks only and there was no previous or subsequent episodes of depression, it is highly likely that this was a grief reaction due to bereavement and not an episode of depression. There are very few people in their fifties who have not had a grief reaction to the loss of someone dear to them and five weeks would not be unusual. Whether antidepressants was necessary is debatable and bereavement counselling may have been more appropriate. Perhaps if your questionnaire included whether the applicant had ever suffered a bereavement and was sad afterwards, she would have answered yes.*

*With regards to the back pain, it has been shown in studies that practically everybody experiences back pain at some stage in their life. It is also recognized that MRI scans will show varying degrees of degenerative disc disease with advancing age, and that the changes do not necessarily correlate with the extent and degree of pain. If the applicant had an isolated episode of back pain, even a severe one, it does not necessarily imply that they will have ongoing problems with their back. This patient to my knowledge did not have further back pain.*

*My concern is that there was a desire to insure this applicant as part of a company policy and that due diligence was not done, to exclude her at the time ensuring that maximum premiums were collected and invested.*

*In my opinion she should continue to be offered cover".*

In the enclosed **Report** dated **6 September 2018**, the Complainant's attending Consultant Psychologist concluded that:

" … [The Complainant] *experienced symptoms of depression in 2004 which met diagnostic criteria for Grief Reactions/Bereavement which did not meet criteria for a depressive disorder. She shows neither the premorbid personality nor the*

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*developmental history associated with the aetiology of depression. Her personality traits show a susceptibility to developing a major depressive disorder.*

*Her failure to document medical procedures which she had undergone, is attributable to the fact that at the time of her assessment for insurance, she was not experiencing pain symptoms".*

Also enclosed was a letter from the Complainant's Representative at the time, to the Provider dated **13 August 2018**, wherein he submitted that:

*"In 2012, when this Income Protection Policy was being applied for,* [the Complainant and I] *were also discussing Executive Pensions, Death In Service and the tax efficiencies of funding a pension versus taking the bonus owed to* [the Complainant] *via income tax. As you can imagine, in the age of compliance, the amount of paperwork that had to be covered at the meeting, as well as the topics to be discussed, were onerous. Furthermore this meeting took place in the* [Complainant's place of employment] *and, to the best of my knowledge took almost two hours. This was partially due to the fact that* [the Complainant] *was called from the meeting on a few occasions, in order to deal with a number of issues that had occurred as part of the day-to-day running of her* [place of employment].

*As the Income Protection Plan application was the last to be completed and a vast amount of paperwork was being covered, I remember telling* [the Complainant] *that she would have to do a medical at a minimum and that a PMA would be carried out. I made this assumption based on the client being in her mid-50s (approx.) and the sum assured was quite high. As we are not privy to underwriting requirements that trigger PMAs or medicals, etc., this was an assumption based on my experience. I have known* [the Complainant] *for a number of years and believe if the questions were put to her properly she would have answered to the best of her ability and with 100% truthfulness.*

*This case has made me look at life assurance applications in a different manner. For instance many questions asked on an application form may contain as many as 12 sub-questions within each question. This, in hindsight, is rather alarming as it is very easy to see why clients could say no to something when they might not hear every single part of the question posed. To use this case as an example, the amount of paperwork and topics that had to be covered on the day would necessitate meeting the client individually to discuss each particular piece of business in order for the client to be 100% au fait with what was going on, especially the way the questions are designed …*

*After this application was completed a Nurse Medical was carried out at* [the Complainant's] *home which, in hindsight, is a more suitable atmosphere to conduct a piece of business as opposed to her place of employment. During the Nurse Medical* [the Complainant] *answered yes to some of the questions that she answered no to on the application that was submitted. I am completely baffled, after carrying out further due diligence, to find out that* [the Provider]*, once they had conflicting*

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*information, did not carry out a PMA on* [the Complainant]. *Instead,* [the Provider] *waited until* [the Complainant] *was at her most vulnerable and in a state of claim to do their due diligence that, I wholeheartedly believe, should have been carried out in 2012, especially when there was conflicting information between the application form and Nurse Medical.*

*I also note that part of the reason for your declining the claim was the non-disclosure by* [the Complainant] *of the fact that she was claiming a difficulty in remembering things in 2012. This, again, shows in the client's defence that this is not non-disclosure but merely poor memory recall.*

*NB – it defies logic that an individual in their 50s, or indeed any age, is 100% liable for the answers to questions asked on an application form while the assurance company is not liable for ensuring that proper due diligence is carried out before they take any premiums from an individual. This is even more valid when neither the client nor myself, the assurance broker, are trained medical professionals. However the nurse who carried out the medical for* [the Provider] *is a trained medical professional and the assurance underwriters, who carry years of medical underwriting experience, have no accountability in any shape or form. I find this grossly unfair and am at a loss as to why the medical professionals did not do a PMA at the time, based on reasons already outlined. In my professional opinion the 2004 issue was grief only and not depression which would indicate that the non-disclosure outlined in your letter bear no resemblance to the reason why the client is claiming and, if dealt with prudently in 2012 through PMA, could have led to a back exclusion on the client (admittedly severe exclusions would have applied) and would have facilitated a successful claim in 2018".*

Following its appeal review, the Provider wrote to the Complainant on **19 October 2018** to advise that it was standing over its original decision to decline the income protection claim and void the policy from inception.

The Complainant sets out her complaint in the **Complaint Form** she completed for this Office on **14 November 2018**, as follows:

*"My complaint is that* [the Provider] *have cancelled my Income Protection Policy unfairly. On discovery I have found that:*

1. *There was a discrepancy between my original Application Form and the details in the Nurse Medical report completed in 2012. This should have been flagged before the Policy commenced in 2012.*

2. *My broker rushed the Application Form and omitted details.*

3. *The Nurse and Nurse Medical failed to elicit necessary information needed.*

4. *I never received a copy of either Application Form or Nurse Medical to view and rectify if necessary in 2012.*

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5. *Both my Doctors and Consultant disagree with the findings of* [the Provider] *to refuse my Policy on Medical History"*.

In her complaint papers to this Office dated **14 November 2018**, the Complainant also submitted, among other things, that:

> *"I am appealing a decision by* [the Provider] *in relation to an Income Protection Policy initiated in Jan 2012. I had occasion to claim on this policy in May 2018. It was refused in July 2018 by* [the Provider]*, and the policy has been cancelled, on the grounds of non-disclosure of medical conditions …*
>
> *I do acknowledge that the initial Application Form recorded answers "No" incorrectly. I did not complete this form and signed all areas mark X as requested by my Broker … The information in the original Application Form was transferred to the* [Provider's] *On Line application form. This was not sent to me for confirmation and signature at the time in 2012. I was only given a copy of this in July 2018 when I requested it after my claim was refused.*
>
> *Before the policy was enacted, these errors in disclosure of medical conditions were corrected in the course of a meeting with a* [Provider] *nurse in Feb 2012. Questions answered incorrectly on the application form were answered correctly at Nurse Medical. The nurse completed a medical questionnaire on an iPad…and he noted my answers to several medical questions, However, it is worth noting that question 15 related to several issues – X-Ray, Scan, MRI, blood tests – but only blood tests were further commented upon by him, and no comments were recorded in relation to X-Rays, Scans, MRI (these were listed as non-disclosures later by* [the Provider]*).*
>
> *At the time of policy inception in 2012, I was healthy, I had no on-going medical condition and I was not* [on] *any medications …*
>
> *I was not given copies of any* [Provider] *documents back in 2012. In particular, had I been given a copy of the original Application Form, the On Line Application Form, or Nurse Medical Form, the errors of non-disclosure would have been obvious to me, and the mistakes made by Nurse Medical could have been corrected …*
>
> *I would like to argue* [the Provider's] *statement on final letter of "significant Medical History":*
>
> - *"History of Disc Degeneration": this was an episode of back pain that, cleared up with medication, and scan reported Disc Degeneration, which is not considered a disease, nor is it progressively degenerative, and my Consultant report on the 20th of February 2009 no significance whatsoever it was "normal wear and tear" …*
>
> - *"Limb Problems": … this is the same complaint as left shoulder (soft tissue with full recovery and MRI was normal)*

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- *"Swelling & tenderness of shoulder" … referring to a period of a few days that resulted in* [soft] *tissue injury only and again MRI scan was Normal.*

- *"You were attending a Neurosurgeon" this implies continuous. I had one visit only for an opinion to read a previous MRI scan, another Scan was taken and all results were Normal.*

- *"Poor Concentration, Memory Loss, Night Sweats" these were all shown to be "normal female Menopause" for a woman in her early 50's*

- *"Stressed and Headache" This can be a normal reaction to working very hard long days with the running of a very busy* [place of employment]*, but again never resulted in medication or missing work …*

*This Application was completed and fill* (sic) *in by my broker…on 26 January 2012. My broker asked me how was my health? I answered that I was in great Health, not on any medications or suffering from any medical conditions. My Broker rushed the application form as we were arranging a pension, and life policy at the same time, saying he believed a PMA will be conducted. I signed, giving consent on my application form for all medical details to be obtained from my Doctors. My broker asked me to sign on the application form on all the areas marked X. My Broker, unfortunately, did not offer me the opportunity to choose a Tele Medical option that was on the Application Form…This would have afforded me the time to collect Medical information for the Tele interview at an agreed time. This Tele interview with a Nurse would have been taped, but more crucial, I would have received a copy of this Interview to read and rectify if necessary before my policy started in 2012.*

*In July this year 2018, when my claim was denied, I requested from my broker a copy of the original application form January 2012. On studying the Application form, I now can see where my broker ticked No to several Underwriting questions i.e. in Q16, that should have been answered yes…which resulted in* [the Provider] *claiming that I had made non disclosures on Application Form.*

*I admit I did not pay enough attention while I was signing the Application Form, I just assumed my broker had filled everything out correctly. I had no reason what so ever not to disclose my Medical History as all my scans and MRI had clear results …*

*On February 7th 2012 one week later after my Broker returned my Application Form, a Nurse called to my house and conducted a medical Examination and told me my results were normal. The Nurse asked me a series of Medical questions using his iPad, I believed I answered all questions put to me. The nurse then asked me to sign my signature at the end of page on his iPad. I was never given a copy of the nurse medical report in February 2012. In July 23rd 2018 I received a letter from* [the Provider] *refusing my claim, I asked for a copy of my Nurse Medical, this was sent to me in July 2018.*

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*On reading the Nurse Medical Form I noticed the following: In Question 15 "have you ever undergone any special examination including chest x-ray, ECG, Scans or Bloods?" I answered Yes to this question, intending Yes to all four items. Section 1 states "details of any Yes answers should be given in section 2". This was not done correctly, only details of bloods were filled in by the Nurse. On Section 2 (supplementary information) the Nurse failed to elicit details of my x-rays, scans and MRI. At the end of Section 2 "have all questions where the Yes box was ticked been answered?", the nurse ticked yes; this was incorrect, as no details were given regarding my x-rays, Scans, MRI.*

*I admit I have made an error on question 8 on the Nurse medical regarding suffering Back problems, the episode with my back was 4 years earlier, and once my Doctor and consultant advised me my condition was normal aging, and I had no further problems with my back, I simply forgot all about it".*

In addition, in her letter to this Office dated **18 March 2020**, the Complainant submitted, among other things, that:

*" … In my complaint to* [the Provider]*, in July 2018, I outlined and stressed the fact that a PMA should have been carried out for my Income Protection Application in January 2012. This was further supported by both of my Doctors in my appeal submission. However, there was no PMA conducted until I was in the unfortunate state of claim in May 2018.*

*In their refusal letter dated the 19th of October 2018,* [the Provider] *stated the following:*

> *"when this application was received by* [the Provider]*, our underwriters had no cause to request any medical reports from your GP as you made no disclosure to any of the medical questions asked on the application completed dated 16/1/2012".*

*However, it now transpires that when the second Income protection policy ****7333* [in April 2013] *was made with the exact same answers to the medical questions and no disclosures to any medical questions asked on the Application in 2013, the underwriters saw fit to request a PMA and an Independent Medical Examination in April 2013.*

*In her letter to* [the Provider] *dated the 6th of November 2018, my regular Doctor…stated*

> *"I feel* [the Provider] *were remiss in not looking for further information and even if they had elicited the full history there would not have been a cause to refuse a policy. I refute that they "would not have been in a position to accept your application" as all results were clear and she was not suffering any medical condition in 2012 when the policy was taken out".*

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*Secondly, I have further discovered that following my Nurse Medical in February 2012* [the Provider] *were in communication with my broker over the Hysterectomy operation that I had in 1996. I have discovered that I was asked to sign a hand-written note…outlining my understanding of the operation. This I believe was not the correct procedure from* [the Provider]*, they should have contacted my Doctor for these medical details.*

*Finally, I have also discovered that there was a second Nurse Medical carried out for* [a different insurer]*…on the 21st of October 2014. This was carried out by Nurse* [P.] *who also conducted the nurse medical in February 2012* [for the Provider]*. On examination of this report I discovered that for Question 13 which refers to Chest, Xray, Scans or Blood tests, I answered Yes, yet the Nurse only recorded Bloods.*

*My husband and I contacted Nurse* [P.] *on the 5th of September 2019 to enquire why on both Nurse Medicals where I had answered yes, as to why only bloods were recorded in both 2012 and 2014.*

Nurse [P.] *explained to us that "he would only consider these if they were recent, so if the results were clear and not recent he would not record them". I explained to* Nurse [P.] *that* [the Provider] *are now claiming non-disclosure on my Income Protection Policy. I asked* Nurse [P.] *if he would explain this to* [the Provider]*. He agreed he would do so".*

Furthermore, in her submission emailed to this Office on **24 June 2020**, the Complainant submitted, among other things, that:

*" … I disagree* [it] *is normal practice to send only the broker the medical questions in 2012, all other insurance companies send out medical questions to clients before the policy starts. The Claimant was sent policy acceptance on the 20th of February 2012 before the online form was returned to Broker on March 6th, 2012. was never shown this online form by* [the Provider] *or Broker which contained medical questions to be checked …*

*…it had been established that the original application form was never sent to* [the Provider] *as part of the application Process.*

*My understanding is that* [the Provider] *did not compare the on-line application form to the Nurse Medical form before policy started …*

*I was never given any instructions by either* [the Provider] *or the broker to look up a web site before the Nurse Medical.*

*The instruction leaflet for a nurse medical, as shown to the claims committee was never given to me by either* [the Provider] *or the Broker.*

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*My appointment was arranged by a letter from* [the Nurse Medical firm] *for me to ring the Nurse to arrange a time for the Nurse medical. The nurse agreed a date and time, but no instruction was given to the Claimant to have medical history available, therefore all my answers were purely from memory …*

*All nurse medical questions are controlled by the Nurse asking the questions, on receiving a positive answer, prompting for further information is also controlled by the nurse, as the patient cannot see the application form …*

*I disagree that the Nurse Medical was not sufficiently different from an underwriting perspective …*

*I would like to demonstrate that the* [Provider's] *Business Ethics Code were not followed in completing their duties with due skill, care, and diligence at processing my application. As follows:*

*The on-line application as accepted by* [the Provider] *with its declaration section 6 not been completed or signed by the Claimant.*

*The online application was accepted with the section 7 declaration form* (sic) *the original application not the online declaration form section 6.*

*The original application form was never requested by* [the Provider] *first to verify online information, and to check that both applications were the same.*

*The nurse medical form was not compared to either the original application form or the online application form … On receipt of Nurse medical form by* [the Provider]*, the person receiving the Nurse medical form, failed to see that positive questions had not all the further information answered yet the Claimant has been accused of non-disclosure for not spotting the same, where further information was not recorded to positive questions, while signing the form.*

*The acceptance of policy was issued to* [the Complainant] *on the 20th of February, on the 6th of March the online form and medical questions answered, were sent to Broker and not sent to the Claimant which I believe is common custom and practice, allowing claimant an opportunity to correct any mistakes before policy started and not be accused of non-disclosures at claim stage …*

*I believe that in this case the claims assessors manging the claim for my Income protection were not supported by the chief Medical officer. Evaluation of my GP Notes from both Doctors were inaccurately evaluated, wrongly duplicated, no explanations were requested from either Doctor re notes, resulting in inaccurate and damaging report of non-existence medical conditions and producing a non-disclosure list to underwriting …*

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*In addition to the inaccuracy of the list of non-disclosures and medical conditions that did not exist, along with visits to neurologists that did not exist …"*

The Complainant attached additional correspondence to her submission emailed to this Office on **24 June 2020**.

In that regard, in a **Report** dated **9 June 2020**, the Complainant's GP submitted that:

*"… Regarding the list of GP attendances, I feel that these were not examined thoroughly and any potential queries were not addressed requesting a PMA/further clarification from ourselves, her primary care doctors. I feel it is unfair to use a list like this as a basis for justifying non-disclosure. For example many of the 'attendances' records are actually just letters received or sent – our IT system records them as attendances.*

*Regarding the two shoulder xrays, these were carried out in the course of two days as they were ordered by two separate doctors. The second one showed some evidence of tendinosis, but this is not confirmed on MRI and is not enough evidence to label it as 'Right shoulder problems'.*

*Regarding the headaches and problems with stress, concentration, memory issues, as discussed these were put down by ourselves to menopausal symptoms, which is not counted as a medical condition.*

*Regarding degenerative disc problems – spine, this is actually related to one short period of acute lower back pain which resolved without treatment, and is based on xray findings and MRI findings – which showed age related degenerative disc changes in the lumbar spine, which is not enough evidence to class it as degenerative disc problems.*

*Regarding mental health issues, as discussed these were not present at time of the policy being taken out. As previously discussed there was one mild short lived episode of adjustment disorder in 2004 following a bereavement"*.

In addition, in a **Report** dated **15 June 2020**, the Complainant's Occupational Physician concluded that:

*"… It is my opinion that the process involved in obtaining medical information regarding* [the Complainant's] *policy at the time of its inception was heavily skewed to the advantage of* [the Provider]*. In adopting the process of using only medical information supplied by the applicant at the time of policy purchase and not requesting a PMA, it ensures that the maximum number of people can be offered cover and yet provide the company a means of declining policies should a claim be made.*

*While this process is legal, it does suggest a "miss selling" of policies …*

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> *The recording of medical information at the Nurse Medical was perfunctory at best, but ignored obvious inconsistencies.*
> *These reflect badly not only on the company obtaining the medical information, but also on* [the Provider] *and the CMO who did not recognise them/act on them during the whole appeal process. It suggests a determined attitude to refuse the claim at all costs.*
>
> *It is also disconcerting that the underwriters who have no medical information, clearly do not understand a lot of the medical terminology, and the significance of results of tests, or the self-limiting nature of various illnesses are scrutinising the confidential medical reports, recording bits of them inaccurately and summarising other parts, and in this case adding in a non-existent illness (depression). They are making decisions on medical issues that basically decide whether an appeal is accepted or rejected. The resulting report prepared for the Claims Committee both at claim and appeal stage was incorrect and misleading.*
>
> [The Complainant's] *policy should be re-instated and any claim made on it should be honoured".*

The Complainant also says that another financial service provider, the broker, forged her signature and the date of that signature on her **Application Form**. In relation to the elements of her complaint contending such fraudulent activity, this Office advised the Complainant in April 2021 that the assertion of forgery that she made is not something that this Office has jurisdiction to investigate.

The Complainant states in the FSPO **Complaint Form** that in order to resolve this complaint she seeks:

> *"that my Policy is reinstated by* [the Provider] *and that I continue to receive cover under my Income Protection Policy that I started in January 2012".*

**<u>The Provider's Case</u>**

The Provider says that the Complainant was the life assured on an **Executive Income Protection Plan** that commenced on **6 March 2012** and that the Policyholder was her employer. The **Executive Income Protection Plan Application Form** details the requirements for 'the Employer' and 'the Employee' to complete, indicating that the policy is designed for a company to provide benefits for an employee as opposed to it being an individual plan.

The Complainant completed an income protection **Claim Form** to the Provider on **28 May 2018**, wherein she advised that she had not attended worked since **22 May 2018** due to *"Stress, lack of sleep, stress, anxiety".*

In addition, the Complainant's GP completed and sent a **GP Claim Form** to the Provider on **21 May 2018** wherein she advised that the Complainant had attended on **8 February 2018**

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and was diagnosed on that date as suffering with *"Depression – Anxiety"*. The GP also advised that:

> *"**Has the patient suffered from any previous condition of a similar nature before?** Yes*
>
> ***If yes, please indicate when first manifested:** 12-7-2004*
>
> ***If yes, please provide full details:** Mild depression – short course SSRI*
> *No sequela & fully resolved*
> *No admission or referral required".*

Following its claim assessment, the Provider wrote to the Complainant on **23 July 2018** to advise, as follows:

> *" …. In completing the Application Form for Executive Income protection in January 2012 you were asked a number of questions regarding your medical history including the following*
>
> ***Q16. Have you ever had, or been suspected of having or consulted anyone, for example doctors, specialists, hospitals, clinics, counsellors, osteopaths or physiotherapists, about any of the following?***
>
> *I)* *Depression, stress, anxiety, chronic fatigue, ME, exhaustion, or any other nervous or mental disorder? **You answered No to this question***
>
> *N)* *Back pain, disc problem, lumbago, sciatica, arthritis, neck pain, gout or any other muscular, rheumatic, bony or joint problem? **You answered No to this question***
>
> *P)* *A CT scan, MRI scan or any other X-Ray examination within the last 5 years? **You answered No to this question***
>
> *Q)* *A blood test, special investigation or any surgical operation within the last 5 years? **You answered No to this question***
>
> ***A declaration form was signed by you on 26.01.2012 confirming the following;***
> *"I have read over the replies to all questions in this application and declare that to the best of my knowledge and belief, all information given is true and includes all material facts and I understand that failure to disclose all relevant facts, including full disclosure of my medical details and history, may delay or prevent the issue of my policy and/or may invalidate future claims. If you are in any doubt as to whether a fact is a material fact you should disclose it".*
>
> *In addition to the completed application form, a Nurse Medical Examination was also completed on 07th February 2012 and were* (sic) *you were asked a further number of questions regarding your medical history including the following:*

/Cont'd…

3. *Have you ever suffered from any mental or nervous disorder including anxiety, depression, psychosis or schizophrenia?* ***You answered No to this question***

8. *Have you ever suffered from back problems or disorders of the muscles or joints including prolapsed/slipped disc, sciatica, gout, osteo or rheumatoid arthritis?* ***You answered No to this question***

14. *Have you ever undergone any surgical operation or been treated in a clinic of hospital?* ***You answered Yes to this question and disclosed you had a hysterectomy 12 years ago.***

15. *Have you ever undergone any special examination including chest X-ray, ECG, Scans or blood tests?* ***You answered Yes to this question and disclosed you had Full Blood Count, Urea and electrolytes, Cholesterol, Glucose, Liver function tests, Thyroid Function test all normal and done routinely with GP.***

***A declaration was signed by you on 07.02 2012 confirming the following:***
*"I declare that I am the person referred to in the information above and that to the best of my knowledge and belief the information I have given is TRUE and COMPLETE".*

*Based on the information you provided to us on the application form and on the nurse medical examination we accepted your application for Executive Income Protection at standard rates. Your policy went into force on 06.03.2012.*

*On receipt of the Income Protection claim form on the 01.06.2018 we requested patient medical notes from both your GP's…in order for us to complete our assessment of the claim.*

*The notes received have confirmed that you failed to advise us of the following significant medical history when you were completing your application for Income Protection:*

*12.07.2004 - Mild depression short course of SSRI*

*25.07.2008 - attended GP advised suffers night sweats swallowing Panadol, develops during the day, works 6/7, frontal and back of head, memory poor referred for MRI*

*30.08.2008 - MRI of Brain*

*03.11.2008 - attended A&E with severe lower back pain and left sciatica*

*04.11.2008 - called to advised* (sic) *acute onset of low back pain brought to casualty by ambulance GP told to arrange MRI*

/Cont'd…

*12.12.2008 - MRI of lumbar spine degenerative disc disease with prominent L4/5 disc bulging and further protrusion to the left causing L5 nerve root compression on the left*

*27.01.2009 - attended neurosurgeon following acute lower back pain that lasted 10 days around November*

*13.10.2009 - working hard and stressed out headache and ache down left arm pain in teeth*

*10.2009 - Chest X ray*

*21.05.2010 - still works v hard notices when walking one leg trips her mostly the left, more forgetful headless and not concentrating, concentration poorer, memory not as good, MMSE at next visit, bloods, MRI, peripheral nervous system exam*

*23.05.2010 - attended A&E with limb problems, noticed swelling and tenderness over right shoulder.*

*26.05.2010 - attended GP shoulder up and down a lot of pain sleep ok with it*

*26.05.2010 - MRI of chest and of shoulder*

*16.06.2010 - attended GP looks like shoulder feels well again movement has improved*

*19.07.2010 - attended GP referred for MRI brain*

*04.08.2010 - MRI cervical*

*04.08.2010 -MRI brain*

*29.08.2011 - attended GP 2 days passing blood in stool*

*The significance of this failure to disclose full medical history is such that our Underwriters have confirmed that had we been aware of this information when considering your application for Executive Income Protection we would not have been in a position to accept your application.*

*Therefore in accordance with Condition 27 of your policy, outlined below, we regret that we must unfortunately decline your Income Protection claim and Void your policy since inception.*

***27. Mis-Statement and/or Non-disclosure***
*If, in connection with any application for Executive Income Protection or with the making of any claim for Disability or Proportionate Benefit or at any time, whether*

/Cont'd…

*or not the Insured is in receipt of Disability or Proportionate Benefit, the Insured or anyone acting on his behalf, makes an untrue statement or omits to disclose any material fact, including but not limited to the provision of evidence or information requested under Condition 21, the insurance in respect of the Insured shall be terminated immediately. All Benefit payable shall be forfeited and any Benefit paid which in any way relied on the making of the untrue statement of the omission to disclose the material fact shall be recoverable. If the Employer makes an untrue statement or omits to disclose a material fact this Policy will immediately cease and no Benefit whatsoever will be payable thereafter.*

*The premiums paid since the policy commencement on 06.03.2012 will be returned to the owners of the policy* [the Policyholder] *shortly …"*

The Provider included with this letter a copy of its Appeals Procedure.

The Provider says that it received on **17 September 2018**, by way of her broker, a letter from the Complainant dated **13 September 2018** appealing the decision to decline her claim and void the policy, and it sent an email that same day acknowledging the appeal.

The Provider says its Claims Department reviewed the appeal on **20 September 2018** and as the queries raised in the appeal letter were in relation to the underwriting process, the Provider says the appeal was referred to its Underwriting Manager as opposed to its Chief Medical Officer for a full review. A response was received from the Underwriting Manager on **3 October 2018**. The Provider says the appeal was then sent to its Claims Committee, which includes the Claims Manager, for a decision. The appeal decision was finalised on **11 October 2018** and a decision letter issued to the Complainant on **19 October 2018** advising her that the Provider was standing over its original decision to decline the claim and void the policy, as follows:

*"… We do not accept the criticisms you have made in relation to our Underwriting process as, when considering any application for insurance, we rely on the full disclosure of all material and relevant facts by the applicant, which did not happen in your case.*

*The importance of providing full disclosure of all material facts was outlined clearly on your application for this policy, and we would suggest that any issues you may have in relation to the application process and the time provided to you to complete this should be referred to your broker for response.*

*As advised in our correspondence on 23/07/2018 the significance of the failure to disclose full medical history is such that our Underwriters have confirmed that had we been aware of this information when considering your application for Executive Income Protection we would not have been in a position to accept your application. In particular your history of disc degeneration, limb problems, swelling & tenderness to right shoulder, poor concentration and memory loss, history of night sweats, stressed out and headaches. You were also attending a Neurosurgeon which if disclosed our underwriters would have requested further information from your GP.*

/Cont'd…

> *Following a full review of this appeal our Claims Committee are satisfied that the original decision made to void this policy and decline claim for Income Protection remains unchanged. The premiums paid since the policy commenced on 06.03.2012 have now been returned to* [the Policyholder] *the contract owners of the policy … "*

The Provider is satisfied that its Appeals Procedure was correctly followed. While the Appeals Procedure it sent the Complainant on **23 July 2018** provides that *"Our Chief Medical Officer will also write to your G.P. outlining the medical reasons for the decision if appropriate"*, the Provider says that as its detailed letters of **23 July 2018** and **19 October 2018** set out clearly for the Complainant the reasons for its decision, it did not consider it necessary to also write to her GP.

The Provider is satisfied that a thorough and comprehensive assessment and review of this matter has been carried out, including the referral of the case to the Underwriting Manager and the Claims Committee, as well as the referral of all medical evidence to the Chief Medical Officer. In addition, the Provider says that following the Complainant's complaint to the Financial Services and Pensions Ombudsman, the full medical file was reviewed once again by its Chief Medical Officer on **4 July 2019** and the decision to decline the claim and void the policy remained.

The Provider says the Complainant failed to disclose her full medical history when applying for cover and that its underwriters confirmed that if it had been made aware of such information when considering her policy application, it would not have been in a position to offer terms of cover. As a result, the Provider declined the Complainant's income protection claim and voided the **Executive Income Protection Plan** from inception and it refunded to the Policyholder all premiums paid since the commencement of the policy.

The Provider says in its **Formal Response** to the complaint investigation by this Office dated **6 May 2020** that it has had several communications with the Complainant in respect of her income protection claim, including her meeting with a Customer Relations Manager on **11 December 2019**, whose recollection of this meeting is that the Complainant primarily wanted to show him her file in preparation for a case against her broker. The Provider says the Complainant raised several complaint points, the main one being a very serious allegation that her broker had falsely and incorrectly completed her **Application Form**.

The Complainant stated that the medical information provided on the **Application Form** had been completed by her broker and she agreed that this was at variance to her medical history, though she confirmed she had signed the **Application Form** as she had trusted her broker to complete it. The Provider says it is important to note that in this application process, the broker was acting as an agent of the Complainant. The Provider says the Complainant asked for assistance in putting together her file and that it provided all documentation requested.

The Provider says it is satisfied that it correctly declined the Complainant's income protection claim based upon the significant level of nondisclosure of material medical information on the **Application Form**, which is the basis for the contract of insurance, and

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also on the **Nurse Medical Form** from the Nurse Medical that was later carried out on **7 February 2012**, and that both documents were signed by the Complainant.

The Provider says there are a number of issues raised by the Complainant within her complaint submissions, but notes that the matter keeps coming back to the fundamental fact that numerous and key events from the Complainant's medical history had not been disclosed during the application for cover in 2012.

The Provider notes that the Complainant says that the broker for the Complainant completed the **Application Form** medical questions and did not do so correctly. The Provider says it was not party to the completion of the **Application Form**, as this was completed by the Complainant with the broker, though it notes that it is not unusual for a broker to complete a policy application for their client, usually in their presence.

The Provider says it did not have sight of the full hardcopy **Application Form** that was completed by the Complainant with the broker, as the broker later keyed in the application online on **30 January 2012**. The Provider says that in accordance with the broker online application process, it would not have sight of the medical underwriting section of the hardcopy **Application Form** as the original (or a copy of the original) hardcopy application was not sent to the Provider.

The Provider notes that its normal business process at that time was for the Section 7 'Declaration' within the hardcopy **Application Form** to be returned to the Provider. The Provider says that these declarations were signed by the Complainant on **26 January 2012** as the 'Life Assured' and 'The Employee'. The Complainant also completed 'The Employer' declaration in her capacity as Managing Director on behalf of her Employer, the Policyholder. The Provider is satisfied that the declarations on the **Application Form** were quite clear and they detailed what the Complainant was signing for.
The Provider says it did not send a copy of the online **Application Form** directly to the Complainant but that in accordance with its normal business process at that time, it did send, as part of the policy documentation, a copy of the online **Application Form** to the broker on **6 March 2012** when the policy commenced. The Provider notes that the Complainant did not request a copy of the **Application Form** directly from it at the time.

As part of the policy application process, the Provider says it arranged for the Complainant to undergo a Nurse Medical, and that this took place at her home on **7 February 2012**. This assessment was performed, on its behalf, by a separate and independent company. During this assessment, the **Nurse Medical Form** is completed on a laptop by a professional nurse, based on the responses provided by the Complainant. The Provider does not have a record of how long the assessment was, but says that such assessments are generally of 30 to 40 minutes in duration.

The Provider says that as part of this process, the Complainant would have been given the opportunity by the nurse, at the time of the assessment, to review the answers recorded before signing the **Nurse Medical Form**. The Provider notes that this process is confirmed by the independent Nurse Medical Firm in its email to the Provider of **27 April 2020**, as follows:

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*"… The accuracy of the reports we receive from* [Nurse P.] *is very good, and as a double check with regard to what he is keying into the report template he repeats the information out loud before moving on to the next question, it is also worth noting that customers review the data captured prior to signing the report …"*

The Provider notes that at the end of the assessment with the nurse, the Complainant completed the **Nurse Medical Form** with an e-signature below a Declaration confirming that to the best of her knowledge and belief the information she had given was true and complete. The Provider is therefore of the view that the Complainant had the opportunity to review the **Nurse Medical Form** when she signed the Declaration on **7 February 2012**. The Provider also notes that the Complainant did not request a copy of the **Nurse Medical Form** directly from it at the time.

The Provider notes that while there were no medical disclosures on the **Application Form**, there were disclosures provided on the **Nurse Medical Form**. Question 14 of the 'Medical History and Background' section, *"Have you ever undergone any surgical operation or been treated in a clinic or hospital?"*, was answered *"Yes"* and the 'Supplementary Information' section noted in this regard that:

*"14. Had a subtotal hysterectomy 12 yrs ago. No problem"*.

In addition, Question 15, *"Have you ever undergone any special examination including chest x-ray, ECG, scans or blood tests?"*, was also answered *"Yes"* and the 'Supplementary Information' section noted in this regard that:

*"15. Had FBC* [Full Blood Count]*, U&E* [Urea and Electrolytes]*, Cholesterol, Glucose, LFTs* [Liver Function Tests]*, TFTs* [Thyroid Function Tests] → *All normal and done with GP routine 2 yrs ago".*

In relation to the disclosure that she had undergone a hysterectomy, the Provider wrote to the broker on **9 February 2012**, as follows:

*"Following additional disclosure by* [the Complainant] *at her Nurse Medical please ask her to confirm* ***in writing*** *the reason for her hysterectomy, histology, treatment and details of any ongoing following-ups?"*

The Provider says that the Complainant subsequently confirmed in writing that she had had the hysterectomy due to fibrosis and that there had been no follow-up treatment, that the histology had been benign and that there was no ongoing problem in this regard.

As the responses to all the medical questions on the **Application Form** were *"No"* and as no underwriting issues arose from the disclosures made on the **Nurse Medical Form**, the Provider says that this was a relatively straightforward underwriting process at the time that required no further investigation.

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The Provider says it considered the contents of the online **Application Form**, the signed hardcopy of the Section 7 Declaration of **26 January 2012** and the contents of the **Nurse Medical Form** before issuing its Standard Acceptance Terms on **20 February 2012**, in line with its normal underwriting new business process at that time.

The Provider says the Complainant had two opportunities at different times and with different people to provide the material medical information, namely, on the **Application Form** she completed with the broker on **26 January 2012** and separately, at the Nurse Medical on **7 February 2012**. The Provider notes that on both occasions, the Complainant signed declarations that the medical information provided was true and complete.

The Provider does not accept the Complainant's contention that the medical questions in the **Application Form** are leading and do not facilitate a comprehensive answer. The Provider says that if an applicant gives a positive answer to a question, then they are requested to provide further details in the sections within the **Application Form**. In this case, the Provider notes that the Complainant provided a *"No"* answer to all medical questions and provided no additional detail.

The Provider says the **Application Form** provided ample opportunity for the Complainant to disclose her medical history in a comprehensive manner and it notes that she should also have had the professional expertise from her broker to assist her in the process.

In relation to the Complainant's comments in her appeal letter to the Provider dated **13 September 2018** that:

> *"… In my original application I consented for a PMA to be completed but this was never done …*
>
> *I think that it is unreasonable and unfair that a PMA was not done as I gave full permission for this on my application form …"*

the Provider says that the consent to a Private Medical Attendant's Report (PMA) (GP Report) is a standard element of Section 7, 'Declaration', of the **Application Form** that does not automatically result in a GP Report being requested. The Provider notes that a PMA (GP Report) asks about an applicant's medical history, current treatment and tests, if any, and that consenting to a PMA (GP Report) does not replace the requirement for an applicant to provide accurate medical disclosure on the **Application Form**.

The Provider says that a request for a PMA (GP report) is based either on the age of the applicant or the benefit amount being applied for at that time, or as a result of material medical information disclosed on the **Application Form**. The Provider confirms that in **January 2012** the Complainant fell below the threshold based on her age and on the level of income protection benefit being sought, and that there was also no material disclosure in the **Application Form** or the **Nurse Medical Report** that identified the requirement for a PMA (GP report).

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The Provider says it is satisfied that at all times it acted correctly and appropriately based upon the medical information it was provided with, at the time of the policy application in **January / February 2012**.

The Provider says that the Complainant appears to be under the impression (allegedly from her broker) that a PMA (GP report) should have been requested at that time. She also appears to be under the impression that if a PMA (GP report) had been requested, then her medical history would have been disclosed and therefore the completion of the **Application Form** was not important. The Provider says that both views are incorrect and it notes that when a PMA (GP report) was not requested before the commencement of the **Executive Income Protection Plan** in **March 2012**, neither the Complainant nor her broker made contact with the Provider to correct the position, if it was their view that a PMA (GP report) ought to have been requested to gather all material medical information.

In relation to further medical reports submitted by the Complainant as part of this complaint process, the Provider says that its Risk Claims Manager notes that the **Report** dated **9 June 2020** from the Complainant's GP confirms the attendances the Complainant had with the GP practice and does not present the Provider with any reason to review its decision. In addition, the Provider says that the **Report** dated **15 June 2020** from the Complainant's Occupational Physician and the clarifications he made therein, do not have a material impact on the claim decision that was taken in view of the extensive medical history that was not disclosed by the Complainant, at the time of her policy application.

The Provider says that an important aspect of retrospective underwriting is to assess what information was known to the Complainant at the proposal stage and to compare this to the disclosures on the **Application Form** and the **Nurse Medical Report**. In essence, the Provider is assessing what information should reasonably have been provided by the Complainant in **January / February 2012** and the implication this would have had on the underwriting assessment at that time.

In that regard, the Provider says that any diagnosis or views that are later expressed on the Complainant's medical records or on her symptoms or treatments up to **January 2012,** are simply not relevant to the retrospective underwriting process.

While it accepts that an applicant can only disclose what he or she reasonably would know or remember, the Provider says it supports the view of its Chief Medical Officer and its underwriters that the level and amount of the Complainant's nondisclosure is significant and within a reasonable period, in that even if one were to look at her medical records for the two years prior to her application for cover, one would reasonably expect for this information to have been provided on the **Application Form** or at the Nurse Medical.

The Provider says that if the Complainant had disclosed her full medical history, it would have requested a PMA (GP Report) as part of its underwriting process, but the fact remains that the Complainant's failure to ensure that her medical history had been disclosed on the **Application Form**, as well as the limited responses to the questions on the **Nurse Medical Form**, meant that there was no obligation on the Provider to refer to the Complainant's GP for further information.

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In relation to the Complainant's comments that:

> *"… when the second Income protection policy* [****]*7333* [made in April 2013] *was made with the exact same answers to the medical questions and no disclosures to any medical questions asked on the Application in 2013, the underwriters saw fit to request a PMA and an Independent Medical Examination in April 2013"*,

the Provider says that when the Complainant applied for a second income protection policy ****7333 in **April 2013** it was not initially notified that this application was intended to replace the existing policy and so, in line with its normal underwriting process, the income protection benefit arising from the policy that commenced on **6 March 2012** and the benefit being sought under application ****7333 were aggregated and that it was this combined benefit total, that triggered the requirement for a PMA (GP Report).

The Provider says it received this PMA (GP Report) on **22 April 2013** and as a result of the information contained therein, its underwriters requested a medical examination. As the Complainant did not proceed with this medical examination, the underwriting process was not completed and application ****7333 was marked as NPW (Not Proceeded With).

In relation to the Complainant's comments that the PMA (GP) Report it obtained in **April 2013** in respect of application ****7333 put the Provider on notice at that time that she had previously failed to disclose material medical information when applying for cover in **January** / **February 2012**, the Provider says that actions taken or events that took place after the policy commenced on **6 March 2012**, such as the separate policy application in **April 2013** or the Complainant on **21 October 2014** attending an assessment for another insurer with the same nurse who had previously assessed her on behalf of the Provider on **7 February 2012**, are not relevant and was not information that it had when it issued its Standard Acceptance Terms on **20 February 2012**.

The Provider says that more importantly, the fact remains that the Complainant failed to disclose material medical information on the **Application Form** she completed with the broker on **26 January 2012** and separately, at the Nurse Medical on **7 February 2012**, and that the underwriting process that occurred in **January** / **February 2012** was correct based upon the medical information provided at that time.

The Provider says its underwriters and claims assessors are specialists in managing income protection applications and claims and they are supported by a Chief Medical Officer who is an accredited Occupational Health Specialist. The Provider notes that there is a completely different set of underwriting criteria when considering a proposal for, say, life assurance, as opposed to that of an income protection policy. For example, a back complaint may not have any impact upon the underwriting of a life policy as it usually does not impact a person's longevity, however it would have an impact upon underwriting an income protection policy, as a back complaint may impact a person's ability to work.

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The Provider says that the evidence is that the Complainant or her broker did not disclose material medical information at application stage on the online **Application Form**, and that the Complainant did not disclose material medical information later at the Nurse Medical. The Provider says it did not decline the claim and cancel the cover due to any one particular nondisclosure, but rather it did so, based on the significant extent of medical history not disclosed on the **Application Form** the Complainant signed on **26 January 2012** or on the **Nurse Medical Form** she signed on **7 February 2012**, even within a period of two years prior to the date of signatures on these forms.

The Provider notes that a number of reasons have been provided for this, but it says it is satisfied that the Complainant had a key responsibility to provide or ensure the provision of reasonable material medical information. In that regard, the Provider says that the Complainant appears to admit to not completing or reviewing the medical information on the **Application Form** or the **Nurse Medical Form**, despite her signing a declaration declaring that she had done so.

The Provider is satisfied that it properly carried out its new business and underwriting assessment processes before the commencement of the **Executive Income Protection Plan** on **6 March 2012**. It also says that its claims assessment, appeal review and retrospective underwriting processes during **2018**, were conducted in a normal and correct manner. The Provider is also satisfied that it acted correctly when it declined the Complainant's income protection claim and cancelled the **Executive Income Protection Plan** from inception due to the material nondisclosure of medical information when applying for the policy, and it did so in accordance with the policy terms and conditions.

## <u>The Complaint for Adjudication</u>

The complaint is that the Provider wrongfully or unfairly declined the Complainant's income protection claim, and wrongfully or unfairly cancelled, from inception, the **Executive Income Protection Plan**. The Complainant says in that regard that:-

- the Provider failed to carry out a comprehensive Nurse Medical on **7 February 2012** and to elicit necessary information from the Complainant during this assessment;

- the Provider failed to accurately assess the Complainant's hardcopy **Application Form** against the online **Application Form** and, separately, these **Application Form(s)** against the **Nurse Medical Form**, or investigate any discrepancies in the answers given on these forms, prior to it enacting the **Executive Income Protection Plan**;

- the Provider failed to provide the Complainant with an opportunity to view and rectify the information and medical details recorded on the completed **Application Form(s)** and the **Nurse Medical Form** received by the Provider, prior to it enacting the **Executive Income Protection Plan**;

/Cont'd…

- the Provider failed to obtain a PMA (GP Report) from the Complainant's GP prior to enacting the **Executive Income Protection Plan** in **March 2012**, yet it did seek a PMA (GP Report) when she later applied for a separate income protection policy with the Provider in **April 2013**; and

- the Provider wrongfully or unfairly deemed the medical history that the Complainant failed to disclose when applying for cover, as significant nondisclosure of material facts warranting the cancellation of the **Executive Income Protection Plan** from inception.

**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 **8 June 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 period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter. In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

Recordings of telephone calls have been furnished in evidence. I have considered the content of these calls. During the course of this complaint investigation, the Complainant raised concerns regarding comments that were made about her by staff, during an internal Provider telephone call that took place on **4 October 2018**. I note that the Complainant and the Provider have, between the parties, resolved this matter, and therefore it does not form part of this complaint investigation.

I note that the Complainant was the life assured on an **Executive Income Protection Plan** that commenced on **6 March 2012** and the Policyholder was her employer.

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I note that some six years later, the Complainant completed an income protection **Claim Form** to the Provider on **28 May 2018**, wherein she advised that she had not attended worked since **22 May 2018** due to *"Stress, lack of sleep, stress, anxiety".*

Following its claim assessment, which included it obtaining medical history records from her treating physicians, the Provider wrote to the Complainant on **23 July 2018** to advise that she had failed to disclose her full medical history when applying for cover and that its underwriters had confirmed that had it been aware of such information when considering her policy application in 2012, it would not have been in a position to offer terms of cover. As a result, the Provider made the decision to decline the Complainant's income protection claim and void the **Executive Income Protection Plan** from inception, and to return all premiums paid since the commencement of the policy to the Policyholder. The Provider stood over this decision on appeal.

The role of this Office therefore is to determine in this instance whether the decision made by the Provider was reasonable, based upon the medical evidence that was available to the Provider at the time when it made that decision, which gives rise to the Complainant's complaint.

I am satisfied that this approach is in accordance with the views of the High Court in ***Baskaran v. Financial Services and Pensions Ombudsman*** [2016/149MCA], where the Court confirmed at para. 61 and 62, that:

> *"**61.** In his decision, the respondent gave consideration to the contents of all medical reports at the time that Friends First made its initial decision to terminate benefit, and such medical reports as became available between that date, and the determination of the appeal by Friends First approximately twelve months later. However, the respondent excluded from consideration the four medical reports subsequently provided by the appellant, on the basis that they could not have been considered by Friends First at the time that it made its final decision. It is submitted on behalf of the appellant that the respondent fettered his discretion in excluding these reports from his consideration and therefore erred in law.*
>
> ***62.** This submission must be rejected for two reasons. Firstly, as a matter of common sense, the approach taken by the respondent was correct. The respondent was engaged in reviewing the decision of Friends First which was based upon the information that it had available to it at that time. Clearly Friends First could not be criticised for failing to take into account reports that were not even in existence at the time that it made its decision, and if the respondent had taken those reports into consideration, he would have erred in doing so."*

The Court made clear its view, at para. 70, that:

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

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I note that as part of its assessment of the income protection claim, the Provider wrote to the Complainant's GP on **6 June 2018** seeking a copy of the Complainant's medical file, which it received on **18 June 2018**.

This medical file included a letter dated **21 May 2018** wherein the GP set out the Complainant's current condition, as follows:

> *"This is to certify that I have examined* [the Complainant] *and have been attending her since Feb 2018 on this occasion. I have made a diagnosis of anxiety and depressive disorder that is moderate DSM-TR. I gave her certificates to cover her work from the date in Feb 2018.* [The Complainant] *struggled on at work against my advice. She was commenced on medication that included antidepressants and sleep medications. She is currently still taking these medications. Today she is clearly unable to continue any further and I have advised her not to return to work as she is unfit to make decisions and needs rest to help with her aggravated mental health condition. She is suffering panic attacks and chronic anxiety and severe insomnia. She was admitted to hospital with acute chest pain and had an angiogram with an outome* (sic) *showed her symptoms were a physical manifestation of her anxiety. She also has an issue with stress related voice changes as diagnosed by ENTconsultant".*

I note that following its examination of the medical file, the Provider identified the following events that it considered the Complainant ought to have disclosed when applying for cover in 2012:

- 12 July 2004, GP consultation:

  *"medical history:* *… mild depression post bereavement (2004) …*

  *repeat prescription:* *… Cipramil 10 mg tablets 28, 1 tabs daily"*

- 25 July 2008, GP consultation:

  *"medical history:* *… night sweats … swallowing Panadol … v busy – goes through pk/week – alt day uses – develops during the day – works 6/7 – frontal and back of head – never before – feels memory poor …*

  *plan of action:* *MRI ordered"*

- 30 August 2008, Examination/Test:

  *"MRI OF BRAIN"*

/Cont'd…

- 3 November 2008, Accident & Emergency Admission:

| | |
|---|---|
| *"Presenting Complaint:* | *Sever* (sic) *lower back pain + L sciatica …* |
| *Treatment:* | *Clin Sacroiliitis + Sciatica – on Difene / Diazepam* |
| *Outcome & Follow up:* | *if symptoms persist, please arrange MRI".* |

- 4 November 2008, GP consultation (by telephone):

| | |
|---|---|
| *"subjective symptoms:* | *Acute onset of low backpain yesterday – brought to casualty by ambulance – Difene im plus other meds – Difene orally and diazepam and zydol orally given … told for GP to arrange MRI"* |

- 12 December 2008, Examination/Test:

| | |
|---|---|
| *"… Examination:* | *MRI Lumbar Spine. 11.12.2008 …* |

***Findings:***

*Degenerative changes at numerous levels with loss of T2 signal and endplate degenerative change. Incidental vertebral haemangiomata within the bodies of L3 and T12. These are not of clinical significance.*

*Broad based disc bulging is noted at the lower three levels with anterior indentation of the thecal sac at all levels but with prominent indentation at L4/5 with barrowing of the lateral recesses on the left side. Furthermore there is direct impingement upon the descending L5 nerve root at this level on the left side. However, there is no visible direct nerve root impingement within the exit foramina.*

***Conclusion:***

*Degenerative disc disease with prominent L4/5 disc bulging and further protrusion to the left of the midline causing L5 nerve root compression on the left"*

- 27 January 2009, Consultant Neurosurgeon consultation:

*" …* [The Complainant] *presented with an acute episode of low back pain around November which lasted about 10 days. She attended* [hospital], *was given pain relieving drugs and was discharged, Currently she is very well. On*

/Cont'd…

*examination, she has a full range of lumbar movement. SLR is free. There is no neurology. MRI of lumbar spine shows signal change at L4/5 with a convexity of the discs. There is no significant neural compression. The other discs are normal.*

*Her syndrome is in keeping with an acute low back strain which has now subsided. I also noted on the scan at about T10/11 on the left side there appears to be a round lesion, probably a facet joint but unfortunately no axial scan was done through this. I am therefore arranging a scan through it"*

- 12 February 2009, Examination/Test:

  *"MRI of spine through T10 & T11"*

  Follow-up letter from Consultant Neurosurgeon dated 20 February 2009 advises:

  > *"Your MRI of spine through T10 & T11 performed 12.02.02* (sic) *shows the abnormality to be haemangiomas which are of no significance whatsoever"*

- 13 October 2009, GP consultation:

  | | |
  |---|---|
  | *"subjective symptoms:* | *Working hard and stressed out – Headache and ache down kleft* (sic) *arm – PAIN OIN* (sic) *TEETH"* |

- 21 May 2010, GP consultation:

  | | |
  |---|---|
  | *"subjective symptoms:* | *still works v hard – notices when walking – one leg trips her mostly the left – 6 times in total over 3-4 mts – never fallen when noticed this but has had 2 right falls ? inattention – stops dead for a split second - ? more forgetful – husband says she is asking where are you tomorrow again – several times a night …* |
  | *plan of action:* | *concentration poorer – memory not as good – MMSE at next visit, bloods, MRI, peripheral nerv sys exam"* |

- 23 May 2010, Accident & Emergency Admission / Examination/Test:

  *"The following is a summary of* [the Complainant's] *recent Emergency Department attendance.*

/Cont'd…

*Date of attendance:* *23.05/2010 02:29*

*Presenting Complaint:* *Limb Problems*

*Diagnosis:* *Other – noticed swelling and tenderness over Rt shoulder. NO trauma/fall. No fever, all bloods are normal. R x NSAID. GP to arrange physiotherapy"*

- 24 May 2010, Examination/Test:

*"Exam(s) Name:* *CHEST SHOULDER LEFT*

*Radiologist's Report*

*Indication: Painful left shoulder. No history of trauma …*

*Findings: A frontal chest radiograph is provided, the cardiomediastinal silhouette is unremarkable. The lungs and pleura clear.*
*Left shoulder. No fracture or dislocation is demonstrated. A 14mm x 4mm oval radiopaque density is seen separate form but adjacent to the left humeral heads that I favour is calcification in a tendon component of the rotator cuff.*

*Opinion: No acute pulmonary process. A well corticated radiodensity is seen in the soft tissue of the left shoulder. I cannot confirm this is the site or cause of the patient's pain. Please correlate clinically. An orthopaedic or rheumatology opinion are considerations"*

- 26 May 2010, GP consultation:

Handwritten notes indicate that the pain in the Complainant's left shoulder is *"up and down*

- 16 June 2010, GP consultation:

Handwritten notes indicate that Complainant's shoulder feels well again and movement has improved

- 19 July 2010, GP consultation:

Handwritten notes indicate that Complainant was referred for *"MRI (Brain)"*

- 4 August 2010, Examination/Test:

*"Procedure:* *MRI Cervical"*

/Cont'd…

- <u>4 August 2010, Examination/Test</u>:

  *"Procedure:- MRI Brain*

  *… Normal brain parenchyma. Specifically, no demyelination plaques and no parenchymal or extra-axial mass lesion.*

  *Normal ventricular morphology and normal flow void within the visualised intracranial vessels.*

  *No other abnormality"*

- <u>29 August 2011, GP consultation</u>:

  *"subjective symptoms: 2 days passing blood in stool"*

Following its claim assessment, the Provider wrote to the Complainant on **23 July 2018** to advise, among other things, that:

> *" …. The significance of this failure to disclose full medical history is such that our Underwriters have confirmed that had we been aware of this information when considering your application for Executive Income Protection we would not have been in a position to accept your application.*
>
> *Therefore…we regret that we must unfortunately decline your Income Protection claim and Void your policy since inception …"*

I note that the Provider made the decision to decline the Complainant's income protection claim on the basis that she had no cover in place as it was, at the same time, also making the decision to cancel from inception the **Executive Income Protection Plan** due to the Complainant's failure to disclose her full medical history when applying for the cover.

I take the view that in order to determine whether the Provider wrongfully or unfairly declined the Complainant's income protection claim, it is appropriate to first determine whether the Provider wrongfully or unfairly cancelled from inception the **Executive Income Protection Plan**. If this Office is satisfied that the Provider acted correctly in accordance with the policy terms and conditions in cancelling the policy, then the element of the complaint regarding the declinature of the income protection claim becomes immaterial, as there would be no policy cover in place under which to consider such a claim.

I note that the Complainant met with the broker on **26 January 2012** and during this meeting she applied for income protection cover by way of completing with the broker a hardcopy of the **Executive Income Protection Plan Application Form**.

Section 6, 'Underwriting Details', at pg. 3 of this **Application Form** contained a number of medical history questions and instructed, as follows:

/Cont'd…

*"<u>Please answer carefully, giving full details</u> and, if necessary, use a sperate sheet for additional information. If you need to alter an answer, please put a line through the incorrect part of the answer and initial the alteration.*

*When completing this application form <u>you must disclose all Material Facts. Failure to disclose all relevant facts, including full disclosure of your medical details and history</u>, may delay or prevent the issue of your policy and/or <u>invalidate future claims</u>. If you are in any doubt as to whether a fact is a Material Fact you should disclose it."*

[My underlining for emphasis]

The Complainant advised in her appeal letter to the Provider dated **13 September 2018** that:

*"… my initial application form was rushed and not given the due time needed …"*

In that regard, Section 5, 'Additional Details for Tele Underwriting Applications', at pg. 2 of the hardcopy **Application Form** allowed for the Complainant to forego answering the medical history questions contained in Section 6, 'Underwriting Details', in favour of partaking in a telephone interview with an experienced nurse at a later date. The Complainant through her broker did not choose this option and instead proceeded to answer *"No"* to all the medical history questions contained in Section 6, 'Underwriting Details', of the **Application Form**.

I note in that regard that no medical history was disclosed.

The Complainant says that the broker did not answer the medical questions correctly and, in that regard, she advised in her letter to this Office dated **14 November 2018** that:

*"… I do acknowledge that the initial Application form recorded answers "No" incorrectly. I did not complete this form and signed all areas mark X as requested by my Broker …"*

I note that the broker later completed the online Provider's Application **Form**, to enter the information captured in the hardcopy **Application Form**, including inserting the answer *"No"* to all the medical history questions, which I am satisfied from the documentation before me reflects correctly the answers given in the hardcopy application.

The Complainant signed Section 7, 'Declaration', at pgs. 6-7 of the hardcopy **Application Form** on **26 January 2012**, declaring, amongst other things, that:

*"I understand that this application, if partly completed online, shall consist of the declarations and consents made by me herein along with the details provided in my online application …*

*I understand that terms and conditions, as provided to me, will apply.*

/Cont'd…

> *I have read over the replies to all questions in this application and declare that to the best of my knowledge and belief, all information given is true and includes all material facts and I understand that failure to disclose all relevant facts, including full disclosure of my medical details and history, may delay or prevent the issue of my policy and/or may invalidate future claims. If you are in any doubt as to whether a fact is a material fact you should disclose it".*

[My underlining for emphasis]

I am satisfied that this Declaration made it clear to the Complainant that the onus was on her to ensure that she had fully disclosed her medical history in the policy application and in that regard, the Complainant signed the hardcopy of the **Application Form** on **26 January 2012** indicating that the answers to the questions contained therein were both true and complete, and that she understood the possible consequences of a failure to disclose her medical details and history in full.

I am of the opinion that it would have been prudent of the Complainant to have read back through the hardcopy **Application Form** before signing the Declaration, to ensure that she was satisfied with the information recorded therein. If having done so she was dissatisfied with the answers to the medical history questions, it would then have been open to the Complainant to have amended these answers accordingly.

I note that subsequently, as part of the policy application process, the Provider arranged for the Complainant to undergo a Nurse Medical, and this took place at her home on **7 February 2012**. During this assessment, the nurse asked the Complainant a number of questions relating to her medical history and background and recorded these answers on a laptop.

Question 14 of the 'Medical History and Background' section of the **Nurse Medical Report**, *"Have you ever undergone any surgical operation or been treated in a clinic or hospital?"*, was answered *"Yes"* and the 'Supplementary Information' section noted:

> *"14. Had a subtotal hysterectomy 12 yrs ago. No problem"*.

In addition, Question 15, *"Have you ever undergone any special examination including chest x-ray, ECG, scans or blood tests?"*, was also answered *"Yes"* and the 'Supplementary Information' section noted:

> *"15. Had FBC* [Full Blood Count]*, U&E* [Urea and Electrolytes]*, Cholesterol, Glucose, LFTs* [Liver Function Tests]*, TFTs* [Thyroid Function Tests] *→ All normal and done with GP routine 2 yrs ago".*

The Complainant advised in her appeal letter to the Provider dated **13 September 2018** that:

/Cont'd…

*"… when the nurse medical was finished I was not given the opportunity by the nurse to scroll back and review the questions from the start, I had answered before I signed, as these were all on the nurses laptop …"*

I note however that the Complainant, by way of an e-signature on the nurse's laptop, signed below the Declaration on the **Nurse Medical Form** on **7 February 2012** confirming that:

*"I declare that I am the person referred to in the information above and that to the best of my knowledge and belief <u>the information I have given is TRUE AND COMPLETE</u>. I understand that the information given will form the basis of the contract between the Insurance Company and myself …"*

[My underlining for emphasis]

I am satisfied that this Declaration made it clear that the onus was again on the Complainant to ensure that the information captured was true and complete and in that regard, I am of the opinion that it would have been prudent of the Complainant to have asked to scroll back up through the **Nurse Medical Report** on the laptop before signing the Declaration, to ensure that she was satisfied with the information recorded therein. If having done so she was dissatisfied with the information or level of detail captured in the **Nurse Medical Report**, it would then have been open to the Complainant to have clarified these answers and provide further information accordingly.

In light of the medical answers provided on both the **Application Form** she signed on **26 January 2012** and on the **Nurse Medical Report** she signed on **7 February 2012**, I am of the opinion that it was reasonable for the Provider to conclude from the medical file it received from the Complainant's GP in 2018, that the Complainant had failed to disclose her full medical history when applying for cover in 2012, and that her failure to do so constituted the nondisclosure of material facts.

The **Executive Income Protection Plan**, 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.

Part 1, 'Contract basis and definitions', at pg. 1 of the application **Executive Income Protection Plan Policy Conditions** provides that:

***"1. Basis of the Policy.***

*… We reserve the right to declare the policy void from inception in the event that we become aware of any non-disclosure or misrepresentation of any relevant personal information whether at the time of proposal or at the time of an in the course of making and receiving a claim for benefit".*

Part 5, 'Making a claim and claim payments', at pg. 7 of the **Policy Conditions** provides that:

/Cont'd…

"***27. Mis-Statement and/or Non-disclosure***

*If, in connection with any application for Executive Income Protection or with the making of any claim for Disability or Proportionate Benefit or at any time, whether or not the Insured is in receipt of Disability or Proportionate Benefit, the Insured or anyone acting on his behalf, makes an untrue statement or omits to disclose any material fact, including but not limited to the provision of evidence or information requested under Condition 21* ['Proportionate Benefit']*, the insurance in respect of the Insured shall be terminated immediately. All Benefit payable shall be forfeited and any Benefit paid which in any way relied on the making of the untrue statement of the omission to disclose the material fact shall be recoverable.*

*If the Employer makes an untrue statement or omits to disclose a material fact this Policy will immediately cease and no Benefit whatsoever will be payable thereafter"*

[My underlining for emphasis]

Insurance contracts are contracts of utmost good faith, and therefore any failure to disclose material information allows the Insurer to void the policy from the outset and to refuse or cancel cover. Once non-disclosure takes place – whether innocent, deliberate or otherwise – the legal effect of that non-disclosure can operate harshly, and it entitles an Insurer to, amongst other things, cancel cover, as the Provider has done in this instance.

I am satisfied that because the Provider was not made aware of the Complainant's full medical history when it agreed to incept the **Executive Income Protection Plan**, the policy cover therefore came into being on the basis of a false premise.

This Office is aware that the courts have long considered the issues surrounding nondisclosure of material facts. For example, in ***Aro Road and Land Vehicles Limited v. Insurance Corporation of Ireland Limited*** [1986] I.R. 403, where the Court determined that representations made in the course of an insurance proposal should be construed objectively, Henchy J said:

*"…a person must answer to the best of his knowledge any question put to him in a proposal form …"*

I am also cognisant of the views of the High Court in ***Earls v. The Financial Services Ombudsman*** [2014/506 MCA], when it indicated that:

*"The duty arising for an insured in this regard is to exercise a genuine effort to achieve accuracy using all reasonably available sources"*.

On the basis of the evidence available, I do not accept that it would be reasonable to conclude that the Complainant took all efforts to ensure that the Provider was provided with accurate answers to the medical questions contained in the **Application Form** she signed on **26 January 2012** or in the **Nurse Medical Report** she signed on **7 February 2012**.

/Cont'd…

I am therefore of the view that the Provider was entitled to cancel the Complainant's income protection cover under the Executive Income Protection Plan, and to do so from inception. As a result, I accept that the Provider was therefore entitled to decline her claim for benefits, because the policy was no longer in existence.

The Complainant says in a number of her submissions that she did not sign the 'Declaration' section of the online **Application Form**, such that the Provider should not have proceeded with the policy until it had obtained her signature. I take the view that it was not necessary for the Complainant to e-sign the online 'Declaration' because she had already signed the same 'Declaration' in the hardcopy **Application Form** on **26 January 2012**. Indeed, this is the reason why the Provider obtained from the broker the hardcopy of the Section 7 'Declaration' signed by the Complainant, a section that clearly states:

> *"… For Broker…online applications, please complete the following and forward only <u>this declarations section</u> to* **[the Provider]** *… "*

In relation to the complaint that the Provider failed to carry out a comprehensive Nurse Medical on **7 February 2012** and to elicit necessary information from the Complainant during this assessment, I am satisfied that the onus was on the Complainant to ensure that she herself provided all of the information necessary to answer truthfully and completely, the questions contained in the **Nurse Medical Report**.

It would have been prudent of the Complainant to have scrolled back up through the **Nurse Medical Report** on the laptop to ensure that she was satisfied with the information recorded therein, prior to her signing the Declaration and if having done so, she was dissatisfied with the information or level of detail captured, it would then have been open to her to have clarified the answers and provide further information.

In relation to the complaint that the Provider failed to accurately assess the Complainant's hardcopy **Application Form** against the online **Application Form** and, separately, these **Application Form(s)** against the **Nurse Medical Form**, or investigate any discrepancies in the answers given on these forms prior to enacting the **Executive Income Protection Plan**, I note that except for the Section 7 'Declaration' signed by the Complainant on **26 January 2012**, the Provider did not have sight of the hardcopy **Application Form** that the Complainant completed with her broker.

Instead, following the Complainant and the broker completing the hardcopy **Application Form** on **26 January 2012**, the broker later entered online to the Provider, by way of the online **Application Form**, the information captured in the hardcopy application, including the answer *"No"* to all the medical questions. I am satisfied from the documentation before me that this reflected correctly the answers provided on the hardcopy application.

I note that there were some medical disclosures included on the **Nurse Medical Form** that the Complainant signed on **7 February 2012**. With regard to the disclosure that she had previously undergone a hysterectomy, I note that the Provider wrote to the broker on **9 February 2012**, as follows:

/Cont'd…

> *"Following additional disclosure by* [the Complainant] *at her Nurse Medical please ask her to confirm* ***in writing*** *the reason for her hysterectomy, histology, treatment and details of any ongoing following-ups?"*

I note that the Provider received the following signed handwritten note from the Complainant on **22 February 2012**:

> "[The Complainant] *had a hysterectomy due to fibrosis, there was no follow-up treatment, histology was benign and no ongoing problem"*.

I am satisfied that this exchange indicates that the Provider took note of the medical disclosures that had been made in the **Nurse Medical Form** and which had not been previously disclosed in the online **Application Form**.

In light of her handwritten clarification concerning her hysterectomy, I am satisfied that there was no obligation on the Provider or its underwriters to contact the Complainant's physicians regarding this disclosure. In addition, I accept the Provider's position that as no further underwriting issues arose from the other disclosures the Complainant made on the **Nurse Medical Form**, the Provider was then in a position to issue its Standard Acceptance Terms on **20 February 2012**, in line with its normal underwriting new business process at that time.

The Complainant also says in a number of her submissions that the Provider failed to notice the discrepancy that her name was inserted as the policyowner on the hardcopy **Application Form** but that her employer's name had been inserted as the policyowner by the broker on the online **Application Form** and that in failing to notice this difference, the Provider put the **Executive Income Protection Plan** into force with her employer as the Policyholder.

I am mindful that the hardcopy **Application Form** contains different sections for first the employer and then the employee to complete, including different subsections under Section 7, 'Declaration'. I note that under Section 1, 'Employer's Details', the Complainant's name is inserted as the *"Name of employer"* in her capacity as *"M/D* [Managing Director]*"* for her employer, and her employer's address is inserted as the *"Business Address"*. I also note that under Section 8, 'Direct Debit Mandate', the name of the bank account from which the premiums are to be collected is a business bank account and that the business account holder is also confirmed to be the policyholder.

I am satisfied from the evidence before me that the **Executive Income Protection Plan** is clearly designed for a company to provide the benefits of cover for an employee, as opposed to it being a personal policy, and thus that the Provider correctly established the policy with the Complainant's employer as the Policyholder, and the Complainant as the insured.

In relation to the complaint that the Provider failed to provide the Complainant with an opportunity to view and rectify the information and medical details recorded on the completed **Application Form(s)** and the **Nurse Medical Form** received by the Provider, prior to it enacting the **Executive Income Protection Plan**, I note that the Complainant signed

/Cont'd…

Section 7, 'Declaration', at pgs. 6-7 of the hardcopy **Application Form** on **26 January 2012** and signed the 'Declaration' on the **Nurse Medical Form** on **7 February 2012**. It would have been prudent of the Complainant, prior to signing both of these documents, to have reviewed the medical answers recorded therein, particularly given that the declarations she was signing clearly placed the onus on her to ensure that the information recorded therein was true and complete. It was also open to her to request a copy, if she wished to review the details at her leisure.

I take the view that the act of being presented with the hardcopy **Application Form** by the broker to sign on **26 January 2012** and separately, by being presented with the laptop by the nurse to sign the **Nurse Medical Report** on **7 February 2012**, meant that the Complainant was afforded the opportunity on each occasion to review the medical answers recorded in both these documents if she so wished, prior to her signing the respective declarations to indicate that the information therein was true and complete.

I note that the Provider wrote to the broker on **6 March 2012**, as follows:

> *" … I am pleased to enclose the following:*
>
> * *Original Policy Documents*
>
> *I trust you find the enclosures to be in order.*
>
> ***If the application was submitted online we have enclosed a copy of the health questions supplied to us. Please be advised that the answers to the questions formed the basis of our underwriting decision** …"*

I am cognisant of the fact that administrative processes evolve over time, and while the Provider may now, as part of its new business process, issue the life assured with a copy of the medical questions and answers for review when cover is commencing, I accept the Provider's position that in March 2012, prior to the Consumer Protection Code 2012 becoming effecting, its normal business process was to only send this documentation to the broker representing the client.

In relation to the complaint that the Provider failed to obtain a PMA (GP Report) from the Complainant's GP prior to enacting the **Executive Income Protection Plan** in **March 2012**, yet it did seek a PMA (GP Report) when she later applied for a separate income protection policy with the Provider in **April 2013**, I note that the Complainant signed Section 7, 'Declaration', at pgs. 6-7 of the hardcopy **Application Form** on **26 January 2012**, declaring, amongst other things, that:

> *"I consent to* [the Provider] *collecting and processing sensitive data relating to my mental and physical health.*
>
> *I consent to* [the Provider] *seeking medical information from any doctor or other medical professional who has at any time attended me concerning anything which affects my physical or mental health. I agree that this authority shall remain in force*

/Cont'd…

> *after my death as well as prior thereto. I further understand that in the event of me being medically examined the answers given by me to the medical examiner acting on behalf of* [the Provider] *shall be deemed to be incorporated into this application".*

I accept that consenting to the Provider seeking medical information from a treating physician at any time (including after the Complainant's death) did not mean that the Provider would necessarily do so. In any event, I am satisfied that such consent in no way replaced or negated the clear requirement for the Complainant to provide accurate medical disclosure on the **Application Form**.

The Provider has advised that a request for a PMA (GP report) is based either on the age of the applicant or the benefit amount being applied for at that time, or as a result of material medical information disclosed on the **Application Form**. In that regard, I accept the Provider's confirmation that in **January** / **February 2012** the Complainant fell below the threshold based on her age and on the level of income protection benefit being sought, and that there was also no material disclosure in the **Application Form** or the **Nurse Medical Report** that identified the requirement for a PMA (GP report).

The Complainant questions why, when she applied for a separate income protection policy with the Provider in **April 2013** and again answered *"No"* to all the medical questions in that application from, did the Provider then seek a PMA (GP Report) when it had not done so prior to enacting the **Executive Income Protection Plan** in March 2012.

In that regard, I note the Provider has advised that it was not notified that this application was intended to replace the existing policy and so when the Complainant made the **April 2013** application, in line with its normal underwriting process, it aggregated the benefit being sought and the existing income protection benefit, and that this combined benefit is what triggered the requirement of a PMA (GP Report). I accept this explanation.

I note the Complainant's comments that the PMA (GP) Report that the Provider obtained in **April 2013** in respect of a separate income protection policy put it on notice at that time that she had previously failed to disclose material medical information when applying for the **Executive Income Protection Plan** in **January** / **February 2012** and in that regard, in her letter to this Office dated **2 September 2021**, the Complainant submits that:

> *" … The Provider had further opportunity in 2013 to reassess my 2012 policy but failed to do so until 2018 when my claim was lodged … "*

The **Executive Income Protection Plan** came into force on **6 March 2012** based on the information presented to the Provider in **January** / **February 2012** at the time of the policy application. In that regard, I take the view that the Provider was under no obligation to undertake a re-assessment process of the validity of an existing policy cover, because of information that came to light at a later date, when the Complainant later applied for a different policy.

In relation to the complaint that the Provider wrongfully or unfairly deemed the medical history that the Complainant did not disclose when applying for cover, as significant

nondisclosure of material facts warranting the cancellation of the **Executive Income Protection Plan** from inception, I note that following a further review of the Complainant's medical records and the submissions made by the Complainant in relation to her medical history, the Provider's Chief Medical Offer emailed the Provider on **18 May 2021** with her **Report** dated **17 May 2021**, as follows:

> *"… **I note*** **[the Complainant]** ***advises 20th August 2020 of an error in my CMO review of case file***
>
> ***Q14.*** *She advises that she was never sent for an MRI for subjective memory loss symptoms and only to rule out parkinson's disease because of her family history*
>
> ***This is not borne out by the medical notes compiled by her GP which confirms***
>
> ***19.7.2006*** *memory poor and concentration appalling*
>
> ***25.7.08*** *? headaches, memory poor - for MRI brain*
>
> ***21.5.2010*** *"Still works very hard" Notices when walking – tripping ? inattention ? forgetful*
>
> *Collateral history from husband confirms asking the same questions repeatedly - GP queries whether not concentrating - GP confirms no red flags but makes notes regarding*
>
> *Concentration poorer - memory not as good*
>
> *MRI referral*
>
> *Neurology referral/Referral to* [Mr D.] *(unclear if this is physician/geriatrician in* [city redacted] *or psychiatrist* [city redacted] *consultant old age psychiatrist)*
>
> *And makes note to do an MMSE at next visit (Mini-Mental State Examination (MMSE) this is a 30-point questionnaire that is used extensively in clinical settings to measure cognitive impairment. It is commonly used in medicine to screen for dementia).*
>
> *The GP notes then does not make reference to a family history of parkinson's disease.*
>
> *A conventional MRI cannot detect early signs of Parkinson's disease*
>
> ***Q15 a – History of stress/depression/anxiety/fatigue exhaustion***
>
> *I note* [the Complainant] *declares that she did not have a history of stress prior to 2018*
>
> *I can only refer to the GP records of attendances with various symptoms*

/Cont'd…

***25.7.2008*** *headaches persistent, paracetamol alternate days, working 6 days a week out of 7, memory poor*

***13.10.2009*** *"working hard and stressed out" - headache and ache down left arm, dental pain*

***21.5.2010*** *"still works very hard"*

***4.8.2010*** *MRI brain 2010: normal*

***I would again advise that subjective symptoms are concerning to rule out dementia and for work related stress with reference to working hard/long work hours/stress etc.,***

***Back pain history:*** *15b History of back pain*

*I note an indication that she has had one acute episode of back pain and to refer to GP notes and* [Mr M. O'S.].

***This is not borne out by the medical records.***

| | |
|---|---|
| *31.7.2006* | *piles and* ***sciatica*** |
| *3.11.2008* | ***attends A/E with low back pain sciatica*** |
| *12.12.2008* | *MRI degenerative disc disease lumbar spine disc bulging at three levels with L5 left nerve root impingement noted* |
| *27.1.2009* | *attends* [Mr M. O'S.] *with acute episode of lower back pain and has an MRI's T spine and cervical spine which he records as satisfactory*<br><br>*Lumbar spine MRI confirms some disc degenerative changes* |
| *4/8/2010* | *Further MRI cervical spine dessicated* (sic) *discs noted cervical spine - It is unclear what triggered referral here but must assume for symptoms* |

***All prior to policy inception date***

***16 a shoulder***

[The Complainant] *advises that there was no MRI of shoulder and that this is incorrectly recorded. She advised that she answered Yes to question 16a. 16a. is not marked with a Yes answer to this Question on the Nurse Medical.*

| | |
|---|---|
| *23.5.2010* | *attended A/E limb problems swelling tenderness right shoulder* |

/Cont'd…

*26.5.2010 attends GP shoulders up and down a lot of pain*

*24.5.2010 MRI of chest and left shoulder - calcified density noted in the soft tissue overlying left shoulder - correlation with site of pain is suggested with orthopaedic or rheumatology opinions a consideration*

*I stand over my comments regarding GP attendance with somatic symptoms.*

*My view remains that there was significant material non disclosure of material facts at proposal stage - on proposal form and at nurse medical.*

*Had these disclosures been made we would have sought a PMA and terms would not have issued for income protection had we then become aware of the extensive medical history".*

I note the Provider has advised that it did not decline the claim and cancel cover due to any one particular nondisclosure, but rather that it did so, based on the significant extent of medical history not disclosed on the hardcopy **Application Form** the Complainant signed on **26 January 2012** and on the **Nurse Medical Form** she signed on **7 February 2012**, even within a period of the two years prior to the date of signatures on these forms.

It is important for an applicant seeking insurance who is asked to disclose his or her medical history, to disclose all consultations and tests, notwithstanding that the results of some or all of those consultations or tests *"came back clear"* and/or were deemed to be *"normal"*. This is because the symptoms that gave rise to those consultations and/or tests form part of the applicant's medical history and omitting such details constitutes nondisclosure. In addition, it is not for the applicant to decide what consultations or tests are of significance to the underwriters.

I accept it was reasonable for the Provider to conclude from the evidence before it that the medical information that was not disclosed during the application for the **Executive Income Protection Plan** in 2012, was material and substantial to the policy application and ought to have been disclosed, and that because the Provider was not made aware of the full extent of the Complainant's medical history when it agreed to incept the policy cover, the policy came into being on the basis of a false premise.

I note that when cancelling the **Executive Income Protection Plan** from inception, the Provider returned all premiums paid since the commencement of the policy, to the Policyholder, on the basis that those premiums should never have been paid in respect of the policy, as it never properly came into existence. I accept that this was the correct action to take.

Having regard to all of the above, in my opinion, the evidence does not support the complaint that the Provider wrongfully or unfairly declined the Complainant's income protection claim and wrongfully or unfairly cancelled, from inception, the **Executive Income Protection Plan**.

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

**Conclusion**

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

**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)**

1 July 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—
(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

/Cont'd…

(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.