An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0224
Sector:	Insurance
Product / Service:	Farm
Conduct(s) complained of:	Rejection of claim - non-disclosure
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant complains that the Provider wrongfully and/or unreasonably voided his policy of insurance *ab initio*, on the basis of material non-disclosure.

The Complainant's Case

The Complainant submits that in good faith he entered into the contract of insurance with the Provider in **2013**, and that that he disclosed details of all of his previous claims to his broker, at the at the time of policy proposal.

He submits that the policy of insurance was renewed in **2014** and that he subsequently submitted two claims under the insurance policy to the Provider, one in respect of a personal injury incident and one for a broken television.

In relation to the personal injury accident claim which he submitted, he states that he had to hire a contractor to run his business for a period of time and he says that he was informed by the Provider that the cost of this would be covered under his claim, which would be paid in full. The Complainant submits that he proceeded to pay the contractor to run the farm, "*on the strength of the settlement of the claim*".

The Complainant contends that the fact the Provider settled the claim in respect of a broken television, in **September 2014**, was "*a clear indicator that there was nothing wrong with the Policy*". He contends that it would have been otherwise impossible to have made a successful claim on the policy, which he was subsequently told never existed.

The Complainant submits that it is "*totally unacceptable*" of the Provider, to have led him to understand, whilst he was paying a contractor for ten months, that there was no problem with the policy. Likewise, he considers it unacceptable for the Provider to have cancelled the Policy while his solicitor was trying to make contact with it, within the time frame indicated by the Provider.

The Provider's Case

This Provider notes that the policy in question was incepted through a Broker on **01 December 2013**. It says that the submission forwarded with the Complainant's proposal form, made no mention of previous personal accident claims made.

The Provider submits that the covering letter which issued to the Complainant through his Broker, at the inception of his policy with the Provider, detailed that:

> *"This document has been prepared on the basis of the information given by you or your insurance broker and forms part of your Contract of Insurance (see Note)*
> *Note:*
> *The information you provided must have been given to the best of your knowledge and belief. You should provide us with all relevant facts which may influence us as to whether we accept your insurance, on what terms and conditions and at what premium. If you are in any doubt whether a particular fact is relevant, you should still declare it. Failure to disclose all material information or disclosures of false information could result in the Policy becoming void in which case we would not be liable to pay any claim. We recommend that you keep a record (including copies of letters) of all information supplied"*

The Provider submits that after the Complainant incepted cover with the Provider in late 2013, a personal injury claim was then notified to it on **23 March 2015**. It says that as part of its investigation into the claim, it discovered that the Complainant had made three personal injury claims on his previous insurance cover, which had not been disclosed to it when his policy had been incepted with the Provider in 2013. The claims details were:

> 2010/2011- Personal Accident - €400
> 2012/2013 - Personal Accident - €2,874.29
> 2012/2013 – Personal Accident - €2,600.00

The Provider says that if it had been made aware of these claims at the relevant time when the Complainant proposed for cover, it would not have agreed to provide insurance cover to him, because these claims placed him outside of its new business acceptance criteria.

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In the circumstances, the Provider subsequently, in **January 2016**, offered the Complainant the following options to proceed:

Option 1: It would void the entire policy and refund all monies paid; or
Option 2: It would void the Personal Accident section only from inception (and return all monies paid in respect of the Personal Accident portion of the premium) leaving the remainder on cover (whereby the Personal Accident claim would not be paid).

In the absence of any response on the matter, the Provider says that it issued a registered letter to the Complainant on **13 January 2016** outlining its position and asking that he revert to it by close of business on **27 January 2016** regarding the options outlined. That letter advised that if the Complainant was not prepared to accept the condition of 'Option 2' that it would immediately proceed and treat this contract as '*Void ab initio*'.

The Provider says that it received a letter from the Complainant's solicitor on **22 January 2016** but that the letter did not mention the acceptance of either option. It submits that, therefore on **29 January 2016,** it issued a registered letter to the Complainant confirming that it was treating the policy as '*Void ab initio'*, due to the non-disclosure of material facts regarding his claims history. A refund of premiums which had been paid by the Complainant, was then issued to him, through his Broker.

The Provider refutes the Complainant's comments, that he was positively advised by the Provider that the contractor costs would be settled/paid in the context of his personal injury claim. It submits that it has no record of such advices having been given to the Complainant, and it says that the standard claim settlement process for valid claims is that all payments are made at the end of a claim assessment.

The Provider submits that it is satisfied that its offer to continue to provide policy cover excluding personal injury cover, was a fair and reasonable one, given the circumstances of his non-disclosure.

<u>The Complaint for Adjudication</u>

The complaint is that the Provider acted wrongfully and unreasonably in voiding the Complainant's policy of insurance in the manner in which it did.

The Complainant maintains in that regard that he had been informed by the Provider that the personal injury claim which he had submitted to it, would be settled and would cover the cost of paying a contractor to run his business while he was injured, but this did not occur.

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Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The 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 **29 November 2021**, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter. Following the consideration of additional submissions from the parties, the final determination of this office is set out below.

I note that the Policy of insurance in question was incepted with the Provider, through a broker and that cover commenced **01 December 2013**. Within the proposal form submitted to the Provider and signed by the Complainant, the claims history for the previous 5 years was stated to be: "*Freezer claim in past 5 yrs 600pd*"

I note that within the Quotation document, which was submitted to the Provider by the Complainant through his broker at the relevant time, the claims history for the previous 5 years was stated to be:

5 livestock claims over 5 years
Mower claim
Trespass claim
Freezer claim PDH

In its formal response to this Office, the Provider noted that "*on the proposal form completed by [the Complainant] he notified of a freezer claim only"* in response to the question as to claims history.

Within the timeline of events which the Provider has submitted in respect of the complaint, it identifies, however, that on **11 September 2015**

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"*underwriting emailed [the Broker] requesting an explanation as to why certain claims were not disclosed prior to policy inception*

Disclosed
5 livestock claims over 5 years €6400
Mower claim, 01.01.2010, €3100
Trespass Claim, 01.01.2011, €4000
Freezer claim PDH, 01.01.2013, €600

Undisclosed
Personal Accident 2010/2011 €400
Personal Accident 2012/2013 €2874.29
Personal Accident 2012/2013 €2600

This appears to suggest that the issue of non-disclosure which arose when assessing the claim was only the Personal Injury claims which had been made under the Complainant's previous insurance cover.

Inception of the Policy
As noted, the Policy in question was incepted with the Provider, through the Complainant's Representative on **1 December 2013**.

At the time of inception, the cover letter which issued from the Provider stated that:

This document has been prepared on the basis of the information given by you or your insurance broker and forms part of your contract of insurance:
Note:
The information you provided must have been given to the best of your knowledge and belief. You should provide us with all relevant facts which may influence us as to whether we accept your insurance, on what terms and conditions and at what premium. If you are in any doubt whether a particular fact is relevant, you should still declare it. Failure to disclose all material information or disclosures of false information could result in the Policy becoming void in which case we would not be liable to pay any claim. We recommend that you keep a record (including copies of all letters) of all information supplied.

The issues giving rise to the voiding of the policy by the Provider, began when Provider was notified of a personal accident claim submitted under the Complainant's policy on **23 March 2015**.

From the Provider's internal notes regarding this personal injury claim, it appears that it had informed InsureLink of this claim by the Complainant, on **30 July 2015**. An internal note of **24 August 2015**, states "*See previous claims…referred to underwriting*". The Provider submits that when it undertook a review of previous claims, it then became aware of three personal accident claims which had not been disclosed by the Complainant at the time of policy inception, namely:

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2010/2011 – Personal Accident €400
2012/2013 – Personal Accident - €2,874.29
2012/2013 – Personal Accident - €2,600

The Provider's position is that this constituted non-disclosure of material facts by the Complainant at the time of his proposal for cover in late 2013, and that if it had been so advised of these claims when insurance cover was sought, it would not have offered him any insurance cover because of that history. The policy was ultimately voided by the Provider on the basis of the Complainant's non-disclosure of these previous claims.

The Complainant has complained that the Provider acted wrongfully in voiding the policy and he has submitted a number of points in this respect. He firstly contends that the fact that the Provider had settled a claim in respect of property damage to a television, in **September 2014**, demonstrates that there was no issue with the Policy and that it could therefore not "*never have existed*" as contended by the Provider.

Although I note the Complainant's arguments in this regard, it is nevertheless the case that it was open to the Provider to retrospectively treat the policy as having been void from the outset, when information became known to the Provider which would in late 2013, have affected its decision to enter into the contract at that time. This is a legal remedy which is available to insurers where there has been a material misrepresentation in the information provided during the proposal or renewal process. I am satisfied that the Provider's settlement of the property damage claim made by the Complainant, did not in any way prohibit the decision subsequently taken by it, to void the policy.

The Complainant has further submitted that the Provider acted wrongfully and/or unreasonably by proceeding to void the contract, in **January 2016**, at a time when his solicitor was attempting to engage with the Provider in relation to the correspondence which it had issued in this regard.

The Provider has submitted the following timeline in this regard:

11.09.15
Underwriting emailed [Broker] requesting an explanation as to why certain claims were not disclosed prior to policy inception…

20.09.15
Chased [Broker] for a response.

16.11.15
[Broker] advised that claims related to the Insured's brother as he was covered on the policy

23.11.15
Provider requested more information from [Broker] as the response was not satisfactory

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27.11.15
[Broker] sent Provider [Complainant's previous insurer] claims experience outlining claims and payments

08.12.15
Underwriting sent a referral to the Provider's Product Underwriting for Sign Off

12.01.16
Product Underwriting approved a letter outlining the Provider's options, to be sent to the policyholder (Letter 13.01.2016)

13.01.16
Letter issued by Registered Post to policyholder outlining the Provider's proposed options

13.01.16
[Complainant's Solicitors] issued a letter to [Broker]

20.01.16
[Broker] issued a response to [Complainant's Solicitors]

29.01.16
Email from Underwriting to [Broker] advising that the Provider would issue a "*Void Ab Initio*" letter as it had received no response following options presented to the Client.

03.02.16
[Complainant's Solicitors] ask the Provider to re-consider offering terms to the Client.

10.02.16
[Provider] issue a letter to [Complainant's Solicitors] declining to offer terms to the Client.

03.06.16
Complaint received

I have had regard to the email of **11 September 2015** from the Provider to the Complainant's Broker, as referenced within the timeline above, which noted that the Complainant had registered a claim with it in respect of a personal accident and that, having checked Insurance Link

> *"it appears the Insured failed to disclose 2 other personal accident claims @27/05/13 and 14/03/11. I have checked the submission and it appears these were not disclosed at policy inception = December 2013. Please advise why these claims were not disclosed."*

The surrounding correspondence has not been made available by the Provider.

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The Complainant has submitted letters he received from his broker in **December 2015**.
A letter of **17 December 2015** referred to a telephone conversation with the Complainant and enclosed certain documents as requested by the Complainant. It also advised that

> *Insurers see the non-disclosure of Personal Accident claims as non-disclosure of material fact and are refusing to deal with the current Personal Accident claim. They have advised the following options*
> *1. Cancel the policy from inception date (01/12/2013) & credits for premium paid on the past 2 years.*
> *2. Cancel the Personal Accident Section from the inception of policy, allow rebate and offer terms on other sections of the policy.*
> *As renewal date was the first of December and Insurers are continuing to hold cover but this will not continue indefinitely, so we must have the benefit of your advices.*

Another letter from the Broker to the Complainant of **18 December 2015** enclosed "*all documents on file on relation to your personal accident claim on 03/03/15*" and "*policy schedules for 2014 and 2015".* The letter stated:

> "*please note that [Provider] have advised that they need a decision on what way you wish to proceed (given the two options that they have offered) by 5pm on Monday 21st December as after that time they will no longer be in a position to hold cover."*

A further letter from the Broker to the Complainant dated **22 December 2015** stated that it had requested renewal terms from the Provider based on the deletion of the personal accident cover and the letter supplied details of this.

The Provider wrote to the Complainant's Broker by letter dated **13 January 2016**, noting that

> "*as we have not received an instruction how to proceed please find attached copy of the registered letter that it being issued to the client today for your records*."

I note that the letter in question, addressed to the Complainant, identified that the claims history which had been made available to it, differed from the details which had been declared when he originally proposed for cover and that, in particular it had noted three personal accident claims which had not been disclosed.

It stated that if it had been so advised at the time of the proposal for cover, this would have put the risk outside of its acceptance criteria and it would not therefore have offered insurance cover and that, in such circumstances, it was treating the contract as void ab initio and it was refunding all monies paid to it in respect of the contract.

The letter noted that this would have implications for the Complainant as regards any future insurance contracts that he may enter into, and "*with this in mind and in an effort to be reasonable"* it was prepared to give two options.

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Option 1 offered was that the Provider would treat the contract as void ab initio and refund all monies paid. Option 2 was that the Complainant would continue on cover but (i) accept the withdrawal/deletion of cover provided under the Personal Accident Section of the policy retrospectively from the date of inception, with the effect of rendering his claim in respect of the personal accident as invalid and (ii) an excess of €1,000 would apply to all claims under the policy with immediate effect. The letter requested a response by **27 January 2016**.

From the documentation supplied, it appears that the Complainant's Broker received a letter from the Complainant's solicitors, dated **20 January 2016.** This letter stated that the Complainant was *"having difficulty regarding his insurance policy arranged by you with [the Provider]".* It contended that the Broker had failed to disclose the previous personal injury accidents which it had been made aware of by the Complainant.

The letter also noted that:

> *"were he to accept any of the proposals being put forward by [the Provider] how would he get personal accident cover in the future as in effect he would be admitting that he failed to disclose a prior personal accident which clearly is not the case.*
> *We would be obliged if you would address these issues as a matter of urgency and we would ask that our client's cover be extended until these issues have been resolved*."

The Broker responded by letter of **20 January 2016**, refuting the contentions made and advised that

> *"[the Provider] have issued a letter to [the Complainant] outlining their position and affording client a further period of time i.e. January 27th to respond, otherwise they will be treating the Policy as 'voided ab initio'. Should this happen then [the Complainant] will have a much bigger problem getting insurance*."

The Broker concluded by requesting of the Complainant's solicitor that "*You might let us have the benefit of your further advises on this before January 27th".*

I note that 2 days later, by email on **22 January 2016,** the Broker sent a copy of its correspondence with the Complainant's solicitor, to the Provider. This was the subject of an internal email within the Provider dated **22 January 2016**:

> *please see attached correspondence from [the Complainant's] solicitor and broker's subsequent response. As outlined in the registered letter I sent to [the Complainant] previously if we do not receive a response by the 27/01/2016 we will have no option but to treat this void ab initio*.

The internal response was:

> *The attached correspondence now indicates that there is a dispute between [the Complainant] and [Broker]. It appears that [the Complainant] is saying he told [Broker]*

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about all his previous claims and [Broker] are refuting this. Either way it is an argument between [Complainant] and [Broker].

For our part we have acted reasonably in this matter in that rather than immediately proceeding and treating this contract as 'void ab initio' due to non-disclosure of previous personal accident claims we gave [Complainant] two options. It would appear that due to the dispute between [Complainant] and [Broker] that he [the Complainant] is not in a position at this time and is unlikely to be in a position at any time in the near future to consider the options that we have put to him. From our perspective we should advise [the Complainant] that this being the case, we cannot leave this matter in abeyance indefinitely and have no option but to immediately proceed and treat this contract as 'void ab initio'.

We should now do the following:
Issue a registered letter directly to [the Complainant] voiding this contract
A refund cheque in respect of all monies paid should be attached to this letter.
Issue a copy of the registered letter to [Broker].

The recovery of the monies paid out in respect of [claim number] can be dealt with as a separate matter.

A further internal email of **25 January 2016** requested clarity on whether as per the letter which issued on the 13 January advising of a response date of 27 January, the letter to void the policy should issue that day.

The Provider response in that respect was that:

"As the letter from [Complainant's] solicitor is not addressed to us then there is no need for us to respond to it. I appreciate that in the letter there is a request to the broker that cover be extended until matters are resolved and I think we can close this out by sending an email to the broker advising in relation to the request by [Complainant's] solicitor for an extension of cover that our position as outlined in our letter of 13th January 2016 is unchanged. Please advise [Complainant] and his solicitor accordingly.
To finalise matters our end, I would just issue a registered letter on 28/01/2016 advising that the contract is being treated as 'void ab initio'."

The correspondences referred to (which was to be issued to the Complainant/his solicitor) has not been supplied in evidence by the Provider.

The Complainant has submitted that prior to the voiding of his policy, his solicitor had written to the Provider but

"*had gotten no response. As it was now the day of the deadline we decided to ring [Agent] of [Provider] who was dealing with the matter. My solicitor failed to contact [Agent] but was speaking with her colleague who said she was away from her desk and gave her personal number to ring [Agent] tomorrow. The following day the solicitor rang both numbers but was missing her call all the time. She rang back then*

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when my solicitor was in court. On Monday I received a registered letter from [the Provider] which stated that they were now treating the matter as void ab initio and no longer had cover."

The Provider has confirmed that "*On 22/01/16 we received a letter from [Complainant's solicitor] however there was no mention of acceptance of either option therefore on 29/01/16 we issued a registered letter to [the Complainant] confirming that we were treating the policy as 'Void ab initio'…"*

I note that the letter which the Provider then issued to the Complainant on **29 January 2016** confirmed it was voiding the policy ab initio, on the basis that it had come to its attention that:

"…at the time of the inception of the above noted insurance policy that you failed to disclose all previous claims. The omission of this information constitutes non disclosure of material information and had we been advised of this information when insurance cover was sought we would not have offered you any insurance cover.
Due to the non disclosure of material information we hereby advise that we are treating the above noted insurance contract as 'void ab initio' which means that a contractual relationship never existed between [Provider] and [Complainant]"

This letter also advised that the Provider was refunding the premiums he had paid.

The Complainant's solicitor then wrote to the Provider on **03 February 2016**:

We refer to our recent telephone call and as indicated on the phone we had endeavoured to make contact with you prior to the time running out on the proposals made to our client. But due to the fact that we missed one another the time had run out by the time we actually spoke as a result of which our client is now left in a situation where his broker has indicated that it will be impossible for him to get insurance.
In all the circumstances we would be obliged if you would reconsider the position which our client now finds himself in.
You will appreciate that the policy that has now been cancelled was a policy in respect of which a payment out was made notwithstanding the difficulties that subsequently arose.
Please let us hear from you in this matter as our client is left in a most difficult situation and is not willing to accept same."

The Provider responded on **10 February 2016**, referred to its letter of **13 January 2016** and advised that it was not in a position to offer any insurance cover to the Complainant.

The Provider was requested by this Office to directly address this aspect of the Complainant's complaint regarding the Provider's conduct in proceeding to void the contract of insurance, at a time when he says his solicitor was engaging with the Provider in relation to the matter and to submit any correspondence between the relevant parties.

The Provider says in that particular respect, that it:

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> *"wrote to the customer on 13/01/16 clearly outlining 2 options that we were offering to him in an attempt to resolve the matter. On 29/01/16 we advised the policyholder's broker [name] that we would be proceeding to void the policy as we had had no response to our registered letter and as the date we had advised [Complainant] to revert by had passed. We then received a letter on 04/02/16 from [Complainant's] solicitor asking us to reconsider our decision. We responded on 10/02/16 advising that we were not in a position to offer insurance to [Complainant].*
>
> *Whilst [Complainant's] solicitor may have been engaging with his Broker during that time, we did not receive a response to our registered letter and proceeded to void the policy in line with the information we provided to [Complainant]"*

The Complainant responded that

> *After receiving the registered letter from [Provider] I went and got legal advice from my Solicitor. My Solicitor was concerned about the short deadline on such a serious matter, that she contacted them by phone straight away while I was in her office.*
>
> *My Solicitor was told on the phone conversation that the person dealing with it would ring her back. This happened several times. As the deadline was getting nearer I insisted she send letters to both [Provider] and [broker]. She assured me that once the matter was ongoing between her and [Provider] that the deadline was not set in stone as there was ongoing communications with all parties.*

The Provider advised this office that it had no additional records to submit.

No phone records or notes of calls have been supplied by the Provider of any calls which took place between it and the Complainant's solicitor. Nor has any explanation been provided as to why these are not available. I noted in my preliminary decision that the record keeping on the part of the Provider was disappointing in this regard. The Complainant suggests that the use of the adjective "disappointing" is very flippant, and in his opinion, this description fails to acknowledge that:

> *"[t]he evidence is clear this insurance company has totally refused to engage or cooperate with myself, my solicitor and the ombudsman.*
>
> *Would anyone believe that an insurance company wouldn't record phone calls, keep records of emails or letters from a client's solicitor that they had sent a registered letter too. Clearly there was a policy of refusing to engage with my solicitor until the deadline in their registered letter had pasted."*

I do not accept this. It is clear from the evidence that the Provider had been seeking additional information from the Complainant since **November 2015**, which it did not receive and, ultimately, it wrote by registered post on **13 January 2016**, putting certain options to the Complainant, although in my opinion, it was not obliged to do so.

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In any event, there does not appear to be any suggestion from the Complainant that his solicitor was seeking to make contact with the Provider to confirm which option the Complainant wished to accept. Rather, in his submission since the preliminary decision of this office was issued, the Complainant makes clear that his solicitor was seeking to challenge the Provider regarding the process during which the policy had been incepted.

Whilst the Complainant has submitted that he was advised by his solicitor:

> *"that once the matter was ongoing between her and [Provider] that the deadline was not set in stone as there was ongoing communications with all parties",*

It is unclear how or why this belief had been formed. Certainly, this understanding does not appear to have derived from any statement or confirmation from the Provider that this was the position, and I don't believe it is appropriate to place any responsibility on the Provider for any such advice. In my opinion, the Complainant was given ample notice of the Provider's position and the letter of **13 January** made clear the two options which were available to the Complainant and requested that he revert with his response if he wished to avail of either option, by **27 January 2016** (namely, that the Provider void the entirety of the policy or void the Personal Accident section only from inception (whereby the Personal Accident claim would not be paid). He did not however revert within that two-week deadline, that had been offered to him and I view this failure to revert, against the background of the interactions which had been ongoing since November 2015.

It appears that the Provider was aware of the Complainant's position from the correspondence which had been sent to it regarding the apparent issues between the Complainant and the broker. I accept however that this did not change the Provider's position, nor did it affect its intention to void the policy, as a result of the non-disclosure which had occurred. The Provider's internal notes reflect the fact that any underlying issues between the Complainant and his broker, which may have caused the non-disclosure, were matters with which it did not consider itself concerned. This, in my opinion, was not an unreasonable position for the Provider to have adopted.

A material fact is any fact that would influence the judgment of a prudent underwriter in its assessment of the risk. It is important to note that all insurance contracts are subject to the duty of utmost good faith. This means that when the proposer applies for cover under an insurance contract, he or she is under a duty of utmost good faith to disclose to the insurer all material facts, known to the person applying for cover, which may affect the risk.

Insurance contracts are contracts of utmost good faith, and the failure to disclose material information allows the Insurer to void the policy from the outset and to refuse or cancel cover, as the Provider did in this instance, because the policy had come into being in late 2013, on the basis of a false premise, insofar as the Provider was not made aware of the previous personal injury claims made against the Complainant's previous insurance cover.

This Office is aware that the courts have long considered the issues surrounding non-disclosure of material facts.

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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"*.

Whatever communications arose between the Complainant and his broker in late 2013, I am satisfied from the evidence that the Provider was not notified of the Complainant's personal injury claims history, at the time of the Complainant's proposal for cover. In those circumstances, I am satisfied that the Provider was entitled to void that policy cover "*ab initio*" thereby cancelling the cover as if it had never been in existence.

Although the Provider made an offer to the Complaint which would have avoided the cancellation of that cover "*ab initio*", it appears from the evidence that the Complainant was not happy to accept that option which the Provider had offered him. As neither the Complainant nor his representative, reverted with confirmation of which option he wished to proceed with, within the timeframe allowed for, the Provider proceeded to void the contract, as it had advised that it would.

I am satisfied that in the circumstances of the non-disclosure, the Provider was entitled to proceed on the basis which it did. I consider that it had acted reasonably in affording the Complainant an opportunity to continue on cover, with the exclusion of personal accident cover; when that option was not accepted by the Complainant within the period permitted, I am satisfied that the Provider was entitled to proceed as it had indicated it would, to void the policy ab initio.

I note that later that year, in **June 2016**, within its letter of response to the Complainant's complaint, it advised the Complainant that in an attempt to resolve the matter, it was prepared even at that stage, to re-offer option 2 – the Complainant could continue on cover with the exception of personal injury cover and with an excess of €1,000 to apply to any claim. The Complainant did not however avail of the opportunity to do this.

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Personal Injury Claim

The Complainant has submitted that he incurred significant costs in hiring a contractor to run his farm over a number of months, while he was injured.

The Complainant submits that he was told by an Agent of the Provider on the telephone, in or about **March/April 2015**, that the personal injury claim would be settled by the Provider and that it would cover the cost of his having hired a contractor to run his business for a period. The Complainant has submitted in that respect that:

> *"When I had my personal accident I had to hire someone to run the farm. After a month of doing this I rang [Provider] with a view of claiming funds to pay this contractor and I was informed that it would be paid in full at the end of the claim. I was also informed that I would be required to undergo a medical examination by [Provider's own doctor which I did in [location]. I proceeded to pay the contractor on the strength of settlement of the claim*."

The Complainant has also submitted that the call in question

> "*was made around March/April to the [Provider's] claims department in [location], in which I was told by the [Provider] employee that the claim would be paid in full at the end and there was no problem paying my contractor myself in the mean time."*

The Provider submits that it has investigated its records, to identify such a call and says it cannot locate a copy of a call recording of such a conversation. The Complainant himself had previously indicated, during the course of this investigation, in **October 2017**, that he would seek an itemised bill from his telephone provider "*for the relevant period which will enable me to find the correct phone number on which I called [the Provider]."*

In **March 2018**, he confirmed to this Office that he had been

> *trying to get an itemised phone bill from [telephone provider] for the last 5 months to no avail. [The Provider] has previously stated that they had searched there systems for my mobile number but could not find it. There is 3 possible numbers in which I could have made this call from. To the best of my knowledge it was a [location] [Provider] number that I called. I would be grateful if [Provider] would search there systems for these three numbers. In the meantime I will keep trying to get my own itemised bill from [telephone provider]. If I get it I will be able to forward you the exact time and date of the call. The 3 possible phone numbers are as follows: [numbers listed]*

This information was shared with the Provider which responded on **22 March 2018** that:

> *I have reviewed the file and all 3 numbers have been checked for previously and we do not have a record of the call [Complainant] says he had regarding the contractor.*
> *If he wishes to submit his itemised bill we can try searching further but we have not been able to trace a call from those 3 numbers.*

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The Complainant responded noting that calls were recorded by the Provider as indicated in the message at the beginning of each call and that it was hard to believe the Provider could not locate such a call and that it "*didn't try hard enough to search for the call or else if they found the call and didn't like its contents".*

The Provider responded that calls may be recorded but that not all calls are recorded however a note is maintained of all customer calls received along with a note of the content of the call. It submitted that there is no note of the discussion that the Complainant contends he had with the claims handler and that the claims handler dealing with the claim was very experienced and

> "*would have no reason to confirm that a claim would be paid when same was still being investigated. All claims are investigated in full and cover is not confirmed until the investigations have been completed. Whilst we are satisfied that we have made every attempt to trace this alleged call, if [the Complainant] wishes to provide evidence of same we will certainly investigate further, We totally refute the allegation that a call was found and that we did not like its contents."*

I note that the Complainant ultimately did not furnish any itemised phone bill.

The Agent/Claims handler's statement of events is set out within an internal email of the Provider of **08 June 2016**, which provides:

> *I only spoke with the Insured in this case once.*
> *I remember it because I was aware that it had been referred to underwriters.*
> *This was after he became aware that payment may not be made, so it would have been after I had emailed U/W back in August 2015.*
> *I did not discuss the claim with him, he had been on to the brokers and I passed the call to underwriters so it may be recorded there.*
> *I certainly would not have, and never have advised any Insured's making a claim on the Personal Accident section that the costs of hiring a contractor would be covered.*
> *It has nothing to do with the cover…..*

Two calls have been supplied in evidence by the Provider as part of the investigation of the within complaint. When these were made available to the Complainant, he noted that the calls in question had occurred in or about **December 2015.** From listening to the calls, it does not appear that either of the Agents who the Complainant spoke to, was the claims handler in question. Rather, the calls in question comprise the Complainant briefly speaking with an initial Agent who passed the Complainant through to an Agent in the Underwriting Department. The Underwriting Agent advised that he generally deals with brokers and advised the Complainant to contact his broker on the matter. The Complainant advised that he was dealing with his solicitor on the matter and the Agent advised that he would ask his broker to get in contact with him.

No further calls have been supplied in evidence.

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As regards the suggested telephone call referred to by the Complainant, from the timeline of events, I note that the personal injury claim itself had been notified to the Provider on **23 March 2015** and the Complainant's position is that the call in question, occurred with the Provider in **March/April 2015**, "*after a month*" of having hired "*someone to run the farm*". It appears that the accident itself had occurred on **03 March 2015**. The Claim Form was completed by the Complainant and dated **27 March 2015,** with a supporting Medical Certificate of **30 March 2015**. The completed form was furnished by the Complainant's Broker to the Provider, by cover letter of **17 April 2015**.

I note that a Medical examination which the Provider arranged for the Complainant to attend, as part of the claim process took place on **04 June 2015**. Such a medical examination is an essential and normal part of the claim assessment process by an insurer and whilst there is no way of ascertaining, without the availability of a telephone recording, what was advised to the Complainant in March/April 2015, I accept given the timelines involved, that it would be highly unusual for an insurer to offer confirmation that a claim would be successful at such an early stage, prior to the assessment of the claim having been undertaken.

I am also conscious that the Complainant had hired a person, before he had any communication with the Provider, and that he did so, not because of any information given to him during such a telephone call, but rather it seems because his injury prevented him from doing his normal farm work, and because it was necessary for him to ensure that the farm would be run on his behalf.

I note that the circumstances which gave rise to the telephone call which the Complainant refers to, were that the Complainant had contacted the Provider seeking to "*[claim] funds to pay the contractor"* for the previous month. He says that he was told by the Provider that any such costs would rather be paid "*in full at the end of the claim"*. Given the Complainant's previous experience of making claims, it is not clear why he formed the opinion that this meant that his claim would be successful. It seems to me that if such a statement was made to the Complainant, as he suggests, this simply referred to the form and timeline in which any such payment would be made by the Provider (if the claim were to be successful).

I note that the advice which the Complainant say he was given by the Provider in March/April 2015, was before the issue of non-disclosure was raised. Whatever that discussion, if any, between the parties, new information then came to light during the assessment/investigation of the claim, that I am satisfied impacted the Provider's position and indeed impacted the underlying contract of insurance.

On the basis of the reasons set out above, having had regard to all of the evidence, I am satisfied that the Provider was entitled to take the view that the Complainant's policy of insurance had come into existence on the basis of a false premise, because it had not been made aware of the Complainant's personal accidents claims history, at the time of the policy inception.

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Once the Complainant's claims history information came to light, and when the Complainant in such circumstances, was unwilling to accept the Provider's offer to continue with the policy on the basis that personal accident cover would be excluded (and with a substantial excess put in place) I accept that the Provider was then entitled to treat the policy as void *ab initio*, and to refund the premiums paid, to bring the matter to a conclusion.

Having considered the matter at length, I am satisfied that the evidence before me discloses no wrongdoing by the Provider and indeed, I note that in **June 2016**, within its letter of response to the Complainant's complaint, the Provider advised that in an attempt to resolve the matter, it was even then prepared to re-offer the Complainant cover (excluding personal accident) and with an excess of €1,000 to apply to any claim. The Complainant did not avail of the opportunity to restore policy cover on that basis, but I am satisfied that the Provider has at all times displayed a reasonable approach to the issue which arose.

Accordingly, for the reasons outlined above, I do not accept that there are any grounds upon which it would be appropriate to uphold the Complainant's complaint.

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)

4 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—

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