Decision Ref: 2022-0314

Sector: Insurance

Product / Service: Income Protection and Permanent Health

Conduct(s) complained of: Dissatisfaction with customer service
Claim handling delays or issues
Disagreement regarding Medical evidence submitted

Outcome: Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant is a voluntary member of a **Group Salary Protection Scheme** since **1 November 1986**. The Scheme provides life, income protection and specified illness cover. The Grantees of this Scheme are a named Trade Union, the individual members of which can organise cover through the Scheme Administrator, a financial services broker engaged by the Grantees. The Provider is the Insurer of this Scheme, responsible for underwriting the applications for cover and assessing claims. This complaint concerns the Provider's administration of the Complainant's income protection claim.

The Complainant's Case

The Complainant, a primary school teacher, completed an **Income Protection Claim Notification Form** sent to the Provider on **25 February 2015**. She advised that she had been medically certified as unfit for work since **11 June 2014**. The Complainant says she had fallen severely ill due to numerous conditions that included post-surgery complications and that she suffered from nerve damage, resulting in her having difficulty using one of her feet, thereafter.

As part of its assessment of her claim, the Provider arranged for the Complainant to have a tele-interview with a nurse on **13 March 2015**. In her letter to this Office dated **9 January 2019**, the Complainant says that the nurse asked her questions in relation to her smoking and alcohol consumption and in that regard, she submits that:

> *"Smoking and drinking alcohol have no bearing on my situation - severe sepsis and dropped foot and post-operative hernia – but I was questioned about both non-existent habits unnecessarily in my opinion"*.

Following its assessment, the Provider wrote to the Scheme Administrator on **15 May 2015** to confirm that it was admitting the Complainant's income protection claim, and the first claim payment was made to her bank account on **1 June 2015**.

The Complainant says that her employer granted her early retirement on ill-health grounds from **16 March 2016** and that she will never be able to work as a teacher again.

As part of a later review of her income protection claim, the Provider arranged for the Complainant to attend for a medical examination with a Specialist in Occupational Health on **15 August 2017**. In her ensuing **Report** dated **24 August 2017**, this Specialist concluded that the Complainant was fit to return to work.

The Complainant says the Specialist's Report contained many omissions and inaccuracies and she set these out in detail in her letter of **16 January 2018** to the Provider's Medical Officer, who forwarded her letter to the Specialist. The Complainant is displeased with the Specialist's response of **14 February 2018** and in that regard, in her letter to this Office dated **18 December 2019**, the Complainant submits that:

> *"…* [the Specialist's] *response to my "errors and omissions" letter clearly indicates that her opinion was that because I could read and critically appraise her report and prepare a detailed response therefore I should be able to resume teaching duties".*

In addition, in her letter to this Office dated **9 January 2019**, the Complainant says that when concluding the examination on 15 August 2017, the Specialist said to her:

> *"…and I quote verbatim, "Now* [Complainant name redacted]*, is there anything else you want to tell me because you are* [age redacted] *and* [the Provider] *will want to get you off* [its] *books"*.

As part of its claim review, the Provider also asked the Complainant to complete a two-day Chronic Pain Abilities Determination at her home on 27 and 29 November 2017. The Complainant says she did not want to undergo the CPAD Assessment without first having sight of the Specialist's Report from August 2017. The Complainant says that the Scheme Administrator, on her behalf, emailed the Provider on **1 November 2017** asking for it to send a copy of the Specialist's Report to her GP but as the Provider failed to do so at the time, the Administrator had to contact the Provider on **15 November** and again on **21 November 2017**. The Complainant says that this delay meant she was not able to review the contents of the Specialist's Report in advance of the CPAD Assessment and this resulted in her cancelling that appointment.

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The Complainant makes particular reference to a telephone call between the Provider and the Scheme Administrator on **22 November 2017** wherein the Provider's Claims Assessor Mr M. blamed the Complainant for cancelling the CPAD Assessment at short notice.

The Complainant reiterates that the cancellation was due to the Provider's failure to issue her GP with a copy of the Specialist's Report when it was first asked to do so, and in her letter to this Office dated **29 November 2020**, the Complainant submits that Mr M. failed to refer to her in a professional manner during the call, in that:

> "[Mr M.] *described me as "unreasonable", referred to me as "the woman", "will have to take a hit", "will have to pay a non-attendance fee", "now she is bringing this into the mix" …*
>
> *I find it hurtful and demeaning that they (*[Provider employees]*) speak about vulnerable consumers in such a way."*

Similarly, in her email to this Office of **14 March 2021**, the Complainant submits that:

> *"I suffered the ignominy of* [Mr M.] *referring to me as 'the woman', describing me as 'unreasonable' and saying that he didn't want to 'antagonise' me, that* [the Provider] *had to take 'a hit' when the CPAD scheduled for 27th November* [2017] *had to be cancelled and wondering if* [the Provider] *would pass the cost on to me when it was all caused by* [the Provider's] *tardiness and subterfuge".*

The Complainant says she cancelled the second CPAD Assessment appointment that the Provider had arranged for 2 and 4 January 2018 as this fell over the Christmas period and she considered such scheduling, during the holiday period, an insult.

The Complainant underwent the CPAD Assessment on **20** and **22 February 2018**. The Complainant says that during this assessment, the Assessor put to her a question concerning her sex life and in that regard, in her letter to this Office dated **9 January 2019**, the Complainant submits that:

> *"One's sex life is not relevant in my case as I do not work in the sex industry. Whether or not I engage in sex or have pain if I do, in no way affects my ability or inability to teach. It is a very intrusive question ranking with asking about one's sexual orientation and religious or political beliefs and is an invasion of one's personal, if not human rights".*

Following its claim review, the Provider wrote to the Complainant on **29 March 2018** acknowledging that the review had been a lengthy process and advising that it was satisfied that she continued to satisfy the policy definition of disablement and that her claim payments would continue, subject to the policy terms and conditions.

In addition, the Complainant submits in her letter to this Office dated **29 November 2020** that during her telephone call with the Provider on **9 April 2018**, Claims Assessor Mr M. *"described my medical team as "advocates"*.

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In the **Complaint Form** sent to this Office, the Complainant submitted that:

> *"As a claimant under the Salary Protection Scheme I found* [the Provider] *to be a company that relentlessly bullied, harassed, threatened, hounded, humiliated, undermined, coerced and stressed me and treated me as a fraudster; I had to acquiesce to all* [its] *demands whether reasonable or unreasonable or risk non-payment of my benefit.* [The Provider] *hounded me from the start of my benefit being paid and were determined to get me off payroll asking for non-relevant information (smoking and drinking –* [during the tele-interview on **13 March 2015**]*) and inappropriate information (sex life –* [during the CPAD Assessment on **20** and **22 February 2018**]*).* [The Provider] *willingly take your money in premiums but are unwilling to pay benefit"*.

The Complainant says that when she made her income protection claim, the Provider ought to have recognised her as a vulnerable consumer and also assessed a specified illness claim for her at the same time and in that regard, in her letter to this Office dated **29 November 2020**, she submits that:

> *"I believe if* [the Provider] *treated all clients as vulnerable consumers (as they claim they do) they would automatically send all relevant claim forms as a matter of course/policy once a claim is initiated. I believe that would be a reasonable expectation …*
>
> *When I applied to* [the Provider] *and submitted my* [Income Protection Claim Notification Form]*…* [it] *should have treated me as a vulnerable consumer and triggered all potential benefits under my policy including Specified Illness Benefit and therefore should have sent me a* [Specified Illness Benefit] *Claim Form. They had proof of nerve damage and proof of coma … Both conditions qualified me for* [Specified Illness Benefit] *which* [the Provider] *paid me on 31/5/2016 …*
>
> [The Provider] *in all the responses to* [the Financial Services and Pensions Ombudsman] *have only addressed the Income Protection Section of the Policy whereas the bulk of my complaint relates to the Specified Illness Section of the policy and is the area in which* [the Provider] *failed totally in* [its] *obligation to me as a vulnerable person …*
>
> *As a vulnerable consumer I should not have to read this tome of a policy to ascertain my entitlements and a vulnerable consumer should not have this level of engagement with their Insurer in order to receive their entitlements".*

The Complainant says the Provider did not treat her as a vulnerable consumer throughout her dealings with it and was in breach of is obligations under the Central Bank of Ireland ***Consumer Protection Code 2012 (as amended)***.

The Complainant submits in the **Complaint Form** that in order to resolve this matter:

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> *"I wish for a sincere and appropriate apology for the impositions made on me by* [the Provider] *… I expect appropriate compensation commensurate with the trials and turmoil I have suffered at the hands of* [the Provider] *and* [its] *Agents"*.

The Provider's Case

The Provider says that the Complainant completed an **Income Protection Claim Notification Form** to the Provider on **25 February 2015**, wherein she advised that she was medically certified as unfit for work since **11 June 2014**.

The Provider notes that in order for income protection benefit to be payable, the claimant must satisfy the following **Group Income Protection Scheme** definition of disablement:

> ***1. Disablement -*** *For the purpose of this Policy*
>
> *(i) total disablement shall be deemed to exist where (a) the Insured Person is unable to carry out the duties pertaining to his normal occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted and (b) the Insured Person is not engaging on a full-time or part-time basis in any other occupation (whether or not for profit or reward or remuneration, including benefit in kind).*

The Provider says that all income protection claims are assessed against this definition of disablement with reference to the job demands of the claimant's occupation and in that regard, the Complainant's claim was assessed against her role as a primary school teacher.

As part of its claim assessment, the Provider says it arranged for the Complainant to undergo a tele-interview with a specialist nurse on **13 March 2015**, during which she was asked to provide details of her medical complaint and history. It was noted that the Complainant was at the time still in the recovery stage of a serious medical condition. The Provider also obtained a **Report** from the Complainant's GP dated **29 April 2015**. It says that based on the information received, it was satisfied that the Complainant met the policy definition of disablement.

The Provider says it wrote to the Scheme Administrator on **15 May 2015** to confirm that it was happy to admit the claim and the first payment was made to the Complainant on **1 June 2015**. In that regard, the Provider notes that as its liability under the claim was not due to commence until **2 May 2015** and as payments are made monthly in arrears, the first payment due under the claim was not due until **1 June 2015**.

The Provider says it wrote to the Complainant's treating Consultant Neurologist on **17 August 2015** for an update on the Complainant's condition and to establish whether a return to work was going to be possible and if so, the timeframe for this. In his letter to the Provider dated **12 September 2015**, this Consultant advised:

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> *"…if there is not near normal recovery over the next 6 months that there may be some level of permanent dysfunction".*

The Provider says that based on this advice, it was satisfied that the Complainant continued to meet the policy definition of disablement and it decided that it would obtain a further update in approximately six months' time.

The Provider notes that the Complainant was granted an ill-health early retirement pension with effect from **16 March 2016** and says that this had no bearing on its management and assessment of her claim or her entitlement to benefit under the policy.

The Provider says it next wrote to the Complainant's treating Consultant Neurologist for an up-to-date report on **5 April 2016**. The Provider notes that in his letter of **6 May 2016**, the Consultant advised that some functional restrictions remained, but offered no comment on the Complainant's fitness, or otherwise, for work.

The Provider says it then arranged for the Complainant to attend for a medical examination with a Specialist in Occupational Health on **2 September 2016** and in her ensuing **Report** of **9 September 2016**, this Specialist advised that:

> *"In my opinion* [the Complainant] *currently meets the definition of disability whereby she is unable by reason of illness to carry out the duties of her normal occupation. I expect her to meet the definition for the next 6-12 months"*.

The Provider says that based on this advice, it was satisfied that the Complainant continued to meet the policy definition of disablement and it wrote to her on **28 September 2016** to confirm that its claim review was complete and that claim payments would continue.

The Provider notes that the Specialist had stated in her Report that the Complainant was due to have a surgical procedure and in order to obtain some additional details in that regard, it wrote to the Complainant's GP on **1 December 2016** asking him to complete a **Medical Questionnaire**. The Provider notes that the GP made no reference to any recent surgery in her response of **30 December 2016**, however the Complainant herself clarified that the surgery had been a minor procedure with no bearing on her ongoing absence from work. The Provider was grateful for this clarification, and it continued claim payments.

The Provider says it was subsequently provided with a letter from the Complainant's treating Consultant Surgeon dated **7 June 2017** advising that the Complainant had been admitted on **30 March 2017** for the *"elective repair of upper abdominal midline incisional hernia resulting from complex abdominal intervention on the past for abdominal sepsis"* and was discharged on **10 April 2017** and reviewed since and found to be recovering *"very well to my satisfaction"*.

The Provider says it later arranged for the Complainant to attend for a further medical examination with the Specialist in Occupational Health on **15 August 2017** to establish if it was likely that the timeframe for recovery as outlined in the Specialist's previous Report of 9 September 2016 was going to be met. In her ensuing **Report** of **24 August 2017**, this Specialist advised that:

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> *"In my opinion,* [the Complainant] *no longer meets the definition of disability. I cannot categorise her as unable by reason of illness or injury to carry out the duties of her normal occupation".*

The Provider notes that the Specialist also advised that:

> *"The insurer may consider chronic pain ability determination to provide further objective evidence of her work ability".*

The Provider says it then arranged for the Complainant to attend for a Chronic Pain Abilities Determination. The Provider says it was happy to continue claim payments while the review was ongoing and it wrote to the Scheme Administrator on **2 October 2017** to advise that it wished for the Complainant to undergo a CPAD Assessment at her home on 27 and 29 November 2017 and it enclosed an explanation of the CPAD Assessment process. The Provider says the Administrator contacted it, on the Complainant's behalf, to ask for some further information in relation to the CPAD Assessment process and the Assessor's qualifications and that it provided this information on **27 October 2017**.

The Provider says that on **1 November 2017**, the Complainant, through the Scheme Administrator, requested that a copy of the Specialist's Report of 24 August 2017 be made available to her GP.

The Provider says that on **6 November 2017**, the Scheme Administrator confirmed by email that the Complainant was happy to proceed with the CPAD Assessment.

The Provider says that following contact from the Scheme Administrator on **15 November 2017**, its Medical Officer sent the Specialist's Report to the GP on that day and that this was confirmed to the Administrator by email at the time. The Provider says that this was the first time it sent the Report to the Complainant's GP and says there is nothing in its records to indicate that it had done so earlier. That said, if one of its staff misstated the position in any way in relation to the sending of the Report to the GP, the Provider says it apologises to the Complainant for this.

The Provider says that on **20 November 2017**, the Scheme Administrator emailed on the Complainant's behalf to cancel the CPAD Assessment, as follows:

> *"*[The Complainant] *called* [GP] *today and secretary confirmed receipt of* [Specialist's] *report. However, the member advised that her GP is not back until 27/11/17 and that other Doctors there could not forward report to member to review before GP returns. Therefore member has stated that she wishes to re-arrange the appointment with* [the CPAD Assessor] *as wants to review report before meeting him".*

The Provider says that this was the first indication it received that the Complainant had placed any preconditions on her engagement with the CPAD Assessment. The Provider says it was happy to allow the Complainant time to review the Specialist's Report with her GP and it confirmed that it would rearrange the CPAD Assessment, as requested.

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The Provider says that on **21 November 2017**, it received a telephone call from the Scheme Administrator asking that it resend its letter of 15 November 2017 to the Complainant's GP by fax, and that this was done on the same day. The Provider says it can offer no explanation as to why the GP does not appear to have received its Medical Officer's letter of 15 November 2017 but confirms that the letter was posted to the correct address and was not returned as undelivered by An Post.

The Provider says that on **23 November 2017**, it wrote to the Scheme Administrator to advise that it wished for the Complainant to undertake the CPAD Assessment on 2 and 4 January 2018.

The Provider says that on **30 November 2017**, it received a letter from the Complainant's GP dated **28 November 2017** seeking permission for the GP to release a copy of the Specialist's Report to the Complainant.

The Provider says that on **1 December 2017**, it wrote to the GP to advise that she could make the Report available to the Complainant if she was satisfied that doing so was not likely to cause serious harm to the Complainant's physical or mental health. This was also confirmed by telephone to the GP's secretary on the same day.

The Provider says that on **15 December 2017**, the Scheme Administrator contacted it on the Complainant's behalf to cancel the CPAD Assessment and it agreed to so do. The Administrator also explained that the Complainant had now received a copy of the Specialist's Report from her GP and had expressed some concerns in relation to this. The Provider advised that if the Complainant put her concerns in writing, it would be happy to seek a response from the Specialist and it also invited the Complainant to submit any medical reports from her GP and/or treating Specialist that she would like to be taken into account in the review of her claim. The Provider also emailed the Administrator to advise that it wished for the Complainant to undertake the CPAD Assessment on 20 and 22 February 2018 and says that given that this was the third time this assessment had been arranged, it advised that:

> *"If* [the Complainant] *is not available for the rearranged appointment in Feb 2018, without adequate reason, we would have to consider if we are in a position to continue benefit payments in this case".*

The Provider confirms that the Complainant's cancelling of the CPAD Assessment on two occasions was not held against her in that the claim remained in payment and that the cancellations did not influence or change the outcome of the claim review in any way.

The Provider says that on **16 January 2018**, it received a telephone call from the Scheme Administrator asking on the Complainant's behalf for a copy of the Specialist's Report from September 2016 to be made available to her GP and that its Medical Officer wrote to the GP enclosing a further copy of the Report, on the same day.

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The Provider notes that the Complainant underwent the CPAD Assessment on **20** and **22 February 2018** and that in his ensuing **CPAD Assessment Report**, the Assessor concluded that:

> *"*[The Complainant] *is not fit to resume her normal occupation on a full-time basis"*.

The Provider says that having completed its claim review, it was satisfied that the Complainant continued to meet the policy definition of disablement and it wrote to her on **29 March 2019** to confirm that claim payments would continue.

The Provider says it carried out a further claim review in **June 2020**, when it asked the Complainant to complete a **Certificate of Continued Disablement**, which she did on **29 June 2020**, and her income protection claim has remained in payment since that time.

The Provider notes that when completing this **Certificate of Continued Disablement**, the Complainant indicated that she was pursuing a legal action against a third party in relation to her medical complaint. This form asks that where such a claim has been settled, for the amount of the claim settlement involved. The Provider notes that the Complainant has questioned whether it is entitled to seek information in relation to awards that may be received in respect of third-party claims. In that regard, the Provider refers to Section 14, 'Benefit Limitations', of the **Income Protection Provisions, Conditions and Privileges Policy Document** which provides, among other things, that it may adjust its benefit to take into account any future loss of earnings settlement received.

The Provider also notes that when completing the Certificate of Continued Disablement, the Complainant made some alterations by way of redaction to both the 'Declaration' and the 'Authorisation to provide information' sections, such that she was clearly seeking to restrict the sources from which the Provider may potentially require information to review her claim in the future. In its **Formal Response** to the complaint investigation by this Office dated **12 November 2020**, the Provider said it could not accept these alterations as this would make it impossible for it to obtain information that it may require in order to review the Complainant's claim, going forward. However, in its letter to this Office of **9 July 2021**, the Provider advised that this particular matter had been resolved, in that it had since received a copy of an unaltered 'Declaration' and 'Authorisation to provide information' signed by the Complainant.

The Provider refers to Section 8, 'Provision of Evidence Tests and Information – Claims', of the **Income Protection Provisions, Conditions and Privileges Policy Document**, which provides that:

> *(i)* *The Grantees and the Insured Person shall furnish to the Company at the Grantees or the Insured Person's expense all such data, evidence, tests and information as the Company shall require upon or with regard to*
>
> *(a) the making of a claim by an Insured Person under this Policy or*

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(b) the continuing payment of a claim in respect of an Insured Person under this Policy.

The Provider says that this policy provision confirms that the Complainant is obliged to provide any information that it requires in order for her claim to be considered and managed. The Provider wishes to assure the Complainant that it only requests the relevant information that it requires as part of the claims process and that it is always aware of its obligations under GDPR in relation to the collection and processing of data.

In relation to the Complainant's comments (that questions posed during her tele-interview on 13 March 2015 in relation to her smoking and alcohol consumption, had no bearing on her situation) the Provider says that the habits and lifestyle of a claimant may be factors to be considered when assessing an income protection claim and therefore the nurse asks a number of questions in relation to tobacco and alcohol consumption during the interview.

The Provider says it believes it appropriate to make such enquiries during the claim assessment process in order to establish whether there are any issues to be addressed in this regard, when the claim is being managed. The Provider says that while it accepts that the Complainant's tobacco and alcohol consumption are not a factor in her claim, it reiterates that it is reasonable to ask all participants in the tele-interview process a small number of habit and lifestyle questions to establish all the facts as they can, in certain circumstances, be a contributory factor in a person's illness and/or continued absences from work.

In relation to the Complainant's comments that during the CPAD Assessment on 20 and 22 February 2018 the Assessor asked her an intrusive and personal question regarding her sex life that has no bearing on her ability to teach, the Provider agrees with the Complainant that the particular question she highlighted has no relevance to the teaching profession but says that all of the questions she answered aided the Assessor in understanding how her foot pain affected her ability to manage her everyday life.

The Provider says it raised this matter with the Assessor and he confirmed that no significance is put on this answer, apart from the score for this question being included along with all the other scores to classify the Complainant's disability. The Assessor also said that the CPAD Assessment Report does not allude to the answer to the question in any way and further advised that he informs all clients that they do not have to answer any questions that they are uncomfortable with and had the Complainant declined to answer the particular question, this would have been fine from his perspective. The Provider confirms that it would have had no issue with this also.

In addition, the Provider notes that during her telephone call with the Provider on **9 April 2018**, the Complainant raised a number of issues including the nurse's enquiries regarding her smoking and alcohol consumption and the CPAD Assessor's question regarding her sex life and following discussions as to the relevance of these questions, the Provider says the Complainant did not request that it take any further action in relation to this matter.

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The Provider notes the comments made by the Complainant in relation to her appointment with the Specialist in Occupational Health on 15 August 2017 and her resultant Report of 24 August 2017. The Provider says that when this Specialist first examined the Complainant as part of a claim review on 2 September 2016, she concluded that the Complainant *"currently meets the definition of disability"*; however when she next examined the Complainant as part of a later claim review on 15 August 2017, she concluded that the Complainant *"no longer meets the definition of disability"*.

The Provider says the Scheme Administrator telephoned it on the Complainant's behalf on **15 December 2017** to explain that the Complainant had some concerns about the content of the Specialist's Report. The Provider says it explained at the time that if the Complainant put her concerns in writing, it would be happy to seek a response from the Specialist. The Complainant subsequently wrote to the Provider's Medical Officer on **16 January 2018** to offer her comments and observations on the Specialist's Report. The Medical Officer wrote to the Complainant on **31 January 2018** to confirm that it had sent her letter to the Specialist to seek her response to the matters raised. The Provider says it also retained a copy of the Complainant's letter on file to hold as an official record of her responses to the Specialist's Report. The Provider notes that the Specialist subsequently replied by way of letter dated **14 February 2018** and this response was then issued to the Complainant on **7 March 2018**. In view of the above, the Provider is satisfied that it responded appropriately to the Complainant's letter of 16 January 2018.

The Provider says that the Specialist, in her role as an examiner, is entitled to provide an opinion on fitness or otherwise for work, and that all such opinions are provided in good faith, based on her expertise and the outcome of her detailed examination. The Provider notes that the Specialist had recommended in her Report of 24 August 2017 that:

> *"The insurer may consider chronic pain ability determination to provide further objective evidence of her work ability".*

The Provider says it arranged for the Complainant to undergo a CPAD Assessment. The Provider notes that it is the role of its claims assessors to decide whether the policy definition of disablement is met, based on the weight of the medical evidence received. The Provider says that following a full review of the available evidence at the time, which included the CPAD Assessment Report, it remained its view, notwithstanding the opinion expressed by the Specialist in her Report, that the Complainant continued to meet the policy definition of disablement and her claim remained in payment.

In response to the Complainant's assertion that the Specialist, when concluding the examination appointment on 15 August 2017, said to her:

> *"…and I quote verbatim, "Now* [Complainant name redacted]*, is there anything else you want to tell me because you are* [age redacted] *and* [the Provider] *will want to get you off* [its] *books",*

In that regard, the Provider notes that in her letter of **22 July 2021**, the Specialist stated:

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> *"I cannot recall the precise wording of consultations that occurred 3 and 4 years ago and this is not a phrase that I would use. It is my practice to ask the claimant at the end of every IME* [independent medical examination] *consultation: "is there anything else you wish to say to the insurance company about you claim". I ask the claimant "please list the reasons why you cannot go back to work". I document the claimant's answers to these questions and* [the Complainant's] *responses are documented in my handwritten notes. I believe asking such questions gives the claimant every opportunity to put forward the case for their claim and to give all the facts that they believe to be relevant. I do not accept that I was disrespectful to* [the Complainant] *at any stage".*

The Provider says that the comments the Complainant attributes to the Specialist do not represent its approach to paying income protection claims. The Provider confirms that its philosophy is to admit and pay all genuine claims, which is what occurred in the Complainant's case, in that her claim was admitted promptly from 2 May 2015 and has remained in payment since.

The Provider confirms that any medical examiner who carries out assessments on its behalf is paid a standard agreed fee for carrying out such assessments, regardless of the outcome of the assessment. As a result, the Provider says that no examiner has a vested interest in the outcome of their assessment, and they are therefore free to provide an objective and impartial opinion on fitness for work in all cases. In addition, the Provider reiterates that it is its claims assessors who make the claim decisions, based on the content of the medical reports and the available objective evidence.

The Provider notes the comments the Complainant made in relation to some of the telephone recordings of conversations involving its staff members. The Provider says it is very sorry if the Complainant found the contents of these conversations to be upsetting, as that is never its intention. The Provider confirms that at no stage during the telephone conversation between Mr M. and the Scheme Administrator on **22 November 2017** did Mr M. state that the Complainant was *"unreasonable"*, nor was this word used to describe her.

In relation to Mr M. referring to the Complainant's medical team as *"advocates"* during his call with the Complainant on **9 April 2019**, the Provider confirms that this is not the view it takes when making decisions on income protection claims, in that the contents of all medical reports are given equal standing and careful consideration is given to every report, based on the objective evidence contained therein, regardless of origin, and the issue of advocacy, therefore, does not apply. In that regard, the Provider notes, for example, that it admitted the Complainant's claim based on the medical evidence provided by her own GP and that her claim was reviewed thereafter for a period of 16 months, on the basis of reports provided by the Complainant's own treating doctors.

In relation to the Complainant's comments that her making an income protection claim should also have automatically triggered a specified illness claim, the Provider says its Income Protection Claims Team have no role in assessing or paying specified illness claims.

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As a result, it says that its procedures do not cater for a situation where the staff would be expected to initiate a specified illness claim on behalf of a claimant who has submitted an income protection claim. The Provider notes that the usual process for the submission of an income protection claim or a specified illness claim is that the claimant would submit a claim to it through the Scheme Administrator, who acts as the claimant's agent in relation to the submission of any claims. The Provider says that in light of the comments made by the Complainant, it is looking into the possibility of changing its process for future claimants. The Provider notes that sometime after making her income protection claim, the Complainant did initiate a specified illness claim and that this was admitted by the Provider in **May 2016**.

The Provider notes the comments the Complainant made, in relation to letters issued by the Scheme Administrator to her on **4 March 2015** and **20 May 2015**. The Provider says it is not responsible for these letters, however, it does say that as part of its standard claims' requirements it asks the Scheme Administrator to provide details of any Ill-Health Early Retirement Pension or Temporary Rehabilitation Remuneration entitlements that the claimant may have and for that reason, the Provider considers the Administrator was correct to have made the enquiry.

The Provider acknowledges that no decisions had been made at that stage in relation to Ill-Health Early Retirement Pension, however, it says that neither the Provider nor the Scheme Administrator would have been aware of this at the time and given that the Complainant had been absent since **11 June 2014**, it was appropriate for it to seek clarification of this matter in order to avoid any delays in the assessment of the claim and to ensure that the correct benefits were paid.

In addition, in its letter to this Office dated **9 July 2021**, the Provider says it wishes to emphasise that the Complainant's relationship with the Scheme Administrator is an entirely separate matter from her relationship with the Provider. In that regard, the Provider says that the Administrator acts as an agent of the Complainant when assisting her in her claim applications to the Provider. The Provider says it is therefore not responsible for any actions undertaken by the Scheme Administrator and that any issues the Complainant may have in relation to the Administrator that she has raised as part of this complaint, are not for the Provider to address.

In response to the Complainant's comments that the Provider *"relentlessly bullied, harassed, threatened, hounded, humiliated, undermined, coerced and stressed me and treated me as a fraudster"*, the Provider says it cannot agree with these statements. The Provider is satisfied that its actions in admitting the income protection claim very promptly in **May 2015** and continuing the payments since, demonstrates its claims' philosophy to pay those income protection claims where the policy definition of disablement is met.

The Provider notes that when the income protection claim was admitted, it is required to review the claim on an ongoing basis in order to confirm whether or not the policy definition of disablement continues to be met and it is satisfied that these reviews were carried out at all times in accordance with the policy.

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The Provider notes that under Section 8, 'Provision of Evidence Tests and Information – Claims', of the **Income Protection Provisions, Conditions and Privileges Policy Document**, the claimant has certain obligations to comply with to assist the Provider in assessing and reviewing their claim. For example, they are required to make available whatever evidence is required of them and they also are obliged to attend for medical assessments when asked to do so. The Provider says it is satisfied that it applied this clause fairly and proportionately at all times during its assessment and reviews of the Complainant's claim.

The Provider says that the Complainant's claim was admitted in May 2015 following a tele-interview and a GP Report. The claim was reviewed thereafter for a period of 16 months on the basis of reports provided by the Complainant's own treating doctors and this did not require any involvement from the Complainant herself. The Provider says it was reasonable for it to send the Complainant for a medical examination in September 2016 to obtain an objective view on her condition at the time. Following that review, the Provider reviewed the claim on the basis of reports from the Complainant's own treating doctors before arranging a further assessment with the Specialist 11 months after her previous assessment. Given the Specialist's recommendation that a CPAD Assessment be arranged, the Provider says it was reasonable for it to do so. The Provider notes that when the CPAD Assessment Report confirmed that the Complainant was not in a position to return to work, it was happy to continue payments under the claim thereafter.

The Provider says that in view of the foregoing, it is satisfied that its assessment and reviews of the Complainant's claim has been fair, proportionate and reasonable and it cannot agree with the comments made by the Complainant in this regard. Furthermore, the Provider says that any time it is assessing and reviewing a claim, it is making a decision on a contract of insurance and is not making any judgment on the character of the claimant, such that when it is seeking evidence to support the ongoing payment of a claim, it is not in any way questioning the honesty or integrity of the claimant.

In response to the Complainant's comments that *"I had to acquiesce to all* [of the Provider's] *demands whether reasonable or unreasonable or risk non-payment of my benefit.* [The Provider] *hounded me from the start of my benefit being paid and were determined to get me off payroll asking for non-relevant information"*, the Provider says it cannot agree with these comments. The Provider says it never made any demands of the Complainant nor did it suggest that there was any risk that the payments under the claim would be ceasing at any stage. In order for any claim to be assessed and be reviewed there are certain requirements to be satisfied and the Provider says its assessment and reviews of the claim have been reasonable and fair. The Provider says that had the Complainant raised any concerns regarding any of the requirements, it would have been happy to engage with her and discuss this further with her at the time.

The Provider says that the only contemporaneous concerns expressed by the Complainant in relation to any of its requirements was when she asked it to cancel the CPAD Assessment appointments for November 2017 and January 2018, and the Provider did so without question. The Provider also notes that the Complainant raised issues with it in her letter of **16 January 2018** and by telephone on **9 April 2018**.

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The Provider says that on both occasions, it was happy to engage with the Complainant, explain its position fully and respond to the issues raised. The Provider notes that when these concerns were expressed, there was no suggestion at any stage that such issues would in any way prejudice the Complainant's right to receive payments under the claim.

In relation to the Complainant's comments that it did not treat her as a vulnerable consumer throughout her dealings with it, the Provider says it identifies all of its income protection claimants as a vulnerable consumer and where required, it will make suitable arrangements and offer any assistance that may be necessary to facilitate them. In the Complainant's case, the Provider says it has communicated clearly with her at all times, set out the reasons for its actions and that it explained her right to refer any matters to the Financial Services and Pensions Ombudsman, if she were unhappy with the Provider's position. The Provider does not accept that its actions in dealing with the Complainant in any way fell short of its obligations for treating her as a vulnerable customer.

The Provider reiterates that the Complainant's claim was admitted very promptly and has remained in payment since. While it has been necessary from time to time to carry out periodic reviews on her claim to ensure that the policy definition of disablement continues to be met, the Provider does not believe that these reviews have been excessive or disproportionate. When the Complainant raised issues in relation to the assessment of her claim, the Provider says it was happy to discuss these with her and explain them further, and when she expressed concerns regarding the Specialist's Report, it was happy to take her comments into account and seek a response from the Specialist to the matters raised.

The Provider says it entered into a contract of insurance with the Complainant in November 1986. This contract provides, among other benefits, for the payment of an income protection benefit when the policy definition of disablement is met. The Provider says that when this contingency arose in May 2015, it abided by the terms of the contract and admitted the Complainant's claim from 2 May 2015 and that the claim has remained in payment since then.

The Provider is satisfied that at all times it complied with the terms and conditions of the Group Salary Protection Scheme and that it assessed and reviewed the claim in a professional manner and always in accordance with its obligations under the Central Bank of Ireland's ***Consumer Protection Code 2012 (as amended)***. The Provider says it cannot accept the Complainant's assertions that it acted unreasonably or inappropriately in its management of her claim, and it sees no grounds for an apology or compensation in this case.

The Provider says that the Complainant is insured under a contract of insurance and that once she made a claim, it was required to gather information in order to establish if it had a liability and once this was established, it is required to review the claim by way of gathering relevant information on an ongoing basis thereafter, to ensure that its liability continues. The Provider says this requires the cooperation of the Complainant and in that regard, it notes that the **Policy Document** places responsibilities on the Complainant. The Provider reiterates that any requests it has made of the Complainant in this regard have been reasonable and proportionate at all times.

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The Provider says that it does not, given the nature of her medical condition, anticipate carrying out any further medical reviews on the Complainant's income protection claim prior to the benefit expiry date of **31 August 2023**, though it confirms that it does reserve the right to request further information that has a direct bearing on her benefit, such as information in relation to her ongoing personal injuries claim.

The Complaint for Adjudication

The complaint is that the Provider maladministered the Complainant's income protection claim under the Group Salary Protection Scheme in that:

1. the Provider wrongfully failed to inform the Complainant when she made her income protection claim of her entitlement to also make a specified illness claim and in so doing, it failed to recognise her as a vulnerable consumer;

2. the Provider, by way of its Agents, asked the Complainant personal and intrusive questions during the assessment of her income protection claim, which she contends were unnecessary and immaterial;

3. the Provider failed to furnish the Complainant's GP with a copy of the Specialist's Report in a timely manner;

4. a Claims Assessor failed to refer to the Complainant in a professional manner during his telephone call with the Scheme Administrator on 22 November 2017;

5. the same Claims Assessor referred to the Complainant's treating physicians as her *"advocates"* during a telephone call she had with him on 9 April 2018; and

6. the Provider *"relentlessly bullied, harassed, threatened, hounded, humiliated, undermined, coerced and stressed* [the Complainant] *and treated* [her] *as a fraudster"* during its claim reviews, in an effort to cease payment of her claim.

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.

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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 **17 August 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.

I note that the Complainant, having been medically certified as unfit for work since **11 June 2014**, completed an Income Protection Claim Notification Form to the Provider on 25 February 2015. Followings its assessment, the Provider admitted the Complainant's income protection claim from **2 May 2015** and following a number of periodic claim reviews, the claim has always remained in payment since.

There are six elements of complaint for adjudication which I have addressed separately below.

Element 1:
The Provider wrongfully failed to inform the Complainant when she made her income protection claim of her entitlement to also make a specified illness claim and in so doing, it failed to recognise her as a vulnerable consumer

The Complainant submits that when she made her income protection claim in February 2015, the Provider ought to have recognised her as a vulnerable consumer and also it should have initiated and assessed a specified illness claim for her, at the same time.

Chapter 3, 'General Requirements', of the Central Bank of Ireland ***Consumer Protection Code 2012 (as amended)*** states that:

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

I note that the **Group Salary Protection Scheme** which the Complainant is a member of provides life, income protection and specified illness cover. The **Specified Illness Cover Provisions, Conditions and Privileges** section of the applicable **Policy Document** provides that:

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> *"Specified Illness means the Insured Person has undergone the surgery referred to below or has been diagnosed and certified (to the satisfaction of the Chief Medical Officer) by a registered medical practitioner acceptable to the Chief Medical Officer as having one of the medical conditions listed below and the surgery or medical condition occurred or was contracted and declared itself after the date the person became an Insured Person and the surgery was performed or the diagnosis made before the person ceased to be an Insured Person".*

The Policy Document clearly sets out the different medical conditions that qualify for a specified illness benefit. I take the view that it was open to the Complainant at any point, to refer to this Policy Document to establish whether her diagnosis satisfied any of the definitions listed.

The criteria for specified illness benefit are different from those of income protection benefit, in that in order to qualify for a specified illness benefit, the claimant must have been diagnosed with one of the specific medical conditions as so defined in the Policy Document, while income protection benefit is more generalised, such that it is payable when the claimant is unable to carry out the duties of their normal occupation by reason of disablement arising from bodily injury sustained or sickliness or illness contracted.

Given the different qualifying criteria for these two types of benefit, I accept the Provider's position that its Income Protection Claims Team have no role in assessing or paying specified illness claims and that its procedures do not cater for a situation where the staff would be expected to initiate a specified illness claim on behalf of a claimant who has submitted an income protection claim.

That said, I note that when responding to this Office, the Provider advised that in light of the comments made by the Complainant, it was currently looking into the possibility of changing this process, for future claimants.

I take the view that the Policy Document clearly sets out the criteria for specified illness benefit, as it also does for income protection, and that it was open to the Complainant to consider these criteria and to make a specified illness claim to the Provider if she considered that she qualified for that benefit, as she did when she made her income protection claim.

I note that the Complainant did submit a specified illness claim to the Provider in **April 2016** and that it admitted this claim on 31 May 2016.

I do not consider the Provider's failure to initiate a specified illness claim on behalf of the Complainant when she submitted an income protection claim to it, as a failure on its part to recognise or treat the Complainant as a vulnerable consumer, as defined by the *Consumer Protection Code 2012 (as amended)*. Neither do I believe that there was an obligation on the Provider to raise this topic, but I welcome the information given by the Provider, when responding to this Office, that it was reviewing its procedures to take account of suitable measures that might be useful, in the context of the Complainant's comment.

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I am of the opinion however that the evidence does not support the complaint that the Provider wrongfully failed to inform the Complainant when she made her income protection claim, of her entitlement to also make a specified illness claim or that in so doing, it failed to recognise her as a vulnerable consumer.

Element 2:
The Provider, by way of its Agents, asked the Complainant personal and intrusive questions during the assessment of her income protection claim, which she contends were unnecessary and immaterial

As part of her initial claim assessment, the Complainant underwent a tele-interview on 13 March 2015, during which the nurse asked a number of questions in relation to smoking and alcohol consumption and in that regard, the Complainant submits that:

> *"Smoking and drinking alcohol have no bearing on my situation - severe sepsis and dropped foot and post-operative hernia – but I was questioned about both non-existent habits unnecessarily in my opinion"*.

I note that when the Provider telephoned the Complainant to arrange the tele-interview, it advised the Complainant that this was a *"health and lifestyle interview"*. I am of the opinion that it is understandable that such an interview would include questions relating to tobacco and alcohol consumption and that it was reasonable for the Provider to ask such questions.

As part of a later claim review, the Complainant underwent a CPAD Assessment on 20 and 22 February 2018. The Complainant says that during this assessment, the Assessor put to her what she refers to in her telephone call with the Provider on 9 April 2018 as a *"gratuitously insulting"* question concerning her sex life and in that regard, in her letter to this Office dated 9 January 2019, the Complainant submits that:

> *"One's sex life is not relevant in my case as I do not work in the sex industry. Whether or not I engage in sex or have pain if I do, in no way affects my ability or inability to teach. It is a very intrusive question ranking with asking about one's sexual orientation and religious or political beliefs and is an invasion of one's personal, if not human rights"*.

I agree. I note indeed that the Provider has also confirmed that it agrees with the Complainant that the particular question she highlighted has no relevance to her teaching profession. The Provider advised that all of the questions she answered during the CPAD Assessment aided the Assessor in understanding how her foot pain affected her ability to manage her everyday life. In my opinion however, there is no link whatsoever between the Complainant's sex life and the policy criteria to be met for benefits to be paid. In those circumstances, I accept that the Complainant is likely to have been disturbed and upset by such a question and it seems likely to me that this will have inconvenienced her and placed her very much ill at ease for the rest of the assessment.

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In my opinion, whilst the Provider will be guided by the medical professionals which it instructs, I take the view that it has an obligation to ensure that in any assessment which it arranges for the purpose of informing itself in its assessment of a claim, that any queries put to a claimant are relevant to the policy provisions to be considered. In those circumstances, I take the view that the question put to the Complainant during the assessment on behalf of the Provider was unreasonable, within the meaning of ***Section 60(2)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017*** and I consider it appropriate to uphold this element of the complaint.

I note that the Assessor has advised all clients are informed that they do not have to answer any questions that they are uncomfortable with. This raises the question as to how relevant such questions are to the assessment process. If such questions are not relevant, I take the view that they should not be put to a claimant, and that claimants should be required to participate in a process only when it is relevant to the policy criteria to be met.

Element 3:
The Provider failed to furnish the Complainant's GP with a copy of the Specialist's Report in a timely manner

I note that the Provider arranged for the Complainant to attend for an examination with a Specialist in Occupational Health on 15 August 2017.

The Complainant then arranged for a CPAD Assessment for the Complainant for 27 and 29 November 2017 but the Complainant did not wish to attend this until she first had sight of the Specialist's Report.

As a result, the Scheme Administrator emailed the Provider on **1 November 2017**, as follows:

> "[The Complainant] *has asked for a copy of the IME report from 15/08/17 to be sent to her GP, can you confirm when same has been sent".*

The Scheme Administrator telephoned the Provider on 15 November 2017 to follow-up on this request and I note that it was then, on that day, that the Provider posted the Report to the GP on that day.

As the GP was by that time on holidays and not returning until 27 November 2017, the Complainant was unable to have sight of the Specialist's Report in advance of the CPAD Assessment and cancelled this appointment.

The Complainant submits that if the Provider had posted the Report to her GP on 1 November 2017 when it was first asked to do so, she would not have had to cancel the CPAD Assessment.

It is disappointing that the Scheme Administrator had to telephone the Provider on 15 November 2017, 11 working days after its initial request of 1 November 2017, before the Provider posted the Report to the Complainant's GP.

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I accept that this delay contributed to the Complainant not having sufficient time to view the Specialist's Report in advance of the scheduled CPAD Assessment and this resulted in her cancelling this appointment.

I note, however, that the Provider was not made aware when the request was first made by email on 1 November 2017, that the Complainant would not attend for the CPAD Assessment until she had sight of the Specialist's Report.

I also note that the cancellation of this CPAD Assessment had no bearing whatsoever on the outcome of the claim review and that the Complainant's claim remained in payment throughout the review. I note that the Provider has advised that 15 November 2017 was the first time it sent the Report to the Complainant's GP and says that there is nothing in its records to indicate that it had done so earlier. The Provider has advised that if one of its staff had previously mis-stated the position in any way to the Administrator, then it apologises to the Complainant for this.

Having regard to the above, I am of the opinion that any error by the Provider was minor, and that it would be unreasonable to uphold this element of the complaint.

Element 4:
A Claims Assessor failed to refer to the Complainant in a professional manner during his telephone call with the Scheme Administrator on 22 November 2017

The Complainant makes particular reference to Provider Claims Assessor Mr M. and says that he failed to refer to her in a professional manner during his telephone call with the Scheme Administrator at **11:46** on **22 November 2017**, in that:

> "[Mr M.] *described me as "unreasonable", referred to me as "the woman", "will have to take a hit", "will have to pay a non-attendance fee", "now she is bringing this into the mix" …*
>
> *I find it hurtful and demeaning that they (*[Provider employees]*) speak about vulnerable consumers in such a way".*

Having listened to the recording of this call, I am of the opinion that the Complainant has taken the terms she attributes to Mr M. somewhat out of context and in isolation. For example, I note that Mr M. said:

> *"…she confirmed that she would attend and on that basis we passed that on to the* [CPAD Assessor] *and they arranged flights and, and, accommodation, the whole lot, but also, as well, at no point did she say that review of the IME report was necessary in order for her to be available or, you know, as kind of a, kind of a requirement for her to attend the CPAD and you know, <u>it's kind of now throwing this into the works</u> …*

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> *… the fact that she, she actually did come back initially and wanted to know what* [the CPAD Assessor's] *qualifications were and we gave her those and we gave her a list of what the CPAD was all about, a description of what the CPAD was all about and we got emails saying she was fine, she had reservations but was happy enough to attend for CPAD and now, like you know, two or three days whatever before its due to happen she's now putting in this other criteria which to be frank is unreasonable given that, you know, everything is in place"*
>
> [Underlining added for emphasis]

I note that subsequently, the Scheme Administrator telephoned the Provider at **14:30** on **15 December 2017** to advise that the Complainant was seeking to cancel her CPAD Assessment scheduled for 2 and 4 January 2018. Having listened to the recording of this call, I take the view that when Mr M. said *"we've already taken a hit on this one on a cancellation fee because it's very late"*, he is simply advising the Administrator that the short notice given of the cancellation of the previous CPAD Assessment scheduled had resulted in the Provider having to pay a cancellation fee.

In addition, I note that when, during this call, Mr M. refers to the Complainant as *"the woman"*, he does so in the context of suggesting that the Provider may have *"to pass* [the cancellation fee] *on to the woman"* and in that regard, I am of the view that he uses the term *"the woman"* inoffensively when referring to the Complainant, as a substitute for using her name, and I do not accept that his use of this term, in that context and in the tone it was said, to have been derogatory towards the Complainant.

Similarly, having listened to the recording of the follow-up call the Provider made to the Scheme Administrator at **14:45** on **15 December 2017**, I note that in much the same way Mr M. uses the term *"the lady"* when referring to the Complainant.

Having regard to the above, I am of the opinion that the evidence does not support the complaint that the Provider failed to refer to the Complainant in a professional manner during his telephone call with the Scheme Administrator on 22 November 2017.

Element 5:
The Provider's Claims Assessor referred to the Complainant's treating physicians as her *"advocates"* during a telephone call she had with him on 9 April 2018

The Complainant say that during her telephone call with Mr M. on 9 April 2018 that:

> "[He] *also described my medical team as "advocates""*.

Having listened to the recording of this call, I note the following exchange:

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Mr M.: *…well we fully acknowledge that and we recognise that a person's GP and their specialist is not only their treating doctor but in the vast majority of cases would be their advocate and would argue strongly on their behalf and that's to be expected -*

Complainant: *You saying they're not impartial?*

Mr M.: *No. No. What I'm saying is - we'd expect them to do that … I'm not saying that they wouldn't, what they, what they put in their reports is not in any way factual or you know clearly represents their view, but they would act as advocate of their patient and we would expect that. We view the independent medical examination as being that, because* [the Specialist] *has absolutely no relationship with you, you know, so she, and other, and other occupational physicians and other doctors we ask people to go, they have absolutely no relationship with a person so they call it as they see it, based on the medical opinion.*

While Mr M. did refer to the Complainant's treating physicians as her *"advocates"*, I note that the Provider had advised that this is not the view it takes when making decisions on income protection claims. It has advised in that regard that the contents of all medical reports are given equal standing and careful consideration is given to every report, based on the objective evidence contained therein, regardless of origin, and therefore, the issue of advocacy does not apply.

Having considered the evidence before me, I note that the Provider admitted the Complainant's claim based on the medical evidence provided by her own GP and that her claim was reviewed thereafter for a period of 16 months on the basis of reports provided by the Complainant's own treating doctors. I am satisfied that this clearly demonstrates that the Provider does consider and rely upon medical evidence from a claimant's own treating physicians to support their income protection claims, in addition to any other medical evidence which may also become available.

In addition, I note that the Provider admitted the Complainant's income protection claim in May 2015 and that the claim has remained in payment since. As a result, while it was ill judged of Mr M. to refer to the Complainant's treating physicians as her *"advocates"*, I take the view that his comments in no way interrupted the payment of the Complainant's claim.

In taking that view, I am cognisant that the telephone call the Complainant had with Mr M. on **9 April 2018** was some 55 minutes in duration, during which Mr M. addressed a wide array of queries from the Complainant, and it is my view that he was professional, helpful and courteous throughout and that he made great efforts to fully answer all of the questions the Complainant had.

Having regard to the above, I am of the opinion that it would be unreasonable to uphold this element of the complaint.

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Element 6:
The Provider *“relentlessly bullied, harassed, threatened, hounded, humiliated, undermined, coerced and stressed* [the Complainant] *and treated* [her] *as a fraudster”* during its claim reviews, in an effort to cease payment of her claim

The Complainant completed an Income Protection Claim Notification Form to the Provider on 25 February 2015. I note that in order for income protection benefit to be payable, the Complainant must satisfy the following **Group Income Protection Scheme** definition of disablement:

> ***1.*** ***Disablement -*** *For the purpose of this Policy*
>
> *(i) total disablement shall be deemed to exist where (a) the Insured Person is unable to carry out the duties pertaining to his normal occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted and (b) the Insured Person is not engaging on a full-time or part-time basis in any other occupation (whether or not for profit or reward or remuneration, including benefit in kind)*.

In addition, Section 8, ‘Provision of Evidence Tests and Information – Claims’, of the **Income Protection Provisions, Conditions and Privileges Policy Document**, provides that:

> *(i) The Grantees and the Insured Person shall furnish to the Company at the Grantees or the Insured Person’s expense all such data, evidence, tests and information as the Company shall require upon or with regard to*
>
> *(a) the making of a claim by an Insured Person under this Policy or*
>
> *(b) the continuing payment of a claim in respect of an Insured Person under this Policy.*

I note that the Provider’s initial assessment of the Complainant’s income protection claim entailed the Complainant partaking in a tele-interview with a specialist nurse in March 2015 and the Provider obtaining a report from the Complainant’s GP in April 2015.

Following this, the Provider confirmed to the Scheme Administrator by letter of 15 May 2015 that it was admitting the Complainant’s income protection claim from 2 May 2015.

I am satisfied that the Provider is entitled to review an income protection claim on a regular basis, in order to ensure that the claimant continues to satisfy the policy definition of disablement.

In this case, the Complainant’s claim was regularly reviewed for a period of 16 months, on the basis of reports provided by the Complainant’s own treating doctors and that this process did not require any involvement from the Complainant herself.

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I accept that once the claim had been in payment for a period of 16 months, that it was reasonable for the Provider to refer the Complainant for examination to a Specialist in Occupational Health in **September 2016**, in order for it to obtain an objective view on her condition at the time. This Specialist concluded that the Complainant satisfied the policy definition of disablement at the time. The Complainant's claim was then reviewed over a further period of 11 months on the basis of reports provided by the Complainant's own treating doctors.

As the Specialist in Occupational Health had recommended in her Report of 9 September 2016 that the Complainant *"currently meets the definition of disability…I expect her to meet the definition for the next 6-12 months"*, I accept that it was therefore reasonable for the Provider to refer the Complainant to this Specialist for a further examination in **August 2017**.

Similarly, as this Specialist recommended in her Report of 24 August 2017 that the Provider *"may consider chronic pain ability determination to provide further objective evidence of her work ability"*, I accept that it was therefore reasonable for the Provider to arrange for the Complainant to undergo a CPAD Assessment, which she did in **February 2018**.

The appointment for the CPAD Assessment was rescheduled on two occasions though in that regard, I note that the Provider generally interacted with the Scheme Administrator.

I note that the Complainant's income protection claim has, following periodic reviews as provided for by the policy, remained in regular payment since 2 May 2015.

In light of this timeline and having examined the evidence made available by the parties, I am of the opinion that the evidence does not support the complaint that the Provider *"relentlessly bullied, harassed, threatened, hounded, humiliated, undermined, coerced and stressed* [the Complainant] *and treated* [her] *as a fraudster"* during its claim reviews, in an effort to cease payment of her claim. I take the view that the steps taken by the Provider to assess and review the Complainant's claim were appropriate to its process of claim assessment and periodic review.

Furthermore, I note that the Complainant, as part of her complaint to this Office, made certain complaints regarding the Specialist in Occupational Health that the Provider referred her to for examination on 15 August 2017 and the contents of this Specialist's Report dated 27 August 2017.

This Office is not the appropriate body to investigate complaints regarding the conduct of medical professionals and in that regard, I note that the Complainant, as was more appropriate, made a complaint directly to the Irish Medical Council citing the poor professional performance and professional misconduct of the Specialist in question.

In addition, it is not the role of this Office to adjudicate in conflicts of medical evidence. Rather, it is the role of this Office to examine the totality of the medical evidence which was before the Provider at the time when it made its decision on the claim, and to determine whether that decision by the Provider was a reasonable one, bases on that medical information.

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As the Provider admitted the Complainant's income protection claim from 2 May 2015 and as this claim, following periodic reviews as provided for by the policy, has remained in payment ever since, I am satisfied that the decisions that the Provider made on the Complainant's claim were to her benefit, as it did not refuse to admit the claim and the benefit payable, has remained in payment.

Having regard to all of the above, I take the view that it is appropriate to partially uphold this complaint and to mark my decision regarding the second element of the complaint, I consider it appropriate to direct the Provider to make a compensatory payment to the Complainant, as specified below.

Conclusion

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

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to (make a compensatory payment to the Complainant in the sum of **€2,500** (two thousand five hundred Euro) to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the Provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

- The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

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

MARYROSE MCGOVERN
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN (ACTING)

8 September 2022

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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

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