An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0324
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Claim handling delays or issues Delayed or inadequate communication Lapse/cancellation of policy Rejection of claim - fibromyalgia Rejection of claim
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainants incepted a **Specified Illness Insurance Policy** with the Provider on **15 July 2016**, which provided each of them with stand-alone specified illness benefit in the amount of **€100,000.00 (one hundred thousand Euro)** for a term of 20 years. The Complainants initially applied for this policy through a Provider Insurance and Investments Manager on **31 March 2016**. The Complainants, as part of the same application process, also applied for a **Life Assurance Policy** with the Provider on the same date, which was incepted on **6 July 2016**.

This complaint concerns the Provider's decision to decline the Complainants' specified illness claim made in **June 2019 (**and to void the Specified Illness Policy due to the non-disclosure of material facts) as well as its associated decision to reduce the cover provided by the Life Assurance Policy due to the same suggested non-disclosures.

The Complainants' Case

The Complainants submitted a **Specified Illness Claim Form** to the Provider on **6 August 2019** in respect of the cardiothoracic open-heart surgery that the Second Complainant underwent in **July 2019** to repair a partial anomalous pulmonary venous drainage. The Second Complainant advises that symptoms of this condition, which her Cardiac Surgeon described to her as *"an extremely rare congenital cardiac defect"*, first commenced during **2018** with the diagnosis made in **June 2019**. The Complainants say that following this diagnosis, *"corrective surgery was held within weeks in July* [2019]*"*.

The Second Complainant wrote to the Provider on **9 October 2019** to query its delay in processing the claim, as follows:

> *"You have had a full concise reports from my Cardiac Consultant and also my GP. Having had major open heart surgery - clearly covered in your terms and condition of our policy - can you explain the reason for the length of the enquiry and repeated requests for information. We were originally told on return of medical reports it would take 5-10 days to process.*
>
> *I have been with the same GP for 8 years which is more than the duration of our policy with you, and I would like to know why you have now requested further information from my GP, having already had a full report.*
>
> *Having spent 2 days in Intensive care, 3 days in High Dependency Unit and a total of 11 days post op in hospital, I am now 10 weeks into a very slow 12 week recovery, and will require a cardiac recovery program for a further 8 weeks.*
>
> *The delay in processing this claim which is in very clear compliance with the terms of our policy is very disappointing and causing distress in my recovery period. We have been a long-term customer of* [the Provider] *… and this customer service level we feel is not appropriate in particular considering the serious and unequivocal nature of my condition and surgery"*.

The Provider replied to the Complainants by letter dated **15 October 2019** advising that it had written to the Second Complainant's GP on 7 October 2019, seeking further information regarding certain medical conditions and investigations (recorded in the medical file her GP had previously sent to it on **28 August 2019**) which pre-dated the commencement of the policy, and which had not been disclosed when applying for cover.

Following its claims assessment, the Provider wrote to the Complainants on **14 January 2020** to advise that it was declining the claim and voiding the Specified Illness Policy because the Second Complainant had failed to disclose material facts relating to her medical history when applying for the cover.

It said that if it had been made aware of these details at the time, it would not have been in a position to offer her any specified illness cover. The Provider then wrote to the Complainants on **28 January 2020** to advise that it had refunded to them the sum of €6,400.98 (six thousand four hundred Euro and ninety-eight Cent), this representing a refund of all premiums paid into the policy, since its inception in 2016.

The Provider also advised in its letter of **28 January 2020** that if it had been made aware of the Second Complainant's full medical history at the time the Complainants had applied for their **Life Assurance Policy**, which was at the same time they had applied for their Specified Illness Policy, it would then have been necessary for the Provider to have applied a loading to that policy.

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The Provider advised the Complainants that while it was entitled to cancel the Life Assurance Policy due to the failure to disclose material facts relating to the Second Complainant's medical history when applying for the cover, it was prepared to allow that policy to remain in place with the life cover reduced however from €281,908.00 to €153,733.00 (one hundred and fifty-three thousand seven hundred and thirty-three Euro) as of 6 July 2019.

The Complainants say the Second Complainant's condition, a partial anomalous pulmonary venous drainage, *"falls absolutely clearly under the conditions listed"* in Appendix A, 'Specified Illnesses', of the **Policy Conditions Booklet**, namely:

> *"**22. Heart Structural Repair***
> *The undergoing of heart surgery requiring thoracotomy on the advice of a Consultant Cardiologist to correct any structural abnormality of the heart".*

The Complainants say that a person can only be born with a structural fault of the heart, in that one does not develop this condition at a later period in life, and while the Second Complainant's congenital heart condition existed prior to them taking out the cover with the Provider, it was nonetheless unknown to her and was only newly diagnosed in **June 2019**, some three years after they first applied for the Specified Illness Policy.

The Complainants say that when they applied for cover through Mr A., a Provider Insurance and Investments Manager, on **31 March 2016**, he informed them that the medical questions he was asking as part of the application process, referred to the previous five years and in that regard, they submit that *"this would make only medical issues from 2011 onwards relevant"* to the Provider and that *"for anything existing beyond 5 years then I understood it not applicable".* The Complainants say they omitted some matters relating to the Second Complainant's medical history as they were *"at all times under the view most of them were previous to the scope of the questions, i.e. greater than 5 years old"*.

The Complainants also describe the manner in which Mr A. presented the medical questions to them as *"a verbal rapid fire set of questions…where the focus seemed to be on closing the sale".*

In addition, the Complainants say that none of the nondisclosures raised by the Provider in justification of its claim declinature, have any bearing on the Second Complainant's diagnosis in that *"we can clearly see anything omitted has no causative symptom or led to a diagnosis of the condition that is the subject of this claim"*.

The Complainants say that the Second Complainant's condition is unrelated to any other medical investigations she had in the past including her previous attendances with a Consultant Cardiologist in 2007, 2008 and 2009. The Complainants also say that these attendances are *"not relevant"* as they were more than five years before they applied for cover with the Provider in March 2016, and that in any event, *"none of* [the Second Complainant's] *symptoms at this time relate to a cardiac diagnosis, and certainly not to the congenital condition that is the subject of this claim"*.

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In addition, as the medical matters the Provider refers to as nondisclosures of material facts only relate to the Second Complainant, the Complainants question why the Provider cancelled their Specified Illness Policy in its entirety, as this resulted in the First Complainant also losing his specified illness cover, which they consider to be *"extremely unfair"*
The Complainants set out their complaint in the **Complaint Form** they completed, as follows:

> *"*[The Provider] *has not settled claim for serious illness condition that is clearly covered by the policy.*
>
> *There has been an extremely lengthy investigation period.*
>
> *We felt that the 'Seller'* [Mr A.] *sped through the verbal questionnaire. Our understanding was every question related to the 5 year window. (Questions specified "within 5 years").*
>
> *We felt the data we did provide* [regarding the Second Complainant's] *medical* [questions] *was clear enough for* [the Provider] *to have requested further info at the start of the policy.*
>
> [The First Complainant] *has had his* [specified illness] *policy cancelled with* <u>*no*</u> *communication.*
>
> *Clearly* [the Provider] *do not cover* <u>*undiagnosed*</u> *rare congenital heart defect diagnosis yet it listed in* [its] *list of illnesses".*

In her email to this Office of **13 December 2020**, the Second Complainant submits, among other things, that:

> *"Since 2016…*[the Second Complainant] *understood that both herself and* [the First Complainant] *were paying for and were fully insured against Serious Health Illnesses as policy stated and took this as being trustworthy and for peace of mind should anything happen to either of* [the Complainants] *during the course of their Mortgage payments.*
>
> *In the now event that something did happen to* [the Second Complainant] *she finds that* [the Provider] *have reneged on* [its] *Serious Illness cover and have done everything possible to avoid paying what she was clearly entitled to …*
>
> [The Second Complainant] *feels the general GP visits made over time should not be formed as a case against her as many are everyday life issues or relative to what she answered on her medical questionnaire …*
>
> [The Second Complainant] *feels the fact that she is now middle aged and female that* [the Provider] *is using the various other GP visits over a period of time against her".*

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In her email to this Office of **28 March 2021**, the Second Complainant also submits, among other things, that:

> *"It is worth noting that despite the many health matters I did have historically down through the years, and the resulting long term effects that I seem to have ended up with, I have never claimed for any illness from any previous policy to date and I also continued to work throughout everything during all of this time. It has only been in the matter of this sudden Cardiac diagnosis and surgery and the implications and seriousness of it that I find myself in the situation of having to claim for…Specified Illness. This is my right as a Policyholder. The rules should not change by the Provider just to suit them".*

The Complainants submit in the **Complaint Form** that in order to resolve this complaint, they seek:

> *"A settlement in full of the €100,000 serious illness cover that we each are clearly covered for (per* [the Provider's] *terms & conditions & list of illnesses covered). We paid our premiums for the specified illness cover (each), in the understanding we had cover if ever needed. The amount of €100,000 is due to* [the Second Complainant] *for payment of serious illness diagnosed June 2019"*.

The Provider's Case

The Provider says that on **31 March 2016**, the Complainants met with Mr A., one of its Insurance and Investments Managers, as they were considering options for life cover and specified illness benefit. The Provider says that during this meeting, Mr A. completed a Personal Review with the Complainants and based on the information they provided, he prepared a Financial Plan for their consideration. The Provider says that Mr A. discussed this Financial Plan with the Complainants and the options open to them in respect of life cover and specified illness benefit.

The Provider says that having explained the features of the life cover and specified illness benefit, Mr A. recommended the cover and provided the Complainants with a letter setting out why he considered that such cover would be most suitable for them. This letter confirmed that it, together with the Financial Plan, the Plan of Action and the Important Information Notice, formed the Complainants' Statement of Suitability. The Complainants signed the letter to confirm that they agreed with the recommendation made and that they wished to take out the recommended cover.

The Provider says that the Complainants were also provided with a Plan of Action and that they both signed this to declare that the information contained in the Financial Plan accurately reflected their circumstances and objectives, that Mr A. had explained the recommendations made and that they understood these recommendations.

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The Provider says that the Complainants then completed the **Policy Application Form** indicating that they wished to take out stand-alone specified illness benefit of **€100,000.00** on both lives for a term of 20 years.

The Provider notes that the 'Material Facts Notice' at pg. 3 of the Application Form highlighted to applicants the importance of disclosing medical and other information during the application process and the consequences of failing to do so, as follows:

> *"The policy may be cancelled, any claim on the policy may not be paid and you may have difficulty purchasing insurance elsewhere:*
> - *If you do not inform us of all material facts*
> - *If any of the information you provide is not true and complete*
> - *If you do not inform us of any changes in your medical and/or other information before the policy commences.*
>
> *It is your responsibility to ensure that the information in this application is true and complete whether the information is completed by you or on your behalf.*
>
> *All the material facts in relation to a person to be covered must be provided by that person and not the policy owner or any other person to be covered.*
>
> *If you proceed with this application, the resulting policy will be based on the information provided:*
> - *In this application form*
> - *In any other form related to your application*
> - *In any notice by you of changes required in advance of the policy start date*
> - *In any questionnaire completed by you or by a medical examiner and signed by you*
> - *In any teleinterview you complete …*
>
> *You must give us details of your doctor. We may not necessarily contact your doctor(s). Even if we do, you must still disclose all material facts …*
>
> *Any changes to the information provided in the application process which occur before the policy start date must be notified immediately in writing to* [the Provider]*".*

The Provider notes that the Complainants signed the 'Declarations/Data protection consent' section at pg. 9 of the Application Form on 31 March 2016 to declare that:

> *"I have read and understand the notes in relation to material facts and understand that if I fail to disclose all material facts in this application, in any questionnaire signed by me, the contract with* [the Provider] *could be void,* [the Provider] *will retain all premiums paid and no benefits will be provided by the policy.*

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I have read and understand the replies to all the questions in this application and confirm that all statements herein and any statements written at my request or in any questionnaire completed by me or by a medical examiner in connection with this application and signed by me are true and complete and shall form the basis of the proposed contract".

The Provider notes that the Complainants also confirmed their understanding that:

"the proposed contract will not come into force until [the Provider] *has accepted me for cover and issued a policy document and I have made the first premium payment …*

… any changes to the statements in

- *This application*
- *Any other questionnaire signed by me and related to this application*
- *Any communication notifying you of any changes required in advance of the policy start date*

must be notified in writing to [the Provider] *before the proposed contract comes into force".*

The Provider says that a copy of the Application Form was posted to the Complainants on 31 March 2016 together with an Important Details Notice. The covering letter invited the Complainants to read the documents carefully as they contained important information in relation to the proposed policy and advised, "*if any of the information is incorrect or incomplete, you must notify us in writing* ***within 10 working days of the date of this letter***".

The Provider notes that the Important Details Notice drew the Complainants' attention to the importance of ensuring that all material facts were disclosed and reminded them that this duty continued up to the date on which the policy commenced, as follows:

"It is important you understand that you, the policy owner(s) and the person(s) to be covered (if different), are legally required to disclose all material facts. Failure to do so could result in the proposed policy being void. This would mean no benefit being payable under the policy in the event of a claim. Material facts are those that an Insurer would regard as likely to influence the assessment or acceptance of an application for insurance. If you are in doubt as to whether certain facts are material you should bring these facts to our attention.

The legal duty to tell us all material facts continues up until the policy start date. This means that you must tell us of any changes in the medical information relating to the person(s) to be covered and/or any other application information before the policy start date…

You are reminded that you are required to notify us at any time of any changes that may occur in medical information to the person(s) to be covered and/or any other application information before the policy start date.

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Failure to contact us in writing could mean that any policy effected in respect of the application could be void which would mean no benefit being payable under the policy in the event of a claim".

The Provider says that the only material medical disclosures made by the Complainants on the application form were by the Second Complainant, who answered *"Yes"* to the following medical questions:

"Do you currently have or have you ever had the following: …

f) diabetes, thyroid problems, raised blood sugar, glucose intolerance or sugar in the urine?"

and

"In the last 5 years have you had, or do you currently have any of the following: …

b) high blood pressure or raised cholesterol?"

The Provider says that the Second Complainant answered a series of further questions in the **'Risk assessment information disclosed'** section of the Application Form and that it also arranged a medical screening for her in relation to those medical conditions disclosed, namely, thyroid, high blood pressure and raised cholesterol. The Provider says that the information disclosed on the Application Form and obtained during the medical screening was used to underwrite the policy.

The Provider says it wrote to the Complainants on **15 July 2016** enclosing a copy of the **Specified Illness Policy Schedule** and the **Policy Conditions Booklet** (setting out the policy terms and conditions) and an updated **Important Information Notice**. The Provider says that the cover letter recommended that the Complainants should study the enclosed documents carefully, to ensure the policy met with their requirements.

The Provider notes that Section 2, 'Legal Basis', of the **Policy Conditions Booklet** outlines that:

"The contract with [the Provider] *is a legal agreement and consists of*

- *the Application (including any recorded telephone interview) completed by you, and the Life Insured*
- *this Policy Document which sets out the standard policy conditions*
- *the Policy Schedule*
- *any written statements made by you, and the Life Insured(s)*
- *any statements made by an authorised person on your behalf…*

The above contains all the terms of the contract and we accept liability only in accordance with these terms.

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For the policy to be valid, we require full and true disclosure in the Application and in any medical or other statements made by the Policyholder or Life Insured or intermediary in connection with the Application…

If there is any misrepresentation of or failure to disclose material facts by or on behalf of the Policyholder, or a Life Insured, the policy is void and all Premiums paid will be retained by us".

The Policy Schedule confirmed that the Specified Illness Policy commenced on **15 July 2016**.

The Provider says that the Complainants sent a **Specified Illness Claim Form** to it on **6 August 2019** in respect of the cardiothoracic open-heart surgery that the Second Complainant underwent in July 2019 to repair a partial anomalous pulmonary venous drainage and enclosed supporting medical reports. The Second Complainant had been hospitalised for 11 nights, from 22 July to 2 August 2019.

The Provider says that on **9 August 2019**, it wrote to the Second Complainant's GP and to her treating Cardiac Surgeon to request details of the surgery, so that it could assess her claim under the policy. The Provider says it also wrote to the Complainants on that day to advise that further medical information had been sought from the Second Complainant's GP and her Cardiac Surgeon and that the claim would be assessed when that information was obtained. The Provider says that on **28 August 2019**, the Second Complainant's GP sent it a completed **Private Medical Attendant's Report** and a copy of the medical records held in relation to the Second Complainant since, she became a patient of the GP in 2013.

The Provider says it sent a reminder to the Second Complainant's Cardiac Surgeon on **3 September 2019** and received his completed **Specialist Medical Report – Heart Valve / Structural Repair Report** and associated medical information on **6 September 2019**.

The Provider says that following a review of the information provided by the GP, it requested further details from the GP on **13 September 2019**, which were provided on **22 September 2019**. In light of the information received up to then, the Provider says it had to request further details from the GP on **7 October 2019**.

The Provider says that the Second Complainant wrote to it on **9 October 2019** to complain about the time it was taking to make its decision in relation to the claim, and its requests for further information from her GP. The Provider says it issued its **Final Response** to that complaint to the Complainants on **15 October 2019**, wherein it explained that as the GP medical file had included details of medical conditions and investigations which occurred prior to the inception of the policy on 15 July 2016, and which were not disclosed during the application process, it needed to seek further details in order to fully assess the claim. The Provider says that by way of example, the Second Complainant had attended A&E on **2 June 2015** regarding a cardiac event and also had a liver ultrasound in **2014**. The Provider says it also explained that it had written to the GP requesting further information on **7 October 2019** and that this information remained outstanding and was necessary to complete the claim assessment. The Provider notes that the GP then sent the information on **18 October 2019**.

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The Provider says it also obtained an additional **Private Medical Attendant's Report** completed on **23 November 2019** by the Second Complainant's former GP, who she had attended in the period from 2006 to 2013. The Provider says that it then wrote to the Complainants on **9 December 2019** to explain that it was currently assessing the information received.

The Provider confirms that its Claims Department and its Chief Medical Officer carefully assessed all of the information obtained from the Second Complainant's GP, her Cardiac Surgeon and her former GP. Following this assessment, the Provider wrote to the Complainants on **14 January 2020** to confirm that it was declining the claim and to explain that the medical information received reflected the non-disclosure of material facts prior to the policy commencing on 15 July 2016, such that at the time of the application for cover, the following medical questions were answered *"No"* by the Second Complainant:

- *Do you currently have or have you ever had any of the following:*

  (a) heart attack, angina, heart surgery, heart murmur, heart related chest pain or any other disease or disorder of the heart or arteries? …

  (g) hepatitis, other liver disorders, pancreatitis, ulcerative colitis or Crohn's disease …

- *In the last 5 years have you had or do you currently have any of the following: …*

  (b) Depression, stress, anxiety, eating disorders, chronic fatigue syndrome or other nervous or mental health disorder …

- *Have you had any medical investigations, medical scans, medical tests or surgery?*

- *Are you taking or have you been advised to take, any prescribed drug(s), medicine(s), tablet(s) or any other treatment?*

The Provider says it was satisfied from the medical information it received from her treating physicians, that the Second Complainant should not have answered these questions in the negative.

The Provider says that had it been aware of the Second Complainant's full medical history when she applied for the policy, it would not have been in a position to offer her any specified illness benefit at that time.

The Provider notes that the Application Form for the policy, which was signed by the Complainants on 31 March 2016, confirmed that all statements in the Application Form were true and complete and therefore formed the basis of the contract of insurance.

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In addition, in accordance with the signed Declaration, there was a continuing duty on both of the Complainants to advise that *"any changes to the statements in…this application…must be notified in writing to* [the Provider] *before the proposed contract comes into force"*. The Provider says that, consequently, the Complainants were under a continuing duty to notify the Provider of any changes up to the time the policy came into force on 15 July 2016.

The Provider notes that the Policy Conditions Booklet clearly states that *"if there is any misrepresentation of or failure to disclose material facts by or on behalf of the Policyholder, or a Life Insured, the policy is void and all Premiums paid will be retained by us"*. The Provider says that regretfully, in light of the above, it had no alternative but to decline the Complainants' claim and treat their Specified Illness Policy as void from inception. The Provider adds that while it was not obliged to do so, it refunded all premiums paid on the policy, in the amount of **€6,400.98**, to the Complainants on 28 January 2020.

The Provider says it is satisfied that it assessed the Complainants' claim in good time when all information had been received and, where additional information was needed, it sought the information in good time. The Provider notes that the progress of its claim assessment was dependent on it receiving medical information from the Second Complainant's different physicians.

The Provider says that on 30 January 2020, the Complainants wrote to it suggesting that during their meeting with Mr A., he had continually used the phrase "within the last 5 years" with respect to medical conditions, and consequently they had focused on disclosing medical history within the preceding five years only. The Provider says it is clear from the Application Form that while some questions relate to a 5-year period, there are a number of questions which do not. The Provider says that even if the Complainants had been advised that all of the medical questions were limited to the 5 years previous - a circumstance which it says it cannot accept was the case - the Provider notes that it is clear from the Second Complainant's medical file that medical attendances arose in the 5 years prior to the policy application that were not disclosed.

The Provider reiterates that the Complainants both signed the 'Declarations/Data protection consent' section of the Application Form on 31 March 2016 and in doing so declared that:

> *"I have read and understand the notes in relation to material facts and understand that if I fail to disclose all material facts in this application, in any questionnaire signed by me, the contract with* [the Provider] *could be void,* [the Provider] *will retain all premiums paid and no benefits will be provided by the policy.*
>
> *I have read and understand the replies to all the questions in this application and confirm that all statements herein and any statements written at my request or in any questionnaire completed by me or by a medical examiner in connection with this application and signed by me are true and complete and shall form the basis of the proposed contract".*

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The Provider notes that the Complainants also asserted in their letter of 30 January 2020 that the Second Complainant's medical conditions which had not been disclosed, were not causative of the surgery which was the subject of the claim and that the claim should be accepted by the Provider because the surgery was listed as a specified illness in the policy Document. In response to these assertions, the Provider says that because not all medical information had been provided in response to the questions asked, at the time of the proposal for cover, it was not afforded an opportunity to fully assess the risk. It reiterates that if the information that came to light during the claim assessment, had been provided at the time of application, it would not have been in a position to offer any specified illness cover to the Second Complainant.

The Provider says it issued its **Final Response** letter to the Complainants on **10 February 2020** to confirm that their appeal letter of 30 January 2020 had been reviewed by its Underwriting Department, and that the decision to decline the claim remained the same, as follows:

> *"I note that in your appeal you state that your medical history which was not disclosed fell outside of the scope of the application question; however, our Underwriting Department have confirmed that this is not the case. The question on your policy proposal form which refers to heart conditions has no limit to 5 years and clearly states the following:*
>
> > *Do you currently have or have you ever had any of the following:*
> >
> > *(a) heart attack, angina, heart surgery, heart murmur, heart related chest pain or any other disease or disorder of the heart or arteries?*
>
> *As a result of the above,* [the Provider] *is satisfied that* [the Second Complainant] *should have declared her attendances with a Cardiologist in 2007, 2008, 2009 and 2015. A diagnosis of mild RV/RPA enlargement had been made.*
>
> *Had our Underwriters been made aware of this diagnosis and attendances with a cardiologist, it would have been necessary to obtain additional medical reports and up to date test results before* [the Provider] *could have considered what cover could have been offered to* [the Second Complainant] *at that time. By not providing this information to us at the outset we were not given an opportunity to truly assess the risk.*
>
> *Further to this, it has been noted that* [the Second Complainant] *had attended her GP for fibromyalgia, back pain, elevated blood pressure, elevated cholesterol and fatty liver disease within a 5 year period prior to the proposal date and these attendances were not disclosed.*
>
> *Had* [the Second Complainant] *answered yes to the specific questions asked on the proposal form, our Underwriters would have requested further information and they have now confirmed that it would not have been possible to have offered her specified illness cover at that time".*

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The Provider says it also confirmed in this letter that the Specified Illness Policy had been voided in its entirety, because it was a dual life contract and that both of the Complainants had signed the Application Form declaring that all statements therein were true and complete.

The Provider says that while it is sympathetic to the Second Complainant for the very difficult time she has been through, regretfully it is not in a position to reinstate the policy and pay out the sum assured. The Provider says it reached its decision to provide cover based on the information provided at the time of the policy application and that such cover was offered on the basis that all information requested had been provided. The Provider reiterates that when it received the Second Complainant's medical file, it was clear that material medical information had not been disclosed to the Provider before the policy went into force and therefore, the Provider says it was not afforded an opportunity to fully assess its risk at the time of the application.

In that regard, the Provider says it is satisfied that the documentation provided to the Complainants both at point of sale and at the time the policy documents were issued, made it clear that there was a duty to disclose material facts up to the date the policy commenced, and that it also clearly highlighted the consequences of failing to do so.

In relation to the Complainants' **Life Assurance Policy** that was incepted on **6 July 2016** and that they applied for on 31 March 2016 with the same application process as their specified illness cover, the Provider says that instead of exercising its contractual right to treat this policy as void as a result of the Second Complainant's nondisclosures, and to retain all premiums paid, it advised the Complainants in its letter of **28 January 2020** that it would allow this policy to remain in force with cover reduced from €281,908.00 to €153,733.00 as at 6 July 2019. The Provider says that in so doing, it retrospectively applied the loading that would have been applied at the time of the application for the life cover, if the Second Complainant's full medical history had been made known to the Provider.

The Complaint for Adjudication

The complaint is that:

1. the Provider wrongfully or unfairly declined the Complainants' specified illness claim in relation to the Second Complainant's medical condition and voided the Complainants' **Specified Illness Insurance Policy** due to the non-disclosure of material facts relating to the Second Complainant's medical history;

2. the Provider delayed in assessing the Complainants' specified illness claim in relation to the Second Complainant's medical condition; and

3. the Provider wrongfully or unfairly reduced the life cover provided by the Complainants' **Life Assurance Policy** due to the non-disclosure of material facts relating to the Second Complainant's medical history.

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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 Complainants were 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 **30 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 substantive submissions from the parties, within the period permitted, the final determination of this office is set out below.

There are three elements to the complaint for adjudication which are addressed below:

Element 1:
The Provider wrongfully or unfairly declined the Complainants' specified illness claim in relation to the Second Complainant's medical condition and voided the Complainants' Specified Illness Insurance Policy due to the non-disclosure of material facts relating to the Second Complainant's medical history

I note that the Complainants submitted a Specified Illness Claim Form to the Provider on 6 August 2019 in respect of the cardiothoracic open-heart surgery that the Second Complainant underwent in July 2019 to repair a partial anomalous pulmonary venous drainage.

Following its assessment, the Provider wrote to the Complainants on **14 January 2020** to advise that it was declining the claim and voiding their Specified Illness Insurance Policy, because the Second Complainant had failed to disclose material facts relating to her medical history when applying for the cover. It said that if it had it been made aware of these details at the time, it would not have been in a position to offer her any specified illness cover.

/Cont'd…

As part of its claim assessment, the Provider obtained information from the Second Complainant's GP, Dr K., who she had attended from October 2013 onwards, as well as her former GP, Dr D., who she had attended from 2006 to 2013.

I note that in its declinature letter to the Complainants, the Provider detailed what it considered to be the material facts in relation to the Second Complainant's medical history that she ought to have disclosed when applying for cover but did not.

In that regard, the Second Complainant's former GP, Dr D., completed a **Private Medical Attendant's Report** to the Provider on **23 November 2019** wherein he advised, among other things, that:

> *"**2. a) Please give details of any illness or accidents requiring treatment or advice from yourself or other medical advisors***
>
> *2006 – 2013 Multiple consultations re stress, anxiety, depression,* [gastrointestinal] *symptoms, gynae problems.*
>
> ***b) Have any of the above conditions left any residual symptoms of disability?***
> *YES ☑ NO ☐*
>
> ***If "yes", please advise details***
> *Ongoing cardiac issues".*

Dr D. also confirmed that the Second Complainant had been first diagnosed with mild right ventricle and right pulmonary artery enlargement in **2007** and he enclosed medical reports he had received from the Second Complainant's then treating Consultant Cardiologist in relation to this diagnosis.

For example, this Consultant Cardiologist confirmed in his letter dated **13 November 2007** that the Second Complainant *"still has mild RV/RPA enlargement".*

In his letter dated **22 April 2008**, the Consultant Cardiologist advised that:

> *"*[The Second Complainant] *recently had an MRI scan which again confirmed mild RV/RPA enlargement. However, there were no associated sinister features, in particular, there was no evidence to suggest right ventricular dysplasia".*

In his letter dated **1 April 2009**, the Consultant Cardiologist advised that:

> *"*[The Second Complainant] *has occasional palpations lasting for a few seconds at a time. They sound highly suggestive of atrial ectopic beats. They can particularly be associated with exercise. She can get them few times a day or not at all for a week. There has been no change over the last few years.*
>
> *Her echocardiogram still shows a dilated right heart but there is no evidence of pulmonary hypertension and the dimensions have not changed at all in the last two*

/Cont'd…

years. She had no evidence of any intra atrial defect and her other valves appear normal.

I have reassured her that all appears to be stable. Her right heart appears to be slightly bigger the usual upper limit of normal. It has not changed at all. As you know her MRI last year was normal".

I also note from the consultation notes that her GP, Dr K., sent to the Provider, that the Second Complainant had been referred to this Consultant Cardiologist again on **2 June 2015** to out rule a cardiac event and that she also attended him for further review on **6 October 2015**.

In addition, I note that Dr D. also furnished the Provider with a Report from the HSE Health Services dated **26 October 2010** that states, among other things, as follows:

*"**Presentation:***

[The Second Complainant] *presented with a long history of depression and anxiety with more severe symptoms since February 2010. She describes herself as feeling "drained, stressed and unwell all the time". She had recently started to have panic attacks …*

Past Psychiatric History:

History of depression and anxiety x several years. Post-natal depression x 2".

Dr D. also confirmed to the Provider that the Second Complainant had attended a Consultant Physician in **October 2011** in relation to treatment for her headaches and bowel issues. In that regard, in her letter of 12 October 2011 to Dr D., this Consultant Physician advised that:

"I have just reviewed [the Second Complainant]*. She has had a bad year with headaches. Her bowel is also very troublesome again with diarrhoea, incontinence and blood at times … She has been on Seroxat for quite some time currently 10mgs daily. I have switched her to Fluoxetine 20mgs daily …*

I have checked on some bloods today. I have also scheduled her for a colonoscopy after a number of weeks because of the rectal bleeding".

The Provider also made specific reference to a number of attendances that the Second Complainant had with her GP, Dr K., as recorded in the Consultation Notes as follows:

22/10/2013 *Transferred from* [previous GP surgery]
… Anxiety and depression
generalised aches and pains
frontal headaches – seen by ENT – not sinusitis …
feels anxiety has increased in recent months

/Cont'd…

29/10/2013 *bloods discussed*
Inflammatory markers marginally raised …
Plan increase eltroxin to 150mcg od …

17/04/2014 *… include USS* [ultrasound] *Gb and liver in view raised LFTS*

25/04/2014 *D97 LIVER DISEASE NOS LIVER DISEASE NOS HEPATIC STEATOSIS LIVER USS 2014*

08/05/2014 *? flare of fibromyalgia*
sore all over
aches and pains…

28/07/2014 *… fibromyalgia flared at present …*

15/12/2014 *… ongoing trouble with fibromyalgia intermittently …*

09/01/2015 *… occipital headaches since RTA 2005, radiates over back of head …*

19/01/2015 *… LFTs have gone up*
USS liver – steatosis …

10/04/2015 *C spine xray …*

02/06/2015 *episode 2/7 ago pain under scapula, felt air at front of chest and felt an ache in arms …*
bp – 157/95 …
Ecg – t wave inversion on v2 and v3
P – refer…clinic a&e outrule cardiac event …

22/07/2015 *check bloods, BP 159/99mmHg, very stressed …*

28/07/2015 *raised lipid profile – LDL and trigs, fatty liver, would recommend statin …*

05/01/2016 *flare of fibromyalgia sx*
aches and pains++
headache x last few days

07/01/2016 *… chol > 6 last few times*
needs to be managed …
BP 170/88 here 150/80 at home ABPM [24 hour blood pressure monitor] *…*

12/01/2016 *ABPM discussed*

/Cont'd…

21/01/2016 *… fibromyalgia flared*
advised start Cymbalta tomorrow, brufen tds

01/02/2016 *BP readings at home*
134/83, 124/81
119/83 144/84 143/87 130/83 …
Fibromyalgia not controlled on cymbalta 30mg …

08/02/2016 *… back pain severe …*
ref MRI full spine as req

25/02/2016 *rt lateral epicondylitis …*
awaiting MRI for her back …

14/03/2016 *discussed MRI results*
Bp 140/90 118/78 at home
disc bulge at C4-5 – otherwise unremarkable
physio advised …
fibromyalgia under reasonable control …

28/04/2016 *fibromyalgia under reasonable control with cymbalta 90mg …*
BP 127/80 …
advised increasing cybalta to 120mg …

05/05/2016 *… ongoing pressure in head …*

14/07/2016 *anxious++ in recent weeks …*
fibromyalgia not a problem at the moment …
BP 141/81 chest clear …
wean cymbalta and start Lexapro after weaning

Having considered the evidence, I am of the opinion that it was reasonable for the Provider to conclude from the medical evidence before it, and which I have cited from above, that when completing the 'Medical history details' section of the Application Form for cover, the Second Complainant ought not have answered *"No"* to the following questions:

- *Do you currently have <u>or have you ever had</u> any of the following:*

  (a) heart attack, angina, heart surgery, heart murmur, heart related chest pain or any other disease or disorder of the heart or arteries? …

  (g) hepatitis, other liver disorders, pancreatitis, ulcerative colitis or Crohn's disease …

- *<u>In the last 5 years</u> have you had or do you currently have any of the following: …*

/Cont'd…

(b) Depression, stress, anxiety, eating disorders, chronic fatigue syndrome or other nervous or mental health disorder …

- *Have you had any medical investigations, medical scans, medical tests or surgery?*

- *Are you taking or have you been advised to take, any prescribed drug(s), medicine(s), tablet(s) or any other treatment?*

[my underlining added for emphasis]

The Complainants have said that the Provider's Insurance and Investments Manager who they applied for the cover through, presented the medical questions to them as *"a verbal rapid fire set of questions…where the focus seemed to be on closing the sale"* and that they omitted some matters relating to the Second Complainant's medical history, as they were *"at all times under the view* [that] *most of them were previous to the scope of the questions, i.e. greater than 5 years old"*.

The Complainants have also said that none of the nondisclosures raised by the Provider in justification of its claim declinature have any bearing on the Second Complainant's diagnosis of a partial anomalous pulmonary venous drainage, such that *"we can clearly see anything omitted has no causative symptom or led to a diagnosis of the condition that is the subject of this claim"*.

I note that the Complainants signed the 'Declarations/Data protection consent' section at pg. 9 of the Application Form on 31 March 2016 to declare that:

> *"I have read and understand the notes in relation to material facts and understand that if I fail to disclose all material facts in this application, in any questionnaire signed by me, the contract with* [the Provider] *could be void,* [the Provider] *will retain all premiums paid and no benefits will be provided by the policy.*
>
> *I have read and understand the replies to all the questions in this application and confirm that all statements herein and any statements written at my request or in any questionnaire completed by me or by a medical examiner in connection with this application and signed by me are true and complete and shall form the basis of the proposed contract".*

I am of the opinion that it would have been prudent of the Complainants, particularly given their stated concerns as to the manner in which the medical questions were verbally put to them during the application process, to have read back through the Application Form carefully before signing this Declaration, to ensure that they understood exactly what was being asked of them and that they were satisfied with the accuracy of the information recorded as their answers. If having done so they were dissatisfied with the answers to the medical history questions, it would then have been open to the Complainants to have amended these answers accordingly.

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It is important for an applicant seeking insurance who is asked to disclose his or her medical history, to disclose all consultations and tests that fall within the scope of the questions being asked, notwithstanding that the applicant may not consider those consultations or tests relevant, because the symptoms that gave rise to those consultations and tests form part of the applicant's medical history and omitting such details constitutes the nondisclosure of material facts. In addition, it is not for an applicant to decide what symptoms, consultations or tests are, or may be, of significance to the underwriters. This is a matter for the underwriters to determine, when assessing risk.

I am of the opinion that it was reasonable for the Provider to conclude from the evidence before it that the medical information relating to the Second Complainant that was not disclosed during the policy application, was material and substantial to the application for cover and ought to have been disclosed. I also accept that as the Provider had not been made aware of the full extent of the Second Complainant's medical history when it agreed to incept the policy, that the policy therefore came into being on the basis of a false premise.

Insurance contracts are contracts of utmost good faith, wherein the failure to disclose information allows the Insurer to void the policy from the outset and refuse or cancel cover. Once nondisclosure takes place – whether innocent, deliberate or otherwise – the legal effect of that nondisclosure can operate harshly, and it entitles an Insurer to, amongst other things, cancel cover.

In that regard, I note that Section 2, '**Legal Basis'**, at pg. 4 of the applicable **Policy Conditions Booklet** states that:

> *"For the policy to be valid, we require full and true disclosure in the Application and in any medical or other statements made by the Policyholder or Life Insured or intermediary in connection with the Application…*
>
> *If there is any misrepresentation of or failure to disclose material facts by or on behalf of the Policyholder, or a Life Insured, the policy is void and all Premiums paid will be retained by us"*.

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

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

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

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

/Cont'd…

Having considered the evidence, I am not satisfied that it would be reasonable to conclude that the Second Complainant took all efforts to ensure that the Provider was provided with accurate answers to the medical questions contained in the Application Form she signed on 31 March 2019. I am therefore of the view that the Provider was entitled to decline the Complainants' specified illness claim and cancel, from inception, the Specified Illness Policy, given that the policy was jointly held. I accept on the evidence available that its actions were in accordance with the terms and conditions of the insurance arrangement in place.

Accordingly, I am of the opinion that the evidence does not support the complaint that the Provider acted wrongfully or unfairly when it declined the Complainants' specified illness claim in relation to the Second Complainant's medical condition and voided the Complainants' Specified Illness Insurance Policy due to the non-disclosure of material facts relating to the Second Complainant's medical history.

Element 2:
The Provider delayed in assessing the Complainants' specified illness claim in relation to the Second Complainant's medical condition

The Complainants completed a Specified Illness Claim Form sent to the Provider on 6 August 2019.

The Provider wrote to the Second Complainant's GP, Dr K., on 9 August 2019, as follows:

> *"We would be grateful if you could complete the enclosed* [Private Medical Attendant's Report] *at your earliest convenience, and forward any copies of hospital reports you may have.* ***Please also include a copy of this patient's medical records dating back to March 2011****"*.
>
> [my underlining added for emphasis]

I note that Dr K. completed and sent the Private Medical Attendant's Report to the Provider on 26 August 2019 and enclosed a copy of the medical records she held in respect of the Second Complainant since she began attending her as a patient in October 2013. Following a review of the information provided, I note that the Provider found it necessary to request further information from Dr K. on 13 September 2019, which was furnished on 22 September 2019, and again on 7 October 2019, which was furnished on 18 October 2019.

As the Second Complainant had only been attending Dr K. since October 2013, I accept that it was necessary for the Provider, in order to fully assess the claim, to then seek information from the Second Complainant's former GP. In that regard, I note that Dr D. completed a Private Medical Attendant's Report, sent to the Provider on 23 November 2019 and enclosed a copy of medical reports he held in respect of the Second Complainant.

The Provider then wrote to the Complainants on **9 December 2019** to advise that it was assessing the information received.

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The Provider subsequently wrote to the Complainants on **14 January 2020** to advise that it was declining the claim and voiding their Specified Illness Insurance Policy because the Second Complainant had failed to disclose material facts relating to her medical history when applying for the cover and that if it had been made aware of these details at the time, it would not have been in a position to offer her any specified illness cover.

As the Provider had to obtain information from different sources in order to fully assess the claim, and given the amount of medical information it then had to review, I do not accept that the Provider unduly delayed in assessing the claim.

Accordingly, I am of the opinion that the evidence does not support the complaint that the Provider delayed in assessing the Complainants' specified illness claim in relation to the Second Complainant's medical condition.

Element 3:
The Provider wrongfully or unfairly reduced the life cover provided by the Complainants' Life Assurance Policy due to the non-disclosure of material facts relating to the Second Complainant's medical history

I note that the Complainants applied for their Life Assurance Policy with the Provider on 31 March 2016 at the same time they applied for their Specified Illness Policy, using the same application process. The Life Assurance Policy commenced on **6 July 2016** and is assigned to a mortgagee.

The Complainants' Life Assurance Policy, like all insurance policies, is subject to the terms, conditions, endorsements and exclusions set out in the policy documentation.

In that regard, I note that Section 2, '**Legal Basis'**, at pg. 4 of the **Policy Conditions Booklet** provides that:

> *"For the policy to be valid, we require full and true disclosure in the Application and in any medical or other statements made by the Policyholder or Life Insured or intermediary in connection with the Application …*
>
> *If there is any misrepresentation of or failure to disclose material facts by or on behalf of the Policyholder, or a Life Insured, the policy is void and all Premiums paid will be retained by us"*.

The Provider has advised that having received the full details of the Second Complainant's medical history, instead of exercising its contractual right to treat the Complainants' Life Assurance Policy as void as a result of the Second Complainant's non-disclosures and to retain all premiums paid, it wrote instead to the Complainants on 28 January 2020 to inform them that it would allow the policy to remain in force with the life cover reduced from €281,908.00 to €153,733.00 as at 6 July 2019.

/Cont'd…

The Provider has advised that in so doing, it retrospectively applied the loading that would have been applied at the time of the application for the life cover, if the Second Complainant's full medical history had been made known to it.

I take the view that instead of voiding the Complainants' Life Assurance Policy in light of the nondisclosures relating to the Second Complainant's medical history (as set out under Element 1 above) that it was a reasonable and indeed generous approach for the Provider to retrospectively apply to the policy, the loading it would have applied at the time of the policy application, if the Second Complainant's full medical history been made known to it at the time of the proposal.

Accordingly, I am of the opinion that the evidence does not support the complaint that the Provider wrongfully or unfairly reduced the life cover provided by the Complainants' Life Assurance Policy due to the non-disclosure of material facts relating to the Second Complainant's medical history. Accordingly, having regard to all of the above, it is my Decision on the evidence before me, that this complaint cannot reasonably be upheld.

Conclusion

My Preliminary Decision is that this complaint is rejected, pursuant to ***Section 60(1)*** 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)

26 September 2022

PUBLICATION

Complaints about the conduct of financial service providers

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will **publish legally binding decisions** in relation to complaints concerning financial service providers in such a manner that—

(a) ensures that—
  (i) a complainant shall not be identified by name, address or otherwise,
  (ii) a provider shall not be identified by name or address,
  and
(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.

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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.