An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0196
Sector:	Insurance
Product / Service:	Term Insurance
Conduct(s) complained of:	Rejection of claim - non-disclosure Rejection of claim – partial rejection
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint is made on behalf of the estate of a deceased person who purchased a life insurance policy with the Provider in 2009 and subsequently passed away in February 2013. The estate of the deceased sought the benefit provided for under the policy but the claim was declined by the Provider on the basis that the deceased had failed to disclose a material fact as regards her health – namely a high blood pressure condition - at the time of the inception of the policy. The Provider, instead, agreed to pay out roughly 60% of the benefit available under the policy.

The Complainant's Case

The Complainant is the executor of the deceased's estate and also her son. He maintains that the deceased did not have a high blood pressure condition. The Complainant submits that, since the early 1980s when she suffered a nervous breakdown, the deceased suffered from anxiety which manifested on certain occasions such as on social occasions and on trips to the doctor. The Complainant states that this anxiety gave rise to a temporary rise in blood pressure on the occasion of visits to the doctor, which was not representative of the deceased's actual health condition. The Complainant also maintains that the deceased's blood pressure may have been temporarily raised after smoking a cigarette. The Complainant asserts that an accurate diagnosis of a high blood pressure condition can only be made on foot of constant monitoring over the course of several days, something the deceased was never required to do.

The Complainant highlights that the deceased, who was a nurse, had her own blood pressure monitor at home and she would regularly test herself which confirmed that "*her blood pressure was always normal*". The Complainant submits that the deceased "*did not take the blood pressure medicine the doctor prescribed because she knew that she did not suffer from high blood pressure*". The Complainant takes issue with the Provider's characterisation of the deceased as dishonest.

The complaint is that the Provider has failed to pay out the full amount of benefit provided for under the policy - €71,500. The Complainant seeks that the Provider pay "*what they agreed to and pay out the remainder of the policy which is €28,661*"

The Provider's Case

The Provider relies on the terms of the policy. The Provider also relies on the deceased's GP records which record a high blood pressure reading in June and in September 2008. The same records document "*very poor compliance*" on the part of the deceased in taking medication which had been prescribed for high blood pressure. The Provider also relies on GP records from October 2008 which again record a high blood pressure reading and which also note the fact that the deceased was "*only taking medication occasionally and was advised to take medication every day*".

The Provider stated as follows in its Final Response Letter:

> *If the medical information was disclosed an extra premium charge would have been applied, which would have reduced the amount of life cover offered.*

The Provider maintains that it would have been entitled to void the contract in its entirety but instead opted to make a reduced payment "*on a proportionate basis*", equal to what would have been provided for under the policy, had full disclosure been made at inception.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally

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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 19 November 2018, 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, the final determination of this office is set out below.

In considering the issues which arise, it is useful to set out the terms of the policy relied upon by the Provider as well as the relevant passages from the deceased's proposal for cover.

Policy Terms and Conditions

The policy document provides as follows:

> ***Basis of Cover***
> *Section 2*
>
> *2.1*
> *We have issued this plan to you on the understanding that the information given in the application form and any related document is true and complete and that we have been given all relevant information. If this is not the case we will be entitled to declare the plan void. If this happens, you will lose all your rights under the plan, we will not pay any claim and we will not return any payments. Information is relevant if it might influence the judgment of a reputable Provider when fixing the level of payments or benefits or when deciding whether to provide cover at all.*

Application for Cover

The application form completed by the deceased contained the following question to which the deceased responded 'NO':

> *Question 5* *Have you ever suffered from or had any treatment for heart disorder, stroke, rheumatic fever, high blood pressure or blood disorder?*

The Complainant has suggested that this question could be misunderstood to mean that one is required to answer 'yes' only if one suffers from all the illnesses referenced. I do not accept this. I am satisfied that the use of the word 'or' at the end of the sentence renders the meaning clear. I am satisfied that a proposer is obliged to answer 'yes' if that proposer has ever suffered from any of the illnesses.

The application form also set out as follows:

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Important – telling [the Provider] about material facts

Please remember that you must tell us everything relevant when answering all of the questions on the application form. If you do not, or if any of the answers to these questions are not true and complete, we could treat the plan as void. If this happens there will be no cover under the plan and we will not refund the payments. In these circumstances we will not pay a claim. A material fact (relevant information) includes anything that a reputable Provider would regard as likely to influence the assessment and acceptance of an application for insurance. If you are not sure whether something is relevant, you should tell us anyway. As this is an automated process we can only regard information recorded on the system as having been disclosed.

…

We will rely on what you tell us and you must not assume that we will automatically confirm with your GP or any other doctor any information you provide.

Proposal Documents

Having completed the application form, the Provider issued the deceased with a document summarising her application. This document contained the following:

When answering the questions, it is very important that you give us all relevant information and that all facts are true and complete. Material facts (relevant information) include anything that a reputable Provider would regard as likely to influence the assessment and acceptance of an application for insurance. If you are not sure whether something is relevant, you should tell us anyway.

Analysis

The Provider has sought to rely on the deceased's material non-disclosure as the basis for not admitting the claim in its entirety. I am satisfied, on the basis of the terms and conditions set out in the policy document and on the basis of the various warnings included in the application procedures, that this is a course of action that is open to the Provider if it can establish that there was indeed a non-disclosure of a material fact.

It is common case in this dispute that the deceased did not disclose any detail as to any high blood pressure condition. The GP records document as follows:

10/06/08 wheeze – bp high- advised see cardiovascular nurse ….

11/06/08 B/P = 159/101, B/P = 158/92

24/09/08 B/P = 186/105, B/P = 185/95 On Centyl very poor compliance with same discussed importance of compliance with med, advised to have rechecked by PN

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17/10/08 bp – 160-95 only taking tb occasionally adv take every day r/v bp in 2 wks…

Each of the blood pressure readings recorded above represents a high reading. The readings on 24/09/08 were particularly high.

The Complainant maintains nonetheless that the deceased was under no obligation to disclose any detail as to any high blood pressure condition as she did not in fact believe that she had any such condition. I am not satisfied however that this is the case. Question 5 from the application form reproduced above clearly enquires whether the proposer has ever suffered from or "*had any treatment for*" a number of conditions including high blood pressure. Quite apart from any of her own convictions as to her state of health that the deceased may have had, it is abundantly clear that the deceased was prescribed medication for high blood pressure (Centyl) which she appears to have taken occasionally but not as regularly as prescribed. I am satisfied that this unequivocally amounts to treatment for high blood pressure during that period in 2008 and, even if taken on its own, would have required a positive answer to question 5.

Even if I was not satisfied as to this clarity regarding the 'treatment' for high blood pressure, the fact is that the deceased was diagnosed by her GP as having high blood pressure (an empirical fact), albeit that the Complainant advises that she disputed that she had a blood pressure condition. This is relevant to addressing the question as to whether the non-disclosure related to a material fact. A material fact is one which would influence a reasonable Provider if disclosed. The policy document refers to this when it states that "i*nformation is relevant if it might influence the judgment of a reputable Provider when fixing the level of payments or benefits or when deciding whether to provide cover at all".* I have no difficulty concluding that the fact that the deceased's GP had diagnosed her as suffering from high blood pressure (as well as having treated her for same) would quite reasonably have had an influence on the Provider in terms of the premium level payable to be covered for benefits under the policy. This influence would have been exerted on the Provider, regardless of the deceased's beliefs, as to her own health.

I completely accept that the deceased was "*an honest hard working woman all her life and was never in trouble whatsoever with the law or any person and filled out* the [Provider's] *application form with honesty"*, as the Complainant has maintained. I do not have any difficulty in accepting that the deceased genuinely believed that she did not have a high blood pressure "condition" and that high blood pressure readings were simply triggered by certain occasions e.g. social occasions or visiting the doctor. Unfortunately however, from the Complainant's point of view, and as noted above, I am of the view that the obligation to disclose this high blood pressure existed nonetheless, notwithstanding any such beliefs that may have been held by the deceased.

In coming to this conclusion, I am mindful of the decision in *Chariot Inns Ltd v Assicurazioni Generali spa [1981] IR 199* where the Supreme Court stated that the test for materiality is:

> "*...a matter or circumstance which would reasonably influence the judgment of a prudent insurer in deciding whether he would take the risk, and if so, in determining*

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the premium which he would demand. The standard by which materiality is to be determined is objective and not subjective."[1]

I have also had regard to the High Court decision of *Earls -v- The Financial Services Ombudsman & Anor [2015] IEHC 536*, where the High Court carried out a detailed analysis of previous case law on non-disclosure and the principles to be applied. From this decision it is clear that this Office should not proceed on the basis that if a material fact was not disclosed then, *ipso facto*, there has been a breach of the duty of disclosure. Rather, in the Court's opinion, this may not always be the case, as the duty arising for an insured in this regard, is to exercise a genuine effort to achieve accuracy using all reasonably available sources, so that, eg. if the form of questions asked in a proposal form might limit the duty of disclosure arising, such an issue would require consideration.

Furthermore, this High Court decision pointed to the fact that materiality falls to be gauged by reference to the hypothetical prudent proposer for insurance. The Court held that the arbiter must also give consideration to what a reasonable insured would think relevant and relevance in this particular context is not determined by reference to an insurer alone.

In this instance, I am satisfied that a hypothetical prudent proposer for insurance, with the deceased's medical history, would not have answered "No" to question 5 on the proposal form.

I might also add that, insofar as the Complainant suggests that the Provider has characterised the deceased as dishonest, I don't accept this. Indeed, the Provider has, for example, accepted the deceased misstatement of her age on the application from as "*a genuine mistake"* and imposed no ramifications for same.

In light of my conclusion that the deceased failed to disclose a material fact, I am satisfied that the Provider would have been entitled to void the policy in its entirety as per the terms and conditions of the policy. In that event, no benefit whatsoever would have been paid. Instead, the Provider opted to make a reduced payment in "*the amount the protection premium would have purchased had the medical history*" been disclosed. In the circumstances, I believe that this was a more than reasonable response from the Provider.

In light of the entirety of the foregoing, and in the absence of evidence of wrongdoing by the Provider or conduct within the terms of ***Section 60(2)*** of the ***Financial Services and Pensions Ombudsman Act 2017*** that could ground a finding in favour of the Complainant, I am not in a position to uphold this complaint.

[1] Kenny J, Chariot Inns Ltd v Assicurazioni Generali spa [1981] IR 199

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Conclusion

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

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

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION AND LEGAL SERVICES

11 December 2018

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.