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Financial Ombudsman Service

Aimed at financial firms and professional advisers – and at consumer advice agencies – we focus each month on news from one of our three case-handling divisions: banking & loans, investment – and this month – insurance.

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## about this issue of *ombudsman news*

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This edition of *ombudsman news* focuses mainly on health issues. Health-related complaints are an important aspect of our work. Private medical expenses insurance and permanent health cover account for about one in seven of the cases handled by the insurance division. But medical issues arise in a wider range of cases – from travel to loan protection.

Where disputes involve both health and money they can be highly charged. Understandably, policyholders will feel that they are best placed to judge many questions about their medical circumstances – for example – ‘am I fit enough for work?’. Certainly most policyholders will prefer to listen to their own doctor’s views about such issues rather than to the views of a medical adviser for the insurance industry. And that is particularly true when the question refers to whether a particular treatment is necessary or likely to cure the policyholder’s medical condition. **S**

In all these cases we need to look carefully at the often-conflicting medical evidence and reach a view about the policyholder's state of health – in some cases as it was several months before we became involved. Our role is to take a practical view of the policyholder's circumstances and to decide, on the basis of what is fair and reasonable, how the case should be settled. Policyholders' views – and those of their own medical advisers – will be important, but not decisive.

In this edition we consider four medical issues. First, in the case of policies sold on a group basis, we look at how far we should expect the insurer (as opposed to the employer) to inform people about policy terms and changes to conditions. Second, we consider how we should handle cases where, initially, the customer has a common general medical condition but it subsequently develops into something far more serious. Third, we look at some of the issues surrounding critical illness policies. Finally we consider the circumstances in which firms should pay for medical reports.

But we also cover a wider range of issues in a round-up of recent cases, ranging from dealing with a dead pet to whether a well-known children's hand-held game can be considered a 'disk'.

In many of the cases we deal with, we conclude that the firm might reasonably be expected to have resolved the complaint sooner and without the need for our involvement. We comment on page 12 on how we will interpret the new complaints-handling rules for firms.

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# 1 medical expenses policies – group schemes

Many private medical expenses policies are provided by employers for their staff. So long as the insurance is for the benefit of individual employees, then the employees can complain to us if they have an unresolved dispute with the insurer. There is no requirement that the employer has to consent to or participate in the complaint. However, actions involving the employer can give rise to quite a few of these complaints.

A typical case arises when the employer transfers the group scheme to a different insurance company. The new scheme may not have identical terms to the old one, even when it has guaranteed 'protected underwriting terms' (in other words, an undertaking that no new underwriting terms will be applied). This provision protects anyone who is already suffering from a medical condition. It will not, however, give any protection for claimants who are affected by a policy exclusion. For example, if the new policy does not provide cover for mental illness, the 'protected underwriting terms' will not continue that cover for employees even though they may have been covered under the old policy.

Insurers generally leave it to the employer to make sure employees are aware of any new terms or restrictions on cover. The changes have often been made at the employer's request (to reduce the cost of the insurance) rather than at the insurer's instigation. Nevertheless, we do not always agree with the insurance company that it can delegate to the employer its responsibility to give clear advice about the change in terms, and not accept any responsibility for that advice.

In cases where the insurance company had details of those employees who would be adversely affected, we are likely to take the view that it is the insurance company's responsibility to ensure the employees in question are given the relevant information. They are, after all, the intended beneficiaries. In some cases, the insurer may not have details of individual employees/beneficiaries under the scheme (or details of the previous scheme). Nevertheless, we would expect the insurer to work with the employer to provide clear factual information about the new policy and its coverage, highlighting – wherever possible – significant changes from the cover previously available.

This responsibility is not, of course, absolute. If an insurer prepares appropriate documentation explaining the changes, but the employer does not then make this available to the employees, we may well consider the insurer to have taken all reasonable steps. On the other hand, the insurer may merely assume that the employer will give information about any significant change in terms to the staff members who will be affected. In such cases, if the insurer then declines claims – on the basis of significant terms that were not explained to the claimant – we may not agree that the insurer acted correctly. Where the line should be drawn will depend on the particular circumstances of each case, but in general we expect insurers to play an active role in notifying the employees of all changes.

## case studies – medical expenses policies – group schemes

■ 13/01

### **Private medical expenses – transfer of cover to new insurer – exclusion for ‘mental illness’ – insured not advised of change in terms – whether claim valid.**

Mr B had the benefit of an employer’s group medical expenses scheme. He suffered from intermittent mental ill-health and the insurer had paid for his treatment. In January 2000, his employer changed insurers. The terms of the new policy excluded ‘treatment of psychiatric and mental disorders unless your company has specifically applied to include this benefit’. The employer had not paid the additional premium required for this benefit.

In May 2000, Mr B was hospitalised for mental problems. The new insurer refused to cover the cost of treatment, relying on the policy exclusion. Mr B argued that he had not been made aware of the change in policy cover. The new insurer said that the employer had made a specific enquiry about continuing mental health benefits for Mr B and it contended that the employer was under a duty to advise Mr B that it had decided not to pay for this extension.

#### **complaint upheld**

The new insurer had taken no steps to ensure that employees such as Mr B were aware of the new policy terms.

And despite being informed of Mr B’s situation, the insurer did not make any effort to notify him of the change, nor did it require the employer to provide him with this information.

If Mr B had been told of the restricted terms of the new insurance, he could have chosen to continue cover for himself under the old policy. The failure to give him correct advice had prejudiced his position.

We required the new insurer to deal with any claims Mr B made during the first year of cover, if these claims would have been valid under the terms of the old policy. However, we did not agree with Mr B that he was entitled under the new policy to indefinite mental illness cover.

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■ 13/02

### **Private medical expenses – transfer of cover to new insurer – exclusion for ‘elective’ surgery – whether new insurer entitled to rely on exclusion.**

Mrs L was an employee of JI, which provided private medical insurance for its staff. When she became pregnant, her doctor told her that her baby would have to be delivered by Caesarean section. This was because Mrs L had undergone uterine surgery some years previously. She telephoned the insurer for advice and was told the operation would be covered.

In March 2000, JI transferred the insurance to a different insurer. Mrs L’s baby was born the following month and she

submitted her claim to the new insurer. It refused to make any payment, explaining that the policy specifically excluded 'elective sections' for maternity claims. It concluded that the Caesarean was 'elective' because the pregnancy was normal and there was no emergency relating to the delivery.

Mrs L complained that no one had told her that the change of insurer meant that, despite the previous insurer's decision, she was no longer covered for the operation. She noted that the company secretary had told her that the new insurer had not asked him any questions about the health of employees or the treatment proposed for any of them. Instead, it had told him that the transfer of cover between insurers was 'on protected underwriting terms', although these were to be based on the new policy wording.

**complaint upheld**

We accepted that the surgery was 'elective', but we did not agree that the limitations on cover had been made clear. The brochure referred to the employer's need to ensure any difference in cover was explained to staff, but there was no evidence that the insurer had drawn those differences to the attention of the company secretary.

Although the policy had been transferred 'on protected underwriting terms', the meaning of this phrase was not clearly defined. In our opinion, it indicated continuous cover. No policy document had been sent to employees by the time the surgery was performed and Mrs L could not have known of the exclusion.

In the circumstances, we decided that the insurer was liable for the cost of the surgery.

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**... the change of insurer meant that, despite the previous insurer's decision, she was no longer covered for the operation**

## 2 conditions and conditions

We continue to face difficult decisions on how insurers have applied exclusions for pre-existing medical conditions. And in considering these cases, we continue to adopt the approach suggested by our predecessors following the House of Lords' decision in *Cook v Financial Insurance Company Ltd* [1998] 1 Weekly Law Reports 1765.

Briefly, 'condition' – in the context of these exclusions – should mean a medical condition recognised as such by doctors (not simply some generalised symptoms). When we consider individual cases we will look at the position when the policy was taken out. In particular, we will review the customer's medical history, including:

- the intensity of symptoms
- the seriousness with which they are regarded
- the diagnosis that has been made; and
- the treatment given.

We will also consider the significance of the difference between the customer's symptoms up to the point when the policy was taken out, and the medical condition that gave rise to the claim, when it was finally diagnosed. The more remote the connection, the less likely we are to accept that the 'condition' existed at the time the policy was taken out. Finally, we try to ascertain what the customer knew about their condition when entering into the policy.

Since the *Cook* case, some insurers appear to have altered their policy wording, in an attempt to extend the exclusion for pre-existing

conditions to conditions that are related to symptoms that were apparent before the start of the policy. Case 13/03 provides an example of this, albeit in the rather specialist context of a moratorium exclusion in medical expenses insurance. A moratorium of this type excludes, for a specified period, a medical condition that existed when the insurance was issued.

The specified period (frequently two years) must then have passed without the policyholder having received any further treatment or advice for this condition before it is covered by the insurance. The use of moratorium exclusions means that the insurer does not require details of the policyholder's health before it issues the policy. Instead, it relies on the exclusion to reject any claim made for existing conditions during the specified period.

Our approach in this area is developing and we will need to consider further, in the light of a wider range of cases, how such exclusions should be interpreted. In particular, we need to consider if it is reasonable:

- to describe a person with a common condition – such as high blood pressure – as having a 'related condition'; and then
- to apply the exclusion when the person subsequently suffers from a more serious condition, such as a stroke, where the original condition is known to be a contributory or risk factor.

Our initial view is that such exclusions have the potential to be onerous. Whatever the case, we are more likely to uphold insurers' preferred interpretation of such exclusions if their wide potential scope was fully and clearly explained to customers before they took out the policy.

## case studies – (medical) conditions and (policy) conditions

■ 13/03

### **Private medical expenses – moratorium – whether emergency condition exempt from moratorium – whether blood pressure ‘related to’ stroke.**

Mr and Mrs L took out insurance in May 1999 to cover the cost of private medical treatment. The policy included a moratorium exclusion. This excluded treatment *‘of any illness or injury ... which existed or was foreseeable prior to or which recurs after the Insured Person’s Date of Entry, until a continuous period of two years has gone by’*.

In February 2000, Mrs L suffered a stroke and was admitted to hospital. Her claim under the insurance was rejected. The insurer said that her stroke was related to the high blood pressure for which she had been treated during the past few years. As the two-year moratorium period had not passed, she was not entitled to any benefit. Mr and Mrs L argued that the insurer should meet her claim, since she had been admitted as an emergency patient and the insurer did not require prior authorisation in such circumstances.

### **complaint rejected**

It was true that emergency admissions did not require pre-authorisation in the same way as other claims, but when Mr L notified the insurer of the claim, it explained that he and his wife would be liable for all expenses if it did not accept the claim.

Mrs L was receiving treatment for hypertension at the time the policy came into force, so hypertension would not be covered until two years had passed without her needing any treatment for it. This exclusion covered not just the condition itself but also *‘any other illness ... related to it’*. Hypertension was a contributory factor for strokes and Mrs L’s stroke was therefore covered by the exclusion. The insurer was entitled to reject the claim.

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■ 13/04

### **Income protection – ‘totally disabled’ – disability due to stress – policyholder physically well – whether possible future stress sufficient to render policyholder ‘disabled’.**

On holiday in France, Mr N had a transient ischaemic attack. He was subsequently diagnosed as suffering from heart disease and he gave up work. He claimed benefits under his permanent health insurance on the ground that his state of health totally prevented him from working. The insurer made medical enquiries and found that although Mr N’s GP and his consultant neurologist had both recommended he should give up work, they agreed that he was physically fit to resume work. His occupation, as managing director of the company he had started many years before, was highly stressful. The insurer maintained that there was no physical reason why Mr N should not return to work.

## 3 critical illness

The medical evidence was inconclusive. So we arranged for Mr N to undergo an independent examination. The independent consultant considered there was no medical reason why Mr N could not return to work, but that he should not do so because of the risk to his health. The consultant felt that Mr N's occupation involved such a degree of stress that the risks of further disability would be increased if he went back to work, and there would be a very real risk of his illness recurring.

### **complaint upheld**

This was an unusual case. Generally, a person with a stable medical condition who is fearful that returning to work may aggravate their condition – perhaps through stress – will have difficulty demonstrating they are not able to work. Here, however, the medical evidence pointed strongly to a worsening of the policyholder's condition being not just a worry but a foreseeable result of returning to work. So although Mr N's position had clearly stabilised after he gave up work, that was not sufficient justification for rejecting his claim. The medical evidence made it clear that he was only well so long as he did not work. Returning to work would put his health at risk, so it was not right to conclude that he was not 'disabled'.

We required the insurer to meet Mr N's claim from the end of the deferred period of six months, and to add interest to the back payments.

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Disputes about critical illness cover are now handled by the insurance division's medical team, not by the investment division of the ombudsman service. 'Critical illness' is a life-threatening condition, which is generally strictly defined. Most critical illness policies provide for the payment of a lump sum benefit if the policyholder is diagnosed as suffering from one of a number of specified terminal illnesses. The payment of a lump sum during illness rather than on death can provide a significant improvement in lifestyle, helping to alleviate the consequences of infirmity.

However, policyholders need to be aware that under many of these policies, claims are only valid if the policyholder survives for 28 days after diagnosis.

Critical illness cover is often linked to term life assurance, so the sum assured will be payable on death. It is normally a condition of this type of dual insurance that only one benefit will be paid. The premium payable for critical illness insurance is low compared with the amount of the sum assured – but the cover provided is of a limited nature.

The Association of British Insurers has issued a statement of best practice, which includes model forms of policy wording. The statement covers the seven 'core' illnesses, but includes terms for over 20 different illnesses. It is up to individual insurers how many of these each policy will cover. Each illness is carefully defined and not all forms of an illness will qualify for benefit. For example, the definition of a heart attack is:

*'The death of a portion of the heart muscle as a result of inadequate blood supply as evidenced by an episode of typical chest pain, new electrocardiograph changes and by the elevation of cardiac enzymes. The evidence must be consistent with the diagnosis of heart attack.'*



The policyholder may have experienced one or more episodes of chest pain, but that will not be sufficient to justify payment unless the other criteria have been met. It is also common for policies to stipulate that the diagnosis of any illness must be made by a 'medical specialist' holding specific qualifications.

As with other types of insurance, a proportion of the complaints referred to us concern non-disclosure (where a policyholder has failed to disclose certain information that the insurer requires). The other major area of dispute relates to the illness itself – is it precisely what is described in the policy? If it isn't, then no benefit will be payable. Unsurprisingly in such cases, policyholders suffering from an illness that is serious – but does not meet the policy description – will often feel aggrieved that they do not qualify for a payment because of what they see as 'a mere technicality'.

In these cases we rely on the medical opinions. Where there is a fundamental disagreement between the insurance company's adviser (whether its Chief Medical Officer or an outside consultant) and those treating the policyholder, we sometimes need to instruct our own independent expert. Such experts may examine the policyholder or may simply express an opinion based on all the available written evidence, depending on the issues involved.

Often, however, the dispute has arisen not because of a fundamental disagreement between the experts, but because each of them has presented their conclusions in the form most palatable to the person or firm that has consulted them. Where this has happened, we can identify the common findings and then make our decision in support of one of the parties.

## case studies – critical illness

■ 13/05

### **Critical illness – misrepresentation – underwriting limits – proposer outside underwriting limits – whether misrepresentation justified cancellation of policy.**

A salesman called on Mr L, a pub landlord, and recommended that he should take out critical illness insurance. This would pay him £10,000 if he were diagnosed with any of the conditions listed in the policy. The salesman completed the application form and Mr L signed it. The form stated that Mr L's height was 6' 1" and his weight, 17 stone.

The policy was issued in November 1999. In December 2000, Mr L was diagnosed with cancer and he submitted a claim. The insurer's enquiries revealed that Mr L had mis-stated his height (he was actually 5' 10"). It therefore cancelled his policy on the ground that he had misrepresented his measurements. It told Mr L that it would not have insured him if it had known his actual height as, combined with his weight, it put him outside its underwriting guidelines.

### **complaint upheld**

Mr L's mis-statement was innocent and not an unusual mistake for someone to make. The difference in height was within a 3% margin and the insurer ought to have made an allowance for such a minor error. The insurer conceded that if it had known Mr L's correct height – and his weight had not exceeded 17 stone – it *would* have covered him. The difference between his actual weight and that stated was also within a 3% margin.

The policy had been sold to Mr L in person. The salesman should therefore have appreciated that Mr L's size brought him close to the insurer's underwriting limits, and he should have stressed to Mr L the importance of giving accurate measurements. There was no reason why Mr L should have been aware of the insurer's underwriting limits. It was irrelevant whether Mr L gave the salesman inaccurate information, or had simply failed to notice that the salesman had recorded the information incorrectly.

In the circumstances, we concluded that the insurer was not justified in relying on the misrepresentation to cancel the policy. It accepted our conclusion that it should pay the £10,000 policy benefit.

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■ 13/06

**Critical illness – non-disclosure – whether insurer entitled to cancel policy because of innocent non-disclosure.**

Mrs C applied for life assurance and critical illness insurance in May 1999. One of the questions she was asked was whether she had a 'lump, growth or tumour of any kind' – she answered 'No'. She was also asked whether she had 'consulted, or been prescribed treatment by a doctor during the last 5 years'. She answered 'Yes' and listed what she and her GP considered relevant information from her medical records.

In July 2000, Mrs C claimed benefit under her critical illness policy as she had been diagnosed with a malignant melanoma. The insurer sought information from her GP and discovered that, in March 1999, Mrs C had asked her GP to look at a mole that had been on her left thigh since birth, and was starting to bother her. The insurer accepted that Mrs C's failure to tell it about this incident was innocent, but it cancelled both her policies. It considered that she should have disclosed this particular GP 'consultation' in response to its direct question about 'growths' and that by failing to do so, Mrs C had prejudiced its position.

Mrs C disputed this decision. She said her GP had told her the mole was nothing to worry about and she had not sought further advice or treatment for it until May 2000. Her GP's notes confirmed that the mole was only mentioned casually at the end of a consultation for an unrelated matter, and that Mrs C was told it was benign and had no sinister features.

**complaint upheld**

A brief mention of a minor problem was not a 'consultation' and we did not consider that Mrs C had provided an incorrect answer to the question about consultations. The GP had not organised any further investigation of the mole or made any recommendation about it. It seemed only to have been included in the GP's notes in case a problem occurred in future.

As to the question about lumps, growths or tumours, Mrs C had acted reasonably in answering 'No'. She had to answer the insurer's questions only 'to the best of her knowledge' – and – to the best of her knowledge, she did not have any condition that she needed to tell the insurer about. Her GP had told her the mole was inconsequential and since it had been present all her life, and was apparently not a matter of any concern, she could not have been expected to mention it.

We did not consider the insurer had sufficient grounds for cancelling the policies and we said it should reinstate them and assess the claim. We also awarded Mrs C £400 for distress and inconvenience.

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■ 13/07  
**Pension – non-disclosure – questions regarding current consumption of tobacco and alcohol – whether proposer required to disclose past excesses.**

In June 1998, Mr S took out a personal pension which included death benefit. He answered questions on the proposal regarding his past health, his weight and his cigarette and alcohol consumption.

In December 1999, Mr S died and his widow applied for the death benefit. As a result of its enquiries, the insurer concluded that Mr S had not given truthful answers to its questions. In particular, it was satisfied that he had failed to disclose episodes of bronchitis and had not given correct information about his weight, smoking and drinking habits.

Mr S was obese, according to his GP, and had smoked 30 cigarettes and drunk about a bottle of vodka every day. He had suffered several episodes of bronchitis between 1970 and 1975.

Mrs S disputed this evidence and asserted that although Mr S had been a heavy drinker and smoker, he had changed his habits after the birth of their first child in 1984. She said that his height and weight had been correctly recorded.

**complaint upheld**

The insurer was unable to produce the signed proposal and this omission had undermined its case. There was no evidence that Mr S had not answered the questions truthfully. Moreover, from a sample proposal form that we obtained from the insurer, it seemed that the questions all related to the *current* health and consumption of the person wanting to obtain the critical illness cover, not to their past history or old habits.

So far as could be ascertained from the medical evidence, Mr S *had* changed his habits by the time he signed the proposal. There was no reference to his drinking or smoking after 1988. He did not seem to have consulted or been treated for bronchitis after 1975.

We decided that the insurer was not justified in concluding that Mr S had failed to provide correct answers to its questions. The insurer agreed to pay Mrs S the death benefit of over £30,000.

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## 4 handling complaints

Customers who refer their complaints to us often note the costs they have incurred in writing letters and making telephone calls to the insurer in an attempt to sort things out. They say that if the firm had acted reasonably (in their view) then they would not have faced this cost and inconvenience.

Normally, we do not make awards to customers to cover any costs associated with complaining to the firm or to the ombudsman. However, in its rules for firms, the Financial Services Authority (FSA) sets out basic complaints-handling standards and makes it clear that responding effectively to complaints is part of the service that firms should offer their customers. If a firm has handled the complaint badly – causing the customer distress or inconvenience – then an award may be appropriate. This could be the case, for example, where there have been excessive delays in responding to the customer's concerns.

We may also make awards where it seems to us that the firm required the customer to take additional and unnecessary steps to resolve a dispute. For example, an award for inconvenience might be appropriate if a firm refused to settle a dispute where our approach was clear and we had upheld similar complaints.

The need to handle complaints effectively is not limited to those cases where the complaint is justified. We will also consider making awards where the original complaint is not upheld but there are justified concerns about the way in which the firm responded to that complaint.

Customers will, on occasion, estimate their costs in pursuing their complaint as several thousand pounds, but most of our awards will be modest.

Further information on our approach to awards for non-financial loss can be found in a briefing note published on our web site: [www.financial-ombudsman.org.uk](http://www.financial-ombudsman.org.uk).

**... responding effectively to complaints is part of the service that firms should offer their customers.**

## 5 paying for medical reports

In the July 2001 edition of *ombudsman news*, we asked for readers' views on who should pay for medical reports. We set out the general issues that commonly arise in the disputes we consider, and we gave examples of cases where we had seen different positions taken by insurers.

We have been considering the matter in the light of readers' responses and the cases that we have decided. As always, our first consideration must be what would be fair and reasonable in the particular circumstances of the case. However, it is now possible to identify some general themes that we expect to use in future decisions, unless the particular circumstances of the case clearly suggest another approach would be more appropriate.

First, we recognise that insurers may reasonably require medical reports and other medical evidence about policyholders to be provided. However, as a number of respondents pointed out, obtaining reports can place burdens on doctors and policyholders. Inevitably, hard-pressed doctors will not give a high priority to completing reports for insurance purposes. Delays in obtaining reports can therefore be expected. We would want to see this reflected by firms in their own procedures. Medical reports should only be requested where there is a clear need to confirm the evidence provided by the policyholder.

A number of respondents suggested that market practice was changing and that – increasingly – insurers are meeting the costs of medical reports where they settle claims. This brings medical reports into line with other expert evidence obtained during claims (for example engineers' reports on vehicle condition or surveyors' reports on subsidence claims) and now appears to represent good market practice. If an insurer has paid for a report, then it is the insurer's property and within its control. The insurer is thus in a position to decide precisely what further questions need to be answered and it can usually act more quickly.

So our general approach will therefore be to presume that – generally – firms should meet the cost of medical reports wherever the customer consents to the report being released to the firm. However, it seems reasonable for a firm to require a *policyholder* to pay for any medical report that is required primarily to prove that a claim is valid, (whether when the claim is first made, or on a continuing basis). Thus, even if some claim payments have been made, the responsibility rests with policyholders to provide the firm with any evidence it reasonably requires to demonstrate they have a valid on-going claim. If that claim is successful, however, then we would expect the insurer to reimburse the cost of such report(s).

## 6 round-up of cases

We also note that insurers' requirements for regular reports about largely stable conditions may place a significant burden on policyholders (and their medical advisers). For example, the costs to the policyholder (both direct and indirect) of a monthly check-up and report may outweigh the benefit under some loan protection policies (even if the firm subsequently reimburses some of the costs). A firm's requirement that a policyholder should obtain numerous reports for low value, on-going claims may – of itself – be onerous.

When a firm is handling cases, we expect it to meet the cost of obtaining information about whether a claim is excluded by the policy terms. If, in reaching a decision on a complaint, the firm plans to rely on one of the policy exclusions (such as pre-existing medical conditions), or on the fact that the policyholder failed to disclose a relevant matter, then the burden of establishing that rests with the insurer, not the policyholder. We expect such cases to be handled sensitively and expeditiously. There is a particular need to resolve matters quickly where the policyholder is being treated for illness abroad.

There is a further situation where medical evidence may be required. Where claims are rejected or terminated on reasonable grounds, then it is for policyholders to produce any new medical evidence that could support their appeal against that decision. If they succeed in establishing that their claim is valid, we would expect the firm to reimburse that cost in full.

**This selection of case summaries gives some idea of the range of cases we deal with. The individual circumstances surrounding some of the cases may be unusual, but the cases all illustrate our approach, and how we reach what we consider a fair and reasonable outcome.**

■ 13/08

**Loan protection – exclusion for pre-existing medical conditions – failure to highlight exclusion – whether customer prejudiced by failure.**

Mr G purchased a car from his local garage. He took out a hire purchase agreement and a loan protection insurance policy – both purchased at the garage. Nine months later he suffered a major heart attack and he has not worked since. The firm rejected his claim for the critical illness benefit because he had suffered previously from angina and generalised chest pain. The policy excluded any medical conditions for which the policyholder had sought advice in the 12 months before starting the policy. A 'condition' was defined as including 'any symptom of [any sickness]'.

Mr G said that he had wanted cover as he had suffered a heart attack eight years previously and was concerned about his ability to continue working if he was ill again. He said he had explained this to the car salesman, but the exclusion was not pointed out to him.

**complaint upheld**

The firm's reliance on the exclusion for pre-existing conditions was questionable. Mr G had suffered in recent years from some generalised chest pain symptoms but his condition appeared to have been minor and

## ... the firm's reliance on the exclusion for pre-existing conditions was questionable.

reasonably stable. It was perhaps debatable whether such relatively minor symptoms could reasonably be described as symptoms of the heart attack that followed. However, this was not a matter we needed to resolve in this particular case because the main dispute rested on whether the policy had been sold properly.

Mr G had signed a declaration that he had read and understood the policy. In fact, it seemed highly unlikely that he *had* read and understood it. The policy wording was complex and little or no effort had been made to draw the important provisions to the attention of policyholders. In particular, the exclusions for pre-existing conditions were not highlighted in any way (either in the policy or in a customer leaflet).

Exclusions for pre-existing conditions are recognised both by the industry and by customer groups as being particularly significant and needing to be explained and drawn clearly to policyholders' attention. In this case, this clearly didn't happen and advice was either not given or misleading. Overall, the sale did not meet the requirements set down in the codes of either the General Insurance Standards Council or the Association of British Insurers.

Our general approach in these cases is to put customers back into the position they would have been in had the firm not made an error. This will often be achieved by returning the premium, as many of these customers would not have bought the policy if they had been correctly advised. In

other cases, we may conclude that the customers suffered no material detriment from a mis-sale, as they would probably have purchased the policy in any event. Conversely, if the unexplained exclusion is unusual or onerous, we may require the firm to meet the claim in full, as alternative policies with wider cover may have been available.

In Mr G's case, the exclusion itself was not unusual. But we were satisfied that if he had been aware of the true nature of the policy, he might well not have bought the car at all, or he might have made more cautious financing arrangements.

On this basis, we required the firm to meet the claim in full; to meet any costs arising from Mr G's inability to make the loan repayments since the claim was made; and to pay him £300 for distress and inconvenience.

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### ■ 13/09 **Household contents – accidental damage to carpets – exclusion for damage caused by domestic animals.**

Ms E's dog died in her lounge. As it was some time before the unfortunate dog was found, the carpet was badly stained. Ms E arranged for the carpet to be cleaned but without success. The staining and foul odour was permanent. Ms E claimed under the accidental damage section of her policy for replacement carpets – valued at

about £1,100 – as well as for the initial cleaning costs. The firm declined to meet the claim on the basis of an exclusion that covered damage caused by domestic animals.

**complaint upheld**

This was scarcely a case of damage caused by a badly housetrained animal. The dog was dead when the accidental damage occurred. It did not seem reasonable to apply the exclusion in these circumstances and we required the firm to meet the claim in full.

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(as required by the policy). As a subsidiary point, it argued that the games should be considered as ‘cassettes or tapes or disks’, which were excluded from cover under the policy.

**complaint upheld**

It seemed to us that Mr H had made appropriate and – in the circumstances – more than adequate efforts to recover the goods. It was not reasonable of the firm to require him to do more. Equally, we did not accept the insurer’s argument that since the location of the goods was known, the goods were not lost. Just as if the items had been dropped from a boat and were now at the bottom of the ocean, there was no practical prospect of recovering Mr H’s lost goods. Goods can be ‘lost’ if their location is known but they cannot – for practical purposes – be recovered.

The list of exclusions from cover was lengthy. It therefore seemed appropriate to interpret the provisions narrowly and, in case of doubt, to favour the customer’s interpretation. A ‘gameboy’ game was not, strictly speaking, a disk (cassette or tape) and we therefore required the firm to meet the claim in full.

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■ 13/10

**Travel – loss of goods when location known – reasonable steps to recover – whether gameboy game a ‘disk’.**

Mr H’s son left a bag containing his ‘gameboy’ and associated games on the back seat of the taxi that took the family to the airport on their way home from the Canary Islands. Mr H contacted the taxi firm through the resort and the missing bag was located. However, the taxi driver concerned had not returned to the airport with the bag by the time the family had to board the plane. Back in the UK, Mr H again tried (through the holiday resort) to get the bag located and returned. He had no success, so he claimed £305 for the ‘gameboy’ and games under his travel policy.

The insurer rejected the claim – initially on the basis that the loss had not been reported to the police. It then claimed that the bag was not, in fact, lost and that Mr H had not taken ‘adequate steps to recover the goods’

■ 13/11

**Personal accident – specified injuries – whether other injuries also covered.**

On the flight home from a family holiday, Mrs M’s toddler son hit her in the face, breaking her nose. She submitted a claim to her travel insurer for the policy benefit of



£20,000. The insurer rejected her claim, stating that the benefit was only payable in three situations: death, loss of one or more limbs or eyes, and permanent total disablement. As none of these had occurred, it maintained it was not liable for Mrs M's injury.

Mrs M argued that the policy wording did not make it clear that only three events would give rise to the benefit. She also felt that she was entitled to be indemnified under the personal liability section of the policy. This provided a maximum payment of £2 million for any personal injury.

#### **complaint rejected**

The policy wording was unambiguous and provided for payment of the personal accident benefit only if one of the three specified events occurred. There was nothing in the policy to suggest that any other personal injury would give rise to a benefit entitlement.

As to the liability section, we did not accept that a two-year-old was capable of being held liable for the injury by a court. The insurer therefore had no responsibility for indemnifying the child against any liability to his mother. Moreover, the policy specifically excluded liability to family members.

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■ 13/12

#### **Income protection – disability from ‘normal pursuits’ – meaning of ‘normal pursuits’.**

Mrs B took out income protection insurance in 1981. This protected her dual occupations of nurse and housewife and would provide a weekly benefit of £50 if she became too ill or disabled to continue work.

When she became ill, the insurer rejected her claim on the ground that she was not disabled from ‘the normal pursuits’ of a housewife. Mrs B protested, arguing that her disability prevented her from continuing with her nursing work, and that this was the situation she had intended the policy to cover. She pointed out that the policy did not define ‘normal pursuits’ and therefore she could not tell whether her claim met the policy criteria. The insurer still maintained that no benefit was payable unless Mrs B was unable to follow the normal pursuits of a housewife. It said that this must have been clear to Mrs B because all the usual references to income had been deleted from the policy.

#### **complaint upheld**

Mrs B had clearly purchased the policy to protect her income, which was solely derived from nursing. The policy was called an ‘Income Protection Policy’ and the fact that it would only pay a benefit if she was *also* unable to perform a housewife’s normal duties had not been explained to her. The wording of the policy was vague, at best, and where an insurer has drafted its contract terms ambiguously, we take the interpretation least favourable to the insurer.

Moreover, since the policy contained no definition of 'normal pursuits' – it was reasonable to interpret it as referring to her occupation of nursing. Mrs B derived no income from housework and it was unreasonable to interpret the policy as meaning that benefit was not payable unless she was unable to perform housework.

We required the insurer to pay benefits to Mrs B from the date of her disability, subject to any deferred period, and to add interest to the amount it paid her.

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■ 13/13

**Household buildings – heave – exclusion for damage to swimming pool when house not damaged – damage resulting from previous subsidence repairs – whether insurer entitled to rely on exclusion in relation to heave damage.**

Mr E's house was affected by subsidence in 1996 and his insurer dealt with the claim. Its loss adjusters decided to stabilise the property by removing and reducing trees on both Mr E's and the next-door properties. Superstructure repairs were completed in 1998, after the property had stabilised. In 1999, Mr E noticed that his swimming pool was seriously affected by heave, which had pushed up the underlying soil and cracked the pool. There was no damage to the house.

Mr E notified the insurer and it appointed the original firm of loss adjusters and an engineer to investigate. The engineer concluded that the cracking of the swimming pool was not connected with the removal of the trees. The insurer rejected the claim. It did not accept that the damage was a continuation of the 1996 claim. The claim was therefore for new damage and only covered under the policy if the house were affected at the same time.

Mr E obtained his own engineer's report. This concluded that the damage to the swimming pool was a direct consequence of the tree management programme implemented by the insurer. However, the insurer refused to alter its decision.

**complaint upheld**

We appointed an independent engineer to assess the damage, and the insurer agreed to accept his conclusions. The independent engineer advised that the tree reductions had most likely caused heave of the site. He accepted that the reduction programme had been undertaken in good faith, but he was concerned that no heave predictions had been made and that the heave consequences of removing the trees had been largely ignored. In the circumstances, he did not think it would be fair for the insurer to rely on the exclusion.

The insurer accepted that it should deal with the claim and agreed that the independent engineer should take over management of the claim from the loss adjusters. It also agreed to reimburse Mr E's engineer's fee.

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■ 13/14

**Motor – driving other cars – extension of cover for driving abroad – whether driving other cars abroad covered.**

For many years Mrs H had held motor insurance with the same insurer. She had family in Northern Ireland and her policy covered her for driving in the Republic of Ireland and for driving other cars. In September 1999, she had an accident, hitting another vehicle while driving her brother’s car in the Republic of Ireland.

Mrs H claimed indemnity under her policy against a third party claim. However, the insurer rejected the claim, saying that her brother’s insurer should deal with it. It referred her to the policy, which stated: *‘Cover for driving other cars does not apply ... in any country outside the United Kingdom’*.

Mrs H argued that this was overridden by the extension, noted in the Statement of Insurance, that permitted her to drive in the Republic of Ireland. However, the insurer explained that this extension was limited to *her* car only. She also contended that the insurer was in breach of the law that required insurers to provide minimum cover throughout the European Union.

**complaint upheld**

It was only by reading the policy document in conjunction with the schedule and the Statement of Insurance that it was clear that Mrs H was *not* covered for driving other cars outside the UK. However, none of these documents made it plain that all three documents had to be read together.

We accepted Mrs H’s argument that the policy was not clear and that she should therefore be given the benefit of the doubt. She had believed she was covered for driving other cars in the Republic of Ireland and that belief was not unreasonable. We therefore required the insurer to deal with the third party claim.

As to the legal position, the legislation required insurers to provide minimum insurance cover, but did not state whether – in this type of situation – it was the insurer of the car or the insurer of the driver which should deal with any third party claim. The Road Traffic Act 1988, as amended, referred to the obligation to insure *‘such person ... as may be specified in the policy’*. In the light of this, it might be reasonable to expect the driver’s insurer to accept liability. However, we did not need to determine this point as the first argument succeeded.

Mrs H had also claimed compensation for the fees her representative charged for pursuing the complaint. We only award these in very rare cases, for example, where the policyholder required legal advice in order to respond to an insurer’s arguments. This was not such a case so we did not award any additional compensation.

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■ 13/15

**Motor – non-disclosure – policyholder stating he had not been asked about ownership or use of car – whether insurer entitled to cancel insurance.**

Mr O applied over the telephone for motor insurance for his son’s car. He answered a series of questions and the insurer then sent him a statement of facts, for checking, based on the answers he had given. The statement showed that there were two drivers, Mr O and his son.

A few months later, the car was stolen and Mr O claimed compensation. The insurer’s enquiries revealed that the car was registered in the son’s name. Mr O and his son said they had bought the car jointly and that the son was the main user. The insurer then cancelled the policy, telling Mr O that if it had known these facts, it would have charged a premium six times higher.

**complaint upheld**

The insurer did not ask Mr O to sign a proposal and it did not keep any record of his answers to its questions. Although it maintained that Mr O had described himself as the ‘main user’, this information was not recorded in the statement of facts and it was impossible to verify whether he had been asked this question. We required the insurer to deal with the claim on the ground that there was insufficient evidence that Mr O had failed to disclose all relevant information.

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■ 13/16

**Livestock – cost of veterinary treatment – exclusion for illnesses arising within 14 days of cover – whether insurer’s failure to highlight exclusion prejudiced policyholder.**

Over a period of several years, Mrs S had insured a number of different horses. These horses did not belong to her, but were lent to her by their owners for long-term use. On 13 March 2001, one of these horses – Chino – was due to be returned to its owner. Mrs S telephoned the insurer that morning to transfer the policy cover from Chino to another horse – Sparky. The insurer agreed to do this immediately.

Later that day, Mrs S’s daughter found that Sparky was unwell. The vet diagnosed colic and the total cost of treatment came to over £4,000. Mrs S claimed under the policy but the insurer rejected her claim on two grounds. It stated that the policy:

- did not cover any horse which the policyholder did not own; and
- excluded claims for any illness that arose within 14 days of the policy’s start date.

Mrs S argued that she had not owned any of the horses she had insured, and she pointed out that the insurer had never raised this matter before. She also said that the insurer had failed to mention the 14-day exclusion, and she presented evidence that Sparky had been in good health on the morning she arranged the insurance for him.

**complaint rejected**

The insurer conceded that it would cover horses on long-term loan to a policyholder, so that issue was no longer relevant. However, even if we accepted Mrs S’s assertion that the exclusion had not been drawn to her attention, it was hard to accept that that failure had prejudiced her position. Sparky had been well when the insurance was taken out, so even if the insurer had pointed out the exclusion, we believe she would still have gone ahead and obtained cover from this insurer.

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- 13/17  
**Household contents – proof of loss – policyholder failing to cooperate with insurer’s enquiries – whether insurer justified in rejecting claim.**

On 8 May 2000, Mr S took out household contents insurance, with additional cover for specified personal belongings, including legal textbooks and a computer. Two weeks later, he set out to travel by train to Glasgow, where he was due to catch a flight to Frankfurt. As he had a few minutes before the train went, he left the station to buy food from a supermarket and was mugged. He submitted a claim for the computer and textbooks; a silver cigarette case; £300 cash; clothing and his air ticket (a total of some £5,000).

The insurer’s enquiries revealed numerous discrepancies. The film from the CCTV cameras in the station did not support Mr S’s account of the mugging, although

he provided more than one version of events. Mr S refused to sign the statement taken by the insurer’s investigator and instead submitted his own summary. The insurer refused to make any payment, stating that Mr S had failed to prove that the incident had occurred or that he had owned the items claimed for.

**complaint rejected**

It is a claimant’s responsibility to prove that a loss has occurred and that the loss is covered by the insurance policy. There were several unsatisfactory aspects to Mr S’s account that he had failed to resolve. This, together with Mr S’s failure to cooperate with the insurer’s enquiries, justified its refusal to meet his claim.

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- 13/18  
**Personal accident – permanent total disablement – accident occurring after policy start – disablement due to combined effects of two accidents – whether benefit payable.**

Mr M was an avionics engineer with the RAF. In 1990, he injured his back but recovered after treatment. He took out personal accident insurance in December 1993. In November 1994, Mr M had another back injury, again returning to work after a temporary absence. However, following a further injury in May 1996, spinal instability was diagnosed. An MRI scan in 1997 showed that he had a

prolapsed intervertebral disc. Several operations were performed but Mr M did not recover and he was discharged from the RAF on medical grounds in January 2000.

Mr M submitted a claim under his personal accident insurance for the lump sum, permanent total disablement benefit of £10,000. The insurer accepted that Mr M was permanently disabled, but concluded that it was the accident in 1990 that had caused the disability. As this had occurred before the insurance came into force, his claim failed.

#### **complaint upheld in part**

The consultant had concluded that *'on a balance of probability, [Mr N] did have a prolapsed disc following the incident that occurred in 1990'*, even though Mr N had been passed fit for work by the RAF after recuperation. We were satisfied that the injury which eventually resulted in Mr N's disablement was in 1990 and that the incident in 1996 simply made it worse.

However, Mr N had not been given a copy of the full policy terms, merely a brochure describing the cover. This began with the words *'If an accident were to happen to you, how would your finances cope?'*. The benefits were said to be payable *'If you are disabled by an accident'*. This wording implied that a policyholder would be entitled to benefit if he were disabled by an accident after the policy had been issued.

The incident in 1996 had, according to the consultant, made the original condition significantly worse. We therefore put it to the insurer that it should make a payment of £5,000 – in other words 50% of the full benefit. It agreed with our conclusion.

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