Case 7/2010

Claim repudiated on grounds of alleged non-disclosure

Background

1. The complainant and his wife bought a house in May 2007, and took out a joint whole life policy to cover the bond. The complainant's wife disclosed her history of diabetes amongst other disclosures and the premium was loaded accordingly. The date of application was 6 June 2007, and the policy commenced on 1 September 2007. On 5 October 2007 the complainant's wife was diagnosed with lung cancer, and she died on 14 May 2008.

2. According to the medical records, the deceased underwent a mammogram, x-rays and ultrasound in February 2007. Results were normal, except that the x-ray, which was done because she had stomach pain, revealed a small opacity. There was a note that it was worth repeating a radiograph in 4 to 6 months time. The insurer Altrisk, on behalf of Hollard in its initial letter of repudiation, maintained that this information was not disclosed, and that if it had been aware of these investigations, terms would have been deferred until the investigations were complete.

3. The complainant disputes that the information was not disclosed. He maintains that, as there were so many underwriting requirements, his wife's entire medical file was supplied from the hospital at the time of application (as well as at claim stage). This, he says, is corroborated by the broker who arranged the insurance. He states that his wife removed her file from the hospital and an employee of Altrisk arranged for a courier to take it to the insurer's head office.

4. Altrisk has provided a copy of the list of underwriting requirements, and the documents received. It maintains that "it does not appear that" the entire file was requested, nor was it received, at application stage. In its response to our office Altrisk also mentions, apparently for the first time, that the oncology notes dated 1 November 2007 state that "the patient was not able to swallow solid food since July 2007. Recently she can only take liquids". Altrisk maintain that the difficulty in swallowing was a health change which occurred before the date of commencement of insurance, and which should also have been disclosed.

5. The complainant replied that, as a diabetic, his wife often ate light snacks in preference to full meals. There were some days in July and August 2007 when she was uncomfortable eating heavy food, but no-one took much notice of this and she did not lose any weight at that stage – she therefore did not see this as a material alteration of the facts that should be disclosed. After her cancer was diagnosed in November 2007 she recalled to her doctor that there were times when she had not felt like eating solid food since July, and he recorded this in his notes.

6. Provisional determination

   Our office made a provisional determination to the effect that we could not find in favour of the complainant that the whole medical file had been disclosed to the

insurer. We made this determination on the following basis in our letter to the complainant:

> *"We understand that your argument is that the information was disclosed, in that, so you allege, your wife's entire medical file was supplied from ... Hospital at the time of application. The insurer disputes that the entire medical file was requested, or that it was ever received by the insurer. There is thus a dispute of fact on this issue. In terms of our rules, we have to resolve material disputes of fact on a balance of probabilities and with due regard to the incidence of the onus. In this case the onus is on you, in line with the dictum that "he who asserts must prove".*
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> *It is not usual practice for an insurer to ask for a complete medical file, and we accept, on the probabilities, that the insurer did not do so in this case. There is no documentary proof corroborating your assertion that the entire medical file was delivered to the insurer. The broker states that he was "led to believe" that the entire file was couriered to Altrisk, and the doctor's secretary cannot remember specifics but states that she normally requests a standard full history print out for the time period that the patient requires. We cannot establish as a matter of fact therefore that the full medical file reached the insurer, and the probabilities are evenly balanced.*
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> *In terms of our rules, if we are of the opinion that a material and conclusive dispute of fact cannot be resolved on a balance of probabilities with due regard to the incidence of the onus, the parties concerned shall be advised that a determination in favour of the one or the other party cannot be made. This is the situation in the present case.*
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> *In any event, even if it were the case that the entire medical file was received by the insurer, this would not have absolved the applicant from the obligation of completing the application form correctly, and answering the specific questions therein."*

We therefore upheld the insurer's repudiation.

7. After the complainant reverted to us with further arguments we reconsidered the matter. We made a provisional determination against the insurer on the grounds that on the documents completed by the deceased the insurer had not proved non-disclosure. We did not change our determination as regards the factual dispute regarding the disclosure of the deceased's medical file to the insurer.

8. <u>Provisional Determination</u>

In our provisional determination it was stated:

"*One problematic issue is the evidence in this case. Not all the evidence on which reliance is placed, is that clear.*

In your letter of 25 January 2010 you state in paragraph 1 "We remain of the opinion that Altrisk has been prejudiced by the non disclosure of material information at assessment stage, **and the possibility that the deceased may have been unaware of her deteriorating health, we are of the opinion, has no bearing on the above position."** *I must point out in this regard that a complainant cannot disclose information of which she is unaware, so the awareness of her condition is therefore not irrelevant when it comes to the question of material non-disclosure. An insured's ignorance of the cause of the deteriorating health or a diagnosis of her condition is of course irrelevant.*

Under point 3 of your letter you mention the facts that have led you to repudiate the policy.

1. *The non-disclosure of the x-ray, which you refer to as a specialist investigation.*

    - *The deceased at application state had ticked the box next to question 4.10 with a "Yes" tick, there was, however, no information provided regarding the particular x-ray in question.*

    - *The deceased's medical examiner had in fact ticked "yes" next to the question "Had any x-rays, ECG's, other examinations, and operations or been hospitalized". No further information about the x-ray was provided.*

    - *The issue is therefore whether it was **material** non-disclosure i.e. would a reasonable person have disclosed further information about the x-ray. The x-ray, it would appear, did not show any cause for the abdominal problem (the reasons for which it was taken). It showed opacity in the lung and the report suggested a follow-up.*

    - *Although the deceased was aware of the x-ray we are not convinced that she was aware of the outcome of the x-ray, because of the manner of recordal of information on the medical files of patients of .... Hospital. We have been advised that medical information for a patient at .... Hospital is not kept on a card/file, as is usual in private practice. Nor does a patient see one particular practitioner when making visits to the hospital. Instead the whole record of the patient is kept as a computer file (reflected in the printout sent to you). It is thus not a simple task for a practitioner to make himself aware of the recent medical history of the patient. In the case of the deceased there were reams of printouts reflecting the previous visits to .... Hospital.*

    - *In such circumstances the patient's awareness of reports cannot automatically be assumed, nor can it be assumed that a practitioner seeing the patient is fully informed about the patient's recent history.*

- *In the case of the x-ray, the report and the follow up suggestion was recorded 7 days after the x-ray. There is no way of knowing whether this follow-up suggestion was conveyed to the deceased.*

2. *The other issue mentioned by you is the weight loss of the patient. The medical records indicate that there was a weight loss of 14 kilograms, but it is not clear over which period this weight loss actually took place.*

    - *The insured's weight as indicated by herself on her application form on 6 June 2007, was 70 kilograms. The insured's weight as recorded by her medical practitioner on 7 July 2007 is 77 kilograms. It is not clear whether the weight loss in question took place after this date and exactly when it started.*

    - *The records do not therefore reflect that the life insured had lost the 14 kilograms prior to the date of disclosure.*

3. *You further indicated that the deceased had difficulty swallowing solids.*

    - *The hospital records on 1 November 2007 state that the patient was not able to swallow solid food from July 2007. This entry took place several months after the actual date on which this problem is recorded to have commenced. Any such entries must of necessity be approximations and not exact dates, where the patient is relying on memory as to when a particular problem commenced. Furthermore the entry took place when the complainant was already aware of her diagnosis, and with the benefit of "hindsight". You would have seen Mr. A's comments in this regard.*

    - *In July 2007 the deceased went for her medical examination (when she weighed 77 kilograms). If she had difficulty in swallowing and was taking no solid foods one would have expected this to have been recorded during this visit to the doctor, or, during the other visits to .... Hospital between July and August 2007 when she visited the hospital for sinusitis, food poisoning and post-nasal drip. Yet there is no entry regarding this problem.*

    - *Once again it is difficult to say with certainty that the entry is accurate as far as the time when the difficulty with swallowing solids started.*

We have previously, on 12 February 2009, upheld your decision to repudiate the policy. Subsequently Mr. A made further submissions and provided further documentation. We have now reconsidered all the evidence. In this case the evidence is finely balanced. The insurer, however, has the onus to prove the non-disclosure, and the meeting on reconsideration could not find that you had discharged the onus in the light of the above considerations. We cannot accordingly uphold your decision to repudiate the policy."

9. The insurer did not accept our provisional determination and the complainant also reiterated his arguments in respect of the submission of the full medical records. An adjudicators' meeting then reconsidered the matter including the further submissions.

Final determination

10. It appears to us that Altrisk did not appreciate all the points made in the provisional determination. Some of the points will therefore be repeated.

11. The insurer has the onus to prove non-disclosure and as we mentioned previously not all the evidence on which the insurer has relied is all that clear as to the timing of the medical problems. The medical records which rely on patient recall of past events cannot always be given the same weight as "direct" medical records. The insurer's reliance on records of 1 November 2007 and thereafter regarding the weight loss and intake of solids, is therefore problematic as pointed out in the provisional determination.

12. The test for material non-disclosure is the following:

> *"The representation or non-disclosure shall be regarded as material if a reasonable, prudent person would consider that the particular information constituting the representation or which was not disclosed, as the case may be, should have been correctly disclosed to the insurer so that the insurer could form its own view as to the effect of such information on the assessment of the relevant risk."*

13. In the light of the circumstances as set out in our provisional determination with regard to both the history of the medical problems and the procedures followed at .... Hospital we are not persuaded that the insurer has proved that there was material non-disclosure as defined in the Long-term Insurance Act.

14. No doubt the insurer would have done further investigations had the information in dispute been disclosed. That, however, is not the test. The test is as set out in 12 above.

15. We wish to point out that it is because of a lack of direct evidence that we are holding in favour of the complainant regarding the 2 issues of weight loss and difficulty swallowing. The first medical evidence of difficulty of swallowing solids was recorded on 28 September 2007. We agree that a diagnosis is not crucial, but there has to be clear evidence as to the time when the weight loss took place and the difficulty with swallowing was experienced. Both these aspects were retrospectively reported. There is no direct evidence, only indirect reports made at a later date after the diagnosis of cancer, with the benefit of hindsight. The report of weight loss in November 2007 mentions that she had lost about 11 kilograms since August in one report and 14 kilograms in another report. It is not clear what weight, if any, she had lost by 1 September 2007 (the date the policy commenced).

16. As regards the x-ray, we were not convinced that the complainant knew the outcome of the x-ray. The x-ray did not show the cause of her stomach pain, the reasons for which the x-ray was taken. The problem of the stomach ache did not feature again it seems and was diagnosed as "unspecified abdominal pain". We are not convinced that a reasonable insured would have disclosed the x-ray in these circumstances if the outcome of the x-ray was not known.

17. It is also necessary to deal with 2 arguments the complainant raised again after the provisional determination i.e.:

    a. that the deceased's medical records from .... Hospital were submitted to Altrisk prior to inception; and

    b. that the medical practitioner who completes the medical report at inception was in the insurer's employ.

18. As regards point a:

    We explained in our first provisional determination that we cannot make a finding on this dispute of fact on the papers. No new evidence was submitted in this regard. We are therefore still not able to find that this disclosure of all the .... Hospital medical records took place.

19. As regards point b:

    The doctor filling in the medical report was never in the employ of the insurer, nor was he the insurer's agent. The duty of disclosure rests with the applicant completing the application form. The report completed by the medical examiner is supplementary information, it does not detract from the applicant's duty. The applicant is not, therefore, relieved of this duty of disclosure because the insurer pays the medical practitioner a fee.

20. This is a difficult case where the probabilities are evenly balanced and the onus of proof in the end is decisive. We don't doubt that the insurer was prejudiced by the non-disclosed information. That is, however, not the test. Our office has to decide whether the test for materiality has been satisfied. In our opinion it has not been satisfied.

Our final determination is that the insurer cannot repudiate the policy and should now assess the claim and pay the benefit if the claim is otherwise valid.

September 2010
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