complaint

Mr and Mrs D have complained HSBC Life (UK) Limited ('*HSBC*') declined various claims under their joint life and critical illness insurance policy.

background

Mr and Mrs D purchased a joint decreasing term assurance policy ('*the policy*') in 2005. The policy included critical illness cover and a total and permanent disability ('*TPD*') benefit, with the sum assured payable upon the first death or critical illness.

In November 2007, Mrs D contacted HSBC to make a claim for critical illness benefit as Mr D had been diagnosed with chronic fatigue syndrome/myalgic encephalomyelitis ('*CFS*/*ME*'). Mrs D was told HSBC would consider a claim if Mr D was off work permanently.

In January 2008, HSBC issued a letter confirming it was unable to allow the claim since CFS/ME was not one of the listed critical illnesses covered by the policy.

In April 2012, Mr D contacted HSBC again, saying in addition to CFS/ME, he had also been diagnosed with fibromyalgia and arthritis as well as suffering a transient ischaemic attack ('*TIA*'). HSBC reiterated it could not consider a claim for CFS/ME. It further confirmed Mr D's additional conditions were also not listed critical illnesses, and again were unable to allow the claim under the policy. Mr D was unhappy since he felt his conditions should be covered, and he and Mrs D complained to HSBC.

HSBC rejected Mr and Mrs D's complaint. It said none of the illnesses which Mr D had disclosed were covered by the critical illness benefit in the joint policy. Further, it had explored whether Mr D would qualify for TPD cover. However, Mr D said of the five criteria under the policy (of which three needed to be met) for a TPD definition, he was only able to meet one. HSBC therefore could not meet a claim on this basis either.

Mr and Mrs D remained unhappy with HSBC's response, and accordingly brought their complaint to this service. They said the benign brain tumour, multiple sclerosis, and stroke definitions in their policy related to Mr D's illness, since his conditions met elements of the definitions. In addition, Mr D said HSBC had told him he was covered for CFS/ME but he would have to wait for five years to establish the permanence of the condition.

Our adjudicator did not consider the complaint should be upheld. She said CFS/ME, fibromyalgia, arthritis, and TIA's are not covered by the policy. She did not consider any of the policy definitions had been met. She did, however, recommend HSBC consider a payment for the inconvenience caused by HSBC in not explaining the policy correctly to Mr and Mrs D in 2007. HSBC rejected this, saying that the call it received in 2008 was not caused by any confusion in 2007. It also felt since Mr and Mrs D did had not made any further contact until 2012, they must have understood the policy terms.

Mr and Mrs D did not accept the adjudicator's opinion. They said HSBC advised not all conditions could be included in the policy documentation, and they would need to telephone to find out if he was covered or not. They also said Mr D has suffered permanent neurological damage/deficit, which is part of the definition of the benign brain tumour and stroke definitions. Mr and Mrs D said Mr D exhibits similar symptoms to those listed under the multiple sclerosis definition in the Life and Critical Illness Guide they had been provided at the time of the sale.

The matter has therefore been passed to me to consider afresh.

my findings

I have considered all the available evidence and arguments to decide what is fair and reasonable in the circumstances of this complaint.

I should firstly say it is clear Mr D suffers from various debilitating illnesses, which cause him considerable distress and discomfort. In reaching my decision, I have not underestimated the seriousness of his medical conditions.

However, HSBC is entitled to decline a claim that does not meet the definitions it sets out in the policy conditions. Critical illness policies are designed to cover specific illnesses listed and defined within the policy conditions, subject to certain exclusions. Neither party disputes Mr D has been diagnosed with CFS/ME, fibromyalgia, and arthritis, as well as suffering a TIA. The main issue I must therefore decide is whether or not any of these conditions met the respective policy definitions as a critical illness.

Mr and Mrs D's policy document defines critical illness as:

> "*a) The Diagnosis of the Life Insured during the term of the Policy, of any one or more of the illnesses listed in Part A of the Critical Illness Definitions.*
>
> *b) Where the Life Insured has undergone the type of surgery listed in Part A of the Critical Illness Definitions during the term of the Policy.*
>
> *c) Diagnosis of the Life Insured during the term of the Policy as suffering as a result of injury, disease or surgical operation, one or more of the conditions listed in Part B of the Critical Illness Definitions section*".

The policy wording expressly states under the 'stroke' definition that "transient ischaemic attacks are specifically excluded". Further, CFS/ME, fibromyalgia, and arthritis are not listed conditions under the policy.

I have considered Mr D's confirmation that he has suffered permanent neurological damage. However, neurological damage is also not a listed condition under the policy. I appreciate Mr D has identified the same effect on his health as the definitions of stroke, benign brain tumour and multiple sclerosis. Nevertheless, I have not seen any clear evidence that Mr D is suffering from any of these conditions, in line with the policy definitions. Should Mr D obtain further medical evidence which he would like HSBC to consider, it is open to him and Mrs D to submit this for its consideration.

Despite my sympathy for Mr D's poor health, I cannot reasonably conclude that HSBC's decision to decline the claim in accordance with the terms and conditions of the policy was unfair or unreasonable in all of the circumstances.

I have gone on to consider any additional compensation, which HSBC do not believe is merited. I agree with our adjudicator and I am satisfied it is warranted. I say this because whilst there were significant gaps in contact from Mr and Mrs D as HSBC has identified, I do not consider this signifies Mr and Mrs D must have understood the policy wording.

I have reviewed the telephone calls made to HSBC by Mr and Mrs D in respect of the potential claims and these records do not suggest they understood the policy wording, since they were querying what the policy covered. In the first call to HSBC of 2007, the advisor informed Mrs D that if Mr D received a permanent diagnosis he could make a claim. Specifically, the advisor stated:

"*If your husband had to be off work permanently for the rest of his working life, we would then consider that as an admissible claim.*"

In fact, the policy did not have an occupational TPD definition, but an activity-based one. The policy relied on three of five activity-based criteria being satisfied – and Mr D later told HSBC that though he could no longer work again, he could only demonstrate one of the five criteria.

On balance, I consider this advice caused Mr and Mrs D confusion as to what claims could and could not be made, and in light of this, a modest sum should be awarded to reflect the inconvenience caused to them. I consider a sum of £200 to be fair and reasonable in the particular circumstances of this case.

my final decision

For the reasons set out above, my final decision is I do not uphold this complaint. I do, however, direct HSBC Life (UK) Limited to pay Mr and Mrs D compensation of £200 in recognition of the distress and inconvenience its actions caused.

Jo Storey
ombudsman