THE HIGH COURT

[RECORD NO. 2012 1486 P]

BETWEEN

JUSTIN HARMON

PLAINTIFF

AND

IRISH LIFE ASSURANCE PLC

DEFENDANT

JUDGMENT of Ms. Justice Creedon delivered on the 26th October day of 2018;

Background

1. These proceedings commenced by way of plenary summons dated the 14th February 2012. The proceedings arise out of events concerning the alleged mis-selling of a unit linked Protection Plan (the policy) in September 1995 to the plaintiff by Irish Progressive Life Assurance Company Ltd. (Irish Progressive) the defendants' predecessor. The plaintiffs' broker Carroll and Associates made an application for a life assurance policy to Irish Progressive Life Assurance Company Ltd. (Irish Progressive). The brokers stated that the plaintiff required cover to allow Mr. Harmon make a draw down on a rental investment property. The policy is currently still in force with life cover of €145,515.

2. The policy bears policy number 75036245 and includes life assurance. The plaintiff says that he completed the proposal form for the policy with the assistance of Ms. Carroll (the broker) on the 5th September 1995 and sought cover for depression. The plaintiff submits he required both critical illness cover on the proposal form and also ticked the box for permanent disability as at the material time the plaintiff was suffering from depression and anxiety.

3. The proposal form of Mr. Harmon forwarded by his brokers to Irish Progressive sought three aspects of life cover namely,

(i) life assurance;

(ii) specific critical illness cover;

(iii) permanent total disability cover.

4. The defendants say that in reply Irish Progressive Life only proposed the specified critical illness and life assurance cover. They say that permanent total disability cover was declined. The policy documentation sent to the plaintiffs' broker and copied to the plaintiff requested that Mr. Harmon satisfy himself that the cover proposed met his requirements. The plaintiff signed an acceptance form on the 5th September 1995 acknowledging acceptance of the critical illness and life insurance cover proposed. The policy subsequently issued on the 7th September 1995.

5.The defendants say that in June 1997, the plaintiff contacted Irish Progressive and requested permanent total disability cover be added to his policy along with increased critical illness cover. They say the plaintiff never replied to further correspondence and details sent by Irish Progressive on the 27th June 1997. Irish Progressive was subsequently taken over by Irish Life Assurance plc.

6. The plaintiff seeks *inter alia*, damages for breach of duty, breach of contract, deceit, negligent misstatement together with repayment of all premiums paid by operation of restitution, rescission or the setting aside of the contract.

Evidence

7. At trial, evidence was given by Mr. John Harmon the plaintiff on behalf of the plaintiff's case. On behalf of the defendant evidence was given by Mr. Colin Aylward Compliance and Agency Manager of Irish Life Assurance plc, Ms. Carol Symes, New Business Department, previously of Irish Progressive and now of Irish Life Assurance PLC. and Elizabeth Sweetman underwriter, again formerly of Irish Progressive, and now working for Irish Life Assurance PLC.

8. The plaintiffs say that the proceedings herein arise from the mis– selling of an insurance policy "critical illness" (the policy) which was signed on the 21st September 1995 by Irish Progressive Life Assurance Company Ltd. via an insurance broker who assisted the plaintiff in completing the proposal, that is Carroll and Associates. The policy bears policy number 75036245 and includes life assurance. The plaintiff says that he completed the proposal form for the policy with the assistance of Ms. Carroll (the broker) on the 5th September 1995 and sought cover for depression. The plaintiff submits he required both critical illness cover on the proposal form and also ticked the box for permanent disability as at the material time the plaintiff was suffering from depression and anxiety.

9. Prior to finalisation of the insurance contract between the parties and having regard to the depression disclosed to the defendant by the plaintiff at the material time, the defendant referred the plaintiff to two psychiatrists prior to the initiation of the policy in June 1995 and the plaintiff says that the defendant applied a loading to the said policy which the plaintiff believed was due to his specific requirement to be covered for depression on the said policy.

10. The plaintiff was employed at the Garda Forensic Laboratory in the Phoenix Park, and due to his depression he was compelled to resign his job in March 2009.

11. Following his retirement from work in May 2009 the plaintiff claimed for depression on foot of his critical illness plan number 75036245 (the policy). The plaintiff submits that at all material times the plaintiff believed he was covered for such an illness and in fact an excess of 50% was applied to the plaintiff's life cover and critical illness premium by the defendant following a medical examination at the request of the defendant prior to the initiation of the said policy on the 7th September 1995. The plaintiff says that at all material times the plaintiff disclosed his depression and specifically sought cover for same. It is submitted by the plaintiff that he purchased the said policy via an insurance broker Ms. Carroll.

12. The position of the broker as agent is set out by statute. An agent is defined as acting for the insurer where he helps the proposer complete the proposal. In that regard the plaintiff sets out s.51 of the Insurance Act 1989 Part 5 as follows: -

"51(1) An insurance agent shall be deemed to be acting as the agent of the undertaking to whom a proposal for insurance is being made when, for the purpose of the formation of the insurance contract, he completes in his own hand or helps the proposer of an insurance policy to complete a proposal for insurance. In such circumstances only, the insurer shall be responsible for any errors or omissions in the completed proposal.

(2) An undertaking shall be responsible for any act or omission of its tied insurance agent in respect of any matter pertaining to a contract of insurance offered or issued by that undertaking, as if the tied insurance agent was an employee of that undertaking."

13. The plaintiff says that the broker has a duty of care to ensure the client has the best available cover to meet his requirements. The plaintiff says a brokers' duty is to: -

(i) Ascertain the clients' requirements;

(ii) Take reasonable steps to satisfy those requirements.

Mr Colin Aylward gave evidence that from his examination of the files, the status of Carroll & Associates from 1987 was as Insurance Brokers and not tied agents of Irish Progressive. Mr Aylward gave evidence of written confirmation now held on the files of Irish Life Assurance PLC confirming that in 1987 Carroll & Associates were confirmed to be on the list of Brokers used by Irish Progressive Life Assurance Company Ltd. (Irish Progressive) the defendants' predecessor. He gave evidence of further written confirmation currently held on the file of Carroll & Associates applying in 2004 to come off the approved list of brokers.

14. Ms Carol Symes worked for Irish Progressive in their New Business Department in 1995. This company merged with Irish Life Assurance PLC in 1995 with which she still works. She gave extensive evidence of the administrative steps that she took on receipt of the letter from Carroll & Associates on the 26th of May 1995 on behalf of the plaintiff Mr Harmon. She took all the necessary steps to open a new file and liaised with the Underwriting Department in respect of their requirement in particular medical examinations and other medical tests required by the underwriters. She gave evidence that Swiss Re a reassurance company based in the UK ultimately confirmed that for Life Assurance and Critical Illness they proposed a loading of plus 50% and they were declining PTD and waiver of premium. She sent a letter of acceptance to Carroll & Associates. She had contact from Mr Harmon who said that he hadn't received it so she sent a duplicate to him. The letter of acceptance was returned on the 7th of September 1995 signed and dated the 5th of September 1995. The policy was then put in force.

15. A further communication was received on the 18th of June 1997 from the plaintiff requesting a revised premium if Critical Illness was increased to £50,000 and PTD of £50,000 was to be added to the policy. The company wrote to the plaintiff on the 23rd June 1997 setting out what the proposed rates would be and enclosing a proposal form for completion. The company received no response to that correspondence.

16. Ms Elizabeth Sweetman confirmed in her evidence that Swiss Re would have referred all of the medical information to their internal Chief Medical Officer who decided that for Life Assurance and Critical Illness Cover they were rating plus 50%. She said as was standard practice then that if a case was rated for Life Assurance or Critical Illness Cover any additional benefits such as PTD or waiver of premium were automatically declined.

Legal arguments

17. Legal arguments put forward by the plaintiff are as follows: -

(i) *Uberrima fides*

The plaintiff says that any consideration of this case is governed by the reciprocal duties of the utmost good faith which the insurer owes to the insured under the doctrine of u*berrima fides*. This duty they say, extends to precluding the insurer from raising defences otherwise available to it against the claims of the insured. They opened the text of Buckley on Insurance Law, 3rd Ed. at pp. 160 – 161, para. 3-140 and 3-141 and the judgment of McMahon J. in *Manor Park v. AIG* (2008) IEHC 174 (2009) ILRM 190. The plaintiffs say that in that case the defendant accepted that the duty of utmost good faith applies to the insurer. He submits that the defendant, either by itself or through its agent, has a duty to act in the utmost good faith and that that obligation includes an obligation to disclose to the plaintiff material facts within the defendants' knowledge. The plaintiff says that it was reasonably foreseeable that there is a risk on the plaintiff's specifically sought insurance to cover risks associated with depression and anxiety which depression and anxiety could result in loss and damage if he was sold a policy by the defendant and/or its agents which excluded cover for depression and anxiety risks without informing the plaintiff and clearly explaining to him that he was not being covered as he had requested. The plaintiff submits that this goes to both the materiality of the risk and the recoverability of the claim. The plaintiff says that the defendant failed to provide the policy sufficient to meet the stated requirements of the plaintiff.

(ii) No consensus *ad idem*

The plaintiff suffered from episodes of depression and says that he specifically requested of the defendant insurance cover against loss of income from his job as a lab technician in the event that he suffered a depressive episode. The plaintiff says that his request was clear and unambiguous in relation to it, and the insurer carried out an extensive and detailed investigation of the medical history of the insured, and required further medical examination of the insured. The plaintiff says that this investigation led to a quote for cover 50% higher than the normal.

The plaintiff says that he assumed entirely reasonably that this quote was in response to his request for insurance cover against the depression particularly as he had had requested no other cover. The plaintiff says that all this was done seemingly in accordance with the insurers' normal procedures otherwise than face to face with the applicant. The plaintiff says that the first explanation given by the insurer as to what was covered by their policy put in place was that given by the insurer on the occasion of their refusal to pay the insured when he claimed payment and suffering loss of income because of an episode of depression. The plaintiff says that had such an explanation as to the nature of the cover been given to the insured when it should have been, that is namely when the policy was being taken out, then the plaintiff would have been alerted to the disparity between what he was being given and what he had requested. The plaintiff therefore says that there was no consensus *ad idem* between the parties and accordingly no contract. The plaintiff says that in the circumstances the plaintiff should receive back from the defendant all premiums paid by him with interest.

Statute of limitations / financial Ombudsman

18. The plaintiff says that following the decline of the plaintiffs' claim in 2010 the plaintiff appealed same via the internal Irish Life Appeals process and the appeal was unsuccessful. The plaintiff submits that by letter dated the 7th January 2011, the plaintiff sought an investigation of the failure of the defendant to pay his claim on foot of the material policy by the Financial Services Ombudsman. The plaintiff submits that following correspondence the Financial Ombudsman sent a letter to the plaintiff dated the 26th January 2012 and the following was contained in the said letter: -

> *"This section expressly provides that the conduct complained of must have occurred within six years of the complainant making the complaint. The complainant says that his complaint only arose when the company refused to meet his claim and accordingly the six – year limitation period only begins then. Unfortunately, this is not the position, as the legislation specifically refers to the conduct complained of. All of the conduct complained of in this instance occurred at the time the policy was sold to the complainant in 1995 and accordingly this complaint cannot be investigated by this office as it is out of time. The complaint is not upheld pursuant to s. 57 C 1(1)(b) of the Central Bank Act 1942 (As Amended by the Central Bank and Financial Services Authority of Ireland Act, 2004). The above finding is legally binding on the parties subject only to an appeal to the High Court within 21 calendar days."*

The plaintiff submits that in the circumstances there was no adjudication of the said complaint by the Financial Services Ombudsman and the plaintiff therefore submits that the plaintiff is not precluded from the within proceedings. The plaintiff submits that he should not be deprived of his constitutional right of access to the courts.

19. In addressing the Statute of Limitations the plaintiff says that the mechanism adopted by the insurer was to offer to the plaintiff and enter into if possible a new agreement each year if terms could be agreed and that is what happened in this case each year after the first year. The plaintiff says that each and every year after the first year of insurance the plaintiff was offered fresh terms of insurance by the defendant particularly as to indexation and given the opportunity, if he agreed to the proffered terms to be insured for the coming year.

Insurance brokers, insurance agents and the Insurance Act, 1989

20. The plaintiff submits that the broker has a duty of care to ensure the client has the best available cover to meet his requirements. The plaintiff submits that a brokers' duty is to: -

(i) Ascertain the client's requirements; and

(ii) Take reasonable steps to satisfy those requirements.

21. The plaintiff submits that the broker herein as the defendants' agent should have *inter alia:* -

(i) Drawn the attention of the plaintiff to the lacuna between the client's requirements and the policy on offer;

(ii) Made him aware of the absence of critical illness cover as relating to depression and anxiety;

(iii) Take instructions from the client regarding the lacuna between his requirements and the policy;

(iv) Should have ensured the clients' interest were not adversely affected.

22. The plaintiff submits that the test for professional negligence is as set out in *Bolam v. Freirn Hospital Management Committee* [1957] 1 WLR 582 at pp. 586 – 587, adopted in Ireland in Dunne v. National Maternity Hospital [1989] 1 IR 91 and 116. The plaintiff says that in the case of Dunne, it was stated as follows: -

> *"The test of the standard which you should apply is that of the ordinary skilled obstetrician exercising the ordinary degrees of professional skill. It is a matter for you, ladies and gentlemen, in the light of the evidence to decide whether in the handling of the plaintiff Dr. Jackson fell below the standard of the ordinary skilled obstetrician".*

The plaintiff says that it was held that a professional should act with the reasonable standard expected that an individual of "…like specification and skill would have followed had he been taking the ordinary care required for a person of his qualifications".

23. The plaintiff submits that the broker herein was required to act with the skill of an ordinary competent broker and failed to do so. The plaintiff goes on to say there is no evidence of any letter signed by the plaintiff to the effect that he is aware the policy did not cover depression and anxiety related claims. It is further submitted that the broker assisted the plaintiff in completing the proposal form as is evidenced by the writing on the form itself. It was further submitted by the plaintiff that the broker then became an agent of the defendant by virtue of the said assistance.

24. The plaintiff says there was a contractual relationship between the plaintiff and the defendant. The plaintiff opens the case of *McKenna v. Best Travel Ltd. T/A Cyprianna Holidays* [1999] 3 IR 57 in which the Supreme Court found that a travel agent had a duty of care re: advising their clients of risks relating to their travel. In those circumstances the plaintiff had been injured by a stone thrown whilst on holidays. Both Hamilton C.J. and Keane C.J. concurred and observed that the duty of care in tort arises from the proximity created by the contractual relationship. The plaintiff makes reference to a text of McMahon and Binchy, 4th Ed. Bloomsbury,at para. 6.91.

25. Furthermore, it is submitted by the plaintiff that there is a duty to disclose which must at least extend to disclosing all facts known to the defendant which are material either to the nature of the risks sought to be covered or the recoverability of a claim under the policy. In that regard the plaintiff opened the case of *Banque Keyser Ullmann S.A. v. Scandia (UK) Insurance Company Ltd. and Ors* [1990] 1QB 665 at p. 772 which stated as follows: -

> *"In adopting the well – established principles relating to the duty of disclosure falling upon the insured to the observe case of the insurer himself due account must be taken of the rather different reasons for which the insured and the insurer require the protection of full disclosure. In our judgment, the duty falling upon the insurer must at least extend to disclosing all facts known to him which are material either to the nature of the risks sought to be covered, or the recoverability of a claim under the policy which a prudent insurer would take into account in deciding whether or not to place the risk for which he seeks cover with that insurer".*

26. The plaintiff says that the defendant did not disclose at the material time that the plaintiff was not covered for depression. The plaintiff further says that at all material times the plaintiff disclosed his depression to the defendant and elected for permanent

disability on the form and paid a higher premium. The plaintiff says that as a consequence of same the plaintiff believed he was insured by the defendant for depression and anxiety and it was not the plaintiff who failed to meet the requisite standards of disclosure of *uberrima fides.*

27. The plaintiff refers the court to the case of *William Harney v. The Century Insurance Company Ltd.* Unreported, 22nd February 1983, where the court, following a submission in *re: Mutual Life Insurance Company of New York* [1925] AC 344 and the judgment of Lord Salveson on behalf of the Privy Council which McWilliam J. held as follows: -

> *"To this I would add that the options open to an insurer are to accept the contract, refuse the contract or make a new offer at an increased premium. There cannot be any course of accepting the premium and waiting until it was seen how the proposers' health progressed so that if the infection cleared up the proposal would be held in future with his premium based for future reference as of the effective date by that if some complication developed the proposers' premium would be returned to him and the policy cancelled."*

28. The plaintiff says that the defendant in this case was well aware of the risk but had sought to avoid payment on foot of the policy in breach of his obligation to the plaintiff. The plaintiff opens the case of re: *Dixon v. Devitt & Co* [1917] 86 LJKB at p. 315 when an insurance broker is employed to effect insurance and the client (as in the plaintiff herein) is entitled to rely on the broker carrying out instructions and is not bound to examine the documents drawn up on performance of those instructions and whether his instructions have in fact been carried out by the broker. The plaintiff says that the broker cannot expect to be exculpated if they fail to draw a client's attention to any particular term other than the terms instructed by the client. They quote from the case as follows: -

> *"The client of an insurance broker is not bound to see whether his instructions to insure had been carried out and for that purpose to look at the documents himself."*

29. The plaintiff goes on to open the case of *re: Latham v. Hibernian Insurance Company Ltd. v. Peter J. Sheridan & Company Ltd*. [1991] and submits that in that case the insurance broker was held liable in circumstances where he failed to disclose a material fact as he was under an obligation to examine such facts. They say that this arose when the insurers themselves had voided the insurance policy. The plaintiff submits as a matter of law the broker, that is Ms. Carroll, is an agent of the defendant and failed to properly advise and ascertain that the policy was suitable for the plaintiff having regard to the material circumstances.

30. He goes on to open the case of *re: Chariot Inns Ltd. v. Assicurazioni Generali SPA and Coyle Hamilton* [1981] ILRM 173 at p. 178 Kenny J. held that a broker owes a duty in both tort and contract, it was held as follows: -

> *"An insurance broker owes a contractual duty to his client to possess the skill and knowledge which he holds himself out to the public as having, and to exercise this in doing the clients' business. He is also liable in tort if he fails to exercise that skill and knowledge."*

Application of the European Communities (Unfair terms in Consumer Contracts) Regulations 1995
31.The plaintiff opens s. 3.5 which states as follows: -

> *"The fact that a specific term or any aspect of a term has been individually negotiated shall not exclude the application of this Regulation to the rest of the contract if an overall assessment of the contract indicates that it is nevertheless a contract as described in paragraph (4) of this Regulation referred to in Article 3.2 of the Council Directive as a pre-formulated standard contract".*

S. 5.2 states as follows: -

> *"Where there is a doubt about the meaning of a term, the interpretation most favourable to the consumer shall prevail".*

32. S. 6.1 states as follows: -

> *"An unfair term in a contract concluded with a consumer by a seller or supplier shall not be binding on the consumer."*

33. The plaintiff submits that the Unfair Terms as above apply to the contract and in the circumstances the interpretation of the true meaning of the policy should be read in terms as most favourable to the plaintiff. The plaintiff further submits that the contra – preferendum rule should apply herein as the policy documents were prepared as set out herein by the defendant. Additionally, the plaintiff submits that the plaintiff is entitled to the reliefs claimed by him in these proceedings as against the insurer and the defendant.

The defendant's replies to the legal arguments
34. *Uberrima fides* – utmost good faith says that whilst the duty of utmost good faith requires an insurer to act in accordance with commercial standards of decency and fairness and to conduct itself reasonably, transparently and with candour, it is submitted that its application does not preclude the defendant from defending its position against the claims raised by the plaintiff. It is submitted that the defendant complied with its duty of *uberrima fides* in dealing fairly with the plaintiff and considering his interests and disclosing all material facts pertaining to the extent of cover.

35. The defendant says that they clearly stated to the plaintiff and his broker that the policy terms offered should be read to make sure it met their approval. Futhermore, the cases of *Manor Park Homebuilders Ltd. v. AIG Europe (Ireland) Ltd.* [2008] IECH 174 [2009] 1 ILRM 190 and *Earls v. Financial Services Ombudsman and FBD Insurance plc*. [2015] IEHC 536 are readily distinguishable on their facts from the plaintiffs' claim. They say that these cases concerned unsuccessful claims under fire policies. The defendant refers the court to the text of Buckley on Insurance Law, 4th Ed. 2006, at pp. 237 – 241, on "An insurers' duty of good faith". By way of contrast, the defendant says the plaintiff has had his own broker to advise and consult on the policy terms proposed. In addition, they say that the plaintiff obtained life insurance cover which was required for a property investment. This cover continues to apply. They refer the court to Eggers & Ors. Good faith and Insurance Contracts, 3rd Ed, 2010 at pp.129-130.

Consensus *ad idem*
36. The defendant submits that there was agreement between the parties. The defendant says that as stated at para D.2 of the defendant's legal submissions, the plaintiff completed the proposal form for the policy with the assistance of his broker, Carroll and Associates. In correspondence, the broker specified that the plaintiff required cover to allow him make a draw down on a rental

investment property. The policy is currently still in force with life cover of €145,515. As detailed at para. A3 of the defendants' legal submissions, the policy documentation was sent to the plaintiff's broker and copied to the plaintiff. The defendant says that the plaintiff was required to attend Carroll and Associates offices in order to sign an acceptance form acknowledging acceptance of the critical illness and life insurance cover proposed. The defendant says that this was accordingly completed by the plaintiff on the 5th September 1995. The defendant further asserts that at that stage the plaintiff was afforded a cooling off period in which he could cancel the policy if after further consideration with his broker, he did not find it suitable for his needs. The defendant said that the plaintiff chose not to avail of this option having presumably satisfied himself as to the policy and signed the letter of acceptance on the 5th September 1995.

Statute of limitations and the Financial Services Ombudsman
37. The defendant says that the defendant is not precluded by the principle of utmost good faith from relying on the principle of *res judicata* as otherwise pleaded in its amended defence.

38. The defendant says that the plaintiff is in error in submitting that the Ombudsman expressly declined to deal with this complaint. The defendant says that where a complaint was made to the Financial Services Ombudsman under its legislation, it may either be substantiated or not substantiated. They say that the Ombudsman in his findings stated that the complaint was not substantiated under s. 57C 1(1)(b) of the Central Bank Act 1942 (as amended by the Central Bank and Financial Services Authority of Ireland Act, 2004). The Ombudsman's letter of the 26th January 2012 in compliance with s. 57 C (1)(9) of the Act, states that: - "The above finding is legally binding on the parties subject only to an appeal to the High Court within 21 days".

39. The defendant says that s. 57CA (3)(a) of the Act provides for an appeal to the High Court against the Financial Services Ombudsman's finding within such period as may be provided by Rules of Court of the High Court. This appeal is provided for by order 84C of the Rules of the Superior Courts on procedure and statutory appeals (SI no. 14 of 2007). O. 84, r. 1 (5)(a) provides for an appeal to the High Court within 21 days following notice of the deciding body's decision. The appeal is by way of notice of motion and grounding affidavit, returnable before the High Court in the non – jury judicial review motion list.

40. The defendant says that an appeal to the High Court under s. 57 CL of the Act was the appellate jurisdiction for the plaintiff to have engaged and advance a claim for such relief as the High Court might provide or direct. The plaintiff says that the plenary jurisdiction of the High Court is further engaged in the courts' jurisdiction under Bunreacht nahÉireann Article 34.3.1°. In *Murphy v. Canada Life Insurance Ltd and Irish Life Assurance plc* [2016] IECA 128, the Court of Appeal dismissed High Court plenary proceedings commenced after an unsuccessful finding of the Financial Services Ombudsman. The Court of Appeal judgment in paras. 8 – 15 otherwise applied the principle of *res judicata* to decisions of the Ombudsman not otherwise appealed under the designated procedure as stipulated by the Act. The defendant says that in the case of *Murphy*, the Supreme Court refused leave to appeal reference (2016 IESC DET 115).

41. The defendant says that the plaintiff has also sought in these proceedings to claim additional reliefs to those claimed before the Financial Services Ombudsman. The defendant says that the plaintiff is further estopped from making such claims. The defendant says that the plaintiffs' claim is further statute barred for reasons previously addressed by the defendants and the court was referred to the Statute of Limitations 1957 section 11 which sets out the six year limitation period applicable in this case.

Insurance brokers, insurance agents and the Insurance Act, 1989
42. The plaintiff says that s. 2 of the Insurance Act, 1989 defines an insurance broker as a person acting with the freedom of choice who brings together persons seeking insurance and carries out work preparatory to the conclusion of contracts of insurance. The defendant says that of utmost significance is the caveat in the definition that an insurance broker in s. 2: - "does not include an insurance agent or an employee of an insurer when the employee is acting for that insurer". An insurance agent is defined in the interpretation of s. 2 as: -

> *". . .any person who holds an appointment in writing from an insurer enabling him to place insurance business with that insurer, but does not include an insurance broker"*

43. The defendant says that the plaintiff is misguided in asserting that his brokers Carroll and Associates, are an "agent" as defined in s. 51 of the Insurance Act 1989. The defendant says that that section relates solely to "tied insurance agents". The defendant says that such form of agency would only apply to Carroll and Associates of they had a contract with the defendant. The defendant says that this is not the case. They say rather that Carroll and Associates at all material times acted solely as insurance broker for the plaintiff.

44. The defendant says that all of the duties of care alleged against the defendant in para. D 9 of the plaintiff's legal submissions might more properly be advanced against Carroll and Associates as brokers, but not against the defendant insurer. The defendant says that the insurance brokers relationship with his client is well discussed in the text Buckley and Insurance Law, 4th Ed. 2016, pp. 75 – 83. The defendants say that they have no application to the plaintiff's claim against the defendant in these proceedings.

European Communities (Unfair Terms in Consumer Contracts) Regulations, 1995
45. The defendant says that it is submitted that the above regulation and the provisions relied upon by the plaintiff have no application in the instant proceedings. The defendant says that there can be no doubt as to the meaning of any term of the policy as required by Regulation 5(2) of the above regulations. The defendant says that the discussion in the texts Eager's Good Faith and Insurance Contracts, 3rd Ed. 2010, at pp. 129 – 130 and also in Clarke on Contract Law in Ireland, 8th Ed. 2016, at pp. 320 – 327 does not advance matters. The defendant says that while the commentators consider the relevant EU Directive 93/13 it has been little considered by the Superior Courts in this jurisdiction.

46. The defendant notes that notwithstanding his admitted defective eyesight only disclosed to the defendant in the plaintiff's reply in the amended defence delivered on the 3rd February 2017, the plaintiff did not rely on his broker to assist in ensuring that he adequately considered and understood the terms of the policy before signing the letter of acceptance on the 5th September 1995.

47. In summary, he says that having regard to the legal principles outlined and made in reply to the plaintiff's legal submissions, it is submitted by the defendant that the plaintiff's claim is ill – considered. They say it has been rejected in an un-appealed finding by the Financial Services Ombudsman. They say there is no entitlement to re- litigate under the guise of a separate plenary proceedings this unsuccessful claim. They say the principle of res judicata is also applicable in the absence of an appeal to the High Court of the above findings where they say that the plaintiff's claim is statute barred.

Decision

Findings of fact
48. The court having considered the evidence finds the facts as follows: -

(i) The plaintiff, Mr. Harmon, completed a life assurance proposal form with the benefit of independent advice from his broker Carroll and Associates.

(ii) The policy requested was for various forms of life insurance cover with options to increase and this commenced from the policy dated the 7th December 1995 grounding life assurance cover of IR£50,000 and critical illness cover of IR£25,000 with options to increase.

(iii) There was one life insurance contract and not a fresh contract being entered into from year to year.

(v) Carroll and Associates provided their service as Insurance Brokers advising the plaintiff, Mr. Harmon, and not otherwise.

(vi) Mr. Harmon was a client of Carroll and Associates and completed the proposal form with their expert brokers' assistance. The insurance policy issued on the 7th September 1995 for life assurance and critical illness cover and clearly did not include permanent total disability.

(vii) The plaintiff benefited from the life assurance policy and assigned it to Irish Life Finance on the 11th December 1995.

(viii) Mr Harmon sought to add Permanent Total Disability cover by contacting Irish Progressive in June 1997 and was sent a proposal form for that by letter dated the 23rd June 1997. This increased critical illness cover to IR£50,000 (from IR£25,000) and added permanent total disability cover for IR£50,000. Mr. Harmon the plaintiff did not take up that proposal.

(ix) On the 31st July 2004, Carroll and Associates transferred their Insurance Brokers practice as investment product intermediaries to John Webber Financial Services. At that time Carroll and Associates had insurance brokers agreements with ten life assurance companies.

(x) The plaintiff's complaint to the Financial Services Ombudsman following rejection by Irish Life of a specified illness claim was rejected in a finding dated the 26th January 2012 which is binding on the plaintiff and Irish Life unless appealed to the High Court within a period of 21 days.

(xi) No appeal was initiated by the plaintiff under O. 84 (c) of the Rules of the Superior Courts appealing to the High Court the finding of the Financial Services Ombudsman in the manner contemplated by the Central Bank Act, 1942, as amended.

The Law
49. The court has considered the legal arguments on both sides, and in light of the law and the facts as found, the court is persuaded by the arguments of the defendant. The court is satisfied that the defendant complied with its duty of *Uberrima fides* in its dealings with the plaintiff.

50. The court is similarly satisfied that the evidence amply supports consensus between the parties.

51. Further having considered the law and facts the court is entirely satisfied that Carroll & Associates at all material times acted solely as Insurance Broker for the plaintiff.

52. The court finds that European Communities (Unfair Terms in Consumer Contracts) Regulations, 1995 have no application to the instant proceedings.

53. With regard to the statute of limitations the critical date is the date of the issue of the plenary summons in this case which is the 14th February 2012. The policy in question was entered into and is dated the 7th September 1995, a period of almost sixteen years before the summons was issued. The request for additional permanent total disability cover by the plaintiff in June 1997 was a period of over fourteen years before the plenary summons was issued.

54. The plaintiff argued that if they do not succeed on the statute of limitations point that their claim is statute barred, then they want to rely on the finding of the Financial Services Ombudsman. The court finds that the finding of the Financial Services Ombudsman is binding on the parties. There is an appeal to the High Court within a period of 21 days and that is contained in the legislation. The relevant legislation is the Central Bank Act, 1942, as amended by the Central Bank and Financial Services Authority of Ireland Act, 2004. The plaintiff did not initiate any such appeal to the High Court within the time limit as provided for in the legislation.

55. Accordingly, the court dismisses the plaintiffs claim and refuses the reliefs sought.