An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0040
Sector:	Insurance
Product / Service:	Multiple Products/Services
Conduct(s) complained of:	Mis-selling
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant is not satisfied with financial advice said to have been given by the Provider (an Insurance / investment Broker) with regard to a €75k investment he had for pension purposes. The Complainant alleges that the Broker carried through with an annuity application without permission and also alleges regulatory breaches by the Broker, that is, allegedly (i) no terms of business supplied (ii) no fact find completed, and (iii) no letter of recommendation issued. The Complainant also alleges mis-selling of life policies in or around 2012 and queries why 2 separate polices were taken out and not just one as two policies cost more to the Complainant. It is also alleged that there were incorrect declarations made by the Broker on the Complainant's behalf regarding his smoking status resulting in policies being voided due to breach of utmost good faith costing the Complainant €8,500.

The complaint is that the Broker did not correctly advise upon and correctly arrange policies for life cover and pension purposes for the Complainant.

The Complainant's Case

The Complainant states that he first engaged the services of the Provider in or about 2011 / 2012. The Complainant says he contacted the Provider having seen his advert in a local publication.

It is the Complainant's positon that in or about the month of February, 2014, the Complainant sought professional advice from the Provider in relation to his financial affairs.

It is stated by the Complainant's representative that in February 2014 it was made known to the Provider that the Complainant was in a position of considerable personal stress in that he had experienced extensive damage and disruption of trade at his retail sale premises. The Complainant states that the Provider met him at his work premises.

The Complainant states that he had a pension policy which matured at his sixtieth birthday early in 2014. The Complainant availed of a tax free lump sum. The Complainant states that he then had a sum of €75,000.00 available for financial planning or investment

The Complainant's representative states that the Complainant contacted the Provider and told him that he wished to remain working and that he did not wish to retire from work. It was of concern to him that he no longer had a pension plan and he sought professional financial advice.

The Complainant states that the Provider was accompanied by an official from a Pension Company.

The Complainant states that the Provider advised him that the best option as to how to deal with the sum of €75,000 was to invest the sum in an annuity and that he would get a monthly payment.

It is the Complainant's positon that he did not wish to enter into an annuity as he would lose funds in tax deductions from the benefits. The Complainant states that he made no decision as to how his funds, then extant in Pension Company following cessation of his previous policy, should be dealt with. The Complainant wished not to incur taxation liabilities on his funds or choice of investment.

The Complainant's position is that he was persuaded by the Provider to sign forms, but the forms were to be held pending his making a decision.

The Complainant states that the Provider failed and neglected or decided not to revert to him for further instruction or confirmation of any order.

The Complainant states that the Provider's meeting with him failed to meet the minimum standards of competency of performance for a financial intermediary which are required of the Provider by law and regulation.

<u>The Complainant states that the Provider:</u>

- Should have given him full written Terms of Business.
- Should have carried out a full examination of facts, but failed to do.
- Should have formulated a set of recommendations and given them to him.
- Should have gone through those recommendations and had them signed by him.
- Should have properly and fully filled up Application Forms with him and have them signed by him only when complete.
- Should have made available to the client any research carried out.

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- Should have made available to the client all documents and fully gone through same with him before getting him to sign same.

The Complainant states that he did not receive any letter of recommendations.

The Complainant states that he was persuaded to sign the Pension Company's documents at the meeting and he was not given any copies of documents.

The Complainant submits that he was still giving consideration to this matter when he received an annuity payment cheque from the Pension Company. The Complainant states that he was surprised and made contact with that Company to ascertain what was happening and to inform that company that he did not want the policy which the Company appeared to have set up. The Policy was an Annuity contract.

The Complainant states he made contact with the Provider regarding the matter and the Provider's response towards him when the Provider visited his workplace, was both abusive and threatening.

The Complainant says that he engaged a solicitor who made contact with the Pension Company for him. It is the Complainant's positon that the Pension Company had acted on instructions placed by the Provider in setting up an annuity policy in the Complainant's name using the Complainant's funds then resting with the Company from the cashed pension proceeds.

The Complainant submits that he never instructed the Provider or the Pension Company to invest his funds in such a policy. The Complainant says that it is clear that in establishing the policy complained of, the Provider was the acting and active party who directed the Pension Company to set up the policy. It is the Complainant's positon that he was deeply shocked and stressed at an apparent railroading of his affairs by the Provider in that €75,000.00 of his funds were placed in an investment which did not suit his needs without full and appropriate advice and advising documents being given to him.

The Complainant states that the unauthorised annuity policy was agreed by that Company to be cancelled immediately. The Complainant says that the Pension Company informed him that his fund would have to be invested in another tax efficient policy or if the monies were to be issued directly to the Complainant they would become taxable.

The Complainant's position is that the Provider mis-sold the annuity policy to him in breach of the standard of minimum competency and professional probity required of the Provider as a regulated financial intermediary.

It is alleged that the Provider procured the making of an investment in an annuity policy utilising the Complainant's funds unknown to him and without his approval or consent and in fact against his expressed wishes.

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The Complainant states that the entire matter has caused him great distress, inconvenience and disruption of his time in seeking to correct matters. The Complainant states that he has felt humiliated by the Provider's treatment of him.

As regards his other dealings with the Provider the Complainant states that in late 2011 or early 2012 he had sought to take out €200,000 worth of life assurance cover to benefit his grandson should the Complainant pass away.

The Complainant states that he was then also under stress in his retail business and he relied upon the Provider's probity, skill and expert judgment to advise him responsibly and in the best interest of him as a consumer client.

The Complainant says that the Provider advised him to enter in to two policies at that time. These were two Life Policies as follows:-

- €100,000 cover with Life Company A with a premium of €100.51 per month.
- €100,000 with Life Company B at a premium of €147 per month.

It is the Complainant's position that he was not told why two policies were taken out and not just one Policy or why the premia for the two policies were at different amounts.

The Complainant states that the Proposal Forms were not correctly completed.

It is the Complainant's position that he had informed the Provider that he was prescribed and taking a prescribed medication for a considerable period. This he says is a medication with certain associated risk factors.

The Complainant states that the location on the application enquiring which would have brought forward an answer to that was ticked "No" by the Provider.

The Complainant says that the level of his smoking habit was under declared by the Provider on the Policy proposal form.

The Complainant states that consequently and unknown to him, there was a wrong disclosure or non disclosure in respect of the proposals for cover. The Complainant says that this was in breach of the duty of utmost good faith required of a proposer for a policy of insurance. The Complainant submits that Policies were void as a result and the Complainant has had to make other arrangements for Life cover .

The Complainant states that he is at the loss of some €8,500 in premia paid for void policies. The Complainant submits that the policies were accordingly mis-sold to him. The Complainant says that this constitutes a severe and fundamental breach of contract on the Provider's behalf in his professional dealing with a customer.

The Complainant states that the Provider was remunerated on a commission basis from the sale of the two policies. The Complainant submits that it would appear that the division

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of life cover in the two policies was motivated by generation of greater commission for the Provider's own benefit rather than any consideration of the welfare and cover needs of the consumer client.

The Complainant's positon is that he was a vulnerable consumer.

The Provider's Case

It is the Provider's position that:

1. It was clearly explained to the Complainant why two policies were taken out and not one policy and why the premia for the two policies were at different amounts.
2. It is denied by the Provider that the Proposal Forms were not correctly completed by him, and that any incorrect information was completed by the Complainant.
3. The Provider denies that he was informed that the Complainant was prescribed and taking tablets for some time. It is the Provider's positon that the Complainant self declared that this was not the case.
4. The Provider states that the question on medication was ticked "No" by the Complainant and not by him.
5. The Provider states that the level of the Complainant's smoking habit was under declared by the Complainant at "Nil" and was increased by the Provider because of his knowledge that the Complainant was a smoker.
6. The Provider says that there was no non-disclosure on his part in respect of proposals.
7. The Provider submits that he is a stranger to the allegation that the Complainant had made arrangements for life cover elsewhere and that no details were furnished.
8. The Provider says he is a stranger to the allegation that the Complainant lost some €8,500 in premia paid for voided Policies. The Provider states that he was informed by the Companies that the Complainant had switched his policies to a different agent.
9. The Provider's positon is that the policies he arranged were not mis-sold.
10. The Provider states that the division of life cover into two policies was not motivated by the generation of greater commission, but for underwriting considerations and possible need for medical examinations if a greater amount of cover was required under one policy. There was also a gap between the two policies being required.
11. The Provider did not consider the Complainant to be a vulnerable customer, that the Complainant had full knowledge of the workings of the industry and was a sophisticated customer.

As regards the Annuity contract, the Provider's positon is that:

1. Notwithstanding the Complainant's dissatisfaction with the Annuity Policy, it was his clear intention to purchase that policy.
2. The Complainant was not persuaded to sign the Application Forms that were held pending the Complainant's decision.
3. It did not fail or neglect to decide not to revert to the Complainant for further instructions or confirmation.

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4. It did not fail to meet the minimum standards of competency of performance for a Financial Intermediary as alleged by the Complainant. The Provider says that all options were explained and all Forms were properly completed.
5. The Complainant was not persuaded to sign documents. The Provider says that the Company provides documentation and it is not correct to say he was at fault because copies of documents were not provided to the Complainant.
6. It was not aware that the Complainant received an annuity payment (under the annuity) despite cancelling the annuity.
7. There was no abusive or threating behaviour towards the Complainant.
8. The Complainant was not railroaded, and nor were his funds placed in an investment which did not suit his needs without full and appropriate advice and advising documents being furnished.
9. It correctly advised the Complainant that with pension polices when encashing to obtain 25% lump sum, there are no other alternative options.
10. It did not mis-sell the annuity Policy in breach of any regulatory requirements.
11. It did not make any investment in an Annuity Policy with the Complainant's funds unknown to him and without his approval or consent or against his express wishes.
12. As the Company refunded the Annuity monies the Provider states that there was no financial loss to the Complainant and therefore no requirement for compensation.

Decision

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

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

The Complainant considers that an Oral Hearing should be held on the matter. Having considered this point at length, and taking into account the particular circumstances of this complaint, I am satisfied that an Oral Hearing would not advance matters further with this complaint. Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on 18th April 2018, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that

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period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

Submission dated 9th May 2018 from the Complainant and submission dated 25th May 2018 from the Provider, were received by the Financial Services and Pensions Ombudsman after the issue of a Preliminary Decision to the parties. These submissions were exchanged between the parties and an opportunity was made available to both parties for any additional observations arising from the said additional submissions. The content of those submissions however has not persuaded me to alter my previous preliminary determination and, consequently, the final determination of this office is set out below.

The issue for investigation and adjudication is whether the Provider correctly advised and set up life cover and an annuity contract for the Complainant.

The Provider states that in regard to both of the life cover applications, that is, for the one dated 19th October 2011 and for the one dated the 9th December 2011, the Complainant signed the following statement: *"Statements made by me/us will help form part of the contract."*

The Provider states that the duty of full disclosure is always on the client and he says that the Complainant did not carry out his duty when he signed both application forms. The Provider submits that he can categorically and absolutely state that the Complainant never, ever mentioned nor declared the fact that he was on prescribed medication. The Provider submits that this is also evident when the Complainant did not mention it in the Company's Data Capture Form, which he says the Complainant completed himself. The Provider says that on the said form, the Complainant stated that he was a non-smoker. The Provider states however, that he found this information to be incorrect, as the Complainant smoked openly on each occasion that they were in contact. The Provider submits that as well as this, when the Complainant looked for an over-the-phone insurance quote on the 07th November 2011, he declared that he did smoke. The Provider says that he therefore, declared on the application form that he smoked 10 cigarettes per day.

The Provider submits that regarding the second life application, he acted as scribe when filling out the Complainant's life questionnaire and says that the Complainant dictated to him that he smoked 20 cigarettes a day.

The Provider states that there was nothing else of relevance on the remaining questions in the form. The Provider's positon is that the first time that he ever heard that the Complainant was on medication was when he received a letter of complaint from the Complainant's solicitor, dated 13th March 2015.

The Provider submits that Life Insurers do not necessarily invalidate a claim because of non-disclosure. And that Claims may be paid out, fully or partly, depending on the circumstances of each claim and it would not, therefore, be correct to say that an in force policy is invalid until the time of a claim. The Provider states that a client disclosing full facts at the time of each application will always, of course, ensure that any potential claim will be honoured in full by the life insurer.

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The Provider states that after both life policies were issued, the Complainant requested to transfer both of his paid up pension policies. The Provider says that he did not seek this business from the Complainant, but says that if the Complainant was so unhappy with his services, why did he request his pension policies to be transferred to his agency.

The Provider says that when the Complainant received his 25% tax-free lump sum from both pension companies, he then signed up for an annuity. The Provider submits that within seven days the Complainant cancelled same and even though the Pension Provider failed for a certain number of months to act on his instructions, by June 2015 all monies were returned to the Pension Company. It is the Provider's position that in this way, the Complainant was not out of pocket and no commission was ever paid to the Provider, by the Pension Company. The Provider states that the Complainant had no financial loss regarding his pension decision and because of a medical report sent on one of the life polices, a loading was imposed on the Complainant due to his past lifestyle and/or health issue on the basis of his GP's medical report.

It is the Provider's position that he acted in good faith as he always does for his clients, and that the Complainant was no exception.

The Provider states that the Complainant claims that he understated his smoking consumption of 10 cigarettes a day, where in Company the second application he admitted to the Provider that he smoked 10 cigarettes a day. The Provider states that there is no difference to two cigarettes or 20 per day. That all life assurance companies will rate the same, that is "a smoker is a smoker"

The Provider states that on Company the first application, filled in by the Complainant himself the Complainant wrote "No" to question 4 – *"Have you smoked tobacco of any kind in the past 12 months?"*

The Provider states that for tobacco consumption (all types of tobacco) per day question, the Complainant drew a line through same.

As regards the medication which the Complainant claims that the Provider was "Informed he was prescribed for and taking for a considerable period", it is the Provider's position that this never happened, and if this was true, why did the Complainant not admit same on his own handwritten Data Capture Form.

The Provider states that he did not receive the policy documents as they were posted direct to the Complainant.

The Provider states that after receiving his 25% tax free cash from the Pension Companies the Complainant had 3 options – to seek an AMRF which in January / February 2014 he could draw down until he was 75 years of age, buy an Annuity Pension (which he probably intended all the years back when he first took out his pension with the other Broker / Brokers or Agent). The Provider says that since he joined the life business in 1992 all that was ever quoted was the 25% tax free lump sum and then a reduced pension annuity, or the third

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option was to do nothing. The Provider states that the Complainant willingly signed for the annuity, and he says he did not railroad the Complainant into signing the Application Form.

The Provider says that the fact that it was not that well up on the rules of pensions and their complex laws, he brought Mr DC from the Pension Company to the Complainant to answer technical questions that the Complainant may have had. This meeting is said to have lasted 40 minutes in the Complainant's retail premises. The Provider states that he has no evidence of the Complainant exercising his cooling off period and cancelling the policy from inception, which was his entitlement. The Provider submits that when the first annuity payment was made in March 2014, the Pension Company acknowledged this and all was rectified by May 2014.

The Provider states that because the Complainant had "drawn" his 25% tax free cash, with the limited options he had willingly taken the Provider's advice at that time (22nd January 2014), and willingly signed up for an annuity. The Provider states that within the next 30 days the Complainant had a change of heart and cancelled same, as was his right to do so. The Provider states that he would still recommend an Annuity to any other of his clients if the circumstances were the same.

The Provider states that he never received any commission on this product.

The Provider submits that as the Complainant's first annuity was returned, the Complainant had no financial loss.

The life products are – (i) a Single Life 10 year convertible Term Policy of €100,000, for the Complainant and (ii) a Single Life 10 year Level Term of €100,000.

As regards the policy documentation that was supplied, the Provider states that no terms and conditions or any promotional literature, brochures, illustrations were provided at commencement of the policy, except the documentation that the insurance companies provided to the Complainant, by post.

As regards whether there was a Fact Find completed, the Provider states that there was no Fact Find completed as both of the life applications were sought by the Complainant over the telephone. The Provider states that there was no need for a Fact Find as all the Complainant looked for was an Application Form which he said he would 'fill out' himself, when he decided which amount he would choose himself.

The Provider states that on 6th September 2011, he received a phone call from the Complainant asking for two quotes for €100k and €200k life cover from him (as he got the Provider's name and telephone number on a local advertisement. The Provider's position is that he asked the Complainant for his date of birth, phone number, and if he was a smoker or a non smoker. The Provider states that the Complainant incorrectly told him he was a non smoker. The Provider says that ten minutes later he telephoned the Complainant back, gave him the two quotes. The Provider submits that the Complainant asked him to call to his business address to leave him the Data Capture Form and Direct Debit Mandate for the insurance company.

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The Provider states that on 19th September 2011 the Complainant telephoned him to tell him that he had filled in his Data Capture Form & Bank Direct Debit details. The Provider says that he called to collect same and told the Complainant that he would input the details on line to the life company. The Provider submits that anytime he called to the Complainant he was smoking, therefore he input him as a 'smoker' to make sure that he would get the true and maximum cover should a claim arise in the following ten years.

The Provider's position is that as the Complainant had done all the writing and filling in of all the information himself, this was 'an execution' only policy and that the Complainant telephoned him to get the quotes from him. The Provider states that the Complainant had asked that he call back to him in 4 weeks as he wanted to get extra life cover for the benefit of his grandchildren.

The Provider states that on 9th December 2011 the Complainant applied for €150k life cover level term, with the second Insurer as that company price matched Insurance Company's premium, which the Provider states was the cheapest shown from his research. The Provider submits that this time it filled in all the answers which were dictated to by the Complainant. The Provider says that at no stage did the Complainant ever state to him that he was on any medication, and, as with his Insurance Company application, every answer was 100% 'No'. The Provider says that when the Underwriting came back from Insurance Company, the Complainant was loaded with a rating. It is the Provider's positon that the Complainant without hesitation accepted this loading with a reduced life cover of €100k (down from the €150k that had been sought). The Provider states that the Complainant never questioned the fact that he had a loading, but about 3 months later the Complainant is said to have stated that he did not like one of the Insurance Companies. The Provider's view is that this was probably because that Insurance Company had charged him extra money for the cover.

The Provider's positon is that straight away he advised the Complainant that in the event of his death, the Insurance Company would be the company that would pay out because it had all the facts on him. The Provider states that the Complainant never made any other comment on this to him.

The Provider submits that in September 2014 he received two letters from the Insurance Companies advising that both policies were being transferred from his agency. The Provider states that the only other detail he has is that the Complainant had to make other arrangements for his new life policies. The Provider understood from that was that both policies were cancelled.

The Provider states that as the Complainant's Pension policy was cancelled from inception, he did not receive any policy documentation. The Provider states that unfortunately the Pension Company mistakenly paid out an amount of money in March 2014, and was refunded by the Complainant in May 2014.

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Evidence

19th October 2011 - Financial Planning Review

Source of client: *"He telephoned for 2 life quotes on 6/9/2011"*

1. **About You** [Name, Marital Status, Address, Telephone No.s, E-mail, Date of Birth, Smoker status, Health / Family Health]

For the "Smoker" status: **"Yes"** is ticked.

2. **Your Family** [**"Adults"** is recorded]
3. Your Job & Income / Expenditure

The Complainant's Occupation is recorded as "…. Retailer" "Selling …."

For "Income" , "Tax rate" **"N/D"** is stated

For "Work pension scheme" **"2 Private Pensions (Both Paid Up)"** was recorded.

For "Net income per wk / mth" **"N/D"** is stated

For "Employment Status" **"Self-employed"** is ticked

For "No of employees **"1 Part Time"** is recorded

For "Income" questions **"N/D"** is recorded

Under "Financial Objectives" **"Life Cover"** it is recorded that the Complainant had **"Nil"** but needed €100 / €250 and it was a "High" priority.

This Financial Review set out information about the Complainant, that is, his name, marital status, address, contact details, date of birth, smoker status, family, Income / Expenditure, employment status, financial objectives, Pension Provision.

19th October 2011 – From the Provider to the Complainant (Complainant alleges non receipt of same)

> *"Statement of Suitability*
> *Thank you for telephoning me regarding a quote on your life cover and for taking the time to meet with me and discuss your financial planning requirements. I have identified Term Assurance from [Insurance Company] as the most suitable product to meet your current requirements. ….*
>
> *I recommend the 10 year term assurance policy form [Insurance Company] as being the most suitable. Their premium is the most competitive on the market and represents excellent value for this type of cover".*

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7th December 2011 – Provider's file note:

> *"Called to [the Complainant] and he said he decided to look for €150k life cover. As [Insurance Company] will price match the cheapest quotation, I recommended that company. I also did not want to apply to [second Insurance Company] again, as he would have pushed his sum assured to €250k and an auto PMA to his doctor. This time he declared that he smoked 20 cigs per day".*

9th December 2011 - From the Provider to the Complainant

> *"Thank you for taking time to meet with me and discuss your financial planning requirements. I have identified Term Assurance from [Insurance Company] as the most suitable product to meet your current requirements. ….*
>
> *I recommend the 10 year term assurance policy from [Insurance Company] as being the most suitable. Their premium is the most completive as they price pledge and will match the most competitive price on the market and this represents excellent value for this type of cover".*

22 January 2014 – Pension Annuity Application (Signed by the Complainant)

> *"Data protection consent / Annuitant's Declaration*
> *I have read through the replies to all the questions in this application from and declare that to my best of my knowledge and belief, all information and statements provided to [chosen Pension Company], whether in handwriting or otherwise, are accurate and complete. I understand that failure to give true and complete answers to all questions may be grounds for rejecting a claim .."*

22 January 2014 – Statement of Suitability from the Provider to the Complainant (The Complainant does not dispute its receipt, but does feel he should have been required to sign same)

> *"Statement of Suitability*
> *Having applied for your 25% tax-free cash from both of your personal pensions with [original pension companies], you now have the choice of two options with regards to your remaining balance.*
>
> *Option A is to put your lump sum into an AMRF and to leave it there for 15 more years until you are aged 75, however, the money cannot be touched until you reach this age.*
>
> *Option B, on the other hand, is to buy an annuity. …*
>
> *I therefore recommend that an annuity with [Pension Company] to be the best choice for you. They have the most competitive annuity quotes at this time and are the best in the market".*

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31st January 2014 – Letter from [original Pension Provider] to the Complainant – advising of tax free lump sum and that balance was forwarded to [chosen Pension Company] to purchase an annuity.

3rd February 2014 – The Provider's notes:

> *"[Mr D C] local inspector of [Pension Company] called with me to visit [the Complainant] at his shop. I wanted [Mr D C] to give impartial advice. [Mr D C] told [the Complainant] of all his legal choices i.e. two, (Annuity & AMRF) which were government controlled. [The Complainant] seemed very unhappy why he could not get more than the 25% of this fund for himself"*

11th February 2014 – Provider's notes

> *"[The Complainant] via his other solicitor [Mr B H] wrote to [Pension Company] in Dublin to cancel his Pension Annuity Policy. At that stage it had not been issued"*

Data Capture Form – signed by the Complainant and dated 19th October 2011

"Health questions for protection cases
..
4. Have you smoked tobacco of any kind in the past 12 months or do you intend to smoke in the future (including occasional smoking)?"

"No" was ticked.

"Tobacco consumption (all types) per day"

There was no amount recorded.

Application Form Insurance Company- 19 October 2011 –

> *"Declaration to [the Insurance Company]*
> *I understand that this declaration, together with the other declarations and consents made by me in this booklet and in my online application form (a copy of which will be sent to me shortly and which is based on the information given by me to [Insurance Company]) is my application for cover under [the Insurance Compan's] normal conditions.*
>
> *I understand and agree that my contract with [Insurance Company]) will be based on the declarations and consents in this booklet, my application form completed (online or otherwise), any supplementary questions answered, any statements made to [the Insurance Company's] underwriting team in response to any phone calls received, any information I give to a medical examiner acting for [the Insurance Company] and all terms and conditions furnished to me by [the Insurance Company].*

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I have read and understand the important information concerning my obligation to tell [the Insurance Company] about all material facts in connection with the application (Online application process and telling [the Insurance Company] about material facts) in this booklet and I understand that if I do not tell [the Insurance Company] all material facts, this contract could be void. If this happens, there will be no cover under the plan and [the Insurance Company] will not refund my premiums. In these circumstances, [the Insurance Company] will not pay a claim.

I declare that all statements recorded in answer to the questions in my application form (online or otherwise) including those about tobacco consumption (together with statements written down for me) are true and complete. I understand that I will receive a copy of the application from questions and my answers for my own records.
..
NOTE: Your signature here covers you for section 2 and 3 of this booklet".

"4. Declaration under regulation 6(3) of the Life Assurance (Provision of Information) Regulations 2001.
…
Declaration of Insurer / Financial Adviser
I hereby declare that in accordance with Regulation 6(1) of the Life Assurance (Provision of Information) Regulations 2001 [the named customer (the Complainant)] has been provided with the information specified in Schedule 1 (Customer Information Notice) to those Regulations and that I have advised the customer as to the financial consequences of replacing an existing plan with this plan by cancellation or reduction, and of possible financial loss as a result of such replacement".

The Complainant signed the declaration confirming that he had received the information specified in the declaration.

Exhibit H - Undated letter

"We wish to draw your attention to the following paragraph:
"Material facts are details that we need to know so we can assess applications for cover and claims for benefits. Material facts could include medical history and details of occupation, travel and pastimes. If you do not tell us about material facts when you apply for your plan or at the claims stage, this might mean that your contract could be cancelled without premiums being returned, or that we don't' pay a claim.

If you are in any doubt as to whether certain facts are material, you should tell us about them anyway. You must also tell us about any changes to the information you give us up until your policy starts".

The following note is written in margin of letter [appears to be written by the Complainant]:
"If Application was filled out correct, why a loading by [Insurance Company]?"

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Broker's Research Reports:

6th September 2011-

> *"Detail Input*
> *Male, .. years .. months ([DOB]), Non-Smoker, life cover €200,000, serious illness €0 10 year term, monthly premiums, mortgage interest 6.00% benefits and premiums not increasing. These premiums include the 1% government levy introduced in August 2009"*

19th October 2011 -

> *"Detail Input*
> *Male, .. years .. months ([DOB]), Smoker, life cover €100,000, serious illness €0 10 year term, monthly premiums, mortgage interest 6.00% benefits and premiums not increasing. These premiums include the 1% government levy introduced in August 2009"*
>
> *Premium was €100.51*

29th November 2011

> *"Detail Input*
> *Male, .. years .. months ([DOB]), Smoker, life cover €100,000, serious illness €0 10 year term, monthly premiums, mortgage interest 6.00% benefits and premiums not increasing. These premiums include the 1% government levy introduced in August 2009"*

9th December 2011

> *"Detail Input*
> *Male, .. years .. months ([DOB]), Smoker, life cover €150,000, serious illness €0 10 year term, monthly premiums, mortgage interest 6.00% benefits and premiums not increasing. These premiums include the 1% government levy introduced in August 2009"*

Term Assurance Application Form

"Personal Details
Have you smoked any cigarettes, cigars, pipes or tobacco in the last 12 months?
If yes, how many per day? Answer recorded was "20"

> *"Underwriting Details*
> *Instructions*
> - *Please answer carefully, giving full details and, if necessary, use a separate sheet for additional information. ….*

/Cont'd…

- *When completing this application form you must disclose all Material Facts. Failure to disclose all relevant facts, including full disclosure of your medical details and history, may delay or prevent the issue of your policy and / or invalidate future claims. If you are in any doubt as to whether a fact is a Material Fact you should disclose it".*

Declarations

..

I/We have read over other replies to all questions in this application and declare that to the best of my/our knowledge and belief, all information given is true and includes all material facts and w1/ We understand that failure to disclose all relevant facts, including full disclosure of my / our medical details and history, may delay or prevent the issue of my/ our policy and /or may invalidate future claims. If you are in any doubt as to whether a fact is a material fact you should disclose it". …

The Complainant signed agreeing these declarations and the application is dated 9th December 2011.

Provider's note of 19/10/2011

> *"[The Complainant] rang me to collect the APP Form from [Insurance Company]. It was 100% clean AP, and on looking at the filled out form I noticed that [the Complainant] said No for being a smoker. At that stage I had seen him 3 times in his shop, and all 3 times he was smoking so I put him down on the Application that he smoked 10 per day to [the Insurance Company]. I did this in the interest of the client himself, as if he died un-expectantly, the Life Assurance Company might not pay out on his potential claim. When policy was issued he asked me to call back to him in November".*

10th January 2012 – the Complainant signed acceptance terms for the Insurance Company's loading on life cover.

22nd January 2014 – Pension Annuity Application

6th February 2014 – Annuity Quotation from Pension Company

> *"Additional Information In Relation To Your Policy*
> *30 days cooling-off option*
> *If, when you receive your Policy, you feel that it is not suitable for your needs then you may cancel it by instructing us in writing and returning the policy documents to us, provided that the instruction and policy documents are received not later than 30 days after the date of issue of the policy documents. …"*

27th February 2014 – Pension Company to the Complainant – sending Annuity Policy Schedule and conditions.

26th July 2016 – communication from Pension Company to Provider

/Cont'd…

"[Pension Company] paid one annuity premium [payment] to the client in March 2014.
This was subsequently refunded by the client in May 2014.
No further payments were made.
All monies received were returned to the original providers i.e. [***]. This was completed in June 2014.
No broker fees or commissions were paid on this case".

It is the Provider's positon that he issued Terms of Business (the Complainant denies receipt of same.

Analysis

The Provider here is an insurance broker. An insurance broker acts as an intermediary between clients and insurance companies. Clients may be either individuals or commercial businesses and organisations. Brokers are required to use their in-depth knowledge of risks and the insurance market to find and arrange suitable insurance policies. Insurance brokers, unlike tied agents, are independent and usually offer products from more than one insurer to provide their clients with the best deal.

The Broker's role typically involves:

- gathering information from clients, assessing their insurance needs and risk profile;
- building and maintaining ongoing relationships with clients;
- foreseeing clients' insurance needs, such as policy renewals;
- researching insurance companies' policies and negotiating with underwriters to find the most suitable insurance for clients at the best price;
- renewing or amending existing policies;
- keeping informed of changes in the insurance market and in their clients' needs.

When carrying out their role and responsibilities Brokers can only rely on the information the applicant provides to them, in order to assess the applicant's situation. For the process to be effective, the applicant should be as forthcoming as necessary and communicate what their goals and objectives are. The recommendations that are made by the Broker are appropriate to the extent that the applicant is prepared to provide all relevant information.

A Broker is required to present the applicant with a Recommendation in writing. A copy of the Fact-find form should ideally be provided. A Statement of suitability and Recommendations should also be given to the applicant.

The evidence in this complaint shows that the Broker did seek information from the Complainant for the purposes of obtaining life cover and for a Pension Annuity. Application forms were completed, Quotations were sought. Thereafter, the Provider communicated to the Complainant what he considered was the best policy / cover option.

/Cont'd…

While it would be a prudent step for a Broker or an Insurance Company to provide a copy of the completed application form, there is no statutory or regulatory requirement for a Provider to automatically do so. A copy of the application is obtainable from the Insurance Company upon request. It is noted that the Application Form from one of the Companies advised that: *"once you have submitted this application you may ask for a copy to be sent to you"*. This is the general positon regarding the provision of an application form. It is noted the other Insurance Company's application did state that a copy of the application form would be provided to the applicant, but it would have been this Insurance Company's responsibility to provide same.

As regards the Fact Find / Data Capture Forms that were completed, there is contradictory reference to same in the Provider's evidence. It is stated that no Fact Find was completed in 2011, but there are Data Capture Forms on file, which would satisfy the same purpose. While I accept it would be prudent that an applicant would sign off on same, and the consumer codes do require verification of a Fact Find, the absence of a signature here would not lead me to conclude that the whole application process should fail.

Here the Broker and the Complainant successfully went through the application process for both the life cover requirements and for the annuity contract. However, the Complainant subsequently considered that the life cover and annuity did not meet his needs and took steps himself to undo what had been arranged.

The reason given by the Complainant for wanting to undo the life cover that was arranged is that not all relevant information was disclosed to the Companies in relation to his health.

It was prudent to make sure all information was disclosed as it is when a claim arises that it would be discovered by the Company that something was not disclosed, and it is then that an assessment is made as to whether it would have influenced the Underwriting decision as to acceptance for cover.

From the evidence submitted by the Complainant, there does not appear to have been any voidance of cover by an Underwriter of the policies that were arranged by the Provider. The Complainant here seems to have had his applications reviewed and noted that a medical issue relating to prescribed medication was not disclosed, and also noted that the disclosures as regards his smoking habit could have been better declared. The Complainant claims that the result was that he had to get new cover arranged, but does not indicate whether he went back to the existing Companies to establish what effect the actual disclosures would have had, if any.

Likewise the Complainant's positon is that he had to make alternative arrangements as regards his annuity contract, but does not indicate what difference was achieved, over and above what had been arranged by the Provider here.

There was no submission made in relation to the steps that were taken and what benefits were achieved by the cancellation of the policies that had been arranged by the Provider.

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Under the European Communities (Life Assurance) Framework Regulations, 1994 a Company must provide a 30-day cooling-off period during which time the policyholder can change his / her mind and cancel the policy if they wish. This is from the date the policy schedule is sent to the policyholder.

I am satisfied that the Broker for the most part did all that it was required in relation to these policies. The Complainant had the early opportunity (by exercising his rights under the 'cooling off' provision) to exit the annuity policy when he became aware of the specifics of same. The Complainant did exercise this option in relation to the pension arrangement and was allowed to re-invest the monies in another product.

As regards the life policies, I am also satisfied that the Broker for the most part did all that was required in relation to the setting up of these policies. The Complainant confirmed by his signature that he had read over the applications and declared that answers recorded were true and complete. The Complainant does not argue that he had any particular difficulty in understanding the documents that he signed. Ultimately, it is an applicant's duty to ensure that all information is correctly provided. The Complainant here is / was in business and would be expected to be familiar with the need to read over documentation before signing same.

I am satisfied that the use of the statutory right to exit a policy is a protection for situations such as this. The duty of good faith and making full disclosures when completing application forms is very important and I accept that it is a two way process, that is the Provider should highlight the need for such full disclosure, and the applicant should make those disclosures. When signing a declaration as to the completeness of the disclosures the applicant should reasonably read over the application form and ensure that it records his or her disclosures fully.

While I accept that the Provider could have had better processes in place for the gathering of information, recording of same, verification of what was been undertaken and in the supply of documentation to the Complainant, I cannot find evidence of unsuitability of the products recommended or how the Provider's actions have adversely affected the Complainant. Overall I find that there appears to have been agreement by the Complainant on how the cover was arranged. Contacts between the Provider and Complainant were either by telephone or by way of the Provider visiting the Complainant's place of work. These modes of dealings, appear to have been at the Complainant's request and it may have helped matters if a more formal arrangement had been in place.

The Provider has argued that the business arrangement that was in place was based on an "Execution Only" arrangement. I accept that there appears to have been some elements of an "execution only" arrangement in place, that is where the Complainant specified what he wanted and did not wholly require the greater advice and attention that another client would have required. That said, if this was the extent of the relationship that was in place, I would have expected greater evidence of a specific agreement between the parties to that effect, with the Complainant being alerted to what such an arrangement entailed and its limitations as regards the advice / service that was going to be provided by the Provider.

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As regards these procedural deficiencies with the Provider's processes, namely the incomplete process regarding the completion of a Fact Find, not having the Complainant verify by his signature the changes the Provider had made on his behalf to the Applications regarding smoking status, not fully setting out for the Complainant what was understood by an "Execution Only" sale, in addition to the above noted deficiencies, it is my Legally Binding Decision that a compensatory payment of €1,000 (one thousand euro) is merited.

Having regard to all of the above it is my Legally Binding Decision that the complaint is partially upheld and the Provider is to pay the Complainant a compensatory payment of €1,000 (one thousand euro).

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially upheld, on the grounds prescribed in ***Section 60(2)(g).***

- Pursuant to ***Section 60(4)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct that the Respondent Provider pay the Complainant the compensatory payment of €1,000 (one thousand euro).

- Pursuant to ***Section 60(6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, where the amount is not paid by the expiry of the 35 day appeal period specified below.

- Pursuant to ***Section 60(8)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** the Respondent Provider is now required, not later than 14 days after the expiry of the 35 day appeal period specified below to notify this office in writing of the action taken or proposed to be taken in consequence of the said direction outlined above.

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

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

20th June 2018

/Cont'd…

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that— (a) ensures that—

(i) a complainant shall not be identified by name, address or otherwise,

(ii) a provider shall not be identified by name or address,

and

(b) ensures compliance with the Data Protection Regulation and the *Data Protection Act 2018*.