Decision Ref:	2018-0106
Sector:	Insurance
Product / Service:	Term Insurance
Conduct(s) complained of:	Lapse/cancellation of policy Delayed or inadequate communication
Outcome:	Substantially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint concerns a life policy taken out by the policyholder in January 2007. The policy lapsed on 10 April 2015, and the policy benefits ceased on 24 May 2015. The policyholder died in tragic circumstances in August 2015, and the Complainant is the Estate of the policyholder and is represented by the Executor of the Estate (hereinafter referred to as "the Complainant").

The complaint is that the Provider failed to notify the policyholder that two direct debits in respect of two months premiums had been returned unpaid, resulting in the policy lapsing and in turn a claim under the policy being refused by the Provider.

The Complainant's Case

The Complainant submits that the policyholder purchased a life cover policy from the Provider on 24 January 2007. The Complainant submits that the policyholder's wife died in November 2006 and the policyholder wanted to make sure that his two children were taken care of, if anything ever happened to him.

The Complainant submits that the policyholder relocated abroad in April 2011 and, at that time, the policyholder had the post office redirect all of his post to the Complainant's address. The Complainant states that the Provider "*did not adequately ensure [its] attempt to inform [the policyholder that his] policy had lapsed reached him. He had outlined he was permanently moving [abroad] to [the Provider] in 2011 and requested post is redirected to his sister's home as it could not be sent [abroad] when he requested it. The address change*

became effective from May 11. Same day as email and address change". The Complainant also states "*I never opened any correspondence that was addressed to [the policyholder]. I would gather it all up every week or so and either mail a parcel to him or send it with a visiting family member… I am certain that [the policyholder] never received any of the correspondence from [the Provider]".*

The Complainant submits that there was never any indication on the outside of any envelope that the contents were important. The Complainant states that "*If there had been, I would have called [the policyholder] and informed him, or sent it to him via registered mail to ensure that he actually received it*". The Complainant submits that he does not know how the Provider had his address, "*I can only assume that at some point [the policyholder] or his insurance broker… had informed [it] of his move [abroad]*".

The Complainant states that the policyholder "*[died]… on August 2nd 2015. I was subsequently appointed Executor to [his] estate, and it was not until much later that I realised that the Life Cover policy was considered "lapsed*". The Complainant submits that it appears the Provider was owed approximately €177.40 when it cancelled the policy two months before the policyholder's death.

The Complainant states *"Since we have absolutely no record of [the policyholder] ever receiving notification from [the Provider] that there was an issue with the direct debit, I would like [the Provider] to honour the Life Cover Policy and provide the death benefit amount of EU 295,491 as guaranteed in the policy, along with any interest that has accrued since August 2015, to his two children, who are, tragically, orphans*".

The Provider's Case

The Provider submits that the policy issued on 24 January 2007, and it issued documentation to the address on the application form. The Provider submits that the Policy provisions were included with this documentation, which sets out the terms and conditions of the policy.

The Provider submits that premiums were paid up to 26 January 2015, and it sent a letter to the policyholder on 27 February 2015 advising that the direct debit due in February 2015 was returned unpaid. The Provider submits that it attempted to debit the bank account again for the March 2015 premium and the outstanding February 2015 premium, however this direct debit was also returned unpaid. The Provider submits that it sent a letter to the policyholder dated 27 March 2015 advising him of this, and confirming that if it did not receive a payment by 10 April 2015 the policy would lapse.

The Provider submits that the policy lapsed on 10 April 2015. It states "*At that stage there was a policy value which continued to meet the monthly costs of providing the policy benefits. The policy value was exhausted on the 24 May 2015 and all benefits ceased on this date as per the terms of the policy*". The Provider also states that it "*did not receive any correspondence by post, telephone call or email in relation to the returned direct debits or the correspondence issued in relation to the returned direct debits or ceasing of benefits by either [the policyholder] or the Complainant. We could not assume that the post was not received by [the policyholder] and that he in fact did not wish to proceed with this policy*".

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The Provider states "*we attempted to debit the bank account we had on file and all correspondence in relation to the failed direct debits was issued to the address on file. As the policy ceased prior to [the policyholder's] date of death on the 2nd August 2015, we regret to advise that there will be no Life Cover payment from this policy*".

The Provider submits that the last payment to the policy was 26 January 2015 and cover did not cease on the policy until 24 May 2015. The Provider states that "*This is a period of 60 working days and 4 letters were issued in this time to [the policyholder] at the address we were provided*".

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.

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 2 July 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 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.

In the absence of additional submissions from the parties, the final determination of this office is set out below.

The issue to be determined is whether the Provider failed to notify the policyholder that two direct debits in respect of two months premiums had been returned unpaid, resulting in the policy lapsing and in turn a claim under the policy being refused by the Provider.

The Provider submits that the policyholder signed his life policy application form on 11 January 2007 and his policy issued on 24 January 2007. The Provider submits that the policyholder signed a quotation to increase the premium on the policy by €10.00 per month

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on 1 February 2011. The Provider submits that a surgical cash claim form and a children's hospital cash claim form were both received on 13 April 2011. It submits that the surgical cash claim for €9,116.50 was paid on 5 May 2011, and the children's hospital cash claim for €250.00 was paid on 10 May 2011.

The Provider submits that on 24 February 2015 it applied for the regular monthly premium, however this payment was returned as 'refer to debtor'. The Provider submits that it wrote to the policyholder on 27 February 2015 to advise the payment had been missed and to telephone to make the payment or a double payment would be applied for on 24 March 2015. The Provider has submitted a copy of its letter to the policyholder dated 27 February 2015, which states the following:

> *"Your bank has notified us that the premium we requested on your policy has been returned unpaid. As a result your last premium payment of €88.70 is now outstanding.*
>
> *So that you can continue to enjoy the benefits offered under your policy it is important that we receive this payment by 17th of March 2015. The good news is that we have a number of easy ways for you to do this:*
>
> 1. *You can make an immediate payment by debit or credit card online at… Please note an email address is required. Alternatively you can contact me on FREEPHONE… during office hours.*
> 2. *If you have not contacted us by the 17th of March we will apply to debit your account on the 24th of March for the overdue amount plus next month's premium.*
>
> *If you have already made this payment please ignore this letter. If there is anything else we can do to help, please feel free to call me on FREEPHONE… or your Sales Associate… on…"*

The Provider submits that as no contact was made it applied for a double payment on 24 March 2015, which was also returned as 'refer to debtor'. The Provider submits that on 27 March 2015 it wrote to the policyholder to confirm that the second payment had been missed. The Provider submits that this letter advised that he could make the payment over the telephone or online, and if no payment was received the policy would lapse on 10 April 2015. The Provider has submitted a copy of its letter dated 27 March 2015, which states:

> *"Your bank has notified us that the premiums we requested on your policy have been returned unpaid. As a result there are now premium payments totalling €177.40 outstanding. So that you can continue to enjoy the benefits offered under your policy it is important that we receive these payments by 10th of April 2015.*
>
> *The good news is that we have a number of easy ways for you to do this:*
> 1. *You can make an immediate payment by debit or credit card online at… Please note an email address is required.*
>   *Alternatively you can contact me on FREEPHONE… during office hours.*

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> 2. *If you would like us to take the premium from a different bank account going forward I have enclosed a Direct Debit Mandate which you should sign and return to me in the enclosed prepaid envelope immediately.*
>
> *If you have not contacted us by the 10th of April your policy will lapse. This means that the important benefits provided by your policy will cease. You should be aware that if your policy lapses you may not be eligible to avail of these benefits again.*
>
> *If you have already made this payment please ignore this letter. If there is anything else we can do to help, please feel free to call me on FREEPHONE… or your Sales Associate… on…"*

The Provider submits that on 13 April 2015 it wrote to the policyholder advising that the policy had lapsed, however his policy value would continue to be used to meet the monthly cost of providing the policy benefits, and these benefits would cease when the policy value was exhausted. The Provider has submitted a copy of this letter, which I note, states:

> *"Unfortunately, due to unpaid premiums your policy has lapsed with effect from the 10th April 2015.*
>
> *The main purpose of your policy was to protect you and your family against the financial hardship that would arise should an event occur in the future that you were protected for under the benefits of this policy. It is important to understand that it may be more difficult to secure policy benefits again should your state of health or occupation change.*
>
> *The good news is that due to the flexible nature of [the Provider's] policies you may have the option to restart your policy subject to normal underwriting requirements. The reinstatement options open to you may include reducing the premium and/or benefits to better suit your current needs.*
>
> *[The Provider] strongly encourages all our clients to consider their reinstatement options carefully. If you would like to discuss your reinstatement options in more detail you can contact me on FREEPHONE… or you can arrange to have your Sales Associate… call to bring you through your options. [The Provider's Sales Associate] can be contacted on…*
>
> *You should note that your policy value will continue to be used to meet the monthly cost of providing your policy benefits. These benefits will cease when your policy value is exhausted. This is why we strongly recommend that you consider your reinstatement options outlined above.*
>
> *If there is anything else we can do to help, please feel free to call me or your Sales Associate."*

The Provider submits that a further letter was sent to the policyholder on 29 April 2015 confirming that the benefits on the policy were due to cease on 24 May 2015 as the fund

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had been exhausted. The Provider submits that this letter also advised that the plan could still be reinstated subject to normal underwriting requirements. I note that this letter states:

> *"The latest premium payment on your policy was on the 26th January 2015. Since then we have continued to provide benefits, the monthly costs being met by cancelling units on your policy. However, the most recent monthly charges resulted in the cancellation of the last remaining units allocated to your policy. Under the terms of your policy all benefits will cease with effect from the 24th May 2015.*
>
> *The good news is that due to the flexible nature of [the Provider's] policies you have the option to continue with your policy. This would be subject to normal underwriting requirements and the resumption of premium payments. One of the options open to you may include reducing the premium and/or benefits to better suit your current needs.*
>
> *[The Provider] strongly encourages all our clients to consider their options carefully. If you would like to discuss this in more detail you can contact me on FREEPHONE… or you can arrange to have your associate… call to bring you through your options. [The Provider's associate] can be contacted on…*
>
> *If there is anything else we can do to help, please feel free to call me or your associate."*

The Provider has submitted a copy of the terms and conditions of the policy. I note that on page 3 of the policy document, under the heading "*Section 2 General Conditions*", it states, among other things, the following:

> *"2.2 Payment of Premiums*
> *(a) You should pay the first Premium before the Commencement Date. All subsequent premiums should be paid by direct debit at the intervals stated in the Policy Schedule. However, if you pay Premiums yearly or half-yearly, then you may elect to pay these by cheque. You may pay Single Premiums at any time. They will be subject to such terms and limits as we may apply at that time.*
> *(b) Premiums continue to be payable up to the date of the death of the Life Assured or earlier total claim. Premiums cease if you choose to surrender your Policy.*
> *(c) You must pay each Premium within thirty days of the date it is due. If the Life Assured dies within this period any Premiums due, but not paid, will be deducted from the benefit payable.*
> *(d) If you fail to pay a Premium in full within thirty days of the date it is due, we will proceed as follows:*
> *i) If there are no Units allocated to the Policy Unit Account, we will terminate the Policy and no benefits will be payable to you.*
> *ii) If there are Units allocated to the Policy Unit Account, we will keep the Policy in force without payment of further premiums. We will continue to make monthly deductions as under Provision 2.9. If at any time, there are insufficient Units to meet these deductions, we will cancel the Policy and no benefits will be payable to you.*

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(e) *Despite Provision 2.2(d), we will normally allow you to reinstate the Policy, on such terms as we may decide. This will include receipt of satisfactory evidence of the good health of the Life Assured which will incorporate a written declaration of health.*

The Complainant submits that letters were sent to the policyholder's rental accommodation up to April 2011, prior to him moving abroad. The Complainant submits that the policyholder then asked the Provider's representative, who sold him the policy, to change the address to the Complainant's address "*and also requested that she would arrange email*". The Complainant states that the policyholder "*spoke with his best friend… and his Sister… about it at the time when planning the move and subsequent to his discussion with [the Provider's representative]. He stated he had requested the post be sent to my address [stated address] as there was some issue with [the Provider] not able to direct his post to the US. He then stated that he provided his email so he could keep up to date. This was his contact email until he died. [The policyholder] requested a copy be sent via email as is noted on the [Provider's] files at that time.*"

The Complainant submits that no registered letters, or letters marked urgent or important were received to his house addressed to the policyholder. The Complainant submits that during the period 24 February 2015 to 5 August 2015 the Provider did not telephone or email the policyholder. The Complainant states that "*On 30/4/2011 [the policyholder] notified [the Provider's] associate… (who sold the initial policy) that he was moving [abroad] and requested his email be added to the file. It was added to the file*". The Complainant states, "*If a registered letter came to our house we would have contacted [the policyholder] immediately. I can say with certainty that [the policyholder] would have paid immediately if he had been made aware*". The Complainant also states that *"I feel that [the Provider] did not make sufficient attempts to inform [the policyholder] that the policy had lapsed other than [its] claim of a standard issue letter after 9 years as a client with this policy alone. I can say I reviewed [the policyholder's] phone records and found there is no record of phone calls from [the Provider] to [the policyholder] to discuss the returned DD*".

The Provider submits that on 30 April 2011 an anniversary call was made to the policyholder and "*the details recorded confirm that [the policyholder] advised he was moving [abroad] permanently. [The policyholder] asked for his email to be added to his file and his address was updated to [the Complainant's address]*". The Provider submits that as per its procedures all correspondence is issued by post unless a specific request is made to correspond by an alternative method. The Provider submits that it did not receive an instruction to post correspondence abroad or by email, and all post from April 2011 was sent to the address provided on 30 April 2011.

The Provider submits that at no time from April 2011 to the date the policy lapsed was any post returned to its office as not delivered, and it was "*not made aware of any issues regarding post being received, or not, as the case may be by the client*".

The Provider submits that the telephone call on 30 April 2011 between its representative and the policyholder was not recorded. The Provider states that it operates "*a direct sales*

force, calls between clients ad their [Provider] Financial Advisors are often on mobile telephones and are therefore not recorded".

The Provider has submitted a copy of the "*Policy Review Sheet – Phone Service*" signed by its representative and dated 30 April 2011. I note that this states, underneath the heading "*Actions*", the following:

> *"[named representative of the Provider], Client wants his e-mail address added as he is going to [named country] permanently. [Email address provided]"*

The Provider has submitted a copy of its "*Service/Call Details*" for 3 May 2011, which I note state the following:

> *"… 1 rang for update on SCC & CHCC. Spoke to [a named representative of the Provider] & advised recvd Med Cert for SCC on 29.04.11 but are waiting on orig Long form birth cert for CHCC. As per branch, client is now [in another country] – he can be emailed [email address]"*

The Provider subsequently issued the following correspondence to the policyholder at the postal address it held on file, that is, the Complainant's address:

- Letter dated 5 May 2011 – enclosing cheque in the sum of €9,116.50 in settlement of the policyholder's Surgical Cash claim
- Letter dated 10 May 2011 – enclosing cheque in the sum of €250.00 in settlement of the policyholder's Child Hospital Cash claim.
- Letter dated 20 December 2011 – Client Information Update
- Letter dated 19 December 2012 – Client Information Update
- Letter dated 24 June 2013 with Client Information Update attached
- 20 December 2013 – Client Information Update
- 23 December 2014 – Client Information Update
- 27 February 2015 – Advice of Unpaid Premium by Direct Debit
- 27 March 2015 – Advice of Unpaid Premiums by Direct Debit
- 13 April 2015 – Advice of policy lapse
- 29 April 2015 - Advice that benefits due to cease on 24 May 2015

The Provider states that none of this correspondence was returned to it as not delivered nor was it made aware of any issues with the policyholder receiving the post that was sent to him at the address requested. The Provider states that "*No contact was made with [the Provider] by either [the policyholder] or the Complainant in relation to the policy or correspondence relating to the policy being sent to [the Complainant's address] at any time while the policy was in force*".

I note that the Provider's "*Service/Call Details*" dated 20 February 2013 state:

> *"Client now lives in [another country]"*

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I also note that the Provider's "*Service/Call Details*" dated 27 May 2016 state, among other things, that:

> *"Spoke to [the Complainant] and explained why the policy lapse[d] and the correspondence we sent each time. He advised he received this correspondence but didn't forward it to [the policyholder abroad] as he usually came home every 3-4 months."*

In response, the Complainant states that "*I would like to confirm that I did not open any mail addressed to [the policyholder] that arrived to my address therefore I have no way to confirm letters came to my home from [the Provider] as I did not open the letters. I had no way of knowing whom they were from. I had assumed they were from [the Provider] when [the Provider] told me they were from [it]. I cannot confirm same as I did not open any post received addressed to [the policyholder]".*

The Complainant states that "*Note on file: 9/4/2015 – [Provider's representative who sold the policy] aware". In her role as financial advisor [the Provider's representative who sold the policy] had [the policyholder's] contact details and email etc. Why at that point was there no other method used to outline the severity of the situation*".

The Complainant also states "*As Executor to his estate, I have gone through all of [the policyholder's] paperwork and have been unable to locate any correspondence from [the Provider] in his files. If [the policyholder] was aware that [his bank account in a named branch], from which [the Provider] was direct debiting his premium, was running low, he would absolutely have taken steps to transfer funds into that account*".

The Provider has obligations pursuant to the Consumer Protection Code 2012. Provisions 4.1 and 4.2 of the Consumer Protection Code 2012 provide the following:

> *4.1 A **regulated entity** must ensure that all information it provides to a **consumer** is clear, accurate, up to date, and written in plain English. **Key information** must be brought to the attention of the **consumer**. The method of presentation must not disguise, diminish or obscure important information.*
>
> *4.2 A **regulated entity** must supply information to a **consumer** on a timely basis. In doing so, the **regulated entity** must have regard to the following:*
> *a) the urgency of the situation; and*
> *b) the time necessary for the **consumer** to absorb and react to the information provided.*

Having carefully considered all of the evidence before me, I must accept that the policy had lapsed prior to the date of death of the policyholder. The Provider and policyholder are bound by the terms and the conditions of the policy, and there is an onus on the policyholder to make the premium payments on the policy to keep the policy in force.

In the absence of a telephone recording of the conversation between the policyholder and the Provider's representative on 30 April 2011, I cannot confirm what was discussed

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regarding the method of communication with the policyholder. However, the policyholder did advise the Provider of his email address on 30 April 2011 and notified it that he would be moving to another country permanently.

I note that the Provider wrote to the policyholder at the address it held on file to notify him that the direct debits were returned unpaid, that the policy would lapse and that the benefits would cease. I must accept that the letters were received at the address provided as the Provider submits that no post was retuned to it undelivered, and that it was not made aware that the policyholder had not received any documentation it had issued since April 2011.

I note that the Provider submits that all correspondence is issued by post unless a specific request is made to correspond by an alternative method. It is clear that the policyholder provided his email address to the Provider during the telephone call on 30 April 2011. While I accept that the policyholder also provided the Complainant's address, I have received no evidence from the Provider to confirm the policyholder's instructions during the telephone conversation of 30 April 2011 regarding the method of communication. Given that the policyholder notified the Provider that he was moving abroad permanently and provided his email address on 30 April 2011 and also that the Provider noted on its "*Service/Call Details*" on 4 May 2011 that "*As per branch, client is now [in another country] – he can be emailed at…*", in the absence of any evidence to the contrary, I accept that the policyholder provided his email address as a method of communication. I consider that the Provider should have emailed the policyholder when the direct debits were returned unpaid to notify him that the policy would lapse if the premium payments were not made, and it is most disappointing that the Provider failed to do so.

Furthermore, I note that the Provider's representative made an annual anniversary telephone call to the policyholder, the last one on 16 January 2015, just over a month before the policyholder's direct debit was returned unpaid. I also note that the Provider's "*Service/Call Details*" dated 9 April 2015 state *"[The Provider's representative] aware*". The evidence before me indicates that the representative referred to on the "*Service/Call Details*" dated 9 April 2015 is the same representative that sold the policy to the policyholder, made the annual anniversary calls to the policyholder and spoke with the policyholder on 30 April 2011. It is disappointing, therefore, that the Provider did not make a better effort to contact the policyholder by telephone prior to the policy lapsing.

It is unfortunate that I have not been provided with definitive evidence by either party, that would confirm what instructions the policyholder gave the Provider in relation to how he wished to be contacted after he left the country. It would appear that after the telephone conversation of 30 April 2011 the Provider commenced communicating by post with the policyholder at his brother in law's (the Complainant's) address. I have not been provided with any evidence that the policyholder requested this however, it is reasonable to assume that he did. What is clear from the evidence submitted is that the policyholder provided his email address in the course of the telephone call of 30 April 2011 and informed the Provider that he was moving permanently to another country.

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In these circumstances and given the serious consequences of lapsing a policy, it is difficult to understand why the Provider did not communicate with the policyholder by email prior to lapsing the policy. I fully accept that the policyholder had a responsibility to pay the monthly premium to keep the policy in force. That said I believe the Provider had a responsibility to inform the policyholder before lapsing the policy. In this case, given the Provider was on notice that the policyholder no longer lived in the country and that the policyholder had given the Provider an email address prior to moving abroad, I am of the view that the Provider should have informed him by email of the pending lapse of the policy.

To conclude, while I must accept that the Provider was entitled to decline the claim under the policy as the policy had lapsed due to the non-payment of premiums, in the circumstances of this complaint, I consider that the Provider should have contacted the Complainant by email to notify him that the direct debits were returned unpaid. Given the shared responsibility of the policyholder and the Provider in relation to this matter, I believe that in order to do justice between the parties, I direct the Provider to pay a sum equal to 50% of the policy benefit to the estate of the policyholder.

Consequently, it is my Legally Binding Decision that this complaint is substantially upheld.

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Conclusion

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

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to pay a sum equal to 50% of the policy benefit to the estate of the policyholder, within a period of 35 days of the nomination of account details by the Complainant to the Provider. I also direct that interest is to be paid by the Provider on the said amount, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

- The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

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

26 July 2018

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.