Decision Ref:	2018-0179
Sector:	Insurance
Product / Service:	Mortgage Protection
Conduct(s) complained of:	Rejection of claim - fit to return to work Failure to process instructions
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant incepted a mortgage repayment protection policy with the Provider in 1999. Having being made redundant in 2010 the Complainant made a claim under the policy and his mortgage repayments were paid under the policy for 12 months. The Complainant continued paying the policy premium and he made a claim under the policy in 2016 only to be told that as he had not returned to work after his redundancy he could not make a claim on the policy.

The Complainant's Case

The Complainant states that he was never informed that if he did not return to work, he could not make a claim on the policy. The Complainant states that as he was not working the policy was "worthless". The Complainant states that the Provider knew that he was unemployed and that despite this they allowed him to pay the policy premiums for five years even though he could not make a claim on the policy. The Complainant cancelled the policy in September 2016.

The Complainant submits that the Provider should have advised him that unless he returned to work the policy was "worthless".

The Complainant states that he sent two letters to the Provider in Dublin but that he received no reply. He states that after a few emails he requested a phone call from the Provider.

The Complainant claims the policy was mis-sold to him.
The Complainant is seeking to have the payments he made for the policy for five years returned.

The Provider’s Case

The Provider states that the Complainant suffered a redundancy and a successful claim was made. The Provider states that a new redundancy event would have to happen for a new claim to be made. The Provider states that as the Complainant remains unemployed there has been no new redundancy.

The Provider states that the only letters they received they responded to. The Provider claims that the complaint was made on 30 March 2017 and a response issued on 28 April 2017.

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 15 August 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.

Following the consideration of additional submissions from the parties, I set out my final determination below.

Dealing with the complaint of mis-selling of the policy, I find that this policy was not mis sold at inception as the Complainant was employed when the policy was incepted and he made a successful claim under the policy on redundancy.

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I will now deal with the claim that the Provider accepted policy premiums from the Complainant when he was unemployed and unable to make a claim under the policy. The Provider was aware on 24th November 2010, when it wrote to the Complainant stating that it was making the final payment under his redundancy claim, that the Complainant was still unemployed, as it was a term of the policy that redundancy payment is paid when a person is "out of work". Despite this, the letter of 24th November 2010 failed to advise the Complainant that he was not eligible for cover under the policy while he was unemployed. I accept that the Complainant could have taken up employment at any time after November 2010.

The Complainant could have cancelled the policy at any time, as he subsequently did or he could have contacted the Provider at any time and asked about his cover. However, I consider that the Provider, who was aware that the Complainant was not working, should have informed him that following the redundancy claim, he would not be eligible for cover under the policy until he was employed.

This Office requested from the Provider, a recording of all telephone recordings of conversations between the Provider and the Complainant. The Provider replied to this Office, "none relevant to the complaint". The Complainant states that he had a telephone conversation with the Provider's agent in 2016, this conversation is very important to the complaint at hand as it would clarify when the complaint was first raised and the manner in which the Provider dealt with the complaint. It was during this 2016 telephone conversation that the Complainant was first told that he was not covered under the policy as he was unemployed. In a letter dated 28 April 2017 the Provider states "*you indicated the agent you spoke with in 2016 was ignorant…*" and the Provider states that *"I have listened to the call in question and I found the advisor to have been friendly, policy (sic) and professional at all times*." As there is clearly a recording of this conversation I found it unacceptable that the Provider took it on itself to decide that this conversation was not relevant to the complaint to hand.

Following the issuing of my Preliminary Decision, the Provider furnished recordings of telephone calls in 2016 to this Office.

It is most disappointing that the Provider did not provide these recordings until such a late stage in the investigation and adjudication process.

I have listened to the recordings of these calls. I note the Complainant rang the Provider at 13.01 on 22 September 2016 stating he wanted to make a claim.

The call was somewhat rushed as the Complainant was concerned that he may run out of credit. While I did not find the agent to be ignorant as alleged by the Complainant, I believe she could have been more helpful.

Under the circumstances when the Complainant was running out of credit the best course of action, in my view, would have been for the agent to offer to ring him back when a more considered and informative conversation could have taken place.

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The conversation ended with the Provider's agent stating:

> "*You are paying into a policy that you are not covered for*".

The Complainant called the Provider later that day (22 September) at 15.17 requesting that a copy of the policy Terms & Conditions be sent to him. Both parties on the call were polite and friendly with each other.

The Complainant was informed by the Provider on 22 September 2016 that he was not eligible to make a claim under the policy.

Given that the Provider, in its response to this Office stated that it had no calls relevant to this complaint and this later transpired to be incorrect, I have no reason to doubt that the Complainant had in fact made a complaint to the Provider prior to March 2017.

I note that in an email dated 27 March 2017 the Complainant wrote to the Provider seeking "*a letter of closure on my complaint*" by email dated 29 March 2017 the Provider stated; "*I am unable to locate a concern or complaint having been raised with us*". I also accept the Complainant's evidence that he sent two letters to the Provider and got no reply. In these circumstances I consider that the complaint was not handled in line with the Consumer Protection Code Provision 10.8 and 10.9.

Furthermore, when a Provider is unable to resolve a complaint, it is required to inform the Complainant of their right to take a complaint to this Office.

I note the Provider sent correspondence to the Complainant in March and April 2017 which included a document entitled "*Our Commitment to Handling Complaints*". This document informed the customer that if they are unhappy with the response of the Provider, they can take their complaint to the UK Financial Ombudsman Service within 6 months.

I am concerned that the Provider is directing Complainants to the wrong organisation and I am particularly concerned that it is informing people that they have only 6 months to make the complaint. These are not the time limits for making a complaint to this Office.

I direct under 60(4) (c) of the Financial Services and Pensions Ombudsman Act 2017 that the Provider furnish the correct information to Complainants who fall within the jurisdiction of this Office in relation to where and when complaints can be made, in accordance with the Financial Services and Pensions Ombudsman Act 2017.

I find the manner in which the Complainant was dealt with to be unacceptable.

Furthermore, I find the way his complaint was dealt with and responded to in the investigation process of this Office to be unacceptable.

For these reasons, I uphold this complaint and direct that the Provider pay a sum of €2,500 to the Complainant in compensation for its conduct.

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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 upheld on the grounds prescribed in ***Section 60(2) (b) and (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 make a compensatory payment to the Complainant in the sum of €2,500, to an account of the Complainant's choosing, 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 compensatory payment, 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

29 November 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.