An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0197
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Failure to advise on key product/service features Delayed or inadequate communication
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants claim that they have been overcharged in respect of premia payments for health insurance.

The Complainant's Case

The First-named Complainant began working with his current employer in or around 2007. As part of his employment terms since the commencement of this employment, the First-named Complainant's employer subsidised the First-named Complainant's health insurance with the Insurer. The Complainants state that at the start of the First-named Complainant's employment, the First-named Complainant selected a health insurance plan that was fully subsidised by his employer resulting in no payment obligations on his behalf.

Thereafter, in August 2011, the First-named Complainant states that "*there was a change in the amount* [his employer] *subsided* [sic] *under the health insurance policy under my terms of employment and I was charged for the difference between the premium and the amount* [his employer] *would cover*". The First-named Complainant initially stated that this difference amounted to €257.05 in 2011 and €486.94 per year from 2012 (when the Second-named Complainant was added to the policy). These figures were amended in subsequent correspondence wherein the total figure "*overcharged*" is stated to be €4,393.48.

The First-named Complainant highlights that he was not told, in or around the time of the change in his employer's percentage contribution in 2011, that the Insurer had opened a new scheme/plan which was *fully* subsidised by his employer.

The First-named Complainant also maintains that, at this time, "*other existing members were moved onto this*" fully subsidised scheme/plan but that that he was neither moved nor informed about the fully subsidised plan. It is claimed that this other fully subsidised plan is more "*extensive*" and provides "*better cover".*

The Complainants cancelled the policy with effect from the 1st of August 2016.

In addition, the First-named Complainant claims that the plan that he was originally on, and that he remained on in 2011, was subsequently discontinued by the Insurer and he alleges that he was transferred to a different policy without his consent.

Finally, the Complainants also have concerns regarding "*document retention procedures*" within the Insurer. The First-named Complainant states that he has requested a copy of his "*signed agreement*" and/or his "*signed application*" in respect of his original joining of the policy but maintains that the Insurer has advised him that it has not retained any copy of any such documents.

The complaint is that the Complainants have been exposed to part payments of premia to which they should not have been exposed. The Complainants calculate the figure they have been overcharged in the amount of €4,393.48 and seek compensation in that amount.

<u>The Provider's Case</u>

The Insurer notes that the policy was incepted in October 2004 (and not 2007) and relies upon correspondence issued in August 2011 and on subsequent renewal dates wherein the First-named Complainant was advised of the fact that the shortfall in premia payments would be deducted from the First-named Complainant's salary. The Insurer maintains that it received no contact from the First-named Complainant seeking to review the cover (as he had been invited to do). Accordingly, the Insurer states that the policy was renewed each year as per the terms of the policy upon receipt of payment of the premium.

With regard to the retention of documents, the Insurer states that it has not retained information regarding the original application, but it maintains that it has complied with the provisions of the Consumer Protection Code.

<u>Decision</u>

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 Complainants were given the opportunity to see the Provider's

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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 16 October 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, my final determination is set out below.

Prior to considering the substance of the complaint, it will be useful to set out the relevant terms and conditions of the policy as well as the content of certain renewal notices.

Policy Terms and Conditions

The Insurer has relied upon the following terms of the policy:

Rule 3) Renewing the Policy

a) Your policy was last for one year unless we agree to a shorter period. At the renewal date, you can renew your policy by paying the premium we request. The Rules and your Table of Benefits in place at the renewal date will then apply to your policy.

Renewal Notices

The Insurer issued a renewal notice to the First-named Complainant on the 25th of August 2011 which provided as follows:

The total cost of your cover for the period 22/08/2011 to 21/08/2012 is €1,112.05. Your group scheme subsidises your cover in the amount of €855.00. Arrangements are in place to deduct the remaining €257.05 from your salary.

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The Insurer issued a renewal notice to the First-named Complainant on the 7th of December 2012 which provided as follows:

> *The total cost of your cover for the period 22/08/2012 to 21/08/2013 is €2,130.64. Your group scheme subsidises your cover in the amount of €1,643.70. Arrangements are in place to deduct the remaining €486.94 from your salary.*

The Insurer issued a renewal notice to the First-named Complainant on the 30th of July 2013 which provided as follows:

> *The total cost of your cover for the period 22/08/2013 to 21/08/2014 is €2,753.50. Your group scheme subsidises your cover in the amount of €2,091.60. Arrangements are in place to deduct the remaining €661.90 from your salary.*

The Insurer issued a renewal notice to the First-named Complainant on the 25th of July 2014 which provided as follows:

> *The total cost of your cover for the period 22/08/2014 to 21/08/2015 is €3,197.00. Your group scheme subsidises your cover in the amount of €2,404.94. Arrangements are in place to deduct the remaining €792.06 from your salary.*

The Insurer issued a renewal notice to the First-named Complainant on the 28th of July 2015 which noted that the total annual cost for the period 01/08/2015 to 31/07/2016 was €3,197.00 and provided as follows:

> *Your group scheme subsidises your cover to the amount of €2,224.22. Arrangements are in place to deduct the balance of €972.78 from your salary.*

The Insurer issued a renewal notice to the First-named Complainant on the 5th of July 2016 which provided as follows:

> *The total cost of your cover for the period 01/08/2016 to 31/07/2017 is €3,419.28. Your group scheme subsidises your cover in the amount of €2,333.24. Arrangements are in place to deduct the remainder from your salary.*

In respect of the latter renewal notice, the unspecified remainder amounts to €1,086.04. The total amount paid by the Complainants over the relevant years as per the renewal notices is €4,256.77, slightly less than the figure quoted by the Complainants.

Analysis

I will address this complaint in three separate parts.

Overcharging Complaint

The Complainants maintain that they were overcharged in respect of premia in circumstances where the First-named Complainant had understood that he was a member

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of group/plan that was fully subsidised by his employer. The Complainants also take issue with the fact that the First-named Complainant was not advised in 2011 of the new fully subsidised plan available to which other employees were transferred.

The terms pursuant to which the contract of insurance operate include a term as to the renewal of the policy as set out above. This clearly provides that the policy will be renewed upon the payment of the new premium. In this case, there is no doubt but that, on each renewal date, the Complainants, in conjunction with the First-named Complainant's employer, made the relevant premium payment thereby renewing the policy.

The precise terms pursuant to which the policy was to be renewed, including, in particular, the terms as to payment and what payment the First-named Complainant would be required to make, were clearly communicated to the First-named Complainant under the cover of each renewal notice. The First-named Complainant has acknowledged that he "*may have received these letters*".

In these circumstances, I can find no fault on the part of the Insurer. The First-named Complainant states that he was unaware of the fact that he was making partial payments from 2012 onwards owing, in part, to the fact that he achieved a promotion in or around this time meaning that he did not notice the deductions from his salary.

However, the detail as to the premia payments was clearly communicated by the Insurer and it cannot be held accountable for the Complainants' failure to study the documentation furnished or examine the deductions from his salary.

Separately, the Complainants complain about the failure to notify them of the existence of a plan that was fully subsidised by his employer. I fail to see how this can be attributed to the Insurer. The Complainants' plan was clearly subject to automatic renewal in the absence of a request for review. It is noteworthy that the renewal notice for 2016 and the letter under the cover of which the 2015 renewal notice was sent note the possibility that the Insurer may have a more suitable plan for the policy holder and invites the policy holder to make contact to discuss same.

In my view, it was incumbent upon the Complainants to investigate this matter had they been aware, as they should have been, that they were making contributions towards the premia with which they were unhappy. The existence of a plan which was fully subsidised by the First-named Complainant's employer was a fact that the First-named Complainant could have easily established. This is a matter that one might reasonably have expected the First-named Complainant's employer (and not the Insurer) to bring to his attention. I do not believe I can hold the Insurer responsible for failing to transfer the Complainants to the fully subsidised plan in the absence of instructions from the Complainants to do so.

Insofar as the Complainants highlight the fact that other employees were transferred to the fully subsidised plan, this relates to employees who were on a different plan to begin with. The Complainants have provided a copy of an email from the First-named Complainant's employer of the 17th of July 2015 referable to this matter. This email, having referred to the transfer to a fully subsidised plan of employees who were originally on a

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different plan (described as Plan 1 below) to the plan the Complainants were on, clearly states as follows:

> *"As before, all members who are currently on different packages with* [the Insurer] *from* [Plan 1] *will remain on these packages with their additional costs continued unless HR is notified.*
>
> *These additional costs will increase depending on your tax bracket/salary band as* [the employer] *will now be funding the cost of* [the fully subsidised plan]. *Anyone unsure of their current cover and charges please contact* [the Insurer] *directly to review their cover"*

It would appear that the Complainants' difficulties stem from the fact that they did not appear to know that they were making contributions towards the premia. This was however a matter that was clearly notified to the First-named Complainant and he would have been in a position to cancel or vary or change his policy on each renewal had he read the renewal notices and found himself unhappy with same. Accordingly, I do not uphold this aspect of the complaint.

<u>Change of Policy Complaint</u>

It would appear that the policy or plan originally joined by the First-named Complainant was the subject of a change of name. I am satisfied that this does not equate to any fundamental change to the terms of the policy which was undertaken without the consent of the policy holder. Accordingly, I do not uphold this aspect of the complaint.

<u>Retention of Documentation Complaint</u>

The Consumer Protection Code 2012 provides as follows at section 11.6:

> *A regulated entity must retain details of individual transactions for six years after the date on which the particular transaction is discontinued or completed. A regulated entity must retain all other records for six years from the date on which the regulated entity ceased to provide any product or service to the consumer concerned.*

In this case, the application form signed by the First-named Complainant was completed in October 2004 according to the Insurer or at some point in 2007 according to the Complainants. On either account, over 6 years had elapsed since that 'transaction' prior to the Insurer ceasing to retain a copy of the document. Accordingly, I do not uphold this aspect of the complaint.

<u>Conclusion</u>

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is rejected.

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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

9 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.