An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0226
Sector:	Insurance
Product / Service:	Term Insurance
Conduct(s) complained of:	Refusal to insure - failure to renew policy Dissatisfaction with customer service
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants held a joint life insurance policy with the Provider which lapsed due to a failure to make certain payments. Subsequently, the Complainants sought to re-activate the policy at which point the Provider requested the completion of an 'Evidence of Health' form. Upon receipt of the completed form, the Provider noted that there had been a change in circumstances as regards the health of the Second-named Complainant and declined to reinstate the benefits on the plan. The complaint relates to the Provider's subsequent refusal to reinstate a plan for the First-named Complainant only, in respect of whom there had been no change in circumstances.

The Complainants' Case

The Complainants maintain that the First-named Complainant should be entitled to have cover reinstated on his life in circumstances were there had been "*no material change*" to his health. The Complainants rely upon a certain provision of the policy "*which clearly draws a distinction between a single life (life assured) and joint lives (lives assured)".* The Complainants submit that the relevant provision of the terms and conditions which authorises the Provider to seek an Evidence of Health form, and which further authorises the Provider to refuse to restore cover on the basis of any change of circumstances highlighted in such a form, does not refer to 'assured lives' but to 'the life assured'. The Complainants contend that the terms do not specify "*that a change in either of the lives assured could lead to the cancellation of cover on both lives*".

The Complainants seek the restoration of cover in respect of the First-named Complainant.

The Provider's Case

The Provider relies on the terms of the policy and states that the definitions section of the policy makes clear that the use of the terms 'you' or 'life assured' is clearly to be understood as you plural or 'lives assured' in the event that the policy covers multiple lives. On the basis of the terms of the policy, the Provider states that it is satisfied that it was entitled to decline to restore cover (on the pre-existing terms) to both Complainants.

In the Provider's response to this Office dated 9 October 2017, it stated, among other things, the following:

To further reinforce this position the Provider also points to the specific note in the margin of the Reinstatement Decision of Health Form (copy of which was enclosed under Section 13 – dated 23 September 2016) which states that:

> *"For policies taken out prior to 21/12/2012 Reinstatements are only allowed on plans unpaid less than 6 months and where there is no change to the original acceptance terms.* ***If there is any change to the original acceptance terms****, or the plan has been unpaid greater than 6 months,* ***then the original plan cannot be reinstated and a new application will have to be taken out on gender neutral rates***".

It is clear from both the Terms and Conditions of this Life Cash Cover Plan and the warning note on the Reinstatement Declaration of Health Form, that it is the whole plan which will be affected by any change in the health circumstances of either of the lives' assured with regard to the Provider's decision to decline to restore cover.

The Provider therefore stands over its decision not to revive/reinstate this Life Cash Cover Plan and restore the benefits of both lives' assured, on the basis that the nature of the change of health circumstances of the female life assured has an impact on the administration of the plan as a whole and also due to the introduction of gender neutral rules under the EU Gender Directive in 2012.

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 Complainants were 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.

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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 21 November 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, I set out below my final determination.

Before embarking on my analysis, it will be useful to set out the relevant terms from the policy and to provide an outline of the timeline of Relevant Events.

Policy Terms and Conditions

Section 1 of the policy sets out certain definitions including the following:

> ***Life assured or lives assured*** *– The person or people named in the plan schedule as the life or lives covered. The benefits of the plan depend on the lives of those people.*

Section 3 of the policy is entitled 'Making payments' and provides as follows:

> *3.1*
> *Although each payment is due on the payment dates shown in the plan schedule, we give you 30 days to make the payment. If you make the payment every month, we give you 10 days to make the payment. (The time allowed is known as a 'period of grace'.) If you become entitled to a benefit during a period of grace, we will take from your benefit any payment that you have not made.*
>
> *3.2*
> *If you have not made a payment by the end of the period of grace, your cover under the plan will end immediately. A payment is not made until we have received it. It is up to you to make sure that we receive your payment. We are entitled to pass on to you any charge which we have to pay because all or part of your payment (for example, a direct debit) is dishonoured.*

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3.3
If your cover under the plan ends as described in section 3.2, you can restore your cover within 60 days from the date the first missed payment became due. You must make all the payments which would have been due if your cover had not ended.

You will not be entitled to benefits for anything that happens between the end of the period of grace and the date we receive all missed payments.

3.4
If, within 180 days of the first missed payment being due, you ask for cover to be restored, the life assured must fill in an evidence of health form and all the payments which would have been made if cover had not ended must be made. If the information on the evidence of health form shows that the health of the life assured is now different to that declared on the application form, we may refuse to restore cover or restore the cover:

- *without any charge;*
- *with an increased payment; or*
- *with new conditions (for example, you might lose cover for certain specified illnesses).*

Timeline

26 November 2007 Inception of policy

5 May 2016 Payment made in an amount less than the total amount owing. No further payments were made or attempted after this date until August 2016.

7 May 2016 Letter noting underpayment and requesting further payment. This letter also records the risk that the policy will "*go out of force"* in the absence of full payment. The relevant portion of the letter is reproduced below:

"*Dear [Complainants],*

Thank you for your payment of €234.84 which we received on 5 May 2016.

This payment has been updated to your plan. However, the payment we received is less than the amount due which means your plan is only paid to 26 April 2016. As a valued customer we must let you know that we need the balance of €117.42 to bring your plan up to date.

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You can pay this balance to us by Debit or Credit Card. Just give us a call and we can process your payment over the phone.

We need to make you aware that your plan will automatically go out of force if the outstanding payment is not received before 22 June 2016".

18 June 2016 — Letter notifying that the plan has now gone out of force. The content of the letter was as follows:

"Dear [Complainants],

We previously wrote to you to tell you that your Life Cash Cover plan is paid to 26 April 2016 and that we have not received payment since that date.

As this has not changed your plan has now gone out of force and your benefits have been cancelled. To restore your plan benefits, please send us the amount due of €234.84 in the prepaid envelope provided, together with the payment slip from the bottom of this letter.

You can also make a payment to us by Debit or Credit Card. Just give us a call and we can process your payment over the phone.

You made an important decision originally to take out this protection plan which provides a great sense of security for you and your family. If your circumstances have changed recently then we may have the options to help you maintain cover on your plan. Please ensure you speak with your financial adviser [Provider's agent] so that you can make a fully informed decision on your best course of action now".

22 June 2016 — Date on which Insurer advised cover would cease in the absence of the making of full payment

15 August 2016 — Date on which Complainants sought to make payment and reactivate the policy. Complainants were informed that an Evidence of Health Form was required.

23 September 2016 — Evidence of Health Form received by Provider.

26 September 2016 — Provider wrote to Complainants to advise that due to a material change in circumstances of the health of one of the

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lives the Provider was unable to reinstate the benefits on the plan.

Analysis

There is no factual dispute in this complaint. The Complainants accept that they missed payments and sought to reactivate the policy after they had been informed it had lapsed.

When the Complainants sought to restore cover the Provider sought an Evidence of Health form. The Complainants each provided the requested forms wherein the Second-named Complainant's form disclosed a material difference in her health.

Thereafter, the Provider declined to restore the cover. The Complainants seem to concede that the Provider was entitled to decline to restore cover in respect of the Second-named Complainant, but they dispute that the Provider was entitled to decline to restore cover in respect of the First-named Complainant.

The Complainants are correct that Section 3.4 refers to the term 'life assured' in the singular. I do not accept that this is an observation that necessarily carries any ramifications in this case.

The use of the terms 'life assured' and 'lives assured' are clearly intended to be interchangeable depending on whether the policy covers one or multiple lives. This however, in my view, is largely immaterial. In this case there was one policy. The Complainants are effectively arguing for the severability of that policy such that one of the lives assured should be allowed to continue under cover.

The Provider states in relation to this:

> "*It is the Provider's understanding that the Complainants are relying on their own interpretation of the wording of the relevant section of the Terms and Conditions …"*

I must point out to the Provider that the Complainants are perfectly entitled to have their own interpretation of the Terms & Conditions and it is a matter for the Provider to set the Terms & Conditions out in a manner that is clear and unambiguous and easy understandable to ensure that all parties can easily interpret them and ideally arrive at the same interpretation.

I further note the Provider's comment that:

> "*The Provider is not in a position to apply non gender neutral rates to this contract which was taken out prior to December 2012 and the introduction of gender neutral rules under EU Gender Directive 2012".*

It is not entirely clear to me why the Provider, even as a compromise, could not have insured one life.

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That said, I am prepared to give the Provider the benefit of the doubt that it could not do so.

However, I have serious concerns in relation to the manner in which the Provider communicated with the Complainants in relation to the lapsing of the policy. In particular, I am not happy that the consequences of not restoring the policy within a specified timeframe was adequately pointed out to the Complainants.

In particular, I would draw attention to the Provider's letter of 18 June 2016.

This was probably the most important communication by the Provider in relation to the Complainants' policy and subsequent to this complaint.

The letter informs the Complainants that the plan has now gone out of force and the benefits have now been cancelled. It goes on to state:

> "*To restore your plan benefits, please send us the amount due of €234.84 in the prepaid envelope provided, together with the payment slip from the bottom of the letter*".

This letter provided no deadline by which the payment must be submitted, nor does it provide the Complainants with the critically important date by which they must make the payment in order to have the policy restored.

I appreciate that this information was included in the Terms & Conditions when they took out the policy in 2007, but I fail to understand why the Provider would not have taken the opportunity to at least remind the Complainants when writing to them that this term would apply if the payment was not made by a particular date.

While I accept that the Complainants were not as diligent as they ought to have been in terms of making their payment, I believe better communication on the part of the Provider could have avoided the unfortunately situation that has arisen.

As I have accepted that the Provider cannot reinstate the policy for one of the lives insured, I believe that in order to do justice to the Complainants, the Provider should offer to reinstate the policy in its entirety for the Complainants.

Therefore, I uphold this complaint and direct the Provider to provide an opportunity to the Complainants to revive the policy on the same Terms & Conditions as originally applied, without the need for any health or medical checks or evidence.

In the event that the Complainants decide to accept the offer to reinstate the policy, it will be necessary for them to pay all premiums due to the date of renewal.

I also direct that the Provider allow the Complainants a period of three months from the date of my Legally Binding Decision to pay any arrears of premiums due.

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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 (c).***

Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to rectify the conduct complained of by providing an opportunity to the Complainants to revive the policy on the same Terms & Conditions as originally applied, without the need for any health or medical checks or evidence.

In the event that the Complainants decide to accept the offer to reinstate the policy, it will be necessary for them to pay all premiums due to the date of renewal.

I also direct that the Provider allow the Complainants a period of three months from the date of my Legally Binding Decision to pay any arrears of premiums due.

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

14 December 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.