An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0024
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Dissatisfaction with customer service Disagreement regarding Settlement amount offered
Outcome:	Substantially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The conduct complained of relates to the value of the death benefit the Complainant received following the death of her late husband. The Complainant submits that the value is lower than she was entitled to; and that this was due to the Provider sending letters to the incorrect address. The Complainant also states that she did not receive the Plan Review letters that the Provider says were sent to her in 2014

The complaint is that the Provider incorrectly administered the policy, particularly in relation to the communication of the Reviews of the Policy and of the reduction of the sum assured under the policy.

The Complainant's Case

The Complainant's complaint concerns the value of the death benefit claim paid in respect of the Complainant's late husband. The Complainant's positon is that the amount that she received was less than she was entitled to and that this was a direct result of:

- The Provider sending correspondence to the incorrect address;
- The Complainant not receiving Plan Review letters in 2014; and
- The Provider's failure to contact the Complainant to ensure that she had received its correspondence.

The Complainant seeks the difference in the amount received and the life assured sum that was communicated in February 2014, which is approximately €60,000.

The Provider's Case

The Provider states that despite the conduct being complained of relating to the value of the death claim paid, the Provider notes that the Complainant has continually referred to correspondence sent to the incorrect address between 2002 and 2009. The Provider addresses this issue before going on to outline its response to the conduct complained of.

The Provider says that when the plan started, the address noted on the application form and therefore recorded on its records was 14 O.. …, Dublin. The Provider states that the Complainant confirms that in 2002 she moved house and her updated address was 9 H… .., Co Meath. The Provider states that a letter sent to the Complainant dated 10 October 2002 was returned undelivered by An Post. The Provider submits that at that time, the Provider contacted the financial adviser to request an alternative address.

The Provider states that on 27 January 2003, the Provider received a completed Confirmation of Address Form from the Complainant, confirming their updated address. The Provider states that unfortunately due to an administration error on its part, it continued to send correspondence to the incorrect address from that date until June 2009, when the Complainant made contact via the telephone. The Provider says that at this point, the Provider updated the address on its records to reflect the correct address of the Complainant; 9 …, Co Meath.

The Provider states that the Complainant requested copies of all correspondence that was sent to the incorrect address; and these were posted on 18 June 2009 as requested. The Provider would like to point out that this is not relevant to the conduct complained of. The Provider submits that the alteration and letters that the Complainant is referring to occurred in 2014, when the correct address was noted on its records.

The Provider is satisfied that it correctly Reviewed the policy in 2014 and correctly communicated the results of the Review to the Complainant's updated address.

Evidence

Correspondences that are said to have issued to the Complainant from the Provider:

27 January 2003 – The Provider receives the Complainant's updated address on its: "Notification of Correct Address Form".

27 January 2003 – Letter from Provider sent to the Complainant's old address:

"Thank you for your phone call of 27 January 2003. Enclosed please find Direct Debit Mandate as requested".

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The Complainant states that she did not receive this letter.

5 February 2003 – Letter from the Provider to the Complainant – sent to the Complainant's old address:

"As requested the method of payment for the above policy has been altered to direct debit".

26 May 2003 – Letter from the Provider to the Complainant – letter was addressed to updated address.
"Thank you for your phone call of 26 May 2003".

12 November 2003 – Letter from the Provider to the Complainant – letter addressed to old address. Indexation letter.

5 January 2004 – Letter from the Provider to the Complainant – letter addressed to updated address – with an additional line added to the address, that is: "Black […]"

"Thank you for your phone call of 5 January 2004. I have set out below the main details of your policy"

February 2004 – Letter from the Provider to the Complainant – letter sent to old address. This letter relates to the first Review of the Complainant's policy, on its tenth anniversary.

2 November 2005 – Indexation letter – addressed to old address.

1 March 2007 – Provider to the Complainant – letter addressed to old address:
"Thank you for your recent enquiry….. I enclose a savings withdrawal form as requested"

December 2008 – Indexation letters sent to old address

3 December 2008 – Letter from the Provider to the Complainant – Address on letter is the Complainant's old address. The letter advised:

"Your plan review is due on 01/01/2010 and we will write to you with full details of the review before this to advise you of your options. … options are usually as follows:
(a) Increase your payments in order to maintain your current level of cover;
Or
(b) Reduce your level of benefits.
There is no need for you to do anything now".

18 June 2009 – Letter from the Provider to the Complainant – letter sent to the updated address:

"Thank you for your phone call of 18 June 2009. Please find enclosed a copy of the letters that were returned to us undelivered".

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19 June 2009 – Letter from the Provider to the Complainant – Address on letter is the updated address.

"Thank you for your recent request.

I can confirm that we have updated your new address on our records as requested".

12 October 2009 – Letter from the Provider to the Complainant – Address on letter is to updated address. The letter dealt with the Review of the protection benefits. The Provider included an Options and Consent Form for completion by the Complainant. The letter stated: "Please choose one of these options, sign the consent form and send it back to us in the prepaid envelope provided before 01/01/2010. These changes will not come into effect until 01/01/2010".

7 December 2009 – Letter from the Provider to the Complainant – letter is addressed to both the Complainant's husband and the Complainant and sent to their updated address:

"If we do not hear from you, in order to prevent your policy from terminating, your benefits will be amended as set out in Option B overleaf with effect from 01/01/2010"

11 January 2010 – Letter from the Provider to the Complainant and her late husband– letter addressed and sent to updated address:

"We wrote to originally on 12/10/2009 endorsing a review of your plan and most recently on 07/12/2009. As of today's date we do not appear to have received a reply.

.. To prevent the plan from terminating, with effect from 01/01/2010 your revised benefits will be as set out in the table below – Revised Life Cover €148,202.95"

November 2010 – Indexation letter – letter addressed to updated address

16 March 2011 – Letter sent to updated address. "Thank you for your recent enquiry – Life Cover €155,613.

November 2011 – Indexation letter – letter addressed to updated address.

November 2011 – Letter sent to updated address advising of change in Provider's Advisory Services.

November 2011 – Letter sent to updated address – Indexation statement

4 November 2011 – letter addressed to updated address – Indexation letter

28 February 2014 – Letter from the Provider to the Complainant in response to recent enquiry – Advising life cover of €180,142.00. Letter sent to updated address.

6 March 2014 – Provider to the Complainant – Letter sent to updated address.

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"Thank you for your phone call of 27 February 2014 requesting details of the value of your plan.
I can confirm that the value of your plan has been helping to subsidise your premium to maintain the same level of benefits. The current monthly premium is €115.29, while the risk costs are €221.62 per month. The additional €106.33 between the premium and risk costs is being deducted from your value each month".

November 2014 - the Provider sends the Complainant an Indexation letter to her updated address.

4 November 2014 – The Provider's 20 year Review Letter – addressed to the Complainant at her updated address.

1 December 2014 – The Provider to the Complainant – addressed to her at the updated address:

"We would ask you to look carefully at the options available to you to maintain your plan to 1 January 2020. The options will require either an increase in your payments or a decrease in your level of benefits. .. If we do not hear from you, in order to prevent your plan from terminating, your benefits will be amended as set out in Option B attached with effect from 1 January 2015".

2nd January 2015 – Letter from the Provider to the Complainant – letter addressed to the Complainant's updated address. Letter advised of reduced Life Cover of €115.655.00

6 March 2015 – Provider's letter sent to updated address – *"Thank you for your recent enquiry. … Life Cover €115,655.00"*

November 2015 – the Provider sends the Complainant an Indexation letter to her updated address.

4 January 2016 – Provider to the Complainant – letter sent to updated address – offering sympathy on the death of her husband and enclosing Claim Form for completion.

The Complaint for Adjudication

The complaint for investigation and adjudication is whether the Provider correctly and reasonably administered the policy, particularly in relation to the communication of the Reviews of the Policy and as to the reduction of the sum assured under the policy.

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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 8th January 2019, 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.

Submissions dated 28 January 2019 from the Provider and submissions dated 30th January 2019 from the Complainant, 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 Provider advised on 8th February 2019 that it did not have anything further to add. I have considered the contents of these additional submissions for the purpose of setting out the final determination of this office below.

In its response to the complaint the Provider states that in accordance with the Terms and Conditions of the plan, a Plan Review was carried out in 2014.

The Provider states that it wrote to the Complainant on 4 November 2014 and advised that after carrying out a review, the current payment was insufficient to maintain the current benefits from 1 January 2015. The Provider states that it provided three different options in order to maintain the plan.

The Provider says it did not receive a response to this letter and so it wrote to the Complainant again on 10 December 2014 and reiterated the options outlined in its

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previous letter. The Provider says it also confirmed that in the absence of a response, the payment would remain as is and the benefits would automatically reduce to those set out in Option B. Option B was that there was a reduced life cover of €115,655.

The Provider states that it would like to point out that the Terms and Conditions of the plan provide for the benefits to be reduced if there is no increase in payment.

The Terms and Conditions state:

> *"Paragraph 20 — Policy Review*
> *At each Policy Review Date the Company's Actuary will:*
> *(a) Determine the maximum Guaranteed Minimum Death Benefit the Company is willing to allow under the Policy until the next following Policy Review Date and in determining the said maximum Guaranteed Minimum Death Benefit, the Company's Actuary will inter alia have regard to the Accumulated Fund on the said Review Date future options and Premiums under the Policy and then current mortality rates. If on a Policy Review Date the Guaranteed Minimum Death Benefit under the Policy exceed the permitted maximum as determined by the Company's Actuary then the Guaranteed Minimum Death Benefit as appropriate will be reduced to the said maximum or at the option of the Proposer the amount of Premium payable in the future will be increased to such amount as the Company's Actuary shall determine."*

The Provider states that again, it did not receive a response to its letter dated 10 December 2014 and so in accordance with the Terms and Conditions of the plan and as set out in its letter dated 10 December 2014, the benefits reduced to those outlined in Option B.

The Provider states that it wrote to the Complainant on 2nd January 2015 and advised that the benefits had been reduced and that the payment remained unchanged. The Provider says that is also advised that this change was estimated to stay in place until the next plan review of January 2020.

The Provider states that it received notification of the Life Assured's death on 4th January 2016 and it posted the claim form to the Complainant on this date. Following receipt of the completed claim form and all requirements, a death claim in the amount of €121,438 was paid to the Complainant on 2 February 2016.

The Provider says that the amount paid to the Complainant was correct and that this was the amount that the Complainant was entitled to. The Provider's position is that the claim amount paid corresponded to the level of benefits on its records; €121,565 (less the monthly payment of €127.11) - €121,438. The Provider states that this was following the Plan Review in 2014 where the benefits reduced from €189,149 as the payment at that time was insufficient to maintain the higher level of benefits.

A complaint was then raised by the Complainant with the Provider on 8 February 2017.

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The Provider states that, the Complainant did not respond to any of its Plan Review letters and so as outlined and in accordance with the Terms and Conditions, the benefits reduced to a level that could be supported by the current payment.

The Provider says it rejects the Complainant's allegations that the Plan Review correspondence sent in 2014 was sent to the incorrect address. The Provider submits that it can clearly be seen from the letters on file that they were sent to the correct address that was previously provided by the Complainant.

The Provider says that furthermore, the Complainant by her own admission confirms receipt of letters sent by the Provider in 2014, where the level of life cover was recorded as €189,149.

The Provider submits that the Complainant telephoned its Customer Service Department on 27 February 2014 and 6 March 2014. The Provider says that it wrote to the Complainant on 28 February and 6 March 2014 following these telephone calls. The Provider submits that these letters were sent to the address on its records, and confirmed as received by the Complainant.

The Provider states that its Annual Benefit Statement were then sent to the Complainant on 10 November 2014 again to the address on its records previously confirmed by the Complainant. The Provider submitted copies of letters it states were sent to the Complainant dated 28 February 2014, 6 March 2014 and 10 November 2014.

The Provider states it will be noted that these letters were sent both before and after the Plan Review was carried out.

The Provider states that following a telephone call from the Complainant to its Customer Service Department on 5 March 2015, a further letter dated 6 March 2015 was sent to the Complainant. This letter confirmed the lower level of life cover, following the Plan Review.

The Provider submits that the Annual Benefit Statement was then sent to the Complainant on 9 November 2015; the level of cover noted on this statement was €121,565.

The Provider states that all of these letters were sent to the address on its records, and the address confirmed by the Complainant - 9 …, Co Meath. The Provider says that none of these letters were returned as undelivered by An Post.

The Provider says therefore that it rejects the Complainant's claim that she did not receive the plan review letters sent in November and December 2014, and January 2015 where the reduction in benefits was confirmed. The Provider states its letters sent both before and after these were received by the Complainants so therefore it is reasonable to assume that the Plan Review letters were also received and the Complainant opted not to respond to them.

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The Complainant alleges that part of the conduct complained of relates not to whether or not the Provider wrote to her to advise of the reduction in benefits, but that no effort was made to determine whether or not she was receiving correspondence. In this regard the Provider says that it is not its process to contact customers who have recently had a Plan Review carried out on their plan, or to send letters by registered post, if it has not received a reply to indicate a chosen Plan Review option.

It is the Provider's position that it is reasonable to assume that its letters are delivered at the address unless it is notified otherwise by An Post.

The Provider reiterates that none of the letters sent before or after the Plan Review in 2014 were returned undelivered by An Post. The Provider states that the letters were sent to the correct address — the address confirmed by the Complainant, and that it received no notification of any issues with these letters being received.

The Complainant also alleges that there was subsequent correspondence sent to the incorrect address after 2009. The Provider again rejects this claim and enclosed copies of all correspondence it states it sent from 2009 to date in its Schedule of Evidence. It is the Provider's assertion that it is evident that all correspondence was sent to the correct address.

The Provider summarises matters as follows:

- The Complainant notified the Provider of a change of address in 2003.
- Due to an administration error, this was not updated on its records until 2009.
- Copies of all correspondence sent between 2003 and 2009 to the incorrect address were sent to the Complainant at the correct address at her request
- In accordance with the Terms and Conditions of the plan, a Plan Review was carried out in 2014 where an increase in payment was required to maintain the current benefits or a reduction in benefits was required to maintain the current payment.
- In the absence of a response from the Complainant, the benefits were reduced to a level that could be supported by the then current payment; €121,565 (indexed amount)
- Following a death claim in respect of the Complainant's late husband in 2015, an amount of €121,565 was paid to the Complainant.
- The Provider rejects the Complainant's allegation that they did not receive the Plan Review letters sent in 2014, and were unaware of the reduction in benefits and this was due to the Provider sending letters to the incorrect address.
- The Provider's position is that all letters were sent to the correct address — the address confirmed on multiple occasions by the Complainant. The Provider says that none of the letters were returned undelivered by An post.
- The Provider states that the Complainant by her own admission confirmed receipt of other correspondence sent to the same address, and alleges that the only letters that were not received were the Plan Review ones which confirmed the reduction in benefits.

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The Complainant's submission of 16th December 2017, in response to the Provider's submission.

The Complainant states that the policy on her late husband was taken out with the Provider in 1994. The Complainant says that from 2002 she has basically received no correspondence from the Provider unless she telephoned about her policy periodically and then she would get an immediate response. The Complainant submits that she was never asked during the telephone calls to update, increase or change anything on the policy on her husband. The Complainant says that increases occurred automatically and she was never asked by telephone or by a representative and as she was not getting any post at her home then there was nothing she needed to do.

The Complainant refers to documents which she considers are very relevant.

1. A Review was to be carried out in January 2010. The Complainant says there was an oversight on the Provider's part and the Review never happened. The Complainant states that at the time she did not know anything as she did not get documentation on this, no apology by telephone, and no one has ever got in touch with her despite all the mistakes.

2. The Complainant states that there was a hold put on her account and no post was coming out to her at her old address or her updated address. The Complainant says that this is obvious from the documents she possesses. The Complainant submits that she can only presume that even though the Provider may have updated her address in 2009 as it said it did, the directive to hold post was not taken off her account, hence the Provider having all these letters on file, but not posted out, so she did not receive them. The Complainant submits that this is the only explanation she can give for not receiving any post from the Provider, other than the sporadic ones she received after her telephone calls.

3. The Complainant refers to a number of Documents from the Provider which specify directly that she has to do nothing unless she wants to change her policy, that the benefits are updated automatically and the payments taken from her account are automatically deducted as well. The Complainant states this is very significant considering that after 30 years of the Provider deducting different amounts of money from her account and not sending her any notification or updating her by telephoning her number given to the Provider or when they were getting no response that it could now be doing what it is doing. The Complainant says that in November 2015 the policy on her husband was valued at €189,149.00 and her husband passed away very suddenly on 31st December 2015. The Complainant states she was then advised of the reduced value on the policy.

4. The Complainant submits that the Provider continued to try to say that the update was carried out on the 18th June 2009. The Complainant's position is that the update on her Account was done when she moved in 2003. The Complainant states that a form was filled in by herself and her husband. The Complainant says that she would have

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no reason to say she did not get letters, and says that someone in the office in the Provider forgot to take the hold off the account and that is why she did not receive letters from the Provider. The Complainant states that in saying that it is quite clear from reading the documentation from the Provider that it was not necessary for her to update it with anything, by the Provider's own words everything was done automatically. The Complainant states that this is confirmed in documentation.

5. The Complainant refers to a letter that states the Provider sent her out a form to fill in for direct debit, which she says she did not get. The Complainant says that this did not seem to stop the Provider updating the amount itself and increasing the payments from her bank.

6. The Complainant states that the Provider identifies no review was carried out on her account and no contact was made with her.

7. The Complainant says that what amazes her is that while the Provider admits the payments are deducted at its discretion without any input from a client it can then decide to do what it will in decreasing the amount insured.

In its submission of 25 January 2018 the Provider states that the Complainant continues to refer to issues and events that predate the issue in dispute, that is the alleged non receipt by the Complainant of the Plan Review Option letters in November / December 2014 and the Provider's subsequent implementation of the Default Option B leading to the reduction of the Life Cover. The Provider accepts that it did not update the Complainant's address until 19 June 2009. The Provider apologises that the address was not updated from when communicated in 2003. The Provider submits that all subsequent correspondence (from June 2009) were sent to the updated address. The Provider states it does not accept that a system "Correspondence Hold" prevented the receipt of correspondence. The Provider says that the "Correspondence Hold" was lifted on 18th June 2009.

As regards the Complainant's concerns about the indexation increases, the Provider's response is that the Complainant had signed up to such increases from the outset and that the Indexation feature is totally separate from the Plan Review Process.

The Provider submits that the 2010 Plan Review did take place as scheduled and that in advance of the Review the Provider contacted the Complainant at the updated address on 12 October and 7 December 2009. A confirmation of the implementation of Option B was said to have been sent to the Complainant on 11 January 2010.

The Provider submits that the more probable explanation for the lack of receipt of post comes from the Complainant's own comments where she explained that her post had been routinely misdirected by An Post due to the location of her house at start of a row of houses, despite being labelled No. 9. The Provider says that this appears to have led to the post being delivered to a house toward the end / back of her row of houses in error. The Provider submits that the Complainant further advised that the reason for the misdirected post was because her elderly neighbour was blind and unaware that he had received

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someone else's post. The Provider states that it was never its policy to issue regular correspondence by Registered Post, as due to a sheer number of customers, it would not be financially viable to register all its letters. The Provider concludes that it is unfortunate that the Complainant's post may have been misdirected by An Post, the Provider says it cannot accept any responsibility for An Post's failings.

The Complainant's response to the Provider's submission of 25 January 2018 is that the Provider in not using alternative means of contacts when it did not receive a response to the letters that it says were sent to her, was not reasonable. The Complainant questions why there was no letter of apology from the Provider when it was alerted to the fact that it did not update her address for some years. The Complainant questions how she could have responded to the indexation increases if she was not receiving same over the years. The Complainant questions the evidence that is submitted by the Provider in relation to the hold that was on her communications, in particular that the Screen Shots show the hold applying to her husband's name and not hers. That all correspondence was being sent to her as policyholder and not to her husband.

The Complainant states that despite the possible other reasons for the non receipt of correspondence, the Provider should have nevertheless made some effort to contact their client when it did not receive a response to its communications.

The Complainant queries the differing responses from the Provider – about contacting a non communicative policyholder. The Provider has set out in its response to the complaint that it would not make such additional contacts, but its representative had advised the Complainant over the telephone that the Provider would endeavour to make contact through a Broker, if there is one, or by telephone or by any means it could make contact. The Provider's response to the Complainant's above submission was set out in a letter dated 19th February 2018. The Provider says is only temporarily put a hold in place when it was brought to its attention that it did not have the current address. It is the Provider's position that from 18 June 2009 it resumed issuing all correspondence to the address as provided. The Provider states that some correspondence issued post June 2009 was for informational purposes only and there would have been no need for the Complainant to make contact upon receipt of these. The Provider gives the following examples, statutory annual statements and indexation increase letters. The Provider specifically refers to the Review letters advising that Option B would apply.

Analysis

I note a number of matters of concern in this complaint, as follows:

At the Review of the Policy, the Provider position is that a number of letters were sent to the Complainant, the first letter advised of the upcoming Review and provided options. This first letter did not have a default option. It was only in the second letter that a default option was included. I consider that there could have been consistency by the Provider in including the default option in both letters.

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There was inconsistency also in the communications that issued from the Provider, in that some were addressed to the Complainant only, while others included both the Complainant and the Life Assured. It is noted that the Screen shot that the Provider submitted of the System Hold / Hold lifted, only includes the Life Assured's name and not the Complainant's name.

The Provider was inconsistent in its advices to this office about whether the first Review had taken place. At a late stage in the Investigation process the Provider acknowledged that there was an admission in its response letter of 8 February 2017 that the 2004 Review was missed, but that this was incorrect. The Provider states that it regrets this misunderstanding and any confusion this has caused.

However, the Provider not only advised that the 2004 Review was missed, but also that concessionary measures were taken because of this missed review, that is, the Provider stated that it had reduced the underlying mortality charges to levels that were cheaper than the ordinary contract rates. The Provider reiterated this in its communication with this office in November 2017. The Provider also referenced this alleged concessionary measure when advising this office on our query as to when it had begun to supplement the cost of cover from the policy fund. The Provider's response was that the Complainant had the benefit of paying for term rates on a whole of life plan. The Provider submitted therefore, that it was not taking the value of the fund into account on any reviews carried out on the plan. The Provider states it was not supplementing the cost of cover from the fund as there was no fund value attached to the plan. This clearly contradicted what was actually happening with this policy, in that the policy fund was being relied upon to supplement the cost of cover for some time. It is clear from the telephone recording of March 2014 that the Complainant had concerns about this situation and does not appear to have understood the reason for this deduction.

From the evidence submitted the following is noted in relation to the complaint.

There was a history of the Provider not receiving a responses from the Complainant to its Indexation increases and Policy Review Options that it communicated to the Complainant over the years. The reason for those non responses was clearly for a time, the Provider's own error in not updating the Complainant's updated address on its systems. This persisted for the period 2003 to 2009.

In 2009 the Provider is said to have updated the Complainant's updated address on its systems. It is the Provider's position that it carried out a review on the Complainant's policy in 2014 and in the absence of the Complainant selecting a Review option the default option was applied, that is, a reduction in the life cover to a level that the then current premium could support. The Provider says that it sent a letter to the Complainant advising of this to the Complainant's updated address.

The Complainant is adamant that she did not receive communications from the Provider in relation to the Review of her policy. In a submission dated 1st August 2018, the Provider included a telephone recording of 12 March 2015 between the Complainant and its

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representative. The Provider had not previously submitted this recording as it resulted from a call from the Complainant in relation to another policy.

It should be noted that this telephone call predated any complaint by the Complainant to the Provider, and predated the death of the Complainant's husband.

In this telephone recording the Complainant clearly advised the Provider's representative that in relation to the policy in dispute she stated: *"I had no review, no one contacted me about a Review"* and the Complainant questioned: *"Who reviewed it, they did not review with me".*

The Recording clearly evidences that the Complainant did not understand the workings of the policy, and could not understand what had happened with the fund value that she considered should have built up on the policy.

There was no follow up on this matter by either party. Upon the Complainant's husband's death the reduced sum assured was paid out by the Provider.

The Provider's post Preliminary Decision submission of 28th January 2019 was that from the telephone call of 12th March 2015, it can be taken that the Complainant had previously received correspondence from the Provider stating the then current value. The Provider also argues that the Complainant was herself to follow up on the matter of the decreased life cover value and the position of there being no savings on the plan.

The Complainant's post Preliminary Decision submission of 30th January 2019 points out that the letter that she had received 6 days previous to the call of 12th March 2015 issued to her as she had not received the information contained therein previously. In this submission the Complainant again denies receiving details of the policy reviews on her policy.

While a follow up by the Complainant with the Provider's Advice Centre may have been the understanding that resulted from the telephone call of 12th March 2015, I consider that the Provider could also have followed up on matters following this telephone call, but did not.

From the above, and on the balance of the evidence submitted, I accept that the Complainant did not receive the Review communications from the Provider. It is difficult to establish why the Complainant did not receive the Review communications. The Complainant does indicate some difficulty with the numbering of the houses in her area, but is confident that this is not the reason preventing the specific communications from being delivered. The Provider is satisfied that it did issue its Review communications.

The Complainant states that her complaint is not whether or not the Provider sent out the Review documentation, her point is that if the Provider was going to change a policy that is the fundamental issue and it should have made some effort to see if the Complainant was receiving the documents by post.

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In this regard the Provider says that it is not its process to contact customers who have recently had a Plan Review carried out on their plan, or to send letters by registered post, if it has not received a reply to indicate a chosen Plan Review option.

I accept that the Provider would not be expected to go to extent of contacting all policyholders in such circumstances, but where there had been a history of non communication because of difficulties caused by the Provider not correctly updating the Complainant's contact address on its systems that is a different matter. I consider that, because of the previous difficulties in contacting the Complainant, it would have been reasonable to expect some follow up from the Provider with the Complainant here to establish whether she had received communications from the Provider which required her to select an option in relation to a change to the policy cover.

The Provider appears to want to brush aside the previous difficulties with its communication with the Complainant as something not relevant to the current complaint, but I consider that the Provider's handling of that communication failure goes to highlight the problems that followed through to the current matter.

There was a Financial Advisor in place and I would have expected to see some communications from the Provider with that party in relation to the non communications from the Complainant on the proposed changes to the policy. The Provider did have the Complainant's telephone number (despite its representative saying it did not, in a telephone call with the Complainant). The Provider was given the Complainant's telephone numbers on the Change of Contact Form submitted to the Provider in 2003.

The Provider was made aware by the Complainant in her telephone call of March 2015 that she did not have any knowledge of the Review of the policy. Given the known previous communication issues, I would have expected there would have been some follow up on this by the Provider. I would have expected that the Provider could have further explored this matter with the Complainant at this early opportunity. The Complainant's husband was still alive at this point and there may have been a possibility that any deficiencies in the process could have been rectified at that early opportunity. It may have been that the Complainant wanted to maintain a higher level of cover, and be willing to cover the extra outlay that was identified by the Provider in the Review.

The post Preliminary Decision submission have not altered my views on this complaint.

Overall, I consider that this is a complaint that should be substantially upheld and one that requires a compensatory payment, as opposed to any adjustment of the Review figures. Therefore, it is my Legally Binding Decision that the complaint is substantially upheld and I direct the Provider to pay the Complainant the compensatory payment of €20,000 (twenty thousand euro).

/Cont'd…

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 make a compensatory payment to the Complainant in the sum of €20,000, 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

12th February 2019

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

ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.