An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0103
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Dissatisfaction with customer service Failure to provide product/service information Maladministration
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint concerns the Complainant's health insurance policy held with the Provider.

The Complainant's Case

The Complainant submits that he received his renewal notice dated 14 December 2016 by post on 16 December 2016, and emailed the Provider on that same day requesting information that it is obliged to furnish and that all future communications take place by email. The Complainant submits that the Provider did not furnish him with this information until he had emailed it on ten separate occasions.

The Complainant states that "*It is clear that my complaint was not properly considered, was not considered on its merits and that [the Provider] failed to exercise even a modicum of fairness or impartiality in dealing with my complaint*".

The Complainant states, in his Complaint Form to this Office, that he is seeking for the Provider:

- To acknowledged that it was not justified in refusing to answer the queries that he initially raised and that its failure to do so was compounded by its obduracy in failing to provide the required information until he emailed it on ten separate occasions.

- To provide an extension of three months, at the Provider's expense, to his cover in order to compensate him for the inconvenience that its obduracy, arrogance, inefficiency and errors have caused him, and to allow him time to properly assess his options.
- To compensate him in the sum of €480.00 in respect of the last four emails (€120.00 per email) that he was obliged to prepare and send to the Provider as a result of its errors and failure to meet its obligations in respect of the information that he requested.
- To compensate him in the sum of €500.00 in respect of the time, trouble and inconvenience that he was unnecessarily subjected to in preparing and completing the complaint which was wholly avoidable if the Provider exercised basic common sense and fairness from the start of the process.
- To compensate him in the sum of €250.00 in respect of its failure to acknowledge that he requested all communications to be by email, and its persistence in attempting to have him engage with it by telephone despite the fact that on two separate occasions he advised it that he was suffering from a disability that precluded him from using the telephone to adequately deal with the matter.

The Provider's Case

The Provider submits that the Complainant's policy was due for renewal on 16 January 2017, and he was issued with his renewal invitation on 14 December 2016. The Provider submits that on the Complainant's renewal papers it set out a specific call to action to contact it to discuss his health insurance needs and to let it know if there were any material changes to his policy. The Provider states that it has "*an extensive suite of products and in order to assess a customer's needs our approach is to have a conversation with the customer in order to gather and record sufficient information from the customer prior to offering, recommending, arranging or providing a product or service appropriate to that customer*". The Provider submits that on receipt of his renewal invitation, the Complainant contacted it by email and asked for a response to three specific items.

The Provider submits that under Chapter 5 of the Consumer Protection Code 2012 (the CPC 2012) it is required to provide guidance based on sufficient knowledge of the specific risks involved and adequate consideration of the relevant insurance principles so that the product it recommends to a customer is suitable for addressing their needs. The Provider states that "*This is conducted via a needs-based assessment, usually verbally with the customer. We have a duty to be competent and to act with due skill, care and diligence in the best interest of our customers*". The Provider submits that it also has obligations under Chapter 2 and Chapter 3 of the CPC 2012, in particular:

> *"A **regulated entity** must ensure that in all its dealings with **customers** and within the context of its authorisation it:*
>
> *2.2 acts with due skill, care and diligence in the best interests of its **customers**;*
> *2.3 does not recklessly, negligently or deliberately mislead a **customer** as to the real or perceived advantages or disadvantages of any product or service;*

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…
*2.5 seeks from its **customers** information relevant to the product or service requested;*
…
*3.8 A **regulated entity** must not, in any communication or agreement with a **consumer** (except where permitted by applicable legislation), exclude or restrict, or seek to exclude or restrict:*
*a) any legal liability or duty of care to a **consumer** which it has under applicable law or under this Code;*
*b) any other duty to act with skill, care and diligence which is owed to a **consumer** in connection with the provision to that **consumer** of financial services; or*
*c) any liability owed to a **consumer** for failure to exercise the degree of skill, care and diligence that may reasonably be expected of it in the provision of a financial service".*

The Provider submits that after it provided the Complainant with the information he requested as best it could, it also extended his cooling off period to 30 days from the first payment date of 5 February 2017. The Provider states that "*We believe this was more than fair and reasonable and gave him ample time to absorb the information he requested and assess his options. This also afforded him the opportunity to change to a plan of his choosing or cancel without penalty*".

The Complaint for Adjudication

The complaint is that the Provider dealt with the Complainant's request for information in an unacceptable manner.

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.

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A Preliminary Decision was issued to the parties on 12 March 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.

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

The Complainant submits that he received his renewal notice dated 14 December 2016 by post on 16 December 2016, and emailed the Provider on that same day requesting information that it is obliged to furnish and that all future communications should take place by email. I note that the Provider's renewal letter to the Complainant dated 14 December 2016 states, among other things, the following:

> ***IMPORTANT INFOMRAITON***
>
> - *We have based your renewal on the plan(s) you currently hold.*
> - *Please contact us if there have been any material changes in your circumstances or in your health insurance needs.*
> - *Please contact us before your renewal date to discuss your health insurance needs as we may have a more suitable plan(s) for you.*
> - *If you do not contact us prior to your renewal date your current plan(s) will be renewed for a further 1 year period.*

I note that the Complainant's email to the Provider dated Friday 16 December 2016 states:

> *"I received the renewal information in respect of the above mentioned policy… today.*
> *I understand that you are required to provide me with certain information regarding my policy/plans and accordingly I request that you provide me with the following information in respect of each of the plans that are applicable to the four members that the policy applies please:*
> *1. Compared to the benefits /conditions in respect of each plan can you please advise if any of the other plans that you provide offer the same level of cover as the current plans at a lesser cost.*
> *2. Taking the current plans as a base line or comparator, please list all of the plans that you offer in descending order of cover relative to the current plan.*
> *3. Taking the current plans as a base line or comparator, please list all of the plans that you offer in descending order of price relative to the current plan.*
> *Thank you. Please respond by email only to this email address. I am contactable by phone on… should you wish to verify this request, but I request that you supply the requested information in an email only please. I would appreciate if you would acknowledge this email.*
> *Thank you…"*

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The Complainant submits that as he had not received a response from the Provider by Monday 19 December 2016, he emailed it again on 19 December 2016 requesting the information. I note that this email states, among other things, the following:

> *"I sent you an email on Friday 16 December requesting information but I have not received an acknowledgement or response, can you please confirm that it was received by you. I am copying that email in case it was not received by you. In addition to the requested information in that email I also request that you inform me as to the reasons for the apparent discrepancy in the cost of the plans under my policy as advised in your renewal notice and the cost of the plans that appear (as furnished by you one assumes) on the HIA comparison website. Please see screenshots that are attached for details of published prices on Sunday 18 December. Can you please include that information when responding to the earlier queries copied below. Please respond by email only to this email address. Thank you…"*

The Complainant submits that he received an email from the Provider on 19 December 2016 that failed to provide him with the information he requested regarding the availability, cover and cost of comparable plans. The Complainant states that "*This email relied on alleged non specific Central bank regulations as justification for the company's failure to respond meaningfully or at all*".

The Provider submits that within two working days of the Complainant's email of 16 December 2016 it responded to the Complainant and outlined the reasons why it wanted to speak with him in order to determine a plan that would be suitable to his needs, his personal circumstances and that of his family. The Provider states that "*It is not possible to go through our entire product suite in the [manner requested by the Complainant]*".

I note that the Complainant's initial email of 16 December 2016 was a Friday, and the Provider emailed the Complainant on Monday 19 December 2016 to state:

> *"Please accept my apologies for the delay in responding to your email, from the [16] December 2016. We are currently experiencing a high volume of emails. I have noted your below concerns on your policy; can you confirm if you wish to log a complaint?*
>
> *In relation [to] your concerns regarding the premium quoted in your renewal invitation issued to you by post on the 14th December 2016 and the premium currently showing on the Health Insurance Authority's website, please note that your renewal is the 16th January 2017 and the quotes shown on the HIA's website are based on today's prices.*
>
> *Please be advised that any quotes issued to you from [the Provider] are at the rate applicable as of your renewal date, the 16th January 2017.*

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In regards to your request for comparable plans, in order to ensure we remain compliant with Central Bank (formerly the Financial Regulator) regulations we will need to speak with you to determine the plan, which would be most suitable to your needs. We are also bound to provide you with full information relevant to the purchase of health insurance policies as they may relate to you, for example the application of waiting periods.

If you are available, we would be happy to call you to obtain this information at a time suitable to you and to advise you to the fullest extent in order to ensure that your requirements are met as fully as possible. Alternatively, you can click on the 'Get Quote' tab on our homepage… and follow the instructions to receive a quotation on-line.

If you would prefer to call us at a time of your convenience, our contact number is…"

The Complainant submits that he emailed the Provider again on Monday 19 December 2016 repeating his request for information and "*alleging [the Provider] was not precluded from my request due to Central Bank guidelines*". I note that the Complainant's email dated 19 December 2016 states:

"Thank you [name redacted] for your response.
In relation to the difference between the price quoted on HIA website and renewal prices it appears that the increases are outside the reported percentage increases for new policies, your views appreciated please.
Reference the request for specific information I am satisfied from a perusal of the Central Bank regulations that there is no requirement for you to speak to me regarding the plan that is most suitable for my needs in advance of supplying the requested information. I am simply seeking factual information that you are in a position to, and are required by the same regulations to supply me with please and I repeat my request that you so do. I am unable to ascertain this information from your website as you have a multitude of different plans that are exceptionally complicated and as you are the experts in this area and most cognisant with your own plans I am simply requesting that you assist me in understanding and comparing them. I believe that unless I have the requested information from you I will [not] be in a position to discuss with you (which I am quite happy to do having received the information) the plan most suitable to my needs…
Please respond by email only"

As he did not receive a response by Wednesday 21 December 2016 the Complainant again emailed the Provider on 21 December 2016 requesting the required information "*before the Christmas Holidays please*".

The Complainant submits that on Thursday 22 December 2016 he received an email from the Provider setting out a series of questions in relation to possible combinations of plans/options that it claimed needed him to answer in order for it to remain compliant with Central Bank guidelines.

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The Provider states that *"[The Complainant] made it clear that he would only communicate with us via e-mail and bearing this in mind, we offered to assess his suitability and offer a selection of plans if he could answer some standard questions for us over e-mail. He advised he was not in a position to do so and repeated his three questions again*".

I note that the Provider's email dated Thursday 22 December 2016 states, among other things, the following:

> *"In order to ensure we remain compliant with Central Bank (formerly the Financial Regulator) regulations, please see below questions which need to be answered in order for us to recommend a plan to you. Some of these questions may not be relevant to you however we are required to ask the question and would need a response.*
> *…*
> *Once we receive the answers to the above we will be able to recommend plans for you and issue you a quotation and details for each alternative level of cover. In regards to the price increase incurred as of your renewal date the 16th January 2016, the cost of providing health insurance has increased considerably over the last 12 months and [the Provider] is forced to increase its premiums as a result. This step is necessary due to the continued increase in medical inflation and trends in how health services are being used which have created a substantial escalation effect on claims costs. Increased claims costs and continuous growth in the use of complex imaging techniques and high cost tailored drugs for treatment of cancer are contributing factors.*
>
> *Furthermore, this change reflects the increases in the cost of private beds in public hospitals, together with costs associated with the health insurance levy imposed on insurers.*
> *…*
> *I have noted your below concerns regarding this issue. Can you please confirm if you would like to log a complaint?"*

The Complainant states that he emailed the Provider on 23 December 2016 "*and repeated my assertion that [the Provider] was not precluded from answering my questions. I replied specifically to [its] email of 22 December 2016… and requested that [the Provider] provide me with a detailed response in respect of all of the potential plans/options that [the Provider] had seen fit to ask me to consider/bring to my attention, even though I had sought and continued to seek an answer to three very simple and straightforward questions from the start*".

I note that the Complainant's email dated 23 December 2016 states the following:

> *"I do not agree with your contention that in order to comply with Central Bank regulations you have to ask me the questions you pose as I am an existing policy holder and simply requested specific information that in all cases is referenced to my current plan/policy so with respect these questions are unnecessary, irrelevant and likely to confuse (which one might be forgiven is in keeping with the corporate*

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philosophy of your Company and other Irish health insurers due to the proliferation of plans that are opaque to say the least and exceptionally difficult to understand and compare).
I repeat the simple questions that I posed and again request a reply to same.

1. Compared to the benefits /conditions in respect of each plan can you please advise if any of the other plans that you provide offer the same level of cover as the current plans at a lesser cost.
2. Taking the current plans as a base line or comparator, please list all of the plans that you offer in descending order of cover relative to the current plan.
3.Taking the current plans as a base line or comparator, please list all of the plans that you offer in descending order of price relative to the current plan.
UNDER PROTEST and in order to ensure that there are no grounds for a refusal by you to furnish the requested information I reply as follows to the queries raised by you. Please note responses in red. Thank you and I look forward to your response. It seems such a waste of time and resources that you feel that you have to answer questions that I have not raised, and as you feel that they are important enough to be raised then so be it and I will deal with your request in the same inflexible and unnecessarily bureaucratic manner that you have dealt with mine. Thank you…
…
What level of hospital accommodation do you require? As you have raised these questions and to allow me to compare all options please supply me with the requested information in respect of each of the "accommodation" options referenced in your question.

· Semi-private room in a public hospital
· Semi-private room in a private hospital
· Private room in a private hospital
· Semi-private room in a high-tech hospital
· Private room in a high-tech hospital

Will there be any children covered on the policy or are you interested in enhanced Maternity Benefits?

· Yes
· No NO

Orthopaedic benefits which are fully covered in public hospital do carry a €2000 co-payment for (knee, hip and shoulder replacements) in Private and H--Tech hospitals. Do you want a plan with full orthopaedic cover or would you like a more affordable plan with an orthopaedic co-payment?
As you have raised these questions and to allow me to compare all options please supply me with the requested information in respect of each of the "orthopaedic cover" options referenced in your question.

· Full Orthopaedic Cover
· More Affordable

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Would you like your private hospital benefits fully covered on your plan or are you willing to choose an excess? As you have raised these questions and to allow me to compare all options please supply me with the requested information in respect of each of the "excess" options referenced in your question.

· Plan with Excess
· Benefits Fully covered

Are you willing to pay an excess of €150 or below or €150 or above? As you have raised these questions and to allow me to compare all options please supply me with the requested information in respect of each of the "excess amount" options referenced in your question.

· More than €100
· Less than €100

We also have plans that give money back on day 2 day medical expenses (GP, Dentist and Physio) would you like to add these to your policy or is it mainly hospital cover you require? As you have raised these questions and to allow me to compare all options please supply me with the requested information in respect of each of the "day to day expenses" options referenced in your question.

· Yes add day-to-day
· No day-to-day

Once we receive the answers to the above we will be able to recommend plans for you and issue you a quotation and details for each alternative level of cover. Thank you, I look forward to your detailed response and trust that both you and the Central Bank will be glad that I will be fully informed on receipt of your response."

As he had not received a response by 30 December 2016 from the Provider to this email, the Complainant emailed the Provider again repeating his request for information and a response together with an extension of his cover for 14 days at the Provider's expense, as a result of its failure to respond adequately or at all.

The Complainant submits that he received an email from the Provider on 5 January 2017 stating that it was not feasible for it to go through the level of detail he had requested via email, and inviting him to engage with it by telephone. I note that the Provider's email dated 5 January 2017 states:

"Due to the volume of plans that [the Provider] provide, it is unfortunately not feasible to go through all of them to the level of detail you wish via email however you can view the full list of all plans we offer here…

It is for this reason that we offer to arrange callbacks with our members, which I can do for you. We will then be able to go through the questions we are required

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to ask you and answer any questions you have in a fluid and dynamic manner. If you would like to accept a callback, please confirm a phone number and convenient time, and I will arrange this.
Please note that our processes are bound by compliance with Central Bank regulations which require us to provide the most accurate information possible, in the most efficient way we can, which is why we are ultimately obliged to discuss alternative plan options by phone."

The Complainant submits that he emailed the Provider on 5 January 2017 and requested a copy of the Central Bank regulations the Provider continued to rely on to justify its failure to respond to his initial query. The Complainant states that "*I formally waived any alleged entitlement under Central Bank regulations to be contacted by [the Provider] by telephone or otherwise in advance of [it] responding to the simple questions and I continued to pose and that [it] failed to reply to. I requested an extension of one month on my policy at [the Provider's] expense to compensate me for the time and trouble I had gone to in order to obtain an answer to three simple questions that [the Provider] was obliged to respond to in order to allow me time to properly assess/evaluate the proposed renewal*".

The Complainant again emailed the Provider on 9 January 2017, as he had not received a response from the Provider to his email of 5 January 2017. The Complainant submits that in this email he again requested a response to his queries, an extension of the policy by one month, and the payment of €120.00 In respect of his time, trouble and inconvenience in having to deal with the matter for so long without receiving an adequate or meaningful response. The Complainant also placed the Provider on notice that he wished to make a formal complaint. The Complainant states that he advised the Provider "*that due to a disability I was unable to deal with this matter on the telephone and asked again for all communications to take place by email*".

The Complainant submits that he received a generic email in response to his complaint from the Provider on 10 January 2017 informing him that it was very busy and it might take up to 5 working days for a response to his complaint. The Complainant submits that he emailed the Provider on that same day requesting confirmation that cover would remain in place as he was travelling abroad for a few days, and again referring to the failure of the Provider to respond to his request for information.

The Complainant submits that on 18 January 2017 he received an email from the Provider with a response to the initial queries he had raised. The Complainant states that the Provider "*did not refer to the alleged Central Bank guidelines that was uppermost in their minds until now. I had not provided any additional information to the company. [The Provider] refused to extend my policy and refused me compensation as previously sought by me*".

The Provider states that "*After several e-mail exchanges and going to exhaustive measures to assist [the Complainant] with his query we provided [the Complainant] with a detailed response on the 18/01/2017*".

I note that the Provider's email dated 18 January 2017 states, among other things, that:

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"We have undertaken a review of the three plans on your policy as requested. In addressing your first point, we found that compared to the level of cover and benefits in each plan, there is no corresponding plan with the same level of cover and benefits. In assessing these plans, we assumed that all aspects of cover in each of the three plans from hospital accommodation to day to day cover were of the same importance to you and the other members currently covered and we have made the comparison on that basis. Please note however, if there are aspects of your plan that are less important than others, there could be plans available to you at a lesser cost and hence we recommend that you talk to one of our agents so that they can find a suitable plan for you based on your needs and the needs of your family as we have not been able to do that here.

In addressing your second point, we ranked our plans in descending order assessing each initially by private hospital accommodation, private hospital excess, hospital list; public hospital private accommodation; high-tech hospital access and accommodation; and finally day to day benefits. The plans and their ranking relative to each of [three named plans] are in the attached in the Product Comparison Cover pdf.

The lists of our plan prices in descending order relative to the price of each of [three named plans] are in the attached in Product Comparison Price pdf and should address your final point.

If you would like me to, I [can] arrange a call to be placed to you, or someone you may wish to nominate to manage the policy on your behalf.
…
I would like to point out that as your renewal date was 16th January 2017 but your first payment date of the policy year is not until 5th February 2017, your 14 day cooling off period will not start until 5th February 2017"

The Complainant submits that he emailed the Provider on 19 January 2017 "*and pointed out factual inaccuracies in [its] email to me of 18 January. I objected to [its] refusal to extend my cover for one month and now requested an extension of two months and an additional payment of €120.00 in respect of the unnecessary time, trouble and inconvenience that I was put to by virtue of [its] wholly unjustified refusal (as evidenced by [its] eventual capitulation in this regard) to provide me with the required information initially*".

The Complainant submits that he subsequently received a letter from the Provider dated 13 January 2017 that was meaningless, referring to his complaint and seeking to rely on Central Bank guidelines. The Complainant submits that he received another letter from the Provider dated 14 January 2017 informing him that his policy had been renewed without any reference to the series of correspondence and queries. The Complainant submits that he received an email from the Provider on 25 January 2017 that acknowledged its letter of 13 January 2017 was sent prematurely and should not have been issued by post.

The Provider, in its response to this Office's Schedule of Evidence Required, states that "*During this assessment it has come to light… that during the complaints process, which is*

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formed in compliance with Chapter 10 of the CPC, in relation to 10.9 (e), a final response letter was inadvertently and prematurely issued on the 13/01/2017 which did not address the issues [the Complainant] raised in his complaint. A full and final response was issued via e-mail on the 18/01/2017, and in this regard we would like to offer [the Complainant] a payment of €25".

Provision 10.9 of the CPC 2012 provides that:

> *"10.9 A **regulated entity** must have in place a written procedure for the proper handling of **complaints**. This procedure need not apply where the **complaint** has been resolved to the complainant's satisfaction within five **business days**, provided however that a **record** of this fact is maintained. At a minimum this procedure must provide that:*
> *a) the **regulated entity** must acknowledge each **complaint** on paper or on another **durable medium** within five **business days** of the **complaint** being received;*
> *b) the **regulated entity** must provide the complainant with the name of one or more individuals appointed by the **regulated entity** to be the complainant's point of contact in relation to the **complaint** until the **complaint** is resolved or cannot be progressed any further;*
> *c) the **regulated entity** must provide the complainant with a regular update, on paper or on another **durable medium**, on the progress of the investigation of the **complaint** at intervals of not greater than 20 **business days,** starting from the date on which the **complaint** was made;*
> *d) the **regulated entity** must attempt to investigate and resolve a **complaint** within 40 **business days** of having received the **complaint**; where the 40 **business days** have elapsed and the **complaint** is not resolved, the **regulated entity** must inform the complainant of the anticipated timeframe within which the **regulated entity** hopes to resolve the **complaint** and must inform the **consumer** that they can refer the matter to the relevant Ombudsman, and must provide the **consumer** with the contact details of such Ombudsman; and*
> *e) within five **business days** of the completion of the investigation, the **regulated entity** must advise the **consumer** on paper or on another **durable medium** of:*
> *i) the outcome of the investigation;*
> *ii) where applicable, the terms of any offer or settlement being made;*
> *iii) that the **consumer** can refer the matter to the relevant Ombudsman, and*
> *iv) the contact details of such Ombudsman."*

While it is disappointing that the Provider did not comply with Provision 10.9 (e) of the CPC 2012 when it issued its final response letter dated 13 January 2017 to the Complainant, I note that the Provider has acknowledged this and offered the Complainant the sum of €25.00 for its error. I further note that on receipt of the Complainant's complaint email dated 9 January 2017, the Provider acknowledged his complaint on 10 January 2017 and provided the Complainant with the outcome of its investigation on 18 January 2017 in compliance with Provision 10.9 of the CPC 2012.

The Complainant submits that he emailed the Provider on 27 January 2017 "*pointing out factual inaccuracies in [its] previous communication, and also pointing out that [the*

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Provider] either failed to understand or ignored the principle underlying a cooling off period. I again pointed out that I had already advised [the Provider] that I was suffering from a disability yet [it] persisted in attempting to get me to engage with [it] on the telephone. I requested that [the Provider] refer the matter to [its] internal Access Officer as [it was] clearly in breach of the Disabilities Act. I again requested an extension of two months to my health insurance and compensation in the total amount of €360 in respect of the time, trouble and inconvenience that [its] failures had caused me".

The Provider submits that on 6 February 2017 it issued a reply to the Complainant's email of 27 January 2017 confirming that it would extend his cooling off period to a length of 30 days from his first payment date of 5 February 2017. The Provider states that "*During this time [the Complainant] was [ ] able to switch to any plan of his choice, or cancel his policy without penalty. We asked again if he would like to nominate someone to speak to us on his behalf but would endeavour to continue to communicate with him via e-mail as instructed*".

In response, I note that the Complainant emailed the Provider on 6 February 2017, and stated, among other things, the following:

> *"This entire series of correspondence could have been avoided if [the Provider] had provided me with an answer to the three simple questions that I first raised on 16 December 2016 and that you were obliged to answer. You eventually answered those questions without any further information having been provided by me so it is clear that your obduracy in relying on non existent excuses to respond based on an incorrect and erroneous understanding of the alleged Central Bank guidelines was misplaced and misguided, or you are in breach of the guidelines by answering my questions".*

I note that on 13 February 2017 the Provider responded to the Complainant's email of 6 February 2017, stating, among other things, that:

> *"I apologise for the delay in responding to you we are experiencing a high volume of emails at the moment.*
>
> *We have reviewed the Disability Act of 2005 which you mentioned, and your request to refer the matter of your recently advised disability to an Access Officer at [the Provider]. Upon review, we have confirmed that as we are not a public body, we are not required under this Act to have a designated Access Officer. We are, of course, happy to try and accommodate your requests in any way possible with respect to the information you have recently provided us. We will endeavour to facilitate you by communicating only in writing with you, or if further assistance is required please don't hesitate to inform us".*

I would point out that any issues regarding Disability Legislation is not a matter for this Office, and is more appropriate for the Irish Human Rights and Equality Commission.

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The Provider does, however, have obligations pursuant to the Consumer Protection Code 2012 with regards vulnerable consumers. A vulnerable consumer is defined in the Consumer Protection Code 2012 as follows:

> ***"vulnerable consumer"*** *means a natural person who:*
> *a) has the capacity to make his or her own decisions but who, because of individual circumstances, may require assistance to do so (for example, hearing impaired or visually impaired persons); and/or*
> *b) has limited capacity to make his or her own decisions and who requires assistance to do so (for example, persons with intellectual disabilities or mental health difficulties)."*

Provision 3.1 of the Consumer Protection Code 2012 provides the following:

> *"3.1 Where a* ***regulated entity*** *has identified that a* ***personal consumer*** *is a* ***vulnerable consumer****, the* ***regulated entity*** *must ensure that the* ***vulnerable consumer*** *is provided with such reasonable arrangements and/or assistance that may be necessary to facilitate him or her in his or her dealings with the* ***regulated entity****."*

I note that the Complainant in his email of 9 January 2017 to the Provider states that "*due to a disability I was unable to deal with this matter on the telephone and asked again for all communications to take place by email*". While the Provider submits that the Complainant did not disclose the disability he suffered from to let it consider alternative communication options, it is disappointing that it did not seek this information from the Complainant in order that it could identify alternative communication options.

Having carefully considered all of the evidence before me, while I note that the Provider on 18 January 2017 furnished the Complainant with a response to the specific queries that he raised in his initial email to it on 16 December 2016, it is disappointing that the Provider did not furnish this information to the Complainant at an earlier stage. While the Provider was seeking to rely on the CPC 2012 for not furnishing the information requested to the Complainant at the outset, the Complainant had not indicated that there had been any material change to his circumstances.

I note that the Provider extended the cooling off period to 30 days from the date of the first premium, that is, from 5 February 2017 and I am of the view that the Complainant had sufficient time from receipt of the requested information, that is, 18 January 2017 to decide whether he wished to proceed with the policy. That said, to mark the Provider's lapses in service, I direct the Provider to make a compensatory payment in the sum of €250.00 to the Complainant. For the avoidance of any doubt, the sum of €250 is inclusive of the €25.00 previously offered by the Provider to the Complainant.

/Cont'd…

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially 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 €250.00, 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

5 April 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
(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.