An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0108
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Maladministration
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint relates to the cessation of payment disablement benefit under a Salary Protection Plan. The policy is an Employer owned Group Salary Protection Plan.

Benefits under the policy are payable in the event of disablement. While the Complainant is not the policy holder, he is eligible to make a complaint to this Office as an actual or potential beneficiary under the policy as provided for under Section 44 (i) of the Financial Services and Pensions Ombudsman Act 2017.

The complaint is that the Provider incorrectly communicated its decision to cease the payment of benefit and failed to adequately advise what was required for an appeal of that decision.

The Complainant's Case

The Complainant states that he commenced employment with his Employer in 1998. As part of his employment his employer provided an Income Protection Plan, underwritten by the Provider to which the Employer paid the premiums.

In 2007 the Complainant made a claim under the policy, which the Provider paid until the 1st February 2013. The Complainant states that each year the Provider communicated to him directly either by phone, e-mail or by visiting his home. However, on 20th November 2012 the Provider informed the Complainant's employer that it was discontinuing the

payment to the Complainant and would be making one final payment to cover the period of the 2nd December 2012 to the 1st February 2013.

The Complainant states that the Provider advised his Employer that if the Complainant was unhappy with the decision he could appeal by the 19th February 2013. It is the Complainant's position that neither the Provider or his employer communicated this to him.

The Complainant says that by the time he found out that he could appeal the decision, the time for appeal had passed. The Complainant's position is that as soon as he became aware of the decision of the Provider he wrote to the Provider concerning an appeal on 25th July 2013 and again on the 2nd August 2013.

The Complainant submits that in those letters he indicated that he wanted to appeal but could not do so as he did not have the necessary information from the Provider. The Provider wrote back to the Complainant on the 14th August 2013 saying that it would contact his Employer.

The Complainant states that his Employer recommenced making full payments to him and told him that it would deal with the Provider as he "*had been hard done by*".

The Complainant says that in early 2014 his Employer stopped paying him, so he then had his solicitor write to the Provider who refused to entertain his appeal due to the lapse of time.

The Complainant states that his complaint is that when it suited the Provider to contact him it did so directly. The Complainant says that the Provider failed to do so when it made the decision to discontinue payment, and it was crucial to him that the Provider should contact him at that time. The Complainant submits that thereafter the Provider delayed responding to him, and he was denied any explanation as to why the Provider had discontinued the claim and further denied him the opportunity to appeal within the time limit.

The Complainant wants (i) the income benefit re-instated from 20/12/2012 (ii) thereafter if the Provider wants to make a decision about eligibility or otherwise, he argues, it should communicate directly with him (iii) that the Provider review the policy of only communicating with the Employer (policyholder) and (iv) that compensation be paid to cover losses from 2nd February 2013 to date.

The Provider's Case

The Complainant is a member of his Employer's Group Income Protection Scheme. Under the terms of the policy, an Income Protection claim is paid when the claimant meets the definition of disablement which states:

> *"total disablement shall be deemed to exist where (a) the Insured Person is unable to carry out the duties pertaining to his normal occupation by reason of*

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> *disablement arising from bodily injury sustained or sickness or illness contracted and (b) the Insured Person is not engaging in any other occupation for profit or reward or remuneration".*

The Provider states that in order to claim Income Protection benefit under the scheme, the Complainant completed a Claim Form on 9 July 2007. On this form, he advised that he was absent from work as a result of: *"Problems with my left knee. Unsuccessful operation on 29th March (cartilage). Surgery again on 19th July".*

The Provider also received a Medical Certificate completed by the Complainant's GP, which advised that the Complainant was suffering from *"Left knee pain — due to meniscal tear".*

As part of the initial assessment of his claim, the Provider arranged for the Complainant to attend for a medical examination with a, Consultant Orthopaedic Surgeon. This assessment was carried out on 5 October 2007.

It is the Provider's position that it is satisfied, based on the medical evidence received, that the Complainant was medically unfit for his role as a Shift Manager and his claim was admitted with effect from 30 September 2007.

The Provider states that it confirmed its decision to the Complainant's employers (the policy owners), on 2 November 2007.

The Provider states that all Income Protection claims are subject to review to ensure that the definition of disablement under the policy continues to be met. As part of one such review of the claim, the Complainant attended for a medical examination with a Consultant Orthopaedic Surgeon, on 3 August 2012. The Provider states that around this time, it also arranged for a private investigator to carry out observations of the Complainant when he was unaware he was being observed.

The Provider states that it received the report and video footage from the private investigator firm on 3 September 2012 and it received the results of the Consultant Orthopaedic Surgeon's medical examination on 5 September 2012. The Provider says it sent a copy of the video footage that had been obtained to the Orthopaedic Surgeon on 18 September 2012 and asked him to review this additional information and provide his opinion on the Complainant's fitness for work.

The Provider submits that the Orthopaedic Surgeon replied on 25 October 2012, and in his response he stated:

> *"This man works as a Shift Manager for [Employer]looking at efficiency and product output, which would require him to stand and go up and down stairs and to move around the factory floor. His physical activity as seen on the video is at complete variance to his description at the time of my assessment. Currently there are no signs of any significant physical symptoms on his day-to-day activities working on a farm. Therefore, I feel this man is exaggerating his symptoms and I deem to be certainly fully physically fit to return back to his job as a Shift Manager. "*

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The Provider states that it was its opinion, based on the medical and objective evidence received, that the Complainant was fit to return to work and no longer met the definition of disablement as required by the policy. The Provider says therefore it ceased payments on the claim and paid it up to 1 February 2013, to allow sufficient time for return to work arrangements to be made. The Provider wrote to the Complainant's employer, as the owners of the policy, on 20 November 2012 to advise of its decision. In the letter, the Provider outlined its appeals process should the Complainant be unhappy with this decision. The Provider also specified that any appeal must be submitted within three months of its letter, that is, by 19 February 2013.

The Provider submits that following its decision, it received an e-mail from the Complainant on 21 November 2012 in which he stated that he gave permission to forward a medical report to his Employer's Occupational Health Physician. The Complainant sent a further e-mail on 27 November 2012 to request that a copy of this report be released to his rheumatologist. The Provider says that on clarification of the report, the Complainant wanted the Provider to send, as well as the name of his specialist, the results of the Orthopaedic Surgeon's examination that were sent by the Provider's Consulting Medical Officer on 21 December 2012 to the Complainant's Consultant Rheumatologist, and to the Employer's Occupational Physician. The Provider states that it confirmed to the Complainant and his employers by e-mail on 21 December 2012 that the Orthopaedic Surgeon's report had been sent to each doctor. The Provider also advised that it could not forward this report directly to the Complainant, as he is a non-medical person. However, the Provider offered to send the report to the Complainant's GP as well. The Provider states that a copy of the Orthopaedic Surgeon's report was then sent to the Complainant's GP, on 15 January 2013.

On 25 February 2013 the Provider received an email from the Complainant's employer asking if it had heard from the Complainant regarding an appeal. The Provider responded on 27 February 2013 advising that it had not received any correspondence from the Complainant regarding an appeal.

The Provider submits that the Complainant wrote to it on 25 July 2013 querying its decision on his claim and also querying why he was not advised of its decision. The Complainant wrote to the Provider again on 2 August 2013 reminding of his previous correspondence. The Provider responded to the Complainant on 14 August 2013 advising him that, as his Employer was the policy owners, it had to correspond with the Employer. The Provider says it wrote to the Complainant's employer on 15 August 2013 and provided it with a copy of its letter to the Complainant. The Provider submits that it also provided the Employer with responses in relation to the Complainant's letter of 25 July 2013 and asked that they contact him regarding his letter. The Provider says that it advised that medical evidence would be sent to the Complainant's GP again, and that the video surveillance from the private investigator had already been sent to his GP and to the Employer, following his consent to send this information.

On 3 September 2013, the Provider received an email from the Complainant's Employer advising that the Complainant was unhappy with the decision made on his claim and asked what would be required in order for it to consider an appeal. The Provider says it replied to

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the employer on 4 September 2013 advising that, in order to consider an appeal, the Complainant would need to submit objective specialist evidence that supports the view that he remains unfit for work.

It is the Provider's position that nothing further was received until the Complainant's Employer contacted the Provider again by e-mail on 11th February 2014. The Provider states that it replied to the Employer on 25 February 2014 advising that it was no longer in a position to consider an appeal, as no medical evidence had been forthcoming since it issued its initial decision, 14 months prior, and that the Provider was unable to retrospectively assess the appeal on the Complainant's behalf. The Provider says that it confirmed that, at this point, its file was closed.

The Provider submits that on 2 April 2015 it received a letter, dated 31 March 2015, from the Complainant's Solicitors, requiring a copy of the Complainant's file be issued to them. The Provider says it responded on 23 April 2015 confirming that it was not in a position to consider an appeal on the Complainant's behalf. The Provider states that it also advised that in order for the data access request to be processed under the Data Protection Acts 1988 & 2003, it would require the statutory fee of €6.35 to be submitted. On receipt of this payment, a copy of the Complainant's file was sent to his Solicitors on 11 November 2015. All medical evidence was sent to the Complainant's GP, to request her permission to release these reports directly to him. The Provider states that it received the GP's response on 20 November 2015 and a copy of the Complainant's medical file was sent directly to the Complainant on 4 December 2015.

The Provider states that the Complainant wrote again on 1 March 2016. In this correspondence, he advised that he had been in contact with the then Financial Services Ombudsman's offices and was advised to lodge a complaint and to allow the Provider the opportunity to address his complaint. The Provider states that it acknowledged the Complainant's letter on 10 March 2016 and stated it was dealing with his complaint. The Provider wrote to the Complainant again on 30 March 2016 in full and final response to his complaint.

The Provider says that the Complainant wrote to it again on 26 April 2016 to advise that he was proceeding with his complaint to the Financial Services Ombudsman.

The Provider states that on 3 May 2016 it e-mailed the Employer and requested copies of correspondence the Employer had on file between the employer and the Complainant regarding the decision made to cease payments on his claim. The Provider also wrote to Complainant on 4 May 2016, advising that it was obliged to write to his employers, as the policy holders and Grantees, informing of the Provider's decision to cease payments on his claim. The Provider says it informed the Complainant that it cannot be involved in any subsequent discussions or correspondence between the employer and employee after this.

On 15 July 2016, the Employer sent copies to the Provider of communication the Employer had with the Complainant regarding the Provider's decision to cease payments on his claim.

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The Provider submits that under the terms and conditions of the Income Protection policy, all claims are subject to regular medical review to ensure that the claimant continues to meet the definition of disablement. The Provider says that following its review in 2012 when the Complainant attended the independent medical examination with the Consultant Orthopaedic Surgeon, and the Provider obtained evidence of the Complainant's daily activities while he was unaware he was being observed, it was the Provider's opinion that he no longer met the definition of disablement as required by the policy and was fit to return to work.

The Provider submits that it paid the claim up to 1 February 2013 to allow sufficient time for arrangements to be made for the Complainant to return to work. The Provider states that it wrote to the Complainant's employer, as the Employer is the policy owner, on 20 November 2012 advising of the decision to cease payments on the claim. In its letter the Provider outlined its appeals process, should the Complainant be unhappy with its decision. The Provider says that it also specified that any appeal of the decision should be submitted within three months of that letter, that is, 19 February 2013.

The Provider says that the Complainant wrote to it in July 2013, almost five months after the appeal deadline had passed, asking the Provider to consider his appeal and querying why his payments have stopped. The Provider states that at this point, it contacted the Employer to advise of the Complainant's correspondence and to reiterate its decision; referring to its letter dated 20 November 2012.

The Provider states that in September 2013 the Provider received another query from the Complainant's Employer asking how the Complainant could appeal and, despite the fact that the appeal deadline of 19 February 2013 had long since passed, the Provider responded on 4 September 2013 to advise that the Complainant needed to submit objective specialist evidence to support the view that he was unfit to return to work. The Provider says it received no further correspondence relating to the claim until the Complainant's Employer contacted it again on 11 February 2014. It is the Provider's positon that at this point, as it had made its decision to cease payments on the claim 14 months previously and been presented with no medical evidence to support an appeal, it confirmed on 25 February 2014 that it was no longer in a position to consider an appeal for the Complainant and that its file was closed.

The Provider submits that it believes that adequate time was given to the Complainant in order to submit an appeal of its decision from November 2012 up to when the file was closed on 25 February 2014.

The Provider says that the Complainant comments that it contacted him directly in relation to certain aspects of his claim, which is correct, as can be noted from correspondence enclosed as part of the evidence submitted to the Financial Services and Pensions Ombudsman (FSPO). The Provider says however, that any correspondence relating to decisions on a claim must be communicated to the policy owners, in this case, the Complainant's Employer. The Provider says that it believe that it fully met its obligations in this regard.

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The Provider states that as part of the Complainant's complaint, he has requested that the Provider carry out a review of this type of policy. The Provider's response it that it believes that this is too non-specific a request and it is satisfied that it has adhered to the terms and conditions of the contract, which is between the Provider and the Complainant's Employer. The Provider says that it can advise that it has been providing this type of cover for over 40 years. The Provider states that in the absence of any FSPO instruction on the matter, it does not intend to conduct a review of this type of policy unless further clarification is provided.

The Provider states that the claim was in payment from September 2007 when the medical evidence supported the fact that the Complainant met the definition of disablement, as required by the policy. The Provider says that payments ceased when the medical and objective evidence confirmed that this was no longer the case, and it advised the Complainant's employers of its decision, as obliged to do so at that time.

The Provider submits that it is its current practice, under the Central Bank provision 7.19, to also write to claimants directly in relation to any adverse claim decisions, however, this practice was not in place at the time the decision on the Complainant's claim was made.

The Provider says that the policy owners and the majority of correspondence on the claim is between the Provider and the Employer. The Provider says that the Complainant was contacted throughout the assessment of claim directly on a number of occasions, for example when a home visit was arranged with its Health Claims Advisors. However, all communications in relation to decisions on the claim were communicated to the Employer, as the Provider says it was obliged to do.

It was the Provider's opinion based on the medical and objective evidence received that the Complainant no longer satisfied the definition of disablement, as required by the policy. The Provider says that when it communicated its decision on the claim to the Complainant's Employer, it clearly outlined the appeals process as part of this decision in its correspondence dated 20 November 2012. The Provider says that it received no medical evidence in support of an appeal on the Complainant's behalf prior to confirming its decision to close the file in February 2014, some 14 months later.

The claim was in payment from 30 September 2007, that is, the end of the required 26 week deferred period, up to 1 February 2013.

The Provider says that its letter of 20 November 2012 outlines the appeals process in full, and what is required of the Complainant should he disagree with the decision to cease payments on the claim. The Provider says it is fully satisfied that it complied with its obligations in relation to informing of the appeals process through the proper channels.

The Provider states that when assessing claims of this nature it must be guided by the objective evidence obtained during the course of the claim. The Provider's position is that in the Complainant's case, the weight of this evidence confirms that he is capable of carrying out the duties of his normal occupation as a Shift Manager on a full time basis.

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The Provider issued its decision to cease payments on the claim to the policy owners, the Complainant's Employer, on 20 November 2012. The decision included details of what was required from the Complainant in the event that he wished to appeal the decision. An appeals deadline date of 19 February 2013 was provided. The Provider says that no appeal was ever received despite the enquiries received from the Complainant's employer regarding what was required in order to submit an appeal. The Provider states that it believes these enquiries were made by the Employer on behalf of the Complainant.

Evidence

The Complainant's submission of 13th April 2018

The Complainant states that the Provider's submission contains a reasonable summary from the Provider, however he states that does not give the full picture of the correspondence passed directly from the Provider to the Complainant.

The Complainant says for instance, correspondence would have gone directly from the Provider between 2008, 2009, 2010, 2011 and 2012 to the Complainant. The Complainant states that in the course of that correspondence it is interesting to note he is referred to as "the client".

The Complainant submits that he notes that the Provider acknowledges that details of its decision was communicated directly to the Employer and not to the Complainant.

The Complainant states that it has been contended by the Provider in its correspondence that he knew about the Provider's decision in 2012. The Complainant states that no correspondence has been produced by the Provider to support this.

However, the Provider received an email on 21st November 2012 from the Complainant and to remove all doubt the reason for that email was when he attended the Provider's appointed Specialist at the direct request of the Provider it was the Specialist who suggested he attend a Rheumatologist. The Complainant states that he did attend a Rheumatologist as suggested by the Provider's Specialist and continues to do so. The Complainant states that was the basis for the request for the medical and none other.

The Complainant states that the Declaration Form completed by him at the start of the process directly puts the onus on him to inform the Provider if he takes up work again.

As regards the Appeal Process the Complainant states that the appeal process, such as it is, is fundamentally flawed for the following reasons.

The Complainant says that there is no defined appeal process. The only information about "an appeal process" is the letter to his Employer dated 20th November 2012. The Complainant says that in essence it states that he can appeal the decision and must do so by the 19th February 2013.

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The Complainant submits that an appropriate appeal process should have included the following.

1. State to whom the appeal must be made
2. The person who will hear the appeal
3. Is the appeal going to be an in-house process or will it be heard by an independent person.
4. Is the Claimant entitled to an oral hearing or is it on the basis of a written letter only.
5. If the Claimant lodges the appeal within the time limit there should have been a procedure setting out what happens thereafter.
6. If the Claimant does not lodge an appeal within the time limit is there grounds for extending the time for appeal in exceptional circumstances.
7. What matters the Claimant would be required to address and what evidence would be required from him for his appeal.

As regards the status of the Complainant, the Complainant states that the Provider made the point that he was not the policyholder and therefore it could not communicate with him directly. The Complainant says however, that as can be seen from the summary given by the Provider this does not appear to be a hard and fast rule but one here to be availed of by the Provider when it suited it.

The Complainant asks if, as the Provider contends, he was not the policyholder and therefore the Provider could not deal with him directly how could he in fact lodge an Appeal. The Complainant says that it would appear that the appeal would have had to come directly from the Employer as the policyholder and not the Complainant. The Complainant submits however, the notification of right to appeal does not deal with this point at all and seems on the face of it to fundamentally contradict the stance of the Provider. The Complainant's position is that if the Provider had a proper appeal procedure in place this ambiguity would not have arisen.

The Complainant states that the Provider appears to be making the point that it has been in business for many years and that it was following a long established practice. The Complainant says however, it is settled Law just because one follows a long established practice does not make that practice a valid practice. The Complainant states that this principal was stated in a High Court decision of Somers -v- Weir a case from the 1970's.

As regards the Provider's point as to its current practice under Central Bank Provision 7.19. it states this practice was not in place at the time the decision on the claim was made.

The Complainant says however, that the protection code which issued by the Central Bank came into effect in 2012 and it was proceeded by a similar code in 2006. The Complainant says that he wonders when the Provider brought in this current practice and why it did not adopt this practice previously bearing in mind the provisions of the Consumer Protection Code of 2006 and more particularly the one of 2012.

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The Complainant concludes that had the Provider done so there would have been no need for the Financial Services and Pensions Ombudsman to be involved in his case.

It is the Complainant's position that he would have had the opportunity to submit medical evidence that would have refuted the decision taken by the Provider.

The Complainant says that this medical evidence is still available and includes the report from his Consultant Rheumatologist who he attended on the specific advice of his Specialist and who he says he continues to attend to this day.

The Complainant's position is that it is arguable that the procedures that the Provider should have had in place before reaching a decision to decline the claim should have included provision that he would be notified of the Provider's intention to decline his claim and that he be given an opportunity to respond and thereafter it could give its decision and he could appeal if he so wished. The Complainant states that this would be in line with the minimum requirements of fair procedures and natural justice. The Complainant submits that the Provider owed him a duty of care and due to the flawed process used by the Provider it failed him in its duty of care.

<u>The Provider's response submission of 26 April 2018</u>

The Provider states that in relation to the Consumer Protection Code (CPC) Provision 7.19, it notes that this has been in place since 2012. The Provider says that at the time, it believed claimants and employers were one and the same for CPC purposes as the employer pays the insurance premiums, makes the claim on behalf of the employee and the claims are payable to the employer. The Provider submits that it is important to note that Provision 7.21 of the Consumer Protection Code refers to policyholders who are not the beneficiary of claim settlements must be the party who are advised in a durable format of the outcome of a claim and for these reasons it always solely wrote to the employer when passing on claim decisions; either ones admitting, ceasing or refusing liability. The Provider states that the Central Bank clarified their understanding of who a claimant is for employer paid schemes, such as this one, in 2015 and since then the Provider has been writing directly to the individual member when passing on any decisions to not pay, or cease a claim.

The Provider states that in September 2013 the Complainant sought the medical records to be sent to his GP as he was unhappy with the decision the Provider made on his claim and he wanted the Provider to consider an appeal. The Provider states that medical evidence was subsequently sent to his GP as requested. The Provider says it is clear at some stage that the Complainant was made aware of the claim decision and, regardless of whether it was November 2012 or around September 2013, on each occasion the Provider invited medical evidence to be submitted to consider an appeal but on neither occasion was it forthcoming. The Provider submits that as regards their being now evidence available, it had pointed out in 2014, over one year after the decision was made, it was too late to reconsider the claim at that stage.

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The Provider states that appeals are submitted by individuals and employers alike, and despite being clear that it required medical evidence to review the decision, none was ever submitted. As regards its appeals process the Provider states that its newer policies do reference the appeals process but the relevant policy on the Complainant's claim is silent on the matter. The Provider submits however, as above, it was very clear how to start the process, and the Complainant's employer would have been very familiar with it. The Provider states that either the Complainant's employer or the Provider would have been happy to provide any assistance to the Complainant at the time had he made enquiries on how an appeal might have played out in the event that he submitted any medical evidence in a timely manner.

The Provider states that it remains satisfied the correct decision was made on the claim in November 2012, and it believes that it showed flexibility by inviting an appeal when it was contacted in September 2013, despite the fact that a significant period of time had gone by from the date it said it would consider one, and also that at no stage had any medical evidence been provided to the Provider. The Provider states that it is now too late to review evidence relating to a claim decision made in late 2012.

<u>The Complainant's submission of 3rd May 2018</u>

The Complainant states that with regard to the Provider's reference to the Consumer Protection Code (CPC) provision 7.19, he notes the Provider accepts that this has been in place since 2012. The Complainant says the Provider then states it did not change their operation because of their belief that claimants and employers were one and the same for CPC purposes.

The Complainant says that it is hard to understand how the Provider could have ever formed this view as it has at all times maintained that there is a crucial distinction between the policy holder and the claimant and that it could only deal with the policy holder and not the claimant.

As regards the Provider's position that the Complainant knew of its decision within the time within which to appeal, the Complainant says however as it has not been able to provide proof that the Complainant knew of its decision in November 2012 it now seems to be suggesting again (without any proof) that he knew of their decision sometime between November 2012 and before September 2013. It is the Complainant's position that he did not know of the decision of the Provider until long after the period of appeal had expired.

The earliest period that the Provider can claim he was aware of the decision is September 2013 when he then sought his medical records. The Complainant says that there was no suggestion in the Provider's response of September 2013 that it was prepared in any way to obtain an Appeal.

The Complainant submits that claim appeals are submitted by individuals and employers alike. However, as the Provider would only deal with the policy holder he is unable to see how the Provider could have entertained an appeal from him.

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The Complainant states that it is worth noting that the Provider admit that it did not have an appeal process in place at the time it made the decision involving him. The Complainant submits that the fact that it now has that situation shows that the policy it had in place in 2012 was defective and deficient.

The Complainant says to suggest that his employer would have been very familiar with the appeal process (whatever process that was) beggars belief. The Complainant states that it is clear that his employer was not familiar with the appeal process otherwise what transpired would not have in fact happened. The Complainant says that it is equally hard to understand how the Provider could say that either his employer or the Provider would have been happy to provide any assistance to him at the appeal as first his employer did not inform him of the correspondence from the Provider and secondly neither did the Provider.

The Complainant says he takes issue with the suggestion from the Provider that it invited an appeal in September 2013 and that the correspondence does not indicate that nor does it suggest it.

<u>The Provider's response submission of 14th May 2018</u>

The Provider states that it generally did not correspond directly with members on claim decisions prior to 2015 due to reasons set out in its previous letter. The Provider says that prior to 2015 it had always passed on claim decisions to policy holders in the belief this was the correct method. The Provider submits that the Central Bank clarified its expectations to the Provider in 2015 and since then it has communicated adverse claim decisions both to the policyholder and member.

As regards the Complainant's positon that he was unaware of the claim decision until long after the appeal period had expired, and not before September 2013, the Provider says that this is incorrect as the Complainant's letters to the Provider in July and August 2013 show he was aware of the claim decision. The Provider says that for clarity, it would like to set out the exact chain of communications issued and received beginning with when the claim was stopped initially:

20/11/2012 — Ceasing letter was issued to the Complainant's employer.

22/11/2012 - Email received from the Complainant consenting the Provider to release a copy of a report to his company doctor, Occupational Health Physician.

27/11/2012 - Email received from the Complainant requesting a copy the report for his Rheumatologist.

03/12/2012 - Email to the Complainant asking for confirmation of his Rheumatologist name and confirmation of which report he wants the Provider to release to the Rheumatologist and the company doctor.

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04/12/2012 - Email from the Complainant confirming that it is Mr N's report that he wants released to his company doctor and he also confirmed the name and address of his Rheumatologist.

08/12/2012 - Email from the Complainant asking for a copy of Mr N's report for his own records.

13/12/2012 - Email from the Complainant's employer looking for an update regarding their request for Mr N's report to be sent to their company doctor

21/12/2012 - Mr N's report release to the company doctor and the Complainant's Rheumatologist

21/12/2012 - Email to the Complainant and his employer confirming that Mr N's report has been sent and confirmed that under the data protection act the Provider cannot release a copy of Mr N's report directly to the Complainant however it could release a copy to his GP if required.

04/01/2013 - Email from the Complainant's employer asking the Provider to confirm if Mr N's report has been released to the Complainant's doctor.

04/01/2013 - Email from the Complainant querying why he cannot receive the report directly. Specialist sends a copy of report.

14/01/2013 - Email to the Complainant's employer advising that the Provider has issued a copy of Mr N's report to the Complainant's doctor as previously requested, the Provider advised employer that it cannot release a copy of the report to the claimant directly and it offered again to issue the Complainant's GP with a copy of the report.

14/01/2013 - Email to the Complainant quoting the Data Protection Act advising that the Provider cannot release a copy of Mr N's report to him directly.

15/01/2013 - Email from the Complainant asking for the Provider to release a copy of Mr N's report to his GP.

15/01/2013 - Letter to the Complainant's GP, forwarding her a copy of Mr N's report.

17/01/2013 — The Complainant's employer were looking for a copy of the PI evidence to be sent to their company doctor.

18/01/2013 — Email to Employer confirming that the Provider needs the Complainant's consent to send the PI DVD to the company doctor before it can issue this.

25/02/2013 - Email from the Complainant's employer querying whether or not the Complainant submitted an appeal as it was aware that the Complainant's claim had

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ceased with effect from 1st February 2013 and the appeal deadline was 19th February 2013.

27/02/2013 - Email to the Complainant's employer confirming that the Provider had not received an appeal of its decision.

13/06/2013 — Email from broker asking the Provider to send a copy of the PI DVD to the Complainant's GP.

18/06/2013 — Email from the Complainant's employer asking if PI DVD has been sent to the Complainant's employer.

26/06/2013 — Email from broker received asking for the Provider to send a copy of the PI DVD to the Complainant's GP.

03/07/2013 — DVDs were released to the Complainant's GP as requested and the Provider advised the Scheme's Broker and the Complainant's employer of same.

18/07/2013 — Email from broker looking for the Provider to send a copy of the PI DVDs to the company doctor, there is an email from the Complainant dated 17/07/2013 advising he and his GP have seen the DVDs.

26/07/2013 - Letter from the Complainant querying why his benefit had stopped in May 2013 and ask for the Provider to consider an appeal.

06/08/2013 - Letter from the Complainant looking for an update following his letter of 25th July 2013.

07/08/2013 — Copy of PIs sent to the Complainant's employer by registered post.

14/08/2013 - Response issued to the Complainant advising that his employers are the policyholders and the Provider will respond via them in the next few days.

15/08/2013 - Email to the Complainant's employer responding to the Provider issuing the decision to the Employer directly and confirmed that it will be issuing a copy of all medical reports to the Complainant's GP.

17/08/2013 - Letter to the Complainant's GP sending a copy of Mr N's reports.

03/09/2013 - Email from the Complainant's employer advising that the Complainant wishes to appeal the Provider's decision.

04/09/2013 - Email to the Complainant's employer advising that the Complainant would need to send the Provider objective specialist evidence that supports that the Complainant is unfit for work. The Provider advised that the evidence submitted should clearly indicate that he is currently totally disabled from following his normal occupation.

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The Provider stated that if no such evidence is available, its decision will remain unchanged.

11/02/2014 - Email from the Complainant's employer asking if it will consider an appeal at this stage.

25/02/2014 - Email to the Complainant's employer confirming that as no specialist evidence has been received to date, it was unable to retrospectively assess the appeal of a decision which was made over 14 months prior. The Provider confirmed to the Complainant's employer that its file was closed.

The Provider submits that it is clear that the Complainant's employer was at various stages communicating with the Complainant in order to obtain various consents, to inform the Provider he wished to appeal etc. which suggests he was kept updated on his claim. The Provider states that while it cannot comment further on communications between the Complainant and his employer, the Employer did advise the Provider in September 2013 that he wished to appeal, and its reply to the Employer reiterated how he could do so. The Provider's position is that taking everything into consideration, it is difficult to accept that the Complainant did not have enough information at the very latest from July 2013 to progress an appeal.

The Provider states that in relation to the comments made in respect of the appeals process, it can confirm that this process has always been in place when a medical decision is made to cease payments on an Income Protection Claim. The Provider says it believes its communications in this regard are clear as to what is required to commence the appeals process and it feels its 3 months deadline from the date of providing the decision is fair for all parties concerned. The Provider's positon is that in the Complainant's case, the Provider even agreed to consider an appeal after this deadline, however, none was forthcoming between September 2013 and February 2014 when it closed its file. The Provider submits that where there are differences of medical opinion, inviting the contradictory evidence to be submitted is proven an effective way to help bring cases to their conclusions.

The Provider states that the Complainant's employer, being the policy holder, did have direct experience of its claims process, including how to appeal a decision. The Provider says that without wanting to comment on any other cases, it can confirm this was an active scheme with lots of claims and the Provider met with the Complainant's employer on several occasions over the years to educate on the processes and to review the claims. The Provider submits that it is satisfied the Employer understood the Provider's claims process sufficiently.

The Provider concluded that it remained satisfied the correct decision was made on the Complainant's claim. The Provider stated that it is also clear he was aware of the decision prior to September 2013, at which point it agreed to look at any medical evidence submitted. In February 2014 when no such evidence had been submitted the Provider closed its file.

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The Complainant's submission of 25th May 2018

The Complainant states he notes the explanation furnished as to the change of heart by the Provider in 2015 when it took to communicating adverse claims decision both to the policy holder and member.

The Complainant says that their explanation states that the Central Bank only clarified its expectations to the Provider in 2015. The Complainant says however that the Consumer Protection Code, about which the Provider seems to have sought clarification from the Central Bank was first issued in 2006. A similar but stronger code containing similar provisions to the earlier code was issued again in 2012. The Complainant states that 9 years is a long time to wait before seeking clarification, particularly for a company of the Provider's size which in turn "is … one of the world's leading Life Assurance organisations".

The Complainant refers to his letter of 26th July 2013 querying why his benefit had stopped in May 2013 and enquiring about an appeal. The Complainant states that he believes this clearly establishes, at the very best from the Provider's point of view that the earliest it can say that he knew about its decision was sometime in July 2013 and not beforehand. The Complainant says it is also clear that he did not know of the decision until the time for appeal was well past.

The Complainant submits that the Provider claims that it had communicated with his employers on several occasions over the years to educate them about their policies and to also review claims. The Complainant says that the Provider goes on to say that it is satisfied that the employer understood the Provider's claim process sufficiently. The Complainant states however, that it is quite clear that his employers did not or it would have communicated the appeal to him and would have advised him on the appeal process (which he says the process itself appears to be veiled in mystery) within the appropriate time limit. The Complainant says that it is clear that this did not happen and indeed the letter to which the Provider makes reference of 26th July bears this out. The Complainant submits that at that stage it should have been clear to the Provider that there was a breakdown in communication - such as it was - yet it continued with a process which had been shown to have been defective and which it knew to be clearly defective.

The Complainant states that he is a beneficiary under the policy affected between his employer and the Provider knew this had known this for a period of 5 years. The Complainant submits that the Provider took no steps whatsoever to safeguard his interests, but were content to rely on the Policyholder to do so. The Complainant says that when this was shown to be defective, that is, the Complainant was not notified of the policy holders right to appeal by the Policy Holder, within the appropriate time limit they continued to deal directly with the policy holder without any thought or consideration for the beneficiary.

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The Complainant's position is that the Provider cannot say when or indeed if the contents of the letter of the 13th September 2014 were passed on to him. The Complainant says that this is because the procedure it adopted was defective and because it failed to correct this defect even though it was on notice that its procedures, such as they were, were defective. The Complainant concludes that the Provider owe him a duty of care and that it failed him in that duty.

Claim decision and appeal correspondence

25 February 2013 – Employer's HR department to the Provider

> *".. [the Complainant] had the option to appeal this decision by February 19th, 2013. Can you clarify as to whether [the Complainant] did, in fact, contact [the Provider] with regard to this decision?"*

27 February 2013 – Provider to the Employer's HR department

> *"I refer to your e-mail of 25 February 2013 and can confirm that [the Complainant] has not been in touch with us in relation to an appeal".*

18 July 2013 – Employer to the Complainant

> *"Please find attached a copy of the letter received from [the Provider] as per my email this morning. It was my understanding that [the Provider] had also issued a copy of same to you".*

25th July 2013 – the Complainant to the Provider

> *"I presume I have in any event a right of appeal on your decision.*
> *However, as you have not notified me on either (a) your intention to no longer pay me under the Income Protection Policy and (b) furnish me with any reasons whatsoever for doing so I am not in a position to consider any appeal against your decision. I await hearing from you as a matter of urgency".*

2nd August 2013 – the Complainant to the Provider

> *"It is with regret that I note that you have not responded to my letter of the 25th of July last. Whilst the matter may not be important to your company it is extremely important to me as I have been denied an income for the last two months without any explanation from yourselves.*
>
> *Unless I have adequate responses to my letter by 13th inst I will be left with no option but to refer the matter to the financial regulator, the insurance ombudsman and the FFO".*

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14th August 2013 – the Provider to the Complainant

"I apologise for the delay in responding to you. Unfortunately there is a backlog of queries and this delayed our response to you.

As [your Employer] are the policy holders we cannot provide any information or discuss any aspect of your income Protection claim with you directly. I will update them with our positon in the coming days and we will also notify you when this has been done".

15 August 2013 – Provider to the Complainant's Employer

"1. [the Complainant] states that he wasn't informed that his payment were due to cease and that they were cut off without prior notice and with no explanation.
…
In relation to point 1, we issued a letter to you on 20/11/12 indicating that following an Independent Medical Examination, we were of the opinion that [the Complainant] was fit to return to work. We made payments to February to allow for arrangements to be made to facilitate a return to work for [the Complainant].

We dealt directly with [the Complainant] in relation to asking him for some medical information, but as [the Employer] are the policyholders, we must deal directly with yourself and we cannot provide any information or discuss any aspect of his income protection claim with [the Complainant] directly"

3rd September 2013 – Employer to the Provider

"I understand [the Complainant] wishes to appeal the decision with regard to his claim but has not received a satisfactory response other than the attached. Please confirm the process [the Complainant] needs to follow with regard to same".

4th September 2013 – Provider to the Complainant's Employer

"For [the Complainant] to appeal our decision he would need to send in objective specialist evidence that support [the Complainant] is unfit for work. The evidence submitted should clearly indicate that he is currently totally disabled from following his normal occupation. If no such evidence is available, our decision will remain unchanged".

27 September 2013 – the Complainant's Employer to the Complainant

"As you know the long term disability cover is an insured benefit provided by a specialist insurance provider. All colleagues accessing the benefit must fulfil the conditions set by the Insurance provider and decisions in relation to the benefit are made solely by the insurance provider. In essence, resolution of this issue lies between you and the insurance provider"

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11 February 2014 – the Complainant's Employer to the Provider

> *"I understand that [the Complainant's] payments have ceased. Our medical professional have deemed him unfit for work and we would like to understand what avenue we can now take to appeal your decision at this stage".*

17 February 2014 – Employer to Provider

> *"Further to my e-mail last week, can you please let me know what appeals process, if any, we can take next".*

21 February 2014 – Provider to Employer – *"we are currently reviewing the appeal request".*

25 February 2014 – Provider to Employer

> *"As you are aware, we ceased [the Complainant's] claim in November 2012 and we outlined our appeals process at this time. It was advised that the appeal deadline was 19/02/13. To date no specialist evidence has been submitted to us in support of [the Complainant's] appeal. Therefore it is not possible for us to retrospectively assess the appeal of a decision which was made over 14 months ago".*

17 April 2014 – Employer to the Complainant

> *"As you are aware, in October 2013 we agreed as an interim measure to make payment to you equivalent to your benefit for a period of 3 months, for the specific purpose of processing your appeal. Unfortunately there was a significant delay in receiving your required medical information from your medical contacts. However, we are now in a positon to update you on the conclusion of that process.*
>
> *We have been in contact again with [the Provider] having received your up-to-date medical information. Regrettably they have indicated that they are unwilling to process an appeal in your case and further more in fact they regard your file with them as now closed. This is on foot of the fact that in the opinion of [the Provider's] medical advisors you were fit to return to your pre disability positon. Consequently the only option available to you is to process an appeal to the financial Ombudsman against [the Provider].*
>
> *In light of the above I must inform you the interim measure of payment will cease with effect from end April 2014"*

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23 October 2014 – The Employer to the Complainant

> *"I know that this issue has been a very significant concern to you for many months now. To that end, the Company [Employer] has supported you in continuing payment to allow you to process an appeal and for us to establish your fitness to work or otherwise.*
>
> *I am happy to say that one element of this matter is now at a conclusion in that following your recent medical reviews you have been medically determined as fit to return to work. Furthermore, I am glad to confirm that the Company is in a positon to facilitate a return to work programme to ensure that you are provided the opportunity for a successful return to employment here on site".*

26th March 2015 – The Complainant's employer to the Complainant

> *"As previously communicated the Company [Employer] is supportive of your appeal given the medical evidence and opinion of our own Occupational Health Specialists.*
>
> *I strongly urge you to pursue this appeal as a matter of urgency, to the Financial Ombudsman if necessary as all avenues pursued by the Company [Employer] in addressing the matter have not provided a resolution to date. The Company [Employer] have also sought to have your case addressed through our new Income Protection provider but unfortunately this has also been unsuccessful in providing a resolution to your case.*
>
> *In a final effort to support your situation in processing an appeal, the Company will agree to continue payment of the equivalent of your Income Protection benefit for a final two months. Therefore your final payment from the Company [Employer] will be payable on May 23rd 2015".*

31st March 2015 – The Complainant's solicitor seeks disclosure of documentation.

23 April 2015 – the Provider to the Complainant's solicitor. The Provider advise that it is unable to consider an appeal due to the delay in submitting the relevant specialist evidence.

3 May 2016 – Provider to the Employer

> *"I would be grateful if you could forward us copies of any correspondence you have on file between yourselves and [the Complainant] regarding the decision to terminate his claim and regarding the appeals process"*

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The Complaint / for Adjudication

The complaint is that the Provider incorrectly communicated its decision to cease benefit and what was required for an appeal of that decision.

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 25th 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.

Analysis

The issue for investigation and adjudication here is whether the Provider correctly assessed the claim and this includes its communication of the claim decision and what was required from the relevant parties to appeal that decision. For the reasons set out below I do not consider that it is appropriate for this Office to investigate and adjudicate upon whether the Provider was correct and reasonable in its decision that the Complainant did not meet the policy criteria for payment of benefit on medical grounds.

In the Provider's letter dated 20th November 2012 it advised the Complainant's Employer that it was ceasing the payment of benefit to the Complainant. In this letter the Provider advised the Complainant's Employer of what the Complainant could do should he wish to

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appeal the Provider's decision on his claim. This letter did not say what the Employer should do to appeal the claim decision. I find that what is missing from this letter is any indication from the Provider that it had or had not separately advised the Complainant of the decision or of the appeal procedures, or indeed that it had or had not been in contact with the Complainant on the matter. It is of particular note that the Provider's letter does not advise the Employer to pass on the information about the decision or the appeal process to the Complainant.

There were instances in the claim process where the Provider or it representatives did contact the Complainant directly, for example 16th January 2008, December 2008, and February 2009, the Provider's Health Claims Advisor wrote to the Complainant advising of a claims management visit with the Complainant. In this letter the Provider stated*:*

> *"From our point of view, personal contact provides us with a better appreciation of your circumstances which may help in many aspects of the future management of your claim"*.

Equally I note that the Provider informed the Employer on 16th January 2008 that it had notified the Complainant directly on an issue. I consider that from such prior communications, the Employer may have expected the Provider to have contacted the Complainant directly on the claim decision and appeal process.

It would certainly have been reasonable for both the employer and the Complainant to have expected the Provider to do so.

It is clear from the evidence that the Provider did not in any way engage with the Complainant directly as regards the claim decision or about an appeal of the claim decision. It is also clear that the Employer thought that there would have been some contact between the Complainant and the Provider on the claim decision and appeal. This is evident from the Employer's communication to the Provider of 25 February 2013 where it enquired:

> *".. [the Complainant] had the option to appeal this decision by February 19th, 2013. Can you clarify as to whether [the Complainant] did, in fact, contact [the Provider] with regard to this decision?"*

The evidence shows that the Complainant was unsuccessful in getting advice from the Provider directly as regards an appeal of the claim decision.

On 3rd September 2013 the Complainant's employer then contacted the Provider with the following query:

> *"I understand [the Complainant] wishes to appeal the decision with regard to his claim but has not received a satisfactory response other than the attached. Please confirm the process [the Complainant] needs to follow with regard to same".*

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On 4th September 2013 the Provider responded to the Complainant's Employer, as follows:

> *"For [the Complainant] to appeal our decision he would need to send in objective specialist evidence that support [the Complainant] is unfit for work. The evidence submitted should clearly indicate that he is currently totally disabled from following his normal occupation. If no such evidence is available, our decision will remain unchanged".*

From the above it can be seen that the Provider appeared to be allowing an additional opportunity for an appeal of the claim decision. However, in this communication of 4th September 2013 the Provider does not set out a time frame for this additional appeal opportunity. It is noted that the Policy Provision do not contain any information on the appeal process.

In a letter dated 27th September 2013, the Complainant's Employer then advised the Complainant that the matter was between himself and the Provider. This advice totally went against what the Provider had advised the Complainant, that is, that claim issues were to be decided upon between the Provider and the Employer.

It appears that the Employer thereafter had begun to prepare for an appeal of the claim decision itself (see letter of 17th April 2014 set out above). From this letter it appears that the Employer had begun the process of obtaining medical information for the appeal of the claim decision. With no time frame in the Provider's last communication to the Employer explaining how an appeal could be made, or a time frame for same, I consider that it would have been reasonable of the Complainant's Employer to proceed on that basis and to make the appeal submission when the information was to hand.

When the Employer had the information gathered for the appeal it wrote to the Provider on 11 February 2014, in this correspondence the Employer stated:

> *"I understand that [the Complainant's] payments have ceased. Our medical professional have deemed him unfit for work and we would like to understand what avenue we can now take to appeal your decision at this stage".*

On 25 February 2014 the Provider wrote to the Complainant's Employer and advised:

> *"As you are aware, we ceased [the Complainant's] claim in November 2012 and we outlined our appeals process at this time. It was advised that the appeal deadline was 19/02/13. To date no specialist evidence has been submitted to us in support of [the Complainant's] appeal. Therefore it is not possible for us to retrospectively assess the appeal of a decision which was made over 14 months ago".*

Both the 2006 and 2012 Consumer Protection Codes set out what is required form a Provider in relation to Claims Handling.

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The Codes state as follows:

"A regulated entity must, within 10 business days of the making of a decision in respect of a claim, advise the claimant in writing of the outcome of the investigation explaining the terms of any offer of settlement. If the claim is denied, the reasons for the denial must be provided to the claimant in writing. ..

A regulated entity must provide a claimant with written details of any internal appeals mechanisms available to the claimant". (2006 Consumer Protection Code)

"If the ***regulated entity*** decides to decline the claim, the reasons for that decision must be provided to the ***claimant*** on paper or on another ***durable medium***.

A ***regulated entity*** must provide a ***claimant*** with written details of any internal appeals mechanisms available to the ***claimant"***. (2012 Consumer Protection Code)

The Provider states that the Central Bank clarified its understanding for the Provider of who a claimant is for employer paid schemes, such as this one, in 2015 and since then the Provider has been writing directly to the individual member when passing on any decisions to not pay, or cease a claim.

I consider that given that the Provider is an Insurer which provides income protection policies for many years and to a great number of individuals whether in Group Schemes or those owning their own policies, that it should have clarified with the Central Bank earlier than 2015 what was meant by claimant for the purpose of these policies. It is important to note that the wording of the two codes are for the most part the same and it took the Provider 9 years to seek clarification from the Regulator on this issue.

Furthermore, I do not believe that the Complainant should be penalised because of the Providers lack of understanding of the Consumer Protection Code. It is also worth noting that the Provider had the benefit of the Central Bank's clarification during the investigation and adjudication of the complaint, and insisted on holding its positon that it was not required to communicate with the Complainant when it knew from 2015 that it was required to do so.

From the evidence and submissions provided to this office, it is clear that:

- The Complainant was not notified directly by the Provider of the decision to cease the benefit payments (which goes against the spirit of the 2006 & 2012 Consumer Protection Codes).
- The Complainant was not notified directly of an appeal process (which goes against the spirit of the 2006 & 2012 Consumer Protection Codes).
- The Provider did not advise the Employer that the Employer had to appeal the claim decision, but in fact advised of the opposite, that is, that the Complainant could appeal.

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- The Provider did not advise the Employer to pass on the claim decision or the information that an appeal could be made by the Complainant, to the Complainant.
- The Provider did not advise the Employer that it had not communicated the claim decision separately to the Complainant.
- When the Complainant sought information about the appeal of the claim decision the Provider did not assist the Complainant, but only advised that: *"As [your Employer] are the policy holders we cannot provide any information or discuss any aspect of your income Protection claim with you directly"* [This contradicted the advice given in the letter to the Employer advising of the cessation of benefit, that is, that the Complainant could appeal the decision.] It also contradicted what the Provider had done in practice.
- When the Provider communicated on 4th September 2013 how the Employer could appeal the claim decision, it did not set out any time frame for this re-offered opportunity to appeal the claim decision.
- The Policy Provisions are silent (i) as to an appeal process (ii) as to who should appeal a claim decision (iii) how such an appeal should happen or (iv) any time frame for appealing a claim decision.

As stated above I do not consider that it is appropriate for this Office to investigate and adjudicate upon whether the Provider was correct and reasonable in its decision that the Complainant did not meet the policy criteria for payment of disablement benefit on medical grounds. This is so, as I consider that the communication of the claim decision was not done correctly and that the appeal process was not correctly communicated to the Complainant or the Complainant's Employer. I do not consider it fair on the Complainant for this Office to decide on the reasonableness of the Provider's decision to cease benefit when the Complainant was not correctly communicated of same and was not provided with the opportunity to challenge same by way of an appeal. Because of the actions of the Provider in denying an appeal, I feel this office would not have sufficient information to assess if it was reasonable of the Provider to arrive at its decision. What I will decide is whether it was reasonable of the Provider to refuse to communicate with the Complainant and deny him the opportunity to appeal its claim decision.

Having regard to all of the evidence and submissions received and summarised above, it is my Legally Binding Decision that the complaint is upheld. From my analysis of the facts presented there was a major fall down in the communication process between the Provider and the Complainant's Employer and the Complainant in the communication of the claim decision to cease benefit, on the appeal requirements, and what had to be done by the respective parties in relation to the appeal of the claim decision. It is unfortunate that the Complainant's positon was unreasonably affected by this unclear communication of the claim decision and of the appeal's process. For this maladministration by the Provider, I consider that the only way that the matter can be remedied is for the Provider to re-instate benefit from when last paid, adjusted for any payments that the Complainant was receiving from his Employer during that time, and I direct accordingly. The back dated benefit payments should be paid to the Complainant in the most tax efficient manner, to ensure he is not disadvantaged by the delay in the

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payment, and I direct the Provider accordingly. The benefit payments should recommence, I direct the Provider accordingly. Thereafter, the Provider remains entitled in the future to re-assess the Complainant's eligibility for benefit and if it does, and it deems the Complainant fit for work, it is to correctly inform the Complainant of his right to appeal that decision, I direct the Provider accordingly. I appreciate that as the Provider is no longer the Insurer of the Employer's scheme that it may have to treat the Complainant as a policyholder in his own right, but I consider that this is something that the Provider must now deal with. I direct the Provider on all of the above, and I also direct the paying of a compensatory payment of €10,000 (ten thousand euro), by the Provider to the Complainant.

There may be matters outstanding between the Provider and the Employer on this issue, but I do not consider that they should be allowed to further impact on the Complainant. Any such outstanding matters should reasonably be left for the Provider and Employer to address between themselves and should not delay the payment to the Complainant.

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)(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 rectify the conduct complained of by:

(i) re-instating benefit from when last paid, adjusted for any payments that the Complainant was receiving from his Employer during that time. The back dated benefit payments should be paid to the Complainant in the most tax efficient manner, to ensure he is not disadvantaged by the delay in the payment.

(ii) the benefit payments should recommence. Thereafter, the Provider remains entitled in the future to re-assess the Complainant's eligibility for benefit and if it does, and it deems the Complainant fit for work, it is to correctly inform the Complainant of his right to appeal that decision.

(iii) I direct the paying of a compensatory payment of €10,000 (ten thousand euro), by the Provider to the Complainant, 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.

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- 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

17th 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.