Decision Ref: 2019-0117

Sector: Insurance

Product / Service: Unit Linked Whole-of-Life

Conduct(s) complained of: Refusal to insure - failure to renew policy

Outcome: Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns a health insurance policy held by the Complainant with the Provider.

The Complainant submits that he telephoned the Provider in **February 2018** to establish whether his health insurance policy would cover him for travelling abroad. He states that during this telephone call the Provider told him his policy had been cancelled in **June 2017** as he had missed a premium payment. The Complainant contends that he was *"surprised and annoyed"* at the cancellation of his policy as he had not been informed about it and *"had received no letters or phone calls"*. The Complainant submits that it is *"unreasonable"* of the Provider to cancel his policy due to one missed payment, and that the actions of the Provider are *"cynical and immoral"* and are *"putting [his] health at risk"*.

The Provider, in its Final Response Letter, contends that it was *"unable to collect [the Complainant's] monthly premium due on the 28th April 2017"*. The Provider submits that it issued a default notice letter to the Complainant's address on the 05 May 2017 and a second notice letter on 17 May 2017 and further contends that "*Following the two failed attempts [it] sent a final reminder on the 1st June 2017, with the cancellation letter sent to [the Complainant] on the 15th June 2017.*"

In resolution of his complaint, the Complainant would like the Provider to *"renew [his] policy [including that he would] still be covered for existing conditions"*.

The Complainant's Case

The Complainant sets out the complaint as follows:

> *"On 28th February* [the Complainant] *rang* [the Provider] *to see if* [his] *policy covered foreign travel as* [he] *was going abroad.* [He] *discovered that* [his] *policy had been cancelled the previous June.* [He] *was quite surprised and annoyed. The first person* [he] *spoke to said they had attempted to call* [him] *on the phone. When* [he] *enquired as to what number,* [the Provider's representative] *gave* [the Complainant] *an incorrect number.* [The Complainant] *asked to speak to* [the Provider's representative's] *supervisor. She contradicted* [the Provider's representative] *and said* [it] *didn't call* [him] *but had written. She said if* [he] *wanted to take out another policy* [he] *would not be covered for any pre-existing conditions."*

The Complainant further submits that he received a letter which, he contends, *"failed to address* [his] *complaint adequately and cherry picks the detail of the conversation, pretending that* [his] *main complaint is that nobody called* [him] *on the phone.* [His] *main complaint is* [he] *received no communication, either letter or phone.* [He wants] *to know if this is legal? Should* [the Provider] *not be obliged to send a registered letter or at least ensure that the client is aware of what is happening? Or* [does it] *have the right to cancel* [his] *policy if a payment is missed without* [his] *knowledge?"*

The Complainant contends that only one payment over a period of five years *"bounced due to lack of funds"* and because of a number of previous claims he further contends that the Provider *"has decided that* [it does not] *want* [him] *as a customer based on* [his] *past health and this is being used as an attempt to get rid of* [him]*"*.

The Provider's Case

Provider records indicate that the Complainant incepted a health insurance policy on **15 February 2013** and this was auto-renewed on **01 March 2017**. This policy covered the Complainant and one child dependent.

The Provider asserts that it was unable to collect the Complainant's monthly health insurance premium of €104.03 on 28 April 2017 and subsequently received a notification from the bank advising that the payment had defaulted as there were insufficient funds in the Complainant's account. It contends that it issued a default notice to the Complainant's home address on **05 May 2017**. It further contends that it issued a second notice by post to the Complainant on **17 May 2017** followed by a final postal reminder on **01 June 2017** and terminated the policy by sending a cancellation letter on **15 June 2017**. The Provider contends that it received no response from the Complainant after issuing any of these letters to his home address.

The Provider notes that it is relying upon a number of Terms and Conditions in cancellation of the Complainant's health insurance policy namely under sections one, four, six and eight of the policy handbook issued to the Complainant on 20 March 2017 along with a copy of the renewal confirmation and Direct Debit Schedule.

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The Complaints for Adjudication

The complaint is that the Provider wrongfully cancelled the Complainant's health insurance policy effective from 31 March 2017 without prior notification or warning to him.

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 14 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 complaint at hand is that the Provider wrongly cancelled the Complainant's health insurance policy without any prior warning or communication to him.

In this regard, the Complainant says that he did not receive any of the four notification letters the Provider contends it sent to his home address advising him that he had defaulted on his monthly premium and that his policy was ultimately cancelled. The Provider asserts that section one of the policy handbook that the Complainant was issued with, states:

> *"ACKNOWLEDGMENTS By entering this policy you are acknowledging that you have read this membership Handbook and understand your cover. In particular, you are*

> *confirming that you understand the contractual documents that make up your contract with us and that your cover may change throughout your policy year."*

Further to this, the Provider advises that page twenty two of section four of the same policy states:

> *"CANCELLING YOUR POLICY Your policy or any of the plans listed on your policy may be cancelled before the end of your policy year for one of three reasons:*
> *…*
> *2)Premiums are not kept up to date We will cancel the policy or any of the plans listed on your policy if you do not pay your premium when it falls due. We will cancel the policy or any of the plans listed on the policy from the date that your premiums were paid up to (the Cancellation Date). We will not pay any claims for goods or services received after the Cancellation Date. We will send you the letter giving you 14 days' notice of our intention to cancel. We will send this to your last known address."*

As evidenced by the letter to the Complainant dated 01 June 2017 highlighting the consequences of not paying an insurance premium when it falls due, that is the cancellation of the policy, the Provider advised the Complainant that he must make payment within the following fourteen days or his policy would be cancelled. In a letter from the Provider to the Complainant dated 15 June 2017, the Provider advises the Complainant that his policy has been cancelled:

> *"Unfortunately we have had to cancel your health insurance policy with* [the Provider] *due to non-payment. We have enclosed your Membership Certificate confirming that your policy cover has now ended."*

In addition, a Renewal Notice submitted by the Provider dated 28 January 2017 addressed to the home address of the Complainant warned, under a copy of its Terms of Business that accompanied the Notice, that if the Complainant did not pay his premium on time to the Provider, it could cancel the policy from the date of the first missed payment.

The Provider, in the evidence submitted to this Office dated 05 October 2018, notes that it had previously sent unrelated documentation to the Complainant in February 2013 but that this mail was returned by the postal service as the Complainant no longer resided at that address. The Provider contends that it contacted the Complainant by telephone and email on this occasion to update its system with the correct details for the Complainant. In this instance, however, the Provider submits that *"there were a total* [of] *4 letters sent to* [the Complainant] *in relation to the direct debit default and subsequent cancellation of his policy none of which were returned to* [the Provider's] *offices meaning that* [it] *had no reason to believe that* [the Complainant] *was not receiving them"*.
The Complainant has responded to this submission by asserting his confusion as to the relevance of this to his complaint. However, he states, that he is *"glad* [the Provider] *included this detail as it helps illustrate the systemic problem with collating data accurately at* [the Provider]*"*. In a telephone call to the Provider dated 28 February 2018, the Provider's representative asked the Complainant if he could *"ask one question that [the Complainant] mentioned there earlier in the conversation…What would happen if* [the Complainant]

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changed address? How would [the Provider] *know if* [he] *changed address unless* [he came] *to* [it] *and tell* [it] *that* [he has] *moved address or changed* [his] *phone number, how* [is the Provider] *supposed to know where* [the Complainant is] *living?"* The Complainant responded to these questions by saying that *"there's things called registered letters"*.

The Complainant further contends that the Provider has made previous errors when recording personal data and makes reference to the Provider previously recording his childhood address as number two instead of number three on the same street but in a completely different county. The Complainant contends that *"there is now a track record of sloppy inaccurate record keeping with* [the Provider]*"* as asserted in a submission to this Office dated 16 October 2018.

However, it is clear from the copies of the letters sent to the Complainant, submitted to this Office by the Provider as supporting evidence, that the Complainant's current address was recorded correctly on the Provider's letters; his correct address was confirmed to this Office by the Complainant in an email dated 15 February 2019.

The Complainant further asserts in a telephone call to the Provider dated 28 February 2018 that he *"will not be punished because* [the Provider's] *systems break down because* [it has his] *incorrect details because* [it] *allegedly issue letters which don't arrive"*. Whilst it is of course possible that the Complainant did not receive one letter of notification from the Provider regarding his missed payment, it seems unlikely that the Complainant did not receive all four letters in May and June 2017 or that such correspondence repeatedly went astray in the post. Indeed, the Complainant does not mention in any written submission or in any telephone call that he has had prior issues with the postal service in the past.

In addition, the Provider further submits that it does *"not place outbound calls in relation to direct debit defaults that have occurred because of insufficient funds in the account. Due to the volume of defaults received, it would not be possible to guarantee enough time to place a call to each member. Instead, all communication for this type of default is sent by post to ensure that each member is notified in a timely manner."*

The Complainant was at all times obliged to ensure that there were sufficient funds in his nominated bank account to cover his monthly commitments and it was for him to ensure that the premiums were paid on time to the Provider. It would appear that the Complainant went almost ten months without realising that his monthly health insurance premiums were not being deducted from his bank account. In a telephone call to the Provider dated 28 February 2018, the Complainant asserts that he pays *"very little attention to these things"* and further acknowledged that the defaulted payment that instigated the cancellation *"was [his] fault on the bank end"*. He contends, however, that it is *"irresponsible on the* [Provider] *that there's not some onus on* [it]*"*.

Having examined the complaint above, I do not accept that the Provider either wrongly cancelled the Complainant's health insurance policy or that it did not communicate the pending cancellation and ultimately the actual cancellation to him. It is my Preliminary Decision therefore, on the evidence before me, that this complaint cannot reasonably be upheld.

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<u>**Conclusion**</u>

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

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.

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION AND LEGAL SERVICES

8 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.