An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0154
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Rejection of claim - did not meet policy definition of illness
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants incepted a dual life assurance policy with the Provider on **8 November 2005**, via the First Complainant in his capacity as a financial broker, which provides them with life cover in the amount of €100,000 and specified illness cover of €65,000 for a term of 14 years, that is, **to 8 November 2019**.

The Complainants' Case

The First Complainant sets out the Complainants' complaint, as follows:

> *"On* [date redacted] *I suffered a sudden 'Cardiac Arrest' while out walking. My heart and breathing stopped. A passer-by administered CPR until an ambulance arrived. I was clinically dead for [duration redacted] minutes. I spent the next [time period redacted] days in a coma in [hospital name redacted] Hospital Intensive Care and 4 days in Cardiac Care Unit, where I had a defibrillator (ICD) fitted in my chest. This has been a life changing event which had left me with severe depression.*
>
> *I submitted a serious illness claim to* [the Provider]*, which was rejected. I was devastated as I took this policy out to assist with my mortgage in the event of a serious illness. Apparently Cardiac Arrest was not covered under my plan but is covered under current plans. I believe that* [the Provider's] *Product Development made a very serious omission prior to 2005 by not including Cardiac Arrest and then*

corrected this omission in 2012. I believe that for such a very serious illness, [the Provider] *should have made it retrospective"*.

As a result, the First Complainant would like the Provider to *"pay the benefit of €65,000 for the serious illness. However, if they still refuse, because it is not in the terms, I then want to request a payment of the life assurance portion (€100,000). In the terms…it states "a life cover benefit event will happen when a life assured dies". It clearly does not differentiate between a person being 'BIOLOGICALLY DEAD' or 'CLINICALLY DEAD'. I was clinically dead for [duration redacted] mins and can provide relevant medical evidence. However, I cannot submit a claim without a death certificate. I feel that if* [the Provider] *want to stand by their small print – then the life assurance amount should be paid out"*.

In addition, the First Complainant notes that in July 2017 and again in November 2017 he requested from the Provider a copy of the terms and conditions of the Complainants' policy but *"on both occasions, I did not receive* [these]*"*.

The Provider's Case

Provider records indicate that the Complainants incepted a dual life assurance policy with the Provider on 8 November 2005, via the First Complainant in his capacity as a financial broker, which provides them with life cover in the amount of €100,000 and specified illness cover of €65,000 for a term of 14 years, that is, to 8 November 2019.

The Provider received an email on **26 January 2017** advising of the First Complainant's condition and requesting that it contact Mr J., a third party authority, to discuss a possible specified illness cover claim. The Provider telephoned Mr J. the following day, 27 January 2017, and left a voice message. During its subsequent telephone call with Mr J. on 30 January 2017, the Provider provided details of the specified illness cover and advised that cardiac failure was not one of the specified illnesses listed under the Complainants' policy for cover.

The First Complainant then telephoned on **31 January 2017** requesting details of the Complainants' policy and the Provider posted the Complainants their policy schedule on 1 February 2017. The First Complainant telephoned again on **7 February 2017** requesting the terms and conditions of the Complainants' policy and the Provider emailed the First Complainant these terms and conditions later that same day.

The First Complainant telephoned the Provider on **10 February 2017**. During this call, the Agent explained the policy definition of *"Heart attack"* and *"Coma"*, specifically the requirement for permanent neurological deficit and the First Complainant was advised that cardiac failure was not covered by the terms of the Complainants' policy and he was advised to review the terms and conditions with his medical attendant.

The First Complainant next telephoned on **17 February 2017** requesting further information. In response to this query, the Provider emailed the First Complainant later that same day with three attachments, namely, the terms and conditions of the Complainants' policy, information on retrospectively added illnesses and a specified illness cover claim form.

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The Provider received a completed specified illness cover claim form from the First Complainant on **25 May 2017** detailing the illness for which he was claiming as *"Cardiac Arrest 18.1.2017. Heart stopped. Passer-by applied CPR + called ambulance. Defibrillator applied".* Whilst this illness is not covered under the Complainants' policy, in order to ensure that it gave full consideration to his condition in order to establish whether he suffered anything that was otherwise covered, the Provider requested medical information from the First Complainant's Consultant Cardiologist, Dr D.

The medical report received from Dr D. on 27 June 2017 confirmed that the First Complainant had not been diagnosed with one of the specified illnesses listed in the Complainants' policy terms and conditions. As a result, in its correspondence dated **12 July 2017**, the Provider advised that Complainants, as follows:

> *"I am writing in connection with the Specified Illness Cover claim submitted in respect of* [the First Complainant] *…*
>
> *We have now concluded our investigation and I regret to inform you that we are not in a position to admit your claim.*
>
> *We assessed your claim against the plan definition of Heart Attack under Section 4.6 of your plan Terms and Conditions which states;*
>
> *"The death of a portion of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction:*
>
> - *typical chest pain;*
> - *new characteristic electrocardiographic changes;*
> - *the characteristic rise of cardiac enzymes, troponins or other biochemical markers;*
>
> *whereby all of the above shows a definite acute myocardial infraction. Other acute coronary syndromes, including but not limited to angina, are not covered under this definition"*.
>
> *During our assessment of your claim we received medical evidence from* [Dr D.]*, Consultant Cardiologist.* [Dr D.]*'s report confirmed that* [the First Complainant] *did not suffer a heart attack and it is for this reason we cannot consider your claim under the above definition.*
>
> *In his report,* [Dr D.] *confirmed* [the First Complainant] *was* (sic) *suffered a cardiac arrest. We note an implantable cardioverter-defibrillator was inserted on the [date redacted] 2017"*.

In addition, the Provider later upheld this decision to decline the specified illness cover claim upon review on **28 October 2017**. In this regard, the Provider is satisfied that the First

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Complainant's diagnosis of cardiac failure is not one of the specified illnesses or conditions contained in the Complainants' policy. This fact is not disputed by the Complainants. As a definition of one of the listed specified illnesses has not been met, the Provider is not in a position to admit a specified illness cover claim.

The Provider has no record of the Complainants requesting the terms and conditions of their policy in July or November 2017. However, Provider records do indicate that the First Complainant telephoned the Provider on **4 October 2017** requesting policy documents and a policy schedule was posted to the Complainants the following day. He telephoned again on **12 October 2017** to this time request *"plan documents and anything that would have been sent out with the plan document at the time"*. A policy schedule was again posted to the Complainants the following day. In this regard, the Provider notes that due to an apparent genuine miscommunication on 4 October and 12 October 2017 a policy schedule was sent, rather than the policy terms and conditions. The Provider acknowledges that the First Complainant wanted to receive a copy of the policy terms and conditions in October 2017; however, his request was not clear and was not interpreted as he desired by the Agent. The Provider notes that not only was the phrase 'terms and conditions' not used during either telephone call, but in any event the Provider had earlier furnished the Complainants with their policy terms and conditions, in February 2017.

The Provider is not in a position to pay a specified illness cover claim as the First Complainant's condition is not one of the specified illnesses listed in the Complainants' policy. In addition, it is not in a position to pay a life cover claim as the First Complainant is not dead. The Provider requires a Death Certificate, as outlined in the policy terms and conditions, before paying a life cover claim. This is a fundamental and standard requirement across the industry and the Provider disagrees that such a requirement is relying on *"small print"*. In addition, when the terms and conditions of the Complainants' policy are read in their entirety, it is clear that the Provider will not pay a life cover claim to a living person. Furthermore, it is not credible that the requirement of a death certificate can be dismissed by the Complainants as *"small print"* and therefore not applicable, yet the omission of the word 'biologically' in relation to describing a death, which is likely to offend most, could be relied upon by the Complainants to secure payment of a life cover claim to a living person.

The Provider retrospectively added eight illnesses to the Complainants' policy in **April 2010**, along with cover for three partial payment conditions at no extra cost.

Later, in **May 2011**, the Provider was the first in the Republic of Ireland to introduce specified illness cover for cardiac arrest with insertion of a defibrillator. This had certainly not been omitted in error previously, as suggested by the Complainants. Since introducing this illness, five other insurance providers in the Irish market now provide this cover. The Provider did not retrospectively add cover for cardiac arrest with insertion of a defibrillator to the Complainants' policy as it had done with other illnesses in April 2010, and this appears to be a significant source of their grievance. In this regard, the Provider considers that it is unreasonable and unrealistic to imagine that it could be possible to retrospectively add illnesses indefinitely. Plans are priced based on the illnesses covered at the inception of the policy in question. The fact is the Complainants' policy was not priced to cover cardiac failure, and thus it was not added retrospectively at a later date.

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In addition, the Provider does not consider it appropriate to write to customers directly to encourage discontinuation of a previously recommended protection plan. The Provider employs committed financial advisors who, prior to making any recommendation on a financial product, carry out a financial and personal assessment. Information on new products is provided to the Provider's financial advisors and to independent Financial Brokers alike. This information can then in turn be reviewed during a financial review at which time cover can be compared and considered. The Provider notes that in this case the First Complainant is himself an independent Financial Broker who arranged the sale of the Complainants' policy in November 2005 himself. It would appear therefore that he is his own financial advisor and it is he – not the Provider – who is obliged to inform himself of developments in the market. Furthermore, in his capacity as an independent Financial Broker, the First Complainant would have been provided with, and had access to significant documentation and sales material relating to all of the Provider's protection products.

Accordingly, the Provider is satisfied that it declined the First Complainant's specified illness claim and life assurance claim in accordance with the terms and conditions of the Complainants' policy.

The Complaints for Adjudication

The Complainants' first complaint is that the Provider wrongly or unfairly declined the First Complainant's specified illness cover claim. The second complaint is that the Provider also failed to furnish the Complainants with a copy of the relevant terms and conditions of their policy despite two requests by the First Complainant in July and November 2017 for it to do so.

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 5 April 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.

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

In this regard, the Complainants incepted a dual life assurance policy with the Provider on 8 November 2005, via the First Complainant in his capacity as a financial broker. The policy provides them with life cover in the amount of €100,000 and specified illness cover of €65,000 for a term of 14 years, that is expiring on **8 November 2019**.

The First Complainant completed a specified illness cover claim form on 17 May 2017 detailing the illness for which he was claiming as *"Cardiac Arrest [date redacted]. Heart stopped. Passer-by applied CPR + called ambulance. Defibrillator applied"*.

As part of its assessment of this claim, the Provider requested medical information from the First Complainant's Consultant Cardiologist, Dr D. and the Provider concluded from his ensuing medical report dated 26 June 2017 that the First Complainant had not been diagnosed with one of the specified illnesses listed in the Complainants' policy terms and conditions. As a result, the Provider declined the First Complainant's specified illness cover claim by way of correspondence dated **12 July 2017**. In addition, the Provider later upheld its decision to decline the specified illness cover claim upon review on **28 October 2017**. In this regard, the Provider is satisfied that the First Complainant's diagnosis of cardiac failure is not one of the specified illnesses or conditions contained in the Complainants' policy and thus it is not in a position to admit a specified illness cover claim.

The Complainants' policy, like all insurance policies, does not provide cover for every eventuality; rather the cover with be subject to the terms, conditions, endorsements and exclusions set out in the policy documentation. In this regard, Section 4, 'Your cover', of the applicable Terms and Conditions Booklet provides at pg. 10, as follows:

> *"4.6 A life assured is 'diagnosed as having a specified illness' if on a date after the start date and before the expiry date of the specified illness cover benefit, the life assured has:*
>
> - *undergone any surgery defined in a plan definition below; or*
> - *been diagnosed as having one of the illnesses or medical conditions referred to in a plan definition below.*
>
> **A. *Alzheimer's disease*** *…*
> **B. *Benign brain tumour*** *…*

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C. Cancer *…*
D. Cardiomyopathy …
E. Coma *…*
F. Coronary artery surgery *…*

G. Heart attack

Plan definition
The death of a portion of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction:

- *typical chest pain;*
- *new characteristic electrocardiographic changes;*
- *the characteristic rise of cardiac enzymes, troponins or other biochemical markers;*

whereby all of the above shows a definite acute myocardial infraction. Other acute coronary syndromes, including but not limited to angina, are not covered under this definition.

In simpler terms
A heart attack (myocardial infarction) happens when an area of heart muscle dies because it does not get enough blood containing oxygen. It is usually caused by a blocked artery and causes permanent damage to the part og the heart muscle affected. The blockage is usually caused by a clot (thrombosis) where the artery has already grown narrow. You can claim if you are diagnosed as having suffered death of heart muscle …

H. Heart value and structural surgery *…*
I. HIV infection or AIDS as a result of a blood transfusion *…*
J. HIV infection or AIDS as a result of an occupational injury (available to certain occupations only) *…*
K. HIV infection or AIDS as a result of a physical assault *…*
L. Kidney failure *…*
M. Loss of hearing *…*
N. Loss of independence *…*
O. Loss of sight *…*
P. Loss of speech *…*
Q. Loss of two or more limbs *…*
R. Major organ transplant *…*
S. Motor neurone disease *…*
T. Multiple sclerosis *…*
U. Paralysis of two or more limbs *…*
V. Parkinson's disease *…*
W. Severe burns *…*
X. Stroke *…*
Y. Surgery to the aorta".

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I note that on 1 April 2010, an additional eight illnesses were retrospectively added to the Complainants' policy, namely, aplastic anaemia, bacterial meningitis, Creutzfeldt-Jakob disease, dementia, encephalitis, liver failure, progressive supranuclear palsy and systemic lupus erythematosus. In addition, three partial payments for €15,000 were also retrospectively added at that time for ductal carcinoma in-situ, loss of one limb and the surgical removal of one eye. In this regard, I am satisfied that the Complainants' policy only provides specified illness cover in respect of those specified illnesses listed in the policy conditions and only where the diagnosis meets the definition of the specified illness provided therein.

The First Complainant completed a specified illness cover claim form on 17 May 2017 detailing the illness for which he was claiming as *"Cardiac Arrest [date redacted]. Heart stopped. Passer-by applied CPR + called ambulance. Defibrillator applied".*

In his medical report dated 26 June 2017, the First Complainant's Consultant Cardiologist, Dr D. advises, *inter alia,* as follows:

> *"Question 3:*
> *(b) Please describe the symptoms in detail.*
>
> ***OOHCA*** [out-of-hospital cardiac arrest]
> ***Bystander CPR***
> ***ROSC*** [return of spontaneous circulation] ***follow external defibrillation*** *…*
>
> *Question 5:*
> *What treatment did the claimant receive?*
>
> ***AICD*** [automatic implantable cardioverter defibrillator] ***implant*** *…*
>
> *Question 8:*
> *Did the claimant undergo surgery? (e.g. angioplasty, coronary artery by-pass grafting)*
>
> ***AICD*** [automatic implantable cardioverter defibrillator] ***implant*** *…*
>
> *Question 9:*
> *Was the diagnosis of myocardial infarction made? Yes ☐ No ✓*
>
> *Question 10:*
> *When was this diagnosis made and by whom?*
>
> ***VF*** [ventricular fibrillation] ***diagnosed by Paramedics****"*.

The Complainant also points out, in a recent submission to this office that:-

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> "*Another term that has been used by another cardiologist for this condition is… RESUSITATED SUDDEN CARDIAC DEATH*."

The Complainant has also supplied an additional letter from his consultant cardiologist dated 4 April 2017 which references the Complainant's "*emergency presentation following necessitated out of hospital cardiac arrest*."

It is notable however, that the cardiac failure suffered by the Complainant was not accepted by the Provider as a "*heart attack*" within the meaning of the policy definition as outlined above at Page 3, which requires specific evidence of acute myocardial infarction. The Provider relies upon the Complainant's consultant cardiologist's report which confirmed that the Complainant did not suffer a heart attack, and rather that he suffered a cardiac arrest which gave rise to the need for the insertion of "*an implantable cardioverter-defibrillator".*

I am satisfied that it was reasonable for the Provider to conclude from the medical evidence before it that the First Complainant did not suffer a heart attack as defined in the Complainants' policy terms and conditions and thus his diagnosis was not one of the specified illnesses listed therein. As a result, I am satisfied that the Provider declined the First Complainant's specified illness cover claim in accordance with the terms and conditions of the Complainants' policy.

I note that the First Complainant submits that *"Cardiac Arrest was not covered under my plan but is covered under current plans. I believe that* [the Provider's] *Product Development made a very serious omission prior to 2005 by not including Cardiac Arrest and then corrected this omission in 2012. I believe that for such a very serious illness,* [the Provider] *should have made it retrospective"*. In this regard, I note that in May 2011, the Provider introduced cover for cardiac arrest with insertion of a defibrillator, to new insurance plans commencing from that date and it did not retrospectively add cover for cardiac arrest with insertion of a defibrillator to existing plans, including the Complainants' policy, which had been incepted in November 2005.

Whilst I note that in April 2010 the Provider did retrospectively add cover at no extra cost for an additional eight specified illnesses and three partial payments for three other specified illnesses to the Complainants' policy, this was a matter for the commercial discretion of the Provider and I am satisfied that it is under no obligation to add specified illnesses to the Complainants' policy during its term, regardless of whether it is offering such cover under its new policies. In this regard, the Complainants' policy was incepted in November 2005 and was priced based on the cover provided at that time. In addition, I note it was always open to the Complainants to cease their policy and incept a new policy with the Provider, or indeed with a different provider, which offered cover for cardiac arrest with insertion of a defibrillator, and pay the additional cost for this extra cover, if that particular cover was something they wanted. The First Complainant is a financial broker and was in an advantageous position in that regard, in selecting the precise policy from the market, which he believed would be appropriate for the Complainants.
The First Complainant questions, *"when 'Cardiac Arrest' was introduced to their term plan in 2012 – did* [the Provider] *write to clients informing them that they could reapply for cover*

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so as to include new benefits?" In this regard, I accept the Provider's position that it does not consider it appropriate to write to customers directly to encourage discontinuation of a previously recommended protection plan. Indeed, I consider that such a communication would have been inappropriate, as the consequences of replacing an existing policy with a new policy, can be very serious for a policyholder. I also accept that in any event, the First Complainant, in his capacity as an independent Financial Broker, would have been provided with, and had access to significant documentation and sales material relating to all of the Provider's protection products, including its new products.

Furthermore, the First Complainant notes that the terms and conditions of the Complainants' policy *"states "a life cover benefit event will happen when a life assured dies". It clearly does not differentiate between a person being 'BIOLOGICALLY DEAD' or 'CLINICALLY DEAD'. I was clinically dead for [duration redacted] mins and can provide relevant medical evidence. However, I cannot submit a claim without a death certificate. I feel that if* [the Provider] *want to stand by their small print – then the life assurance amount should be paid out"*. In this regard, Section 7, 'Claims', of the applicable Terms and Conditions Booklet provides, *inter alia*, at pg. 30, as follows:

> *"If you are claiming for the death of a life assured…we are entitled to ask for proof of death in the form of a death certificate"*.

It is clear that the First Complainant is not in a position to satisfy this policy condition and provide a death certificate as, happily, he is currently alive, regardless of the events of [date redacted], when he was previously *"clinically dead for [duration redacted] mins and can provide relevant medical evidence"*. I am satisfied that it is an industry standard that life cover cannot be paid where the life assured remains alive.

Finally, the First Complainant states that *"in July 17 and again in Nov 17 – I requested a copy of all documentation that was sent to me in 2005. On both occasions – I did not receive 'Terms & Conditions'"*. I note that the Provider has no record of the First Complainant requesting the terms and conditions of the Complainants' policy in either July or November 2017. However, I have listened to a recording of a telephone call the First Complainant made to the Provider on 4 October 2017 and note the following exchange:

Agent:	*So you're just looking for a copy of your plan schedule?*
First Complainant:	*Yeah, a copy of the policy document that was originally sent out and I assume any, you know, conditions or whatever come with it, isn't that right? … So a copy of the policy document please.*

I have also listened to a recording of a telephone call the First Complainant made to the Provider on 12 October 2017 wherein he requested a Final Response letter and note the following exchange:

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First Complainant: *I did put in a request for a copy of the policy document to be sent out to me … would you do me a quick favour, would you just request a copy of that document to be sent out to me -*

Agent: *Ok, so just a copy of the plan doc?*

First Complainant: *Yeah, and anything that was sent out to me with that"*.

Following both calls, the Provider posted the Complainants their policy schedule. I note that the Provider acknowledges that the First Complainant wanted to receive a copy of the policy terms and conditions in October 2017; however, his request was not interpreted as he desired by the Agents in question during the telephone calls on 4 October and 12 October 2017. I note however that the Provider had earlier furnished the Complainants with their policy terms and conditions on two separate occasions in February 2017.

I further note from the documentary evidence before me, that at the time when the policy was incepted, the Provider wrote to the Complainants on **8 November 2005**, as follows:

> *"Your welcome pack contains important information about your plan and we recommend you study these documents carefully to make sure the type and amount of cover are in line with your expectations. This pack includes the following: …*
>
> - *A **terms and conditions** booklet, which sets out your plan rules in plain English"*.

The First Complainant advises that *"I have no record of ever having received terms and conditions in 2005"*. In this regard, I also note that during his telephone call to the Provider on **31 January 2017** that the First Complainant advised the Agent that *"in my office there was very serious flooding going back some years ago and I lost kind of half my paper files and I'm only realising my own file was among those files"*.

I note that in those circumstances the Provider sent the Complainants their policy schedule on 1 February 2017 and after another telephone call, also emailed the First Complainant the terms and conditions of the policy on 7 February 2017. A further copy of the policy document was then sent again on 17 February 2017.

It was certainly an error on the Provider's part that the terms and conditions of the policy i.e. the full policy document was not sent to the Complainants in October 2017, on foot of the content of the telephone calls which are quoted above on Page 9. Although the Complainants had been sent a copy of the policy document twice in February 2017, this request was being made some 6 months later. Whatever had occurred whereby the Complainants were unable to access the policy document sent to them in February 2017, in my view the Provider ought to have facilitated the request which was made again in October 2017.

Whilst objectively this may be considered a minor error, I am conscious that the First Complainant had been through a very significant event in [date redacted], and was in the

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process of giving further consideration to the decision of the Provider in July 2017 to decline the claim for benefit. In my opinion, the Provider should have responded to his clear request at that time by issuing the policy document to him again, if he required it.

Accordingly, on the basis of the evidence before me, I am satisfied that the Provider was entitled to decline the Complainants' claims for benefit and accordingly the substantive complaint cannot be upheld. I believe it appropriate however, to partially uphold this complaint in light of the Provider's failure to respond to the First Complainant's request for a copy of the full policy document, twice in October 2017.

To mark that finding I direct the Provider to make a compensatory payment to the Complainants in the sum of €250, to an account of the Complainants' choosing, within a period of 35 days of the Complainants' nomination of account details to the Provider.

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(20 (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 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 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

23 May 2019

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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.