An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0226
Sector:	Insurance
Product / Service:	Personal Accident
Conduct(s) complained of:	Lapse/cancellation of policy Maladministration
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants incepted a life insurance policy with the Provider on **24 February 2015**. This policy provided the First Complainant with cover for life, specified illness, accidental injury, hospitalisation payment and broken bones. The underwriter of the policy was a separate financial service provider (referred to below as the insurer).

Following an accident at work, the First Complainant made a claim under his policy in or around **2016** but the insurer declined to admit the claim and ultimately voided the Complainants' policy on the basis that the First Complainant's occupation recorded on the proposal form was misleading and had failed to disclose the nature of the First Complainant's occupation, which included manual duties.

The complaint is that the Provider failed to accurately record the First Complainant's occupation details at the point of sale of the policy, thereby leading to the Complainants' policy being voided from inception, by the insurer.

The Complainants' Case

The Complainants submit that when the policy was sold, details were incorrectly recorded in respect of the First Complainant's occupation during a sales meeting held with the Provider.

The First Complainant states that-

> *"I believe that my position has been misrepresented at your side at the time of me joining the policy and you should take the responsibility for not taking down the information correctly …".*
>
> *"I have clearly explained my role and my duties to your agent at the time of joining and not quite sure where the word "admin" came from in my position"*

The First Complainant states that he was told by the Provider that he would have to correct the details on his insurance policy as he had given the wrong details at the time of purchasing the policy. The First Complainant sought to show that the details were correct from the time of the inception of the policy, with documents that were filled out when purchasing the policy, that reflected the First Complainant's job description.

The First Complainant states that he told the Provider in February 2015, that he required insurance as his job title had changed to a 'team leader' and that there was a greater risk associated with this position.

The First Complainant states that he received a text message from the Provider outlining that he never informed the Provider that his job would involve operating a fork-lift and pallet truck. The First Complainant was informed by the Provider that it had a cheque in the amount of €300 for him, however, in order to receive the cheque he would need to sign a special terms letter.

The First Complainant states that on **11 December 2016** the Provider wrote to him to inform him that his policy had been terminated and that if he wanted insurance cover he would have to purchase a new policy. The First Complainant asked the Provider what the reason was for terminating the policy. He states that the Provider told him that the policy was terminated as he did not sign the special terms letter, which would alter the premium payable by the First Complainant.

The Complainants did not sign the policy upgrade letter as requested by the Provider and the policy was cancelled from inception by the Insurer, and a refund of premium totalling €973.98 was issued to the Complainants.

The First Complainant states that the Provider knew that he worked as a team leader from the time of the inception of the policy. He further submits that the Provider stated that the 'team leader' position is more dangerous than 'team leader admin'.

The Complainants are seeking for the Provider to pay compensation in the amount of €1,500 comprising medical expenses, ongoing treatment, loss of income and back injury compensation.

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The Provider's Case

The Provider submits that it became aware of the error in the job description on the Complainants' policy after the accident had occurred.

The Provider states that at the time of purchase of the policy, the First Complainant disclosed his occupation as "team leader" and verbally clarified that he had administrative responsibilities only.

The Provider states that following the First Complainant's accident it requested a Personal Accident Claim form from the Insurer. On **12 February 2016** a completed claim form was forwarded by the Provider to the Insurer.

By letter dated **2 March 2016** from the Insurer to the Complainants, the First Complainant was asked to confirm his exact occupational duties.

Following confirmation of the First Complainant's occupational duties, the Provider noted that

> *"…on his application form was noted as being a Team Leader, with admin work only. However his occupation on the claim form was a Team Leader but his duties also include forklift driving, PPT driver loading and unloading trucks and machinery operator"*

By letter dated **13 April 2016,** the Insurer wrote to the Complainants in relation to the details of his occupational duties

> *"Having reviewed the information* [the First Complainant] *supplied regarding his occupation, had we been aware of his exact occupational details when he applied for his policy, a higher premium would have been charged in respect of his Accident Payment and Broken Bones Payment benefits"*

The First Complainant was asked by the Insurer to sign a special terms acceptance letter which would require a higher premium payment of €55.32 excluding government levy. The First Complainant was advised that upon receipt of the signed special terms acceptance letter, the Insurer would review his claim further.

A letter dated **15 July 2016** from the Insurer to the Complainants advised them as follows:-

> *"Thank you for the additional information that you sent in relation to your Accident Payment claim.*
>
> *Based on representations made by your broker we have agreed to admit your claim without receipt of the signed special terms letter. I enclose a copy of our original Special Terms letter, please note we require them to be completed by you and returned to us.*

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Please find enclosed a cheque for €300. This is payment of your benefit from the 5 February 2016 to the 1 March 2016. We note that you were fit to return to work on the 1 March 2016. The first 2 weeks of this claim are not payable in line with the policy terms and conditions.

Accident payment benefit is payable for a maximum of 52 weeks in total over the duration of the policy. To date, 2 weeks have been paid on your policy.

We have also written to your broker [the Provider] *who will be available to help with any queries you may have regarding your claim or policy cover.*
…".

The Provider received a letter dated 15 July 2016 from the Insurer, which advised:-

"Please find enclosed a cheque and letter for you to pass on to your customer.

We would be grateful if you would get [the First Complainant] to sign the Special Terms letter before passing on the cheque.
…".

The Provider states that the First Complainant refused to sign the special terms letter and he would not accept the cheque. The Provider states that it spoke with the First Complainant on **19 July 2016** to further discuss his claim and job description. An email from the Provider to the First Complainant on 19 July 2016 asked:-

"Can you please send written confirmation from your employer regarding your full job description. A scanned copy sent to this email will suffice."

Subsequently, following a query raised by the First Complainant, which advised the Provider that:-

"Because my work …. Don't understand what you want … from them, they already gave you my work description."

the Provider wrote to the First Complainant on 29 July 2016 confirming as follows:-

"We will need your employer to give us your exact job title and a description of your daily duties. If your employer can write a letter from the company with these details, and we can progress the details further."

I note that subsequently, a job description, including a list of duties and responsibilities was received by the Provider and passed to the Insurer on **12 August 2016**. I note that the Insurer subsequently wrote to the Complainants on **18 August 2016** confirming that it had written to the employer seeking some additional information regarding the First complainant's occupation.

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By letter dated **30 August 2016** from the Insurer to the First Complainant, the Provider confirmed that it received a detailed description of the First Complainant's daily duties.

> *"I regret to advise you that our Underwriters are satisfied that had we been provided with full details of your occupational duties when you proposed for cover under the above contract, additional loadings would have applied to your Accident Payment and Broken Bones benefits.*
>
> *Therefore, the decision remains as per our letter to you on April 13 last. The result is that in order to maintain your cover your premium must increase to €55.32 per month.*
>
> *Under the circumstances and as a gesture of goodwill we have paid your Accident Payment claim in full for the sum of €300. The cheque was forwarded to your broker on July 15 last. We have also agreed to waive the arrears accruing on your policy of €202.02 (€11.39 per month from March 2015 to August 2016). However, please note that with immediate effect the monthly premium of €55.32 is due.*
>
> *Please note that if we do not receive your response within 14 working days we will assume that you do not wish to accept the revised terms and the Accident Payment and Broken Bones Payments will be removed from your policy"*

By letter dated **10 November 2016,** the Insurer wrote to the Complainants as it had not received any response to its correspondence.

> "*It was necessary for* [Insurer] *to issue revised terms when we became aware of the true nature of your occupation. I note that you did not return the revised terms issued to you on 13 April 2016.*
>
> *Under the circumstances I have agreed to cancel your policy and refund all premiums paid. You should note that your policy has now ceased and no further benefit is payable. Please find enclosed a cheque for €973.98."*

The Provider received a letter of complaint from the First Complainant dated **16 February 2017** advising, *inter alia*, as follows:-

> *"I note from your internal notes that my position is stated as "Team Leader Admin" however I have never indicated in my application form that my position was of administrative nature. Also I note that your internal form is <u>not signed</u> by me.*
> *… I believe that my position has been mis-interpreted at your side at the time of me joining the policy and you should take the responsibility for not taking down the information correctly…*
> *I will not be signing any policy upgrade forms until my claim is closed and paid in full."*

This letter was responded to by the Provider on **1 March 2017** which included the following:-

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"I would… like to bring to your attention to the letter which was sent to on the 04th of March 2015, a copy of which is enclosed. It does clearly state that if any of the information is incorrect or incomplete, you must notify us in writing within 10 working days. Unfortunately, the only time that we became aware of this error was when your accident occurred.

In relation to the internal form not signed, this is not a requirement, as this internal form is just an exact copy of what was completed with you at the point of sale.

Again, I draw your attention to the section under "Important Details" where it again asked you to return or amend any information which you felt was inaccurate at the time via a freepost address. "

The Complaint for Adjudication

The complaint is that the Provider failed to accurately record the First Complainant's details at the point of sale of the policy, in particular, his occupation.

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 Complainants were 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 8 July 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.

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

The Complainants submit that when their insurance policy was sold, details were incorrectly recorded in respect of the First Complainant's occupation, by the Provider.

The policy provided the First Complainant with cover for life, specified illness benefit, accident payment, hospitalisation payment and broken bones payment.

In 2016, the First Complainant had an accident at work and submitted a personal accident claim form to the Insurer. It was at this point that an issue arose in relation to the First Complainant's occupation, from which this complaint arises. In the context of the claim, the First Complainant was asked to provide further information in relation to his occupational duties.

From the documentary evidence before me, I note that the proposal for insurance from the Complainants to the Insurer in March 2015, was processed and gave rise to a policy being incepted on the basis of the First Complainant's occupation of *"Team Leader (Admin)"*

The First Complainant states that his position within the company has not changed since he commenced employment there. I note however, that the Complainants were asked to review the policy documentation at the time when the policy commenced, and if any of the information was incorrect they were asked to notify the Provider within 10 days. The Complainants did not make any changes to the policy or tell the Provider that there was any error. Following the Complainant's accident however, when the Insurer made enquiries regarding the nature of the Complainant's occupation, it transpired that the policy premium quoted to the Complainants for the purpose of incepting their policy in March 2015, was lower than if the true nature of the Complainant's occupation had been recorded correctly. It was at that time that the Insurer sought to correct the records and implement the correct premium level, so as to ensure that the policy could continue, on the basis that the risk was properly underwritten.

Whilst the Insurer had a difficulty with admitting the Complainants' claim, given that the correct premium level had not been paid for the risk involved, nevertheless, I note that following the intervention of the Provider, in its capacity as the Complainants' broker, the Insurer agreed to admit the claim and to continue the policy, subject however to the Complainants signing a Special Terms letter in order to correct the details of the risk involved and the accompanying premium, into the future.

The First Complainant was advised that the Insurer was not aware of his exact occupational details when the Complainants incepted the policy, and that if it had been aware, a higher premium would have been charged in respect of Accident Payment and Broken Bones Payment benefits. It was for this reason that the First Complainant was asked to sign a Special Terms acceptance letter which would increase his premium to €55.32 per month, excluding government levy, in order to stay covered for these benefits.

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I note that the Complainants would have had to pay an extra €11.39 per month, excluding government levy to cover the corrected cost of the occupational rating. I also note that it seems that the Insurer was willing to forego the arrears of premium, but wished to ensure that the correct premium was paid into the future, if the policy was to continue.

The Complainants however refused to sign the special terms acceptance letter. I note that following correspondence between the Provider and the Insurer it was agreed that the First Complainant's claim would be admitted without receipt of the signed special terms letter and a cheque of €300 was made payable to the First Complainant.

I further note that by letter dated **15 July 2016** the Insurer had asked the Provider to ensure that the First Complainant signed the special terms letter before passing the cheque onto the First Complainant, despite the First Complainant being advised that he would not have to sign this letter. The Insurer's letter of **30 August 2016** then notified the First Complainant that the claim benefit was paid, as a gesture of goodwill.

The First Complainant did not sign the acceptance letter nor did he accept the cheque. Ultimately, the policy was cancelled from inception, in **December 2016** and a refund totalling €973.98 was issued to the Complainants.

The complaint against the Provider is that it failed to accurately record the First Complainant's details at the point of sale of the policy, in particular regarding his occupation.

In reviewing the evidence on file, I note that there was considerable confusion regarding the precise occupational duties of the First Complainant. The Insurer's primary difficulty with the premium which had been paid for the cover, prior to the First Complainant's accident in 2016, was that his occupation required him to drive a forklift truck, but this had not been made known at policy inception. I note that the document outlining the First Complainant's duties and responsibilities which was sent by the First Complainant to the Provider by way of email on 3 August 2016, does not include any reference to driving a forklift truck; for the most part, it lists administrative duties.

I am also conscious of the contents of an email sent on 14 October 2016 which is included in the evidence made available to this office, which includes the following details:-

> *"I spoke to* [the First Complainant] *at length during the Summer, in July and explained that his job description wasn't as stated on the original application form, to be totally honest he changed his job description to me on 2 occasions during the telephone call and I also explained to him that his claim would be considered and at that stage we knew processed, provided he signed and accepted the "Special Terms" letter with the loading due to his manual and not administrative job.*

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> *At this point the client…categorically stated that his job was "now and had always been" one of an administrative non manual position, I explained that this challenge with his job description had been going on for a while and that when the policy was applied for he had received a copy of the online proposal with his job description listed, and he had not challenged it then and he would now need to have a company headed letter with a comprehensive description of his job sent into* [the Insurer] *if he wished to have his loading reconsidered…".*

At this remove, it is unclear as to how it arose that the Complainant's job description was listed on the proposal to the Insurer as "Team Leader (Admin)" i.e. whether this was an error on the part of the Provider or the Complainant's error in describing his duties, or whether indeed it was simply a mis-communication between them. Whatever the explanation, it is clear that the policy arranged with the Insurer by the Provider, to cover the First Complainant, was not rated to include duties involving his driving of a forklift truck.

Having reviewed the evidence before me however, I note that following the discovery of the error which had occurred, the Provider made every effort to ensure that the Complainant would not prejudiced by the description of his occupation in the original policy proposal. In that respect, I note that the Provider liaised with the Insurer and made an opportunity available to the Complainant to have his claim admitted, notwithstanding the error in his occupation (as described in the proposal) and this opportunity also included the Complainant being able to continue with cover, but on the basis of a premium which more accurately reflected the risks inherent in his occupation, now that those details were fully understood, and indeed the Insurer was willing to forego the arrears.

It is unclear to me as to why the First Complainant was unwilling to sign the Special Terms letter which would have permitted the policy cover to continue on the corrected basis. It is clear however, that he made a decision in the knowledge that if the error could not be corrected, the Insurer would not be in a position to continue making cover available, given the error contained in the original proposal.

In those circumstances, I am firmly of the opinion that the Provider in this instance acted in the Complainant's best interests and took every reasonable step to address the error in the proposal in a way which would not prejudice the Complainant's position. I also note that it was based upon the entreaties of the Provider, that the Insurer agreed to admit the claim for payment, and also offered a solution which would have allowed the cover to continue (in the form of the Special Terms letter and increased premium).

In all of the circumstances, on the basis of the evidence before me, I do not consider that it would be reasonable to uphold this complaint. I do not believe that the evidence made available to this office discloses any conduct of the Provider which was wrongful, such that it would be appropriate to do so.

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Conclusion

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

30 July 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.