An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0255
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Failure to provide correct information Delayed or inadequate communication
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant is 58 years old. He is a member of a Group Income Continuance Plan and a Group Life Plan. The policyholder of both is a Trade Union, the individual members of which can opt to join the Plans through the Provider. The Provider is the administrator of these Plans since **2006**, at which time the Complainant was already a member.

The Complainant's Case

On **31 July 2014**, the Complainant, who was in receipt of income continuance benefit under his Group Income Continuance Plan at the time, retired on ill-health grounds. Thereafter the benefit payments continued.

Subsequently, he received correspondence from the Provider dated 6 October, 10 October and 20 October 2014 that provided him with incorrect, conflicting and confusing information regarding his entitlements under the Group Income Continuance Plan and the Group Life Plan. He placed a telephone call to the Provider on **21 October 2014** to try and confirm his entitlements but this *"further complicated"* matters for him and he notes that the Provider offered no apology at that time, for the errors contained in the correspondence.

In this regard, the Complainant sets out his complaint, as follows:

"When I retired on ill-health grounds in late 2014 I was informed (incorrectly) by [the Provider]:

1. *That I was no longer on cover and they thanked me for my support over the years (letter dated 6th October 2014)*

2. *That my disability claim under the scheme ceased at age 60 (even though I was only 54 at that time!) (*[letter dated] *10th October 2014)*

3. *That I was on cover under the Free Life Cover element of the Group Life Plan until age 65 and that upon reaching age 65 I would be eligible to join the Life Cover Plan for Retired Public Sector Employees which provides cover up to age 85 (and there would be no need for medical underwriting once I joined within 4 months of reached age 65)* ([letter dated] *10th October 2014)*

4. *That my membership and cover of the…Group Life Plan had ceased and I was no longer covered (*[letter dated] *20th October 2014)*

5. *That I could join the Public Sector Retired Members Life Cover Plan (if I had not already applied!) (*[letter dated] *20th October 2014).*

There were a litany of errors made over the course of October 2014 and this was further complicated with a phone call I had with [Ms O.] *on 21st October 2014. I received a letter from…*[the Provider] *dated 27th July 2017, which outlined the errors made by* [the Provider] *regarding my case and the life cover with an apology (and a cheque for €150). I didn't feel at the time, and I still don't feel, that this was an adequate response to the issues identified. I have a number of issues that I feel compelled to address:*

1. *At the time this was all going on I was in transition from full-time employment…where I had worked for the previous 28 years, into retirement on ill-health grounds (due to cancer [melanoma] in my lower right leg). At that stage I had the first melanoma removed but was scheduled for a follow-up appointment with my consultant (which subsequently resulted in the removal of 3 more melanomas).*

2. *I was also undergoing treatment for the first episode of cancer (Interferon)*

3. *When I was working…I always actively encouraged and endorsed the Income Protection and Group Life Plans to colleagues...(in the face of growing disillusionment with both the scheme(s) and the service provider) …*

4. *At NO stage throughout the above process did anybody offer an apology to me or indeed enquiry as to the status of my health i.e. how I was doing. This was only forthcoming within the past 3-6 months – up until then I felt like I was being treated like an annoying customer that would hopefully just go away.*

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The error was only identified when I rang [the Provider] *in early* ***July*** **[2017]** *to confirm the level of cover I had in place and how much it would cost when I reach age 65 (i.e. the option of taking out cover without medical underwriting up to age 85).*
This phone call was made following a conversation I had with a retiring colleague who attended a retirement seminar in [a hotel] *where during a discussion he became aware of the Life Cover option up to age 85.*

All of the above leaves a horrible taste in my mouth regarding my dealing with [the Provider] *that are supposed to have my best interest at heart. I found the whole process extremely distressful (and indeed irritating)…I would expect that the agents appointed to deal with my case would have the relevant product knowledge to advise members of what cover they did and did not have.*

The only satisfactory outcome…is where I am provided with the level of cover I was always of the opinion I had (and informed by [the Provider] *that I had in place) i.e. free cover under the Group Life Plan up until age 65 with the option to join the Public Sector Retired Members Life Cover from age 65 to age 85. The fact that I am a cancer sufferer (& survivor to date!) only increases the importance of life cover. While I will hopefully still be alive at age 65 I most certainly won't by the age of 85 and I want to ensure my wife is adequately provided for (which I thought I was doing all along)"*.

The Provider's Case

The Provider notes that the Complainant is a member of a Group Income Continuance Plan and a Group Life Plan. The policyholder of both policies is a Trade Union, the individual members of which can opt to join the Plans through the Provider. The Provider is the administrator of these Plans since 2006, at which time the Complainant was already a member.

Provider records indicate that with regard to the Group Income Continuance Plan, the Complainant has made two income continuance claims since the Provider became the administrator of the Plan; one in **2011**, which was paid for a period of time, and one in **2014**, which remains in payment. This Plan also provides a specified illness benefit that pays a once off lump sum, in the event the member is diagnosed with one of the listed illnesses covered in the Plan policy document. In this regard, the Complainant made a specified illness claim in **2011** and this was also paid by the Insurer.

The Provider notes that the Complainant retired on ill-health grounds on **31 July 2014**. He remains a member of the **Group Income Continuance Plan** and continues to receive income continuance benefit from it. In accordance with the Plan's terms and conditions, this benefit will cease on his recovery (determined by the underwriters, based on medical evidence, that the Complainant is no longer prevented from doing his normal job because of illness or injury), his return to work, his 60th birthday or his death, whichever is the earliest.

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The Complainant is also a member of the **Group Life Plan**. When the Complainant retired on ill-health grounds in July 2014, he was eligible to remain a member of this Group Life Plan and as agreed with the Insurer, he is not required to pay a premium for this cover.
In accordance with the Plan's terms and conditions, this cover will cease on his 65th birthday or death, whichever is earliest.

The Provider wrote to the Complainant on **6 October 2014**, as follows:

> *"I am writing in connection with the* [Group Income Continuance Plan] *and note that you have recently retired.*
>
> *Therefore, your membership of the* [Group Income Continuance Plan] *has ceased and you are no longer on cover for any benefits.*
>
> *We have made the necessary arrangements to cease the collection of premiums"*.

This letter advised the Complainant that he was not on cover for any benefits, which was incorrect given that he was in receipt of benefit from the Group Income Continuance Plan and continues to be. The Provider notes that this letter was automatically generated when a staff member used an incorrect deletion code to delete the Complainant's membership of the Plan from its system. The staff member was deleting his membership from the system as the Complainant had retired and this was a measure to ensure that the Provider never sought premiums from the Complainant again. The letter that was generated, was appropriate for members of the Group Income Continuance Plan who were retired, but who were not claiming from this Plan.

The Complainant telephoned the Provider the following day, **7 October 2014**, on receipt of this letter. The Agent clarified during this telephone call that the letter the Complainant had received was an automatic letter that was applicable to regular retirees who were not in receipt of a claim and this had been sent to him in error. In this regard, the Agent confirmed that the Complainant's income continuance claim was in payment and as a result he was entitled to, and had free, Group Life Plan membership.

The Complainant asked for this clarification to be sent to him in writing. As a result, the Provider wrote to the Complainant on **10 October 2014**, as follows:

> *"We write with regard to your claim under the* [Group Income Continuance Plan].
>
> *As you are aware, your Disability Claim under the above named scheme ceased at age 60, this is the ceasing age of the Disability Benefit under this scheme.*
>
> *We are now pleased to advise you that as your Disability Claim was in payment up to the cessation age, you are now entitled to Free Life Cover under this scheme up to age 65. Details of this cover are outlined in the enclosed scheme booklet. This is no cost to you for this cover up to age 65.*

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> *Upon reaching age 65 all cover under this scheme will cease, however you will then be eligible to join the Retired Members' Life Cover Plan for Public Sector Employees, which provides member with an element of Life Cover up to age 85, without the need for medical underwriting within 4 months of your reaching age 65"*

This letter, which was manually drafted by a staff member, incorrectly advised the Complainant that his income continuance benefit had *"ceased at age 60"*, even though at the time he was only age 54 and thus had not reached the ceasing age. The letter then correctly advised the Complainant that he had free life cover up to age 65, however it went on to advise incorrectly that at age 65, he would be eligible to join the Retired Members' Life Cover Plan without medical underwriting.

The Provider wrote the Complainant on **20 October 2014**, as follows:

> *"I am writing in connection with the* [Group Life Plan] *and note that you have recently retired.*
>
> *Therefore, your membership of the Scheme has ceased and you are no longer on cover for any benefits.*
>
> *We have made the necessary arrangements to cease the collection of premiums …*
>
> *You now have the option of joining the Retired Members' Life cover Plan.*
>
> *If you have already applied to join the Retired Members' Life cover Plan, we will be in touch with you shortly to advise on the progress of your application.*
>
> *Alternatively, if you have not already applied and are interested in joining the Plan, please contact us and we will forward the necessary forms to you"*.

This letter incorrectly advised the Complainant that he was no longer on cover for any benefits under the Group Life Plan, and that he had the option of joining the Retired Members' Life Cover Plan. The Provider notes that this letter was automatically generated when a staff member used an incorrect deletion code, to delete the Complainant's membership of the Plan from its system.
The staff member was deleting his membership from the system as the Complainant had retired and this was a measure to ensure that the Provider never sought premiums from the Complainant again. The letter that was generated was appropriate for members of the Group Life Plan who were retired, but not claiming from the Group Income Continuance Plan.

The Provider acknowledges that all three letters were contradictory and confusing and the Complainant telephoned the Provider on **21 October 2014** to clarify matters. The Agent did correctly advise the Complainant that his income continuance claim remained in payment under the Group Income Continuance Plan and that as he had now retired, he had free life cover under the Group Life Plan. The Provider accepts however that it is obvious from listening to a recording of this telephone call, that the Agent caused the Complainant

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significant frustration by failing to clearly explain what level of cover he had and how the errors in the letters occurred. The Provider notes that, unfortunately, the Agent did not acknowledge the inaccuracies in the letters, or apologise for these errors.

The Complainant telephoned the Provider on **11 July 2017** to confirm the level of cover he had in place and to ascertain how much it would cost to continue this cover when he reached age 65. It was during this telephone call that an error contained in the Provider's correspondence of 10 October 2014 came to light, insofar as the letter had advised the Complainant, *inter alia*, as follows:

> *"Upon reaching age 65 all cover under this* [Group Life Plan] *will cease, however you will then be eligible to join the Retired Members' Life Cover Plan for Public Sector Employees, which provides member with an element of Life Cover up to age 85, without the need for medical underwriting within 4 months of your reaching age 65"*.

The Provider accepts that its communication to the Complainant in October 2014 was poor and that the errors should have been clarified at that time. The Provider set out clearly the status of his cover on **27 July 2017**, as follows:

> *"I write with regard to your membership of the* [Group Life Plan]*, and in particular your telephone call on the 18th July 2017 and your previous telephone calls on the 11th and 12th July 2017 with my colleague…As per our telephone conversation on the 18th July 2017, I wish to apologise for the poor communication you received from us in October 2014. Please now find below, clarification on the application process for the Retired Members' Life Cover Plan, details of the communication errors that occurred in October 2014 and confirmation of your current level of cover.*
>
> ***Retired Members' Seminar***
> *You advised that you were prompted to contact our office when colleagues of yours had informed you that they attended a retired members' seminar at which they were informed that when they reach 65 they could automatically join the Retired Members' Life Cover Plan without medical underwriting.*
>
> *I discussed the matter that you raised about the retirement seminar with my colleague…Head of Life & Pensions. He confirmed that a number of retirement seminars are held throughout the country to which* [Trade Union] *members who are close to, or who have reached retirement age, are invited. These seminars are specifically concentrated around the area of pensions and do not cover sick pay, Income Continuance Plans, or the* [Retired Members' Life Cover Plan].
>
> *All members in the* [Trade Union] *between the age of 50 and 70 can apply to join the* [Retired Members' Life Cover Plan]. *In order to apply they must complete a Standard Application form which is subject to full medical underwriting by* [the underwriters]*…Applications must be submitted within 12 months of a member's retirement date or free life cover ceasing.*

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***Communication from* [the Provider]**
Our records show that you received three letters from [the Provider] *in October 2014, details of which I have set out below:*

- *6th October 2014 – referred to the Income Continuance Plan, your recent retirement and that you were no longer on cover for any benefits*
- *10th October 2014 – referred to your Disability Claim which ceased at age 60, that you had free life cover to 65, and that you would be eligible to join the* [Retired Members' Life Cover Plan] *without medical underwriting at age 65.*
- *20th October 2014 – referred to the Group Life Plan, your recent retirement and that you were no longer on cover for any benefits and that you now had the option to apply for the* [Retired Members' Life Cover Plan]*.*

Parts of each of these letters were incorrect, and parts of the letters contradicted wording in the other letters and hence we acknowledge that all of the letters are confusing. Letters 1 and 3 were automatically triggered when we manually deleted your policies following your retirement. These letters were for members in the Income Continuance and Group Life Plan who inform us that they have retired, and they did not reflect that you were still claiming from the Plan. Letter 2 was a manual letter, which was issued to you in error and was not reflective that you were still a claimant under the Plan.

After you had received these letters, our records show that you telephoned our office on the 21st of October 2014 to clarify matters and you spoke with my colleague [Ms O.]. *It is obvious from listening to this call that we caused you significant frustration by failing to clearly explain what level of cover you had and how the errors with the letters occurred …*

On reflection, following your telephone call to our office on the 21st October 2014, we should have sent you a letter of apology and explained the exact level of cover you had, We very much regret that none of these actions were completed.

Current Cover
As you had retired on Ill Health Grounds you are maintained in the Group Life Plan free of charge up to your 65th birthday and the level of cover provided to you under the Plan from age 55 to 65 is as follows:

Member's Benefit	*Spouse's Benefit*
€67,500	*€33,750*

I am enclosing the [Trade Union] *Group Life Plan Guide to your Benefits booklet for your records and I direct you to page 5 of the booklet under the heading 'Ill Health Retirees'.*

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> ***Option at age 65***
> *After your free life cover ceases at age 65 you have the option to join the* [Retired Members' Life Cover Plan] *which will be subject to medical underwriting and* [the Provider] *will write to you closer to this time"*.

In acknowledgement of its errors and miscommunication, on **4 August 2017** the Provider sent the Complainant a cheque in the amount of €150, as a tangible measure of its apology.

It is regrettable that the Complainant was under the assumption, due to the incorrect statement in the Provider's correspondence dated 10 October 2014, that he would have access to the Retired Members' Life Cover Plan without medical underwriting on reaching age 65. Nonetheless, I am conscious that this letter has not diminished the Complainant's actual cover or options, that is, he still has the same cover and options afforded to him now, as he did before the incorrect letter was sent to him.

In this regard, as he retired on ill-health grounds, the Complainant enjoys free life cover under the Group Life Plan until he reaches age 65, when he will then have the option to apply for membership of the Provider's Retired Members' Life Cover Plan with medical underwriting. In this regard, the Provider notes that no Group Income Continuance Plan or Group Life Plan member (whether a claimant or not) has, or ever had, the option of becoming a member of the Retired Members' Life Cover Plan without medical underwriting. As administrator, the Provider is not in a position to change the terms of these Plans. Nonetheless, under the circumstances, the Provider did make representations to the underwriters of the Retired Members' Life Cover Plan to determine if they would allow the Complainant enter the Plan without medical underwriting when he turns age 65. Regrettably, the underwriters confirmed that they are not in a position to allow a concession in this regard.

In conclusion, the Provider apologises for the confusion and inconvenience that its communications with the Complainant in October 2014 caused. The Provider is however satisfied that these errors have not diminished the Complainant's cover or options insofar as he still has the same cover and options afforded to him now, as he did before the incorrect correspondence was sent to him in October 2014. Nonetheless, the Provider acknowledges that it gave the Complainant an incorrect expectation in the letter of 10 October 2014, and therefore in December 2018, as a tangible measure of its apology for this and its poor customer service, it advised that it wished to offer the Complainant an amount of €1,000 in full and final settlement of this dispute.

<u>The Complaint for Adjudication</u>

The Complainant's complaint is that the Provider provided him with poor customer service insofar as it furnished him with incorrect and conflicting information regarding his entitlements and options under the Group Life Plan.

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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 12 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.

Following the consideration of an additional submission from the Provider, the final determination of this office is set out below.

The complaint at hand is that the Provider provided the Complainant with poor customer service insofar as it furnished him with incorrect and conflicting information regarding his entitlements and options under the Group Life Plan that he is a member of. In this regard, the Complainant is a member of a Group Income Continuance Plan and a Group Life Plan. The Provider is the administrator of these Plans since 2006.

Following his retirement on ill-health grounds in 2014, the Provider wrote to the Complainant on 6 October, 10 October and 20 October 2014. I note that it is accepted by the Provider that these three letters contained incorrect and contradictory information. The Complainant telephoned the Provider on 21 October 2014 to clarify matters and I have listened to a recording of this call. Having expressed his understandable frustration and upset with the contents of the letters he had received, I note the Complainant advised the Agent that *"if I don't get off the phone, I'll just get annoyed with you"*.

Whilst this deprived the Agent of the opportunity to try to clarify matters for the Complainant there and then, I note that she replied, *"Ok, fair enough, leave it at that and let me look into it"*.

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It is regrettable, particularly given his evident frustration and upset at that time, that the Agent did not then pursue this matter further in any manner which has been evidenced, in order to arrange for the Complainant to be written to, to both clarify matters and to apologise for the errors contained in the letters previously sent.

In particular, in its correspondence to the Complainant dated 10 October 2014, the Provider advised, *inter alia*, as follows:

> *"Upon reaching age 65 all cover under this scheme will cease, however you will then be eligible to join the Retired Members' Life Cover Plan for Public Sector Employees, which provides member with an element of Life Cover up to age 85, without the need for medical underwriting within 4 months of your reaching age 65"*.

I note that this letter incorrectly advised the Complainant that upon reaching age 65, he could apply to join the Retired Members' Life Cover Plan without the need for medical underwriting when such an application would in fact be subject to medical underwriting. The Provider has since advised that no Group Income Continuance Plan or Group Life Plan member (whether a claimant or not) has, or ever had, the option of becoming a member of the Retired Members' Life Cover Plan without medical underwriting and as administrator of the Plan, it is not in a position to change the terms and conditions that apply.

In this regard, I note that the Group Plans that the Complainant is a member of, are not plans listed in the Provider's Retired Members' Life Cover Plan booklet which obtain auto or preferential entry into the Plan with no medical information required.

I note that this error contained in the Provider's correspondence of 10 October 2014 only first came to light when the Complainant and his wife later telephoned the Provider on 11 July 2017, to query his life cover. The Agent acknowledged during this telephone call that the letter contained an error and he correctly advised the Complainant that upon his reaching age 65, his application to join the Retired Members' Life Cover Plan would be subject to medical underwriting. Having listened to a recording of the telephone calls placed between the Complainant and the Provider on 11 July, 12 July and 20 July 2017 in relation to this matter, I am satisfied that the two Agents were courteous, helpful and detailed in their efforts to address the Complainant's complaint.

Nevertheless, I find that the incorrect and contradictory contents of the letters that the Provider sent to the Complainant on 6 October, 10 October and 20 October 2014, within months of his retirement, and the lack of follow-up to his telephone call on 21 October 2014 constituted a level of customer service that was poor and wanting. Indeed, if a thorough review of the letters had been carried out following the Complainant's telephone call to the Provider on 21 October 2014, then it is reasonable to assume that the error contained in the correspondence dated 10 October 2014 (regarding the need for medical underwriting to join the Retired Members' Life Cover Plan) would have been identified at that time, and not some 2½ years later, when the Complainant telephoned the Provider in July 2017.

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Administrative errors and poor customer service are unsatisfactory and can cause considerable confusion and frustration, as was the case in this instance. The Complainant ought to be able to rely on the expertise and administration of the Provider with regard to information concerning his policy cover and options. I note that in acknowledgement of its errors and miscommunication, the Provider sent the Complainant a cheque in the amount of €150 on 4 August 2017.

However, during the investigation of the complaint by this Office, on 14 December 2018, the Provider advised that it would like to offer the Complainant the further amount of €1,000 in full and final settlement of this dispute.

I am mindful that the errors and poor customer service in question have not diminished the Complainant's cover or options insofar as he still has the same cover and options afforded to him now, as he did before the incorrect correspondence was sent to him in October 2014, and that the letter containing the error regarding his life cover options at age 65, was sent to him when he was age 54 and that the error came to light in July 2017, when he was 56.

As a result, I consider that the Provider's offer in December 2018, of a payment to the Complainant in the amount of €1,000 to be very reasonable in these circumstances, though it is disappointing that such an offer was only made, after no less than 4 years had elapsed, since the errors were made.

At the time when the Preliminary Decision was issued to the parties on 12 July 2019, it was not clear whether the Provider's offer remained open to the Complainant for acceptance, but since that time, following a further submission from the Provider, I am satisfied that the Provider offer of December 2018 is one which the Complainant may now still accept.

Taking into account:

- the incorrect and contradictory contents of the letters that the Provider sent to the Complainant in October 2014
- the lack of follow-up to the Complainant's telephone call on 21 October 2014, which left the error contained in the correspondence dated 10 October 2014, unidentified until some 2½ years later (when the Complainant telephoned the Provider in July 2017) and
- the fact that the Provider's inadequate offer to the Complainant of €150 in August 2017 has been more recently followed by an offer of €1,000 from the Provider in December 2018, which is a more appropriate figure in the circumstances, and which is now open to the Complainant to accept,

I do not consider it necessary to uphold this complaint. It will be a matter for the Complainant to communicate directly with the Provider, if he wishes to accept the reasonable offer, which the Provider is making available to him. Should he wish to do so, the Complainant should proceed expeditiously to communicate with the Provider in that regard, as the Provider cannot be expected to hold that offer of compensation open indefinitely.

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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

6 August 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.