An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0268
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Misrepresentation (at point of sale or after)
Outcome:	Upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants incepted a life assurance policy in **November 2004** with a financial service provider (referred to hereafter as "the original provider". The policy was transferred to the Provider in or about **May 2013**. The Complainants contend that the policy provided Personal Accident Benefit cover of €400 per week.

The First Named Complainant (the Complainant) made a claim for Personal Accident Benefit under the policy in respect of an accident that occurred in **August 2017**. The Provider states that the Personal Accident Benefit cover is not €400 per week but the lower of €719 or 50% of the First Complainant's normal weekly earnings at the time of making the claim.

The Complainants' Case

The Complainants state that in **November 2004** they were sold life assurance. The First Complainant states that an agent visited his home and went through what he wanted in the policy. Referring to the Statement of Suitability, the First Complainant states that he asked if he could get accident cover of €400 per week and he says that this was sold to him as part of the policy. In the annual statements the Complainants received from the Provider between 2010 and 2014, it showed the sum of €400 per week for Personal Accident Benefit. However, the First Complainant states that in 2017 this changed to €719 per week.

The First Complainant states that when he spoke with the Provider's agent regarding his claim he was told that it would be settled at €719 per week. The First Complainant states that he paid for a plan that was to provide him with Personal Accident Benefit cover and that is what he should get. The First Complainant states that he was told in 2004, that he "*would get €400 per week, not 50% of my wages*".

The Complainant is dissatisfied that when he found it necessary to make a claim for benefit under the policy in 2017, benefit was ultimately assessed, by the Provider, at a figure of €60 per week. When the Complainant became aware of how the benefit was being assessed by the Provider at that time, he immediately made a complaint and pursued the matter to the Financial Services Ombudsman.

The Provider's Case

The Provider states that every effort was made to inform the Complainants of the restrictions associated with Personal Accident Benefit prior to their decision in 2004 to include it in their application. The Provider states that a copy of the terms and conditions along with all policy documents were issued to the Complainants, on the day the policy commenced. The Provider points to the notice included in the Notes section of the Application Form, regarding the maximum amount payable in respect of Personal Accident Benefit which states that it:

> *"shall not exceed the lesser of €350 per person per week in respect of all policies held or 50% of gross weekly earnings."*

The Provider also states that there is a quotation on file which was generated prior to the Complainants' agreement to apply for the policy which notes on page 4 under the heading Personal Accident Benefit that

> *"[*First Complainant*] covered for an amount EUR 400 per week, subject to this amount not exceeding 50% of pre-tax earnings."*

The Provider states that the policy documents and the terms and conditions explain that Personal Accident Benefit will be the lower of either 50% of weekly earnings or the nominated €400 weekly benefit. The Provider also states that Annual Benefit Statements were issued to the Complainants between 2010 and 2016, outlining the benefits attaching to the policy and that all benefits are subject to the terms and conditions of the policy.

The Complaint for Adjudication

The complaint is that the Provider breached the terms and conditions of the policy by failing to settle the First Complainant's claim for Personal Accident Benefit cover at €400 per week.

The Complainant refers in that regard to the sale of the policy to him in **2004**, and his stated requirements at that time, to secure cover for Personal Accident benefit of €400 per week.

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The FSPO is satisfied in that respect that the Complainants' complaint comes within the time limits set out at ***Section 51*** of the ***Financial Services and Pensions Ombudsman Act 2017***.

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 on 10 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.

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

Evidence

- Personal Financial Profile

The documentary evidence made available to this office includes a copy of a Personal Financial Profile signed by the Complainants on **24 November 2004**. The document contains a number of the Complainants' personal details, and the Statement of Suitability on the final page of the document reads as follows:-

> "[The Complainants] *have the mortgage cover with us*. [Second Complainant] *has SSIA with us*. [First Complainant] *has pension with us.*
> *All is left is the life cover - &S/I. As highlighted in review.*

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250K life cover for [First Complainant]
400K life cover for [Second Complainant]
30K x 2 S/I all is within budget i.e. 150 plus 400 p.w. Personal accident cover as [the First Complainant] *is a taxi man. Wanted w.o.l. policy.*
Cost is v. important.
Budget 150 p.m.
That is why I recommend same."

- **Application Form**

The Application Form is dated **30 November 2004** and has been signed by both Complainants. Section E of the Application Form provides that Personal Accident Benefit of *"€400 per week"* is being applied for by the First Complainant.

Beside the words *Personal Accident Benefit* the following symbols have been inserted: ^* and a Notes section is included in this form and provides an explanation of the symbols:

*"**Section E Notes:***
For full details on all features in Section E please refer to the relevant product brochure.
…
** Delete as appropriate*
…
^ The maximum Personal Accident Benefit payable shall not exceed the lesser of €350 per person per week in respect of all policies held, or 50% of gross weekly earnings. …"

- **Quotation**

I note that the documentary evidence made available to this office includes a copy of the original provider's omniquote details printed on 30 November 2004 which I see included the following on the first page:-

"	**First life**	**Second life**
Life/Serious Illness Cover	*Double Payout*	*Double Payout*
LIFE COVER	***EUR 250,000.00***	***EUR 400,000.00***
Terminal Illness Benefit	***EUR** 175,000.00*	***EUR** 280,000.00*
Children's Life Cover	*Yes*	*Yes*
SERIOUS ILLNESS	***EUR 30,000.00***	***EUR 30,000.00***
Children's Serious Illness	***EUR** 15,000.00*	***EUR** 15,000.00*
Personal Accident Benefit/Week	***EUR** 400*	
Inflation Protector Option	*Yes*	*Yes* "

I also see that on the 4th page of this 11 page document, the following details appear under "**Personal Accident Benefit"**:-

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"*This benefit provides you with a weekly income payment if you are unable to perform your own occupation for a period of more than 2 weeks due to an injury which arises as a result of an accident. You will be entitled to receive the benefit for the duration of the disability, up to a maximum of 52 weeks. Entitlement to this benefit ceases at your 60th birthday.* [First Complainant] life *is covered for an amount of* ***EUR*** *400 per week, subject to this amount not exceeding 50% of pre-tax income".*

- **Policy Schedule**

I note that the details displayed on the Policy Schedule dated 10 December 2004, includes the following:-

"SPECIAL CONDITIONS AND EXCLUSIONS:
Personal Accident Benefit has been selected on the first life. The benefit is €400, subject to a maximum of 50% of gross weekly earnings…"

The final paragraph of the schedule states:

"This policy records that, in consideration of the premiums paid by the Policyholder named herein, [the original provider] will grant the benefits in accordance with the above particulars and upon the conditions attached hereto and any endorsements to the policy."

- **Policy Terms and Conditions**

A copy of the Policy Document containing the terms and conditions applicable, has also been furnished. Section 1 states:

"1. Cover Provided

This section sets out all the benefits available under your Policy.
The specific benefits that apply to your Policy are specified in the Policy Schedule, subject to any subsequent endorsements to the Policy.
…
Any exclusions that apply to the payment of benefits are set out in Section 2 …"

Paragraph F of Section 1 deals with Personal Accident Benefit and states:

"F. Personal Accident Benefit

This benefit applies only if it is specified on the policy schedule.
This weekly benefit will be the lower of 50% of the Life Assured's normal weekly earnings at the time of making the claim, and the amount stated on the Policy Schedule, subject to any subsequent endorsements …"

[My emphasis]

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- **<u>Correspondence</u>**

Since the commencement of the policy a series of updates and annual statements were sent to the First Complainants in respect of the benefits under the policy. In an update dated **16 July 2010** a summary of the First Complainants' policy is set out and under this summary which confirms "*Personal Accident Benefit - €400*", it states the following:

> *"**Note:** All your policy benefits are subject to policy conditions, detailed in your Policy Document."*

Likewise, in the **2010** annual statement which includes "Personal Accident Benefit - €400", it states:

> *"Your policy benefits are subject to terms & conditions. Please consult your Policy Conditions and Policy Document for further details."*

Statements similar to the ones outlined above were contained in the equivalent documents received in **2011**.

From **2012** to **2014**, the annual statements contained the following indorsement:

> *"Please refer to your Original Policy Document for details of how these benefits are payable in the event of a claim.*
>
> *Your policy benefits are subject to terms and conditions. Please consult your Policy Conditions and Original Policy Document for further details."*

These Annual Statements each confirmed a Personal Accident Benefit for the First Complainant of €400.

In a letter dated **November 2015** and addressed to the Complainants it is stated:

> *"Important information for your benefits and payment details*
>
> - *This is a summary of your payments and plan benefits. You may have other benefits on your plan. You can find full details of all the benefits in your plan schedule and your terms and conditions booklet, including any special conditions or endorsements.*
>
> - *We provide your benefits in line with the terms and conditions booklet, and any special conditions or endorsements agreed with us and as outlined in your plan schedule."*

A letter dated **November 2016,** and containing the same statement was also sent to the First Complainants.

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I note that on **3 April 2017**, a letter was sent by the Provider to the Complainants' mortgage provider furnishing details of an alteration to the benefits of the Complainants. The details confirmed within the Table of Benefits specified a "*Personal Accident Benefit*" for the First Complainant at that time, of **€719**.

I note that on 5 April 2017 the mortgage provider confirmed that it no longer retained any interest in the policy.

Thereafter, on **10 April 2017**, the Provider wrote to the Complainants confirming that a letter of no further interest had been received from the mortgage provider and notified the Complainants that "*the premium and benefits on the above plan will alter with effect from 1 May 2017*" as follows:-

> *"…*
> *Personal Accident Benefit €719.00 (unchanged)*
>
> *This change will stay in place until your next review date on 1 January 2020."*

I also note that an amended policy schedule issued to the Complainants on **14 April 2017** similarly confirming the Personal Accident Benefit of €719. Subsequently, in August 2017 the First Complainant sought to make a claim for Personal Accident Benefit, following a fall when he slipped and injured his left wrist.

On **28 September 2017** the Complainants were notified that the terms and conditions of the policy specified that weekly benefit would be the lower of 50% of the life assured's normal weekly earnings, at the time of making the claim. Accordingly, the Provider had taken into account the First Complainant's earnings of €6,223 in 2015, which thereby allowed for a weekly benefit of €60 to the First Complainant, in accordance with the policy provisions. At that time, the Provider made a payment of €600 representing 10 weeks of benefit for the period 20 August 2017 to 12 November 2017 and the First Complainant was asked to contact the Provider further, if he remained unable to work after this time.

- **<u>Audio Evidence</u>**

During a telephone call which took place between the First Complainant and a member of Provider's complaints management team on **25 September 2017**, the First Complainant states:

> *"… what was sold to me was you are going to get X amount per week if you are out injured … X amount a week to me was whatever was on the page … I thought no more of it …"*

During this telephone call the Provider's agent informs the First Complainant that the original paperwork for his plan First Complainant if he recalled reading that paperwork at the time and he replied as follows:

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> *"… how many years ago was it … everything was being thrown at me at the same time because I just didn't get that, I got a pension, I got home insurance, … I got a PPS … there was 5 or 6 different things on the table all at the same time … this one slipped by me … this is one that just slipped under the radar …"*

One can fully understand indeed why the Complainant may have been confused regarding the manner in which the Personal Accident Benefit would be calculated. I note that the Application Form specifically confirmed the Complainant's requirement for a Personal Accident Benefit of "*€400 per week*" and in due course this was increased to "*€719*" per week.

Given the terms and conditions of the policy at the time of inception however, it would appear that it was in fact a mathematical impossibility for the Complainant to recover benefit of €400 per week at that time, irrespective of his earnings. Based on the "*Notes*" attached to the Application Form, and the manner in which the Personal Accident Benefit would be calculated pursuant to the terms and conditions, it seems that it may have been utterly irrelevant, what figure was entered in the Personal Accident Benefit field on the Application Form, as the benefit was limited to a maximum of €350 per week, or 50% of gross weekly earnings, if this was lower.

I am also conscious of further conflicts between

(1) the details in the "Notes" section of the Application Form, which indicated that

> *The maximum Personal Accident Benefit payable shall not exceed the lesser of €350 per person per week in respect of all policies held, or 50% of gross weekly earnings*

(2) the policy terms and conditions which specified recovery of benefit calculated to be

> "*the lower of 50% of the life assured's normal weekly earnings at the time of making the claim and the amount stated on the policy schedule*"

and

(3) the amount of €719 stated on the Policy Schedule which was effective in 2017, at the time of the accident.

I remain unconvinced that a proper explanation could have been given to the Complainants in 2004, at the time when they made their application for the cover in question, given that the Application Form itself created a conflict as between the figure of €350 referred to in the Notes and the figure of €400 referred to as the Complainant's required benefit. In addition, given the reference in the policy terms and conditions to the life assured's earnings at the time that the claim is made, it remains entirely unexplained by the Provider as to why the claim was assessed in 2017 on the basis of the Complainant's self-employed accounts for 2015.

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The Provider has confirmed the it holds no records of any assessment by the agent of the original provider, at the time when the policy was sold, of any proof of employment or income tax return or self-assessment, such that an opinion might be formed regarding how suitability was established for the First Named Complainant at that time, regarding the level of benefit sought to be covered.

In addition, one can well understand why the Complainants believed at all times that the Personal Accident Benefit recoverable was €400 per week, and subsequently €719 per week, given that the Annual Benefit Statements issued periodically confirmed those respective figures, without any clarification or asterisk or warning or proviso.

It is indeed disappointing that at no time after the inception of the policy was the Complainant furnished with any periodic update or reminder regarding the manner in which the Personal Accident Benefit would be calculated. Instead, the Periodic Valuations issued to him gave him the not unreasonable expectation that the benefit to which he was entitled, if injured, was a figure of €400 per week, subsequently increasing to €719.

The amount payable in respect of Personal Accident Benefit appears to have been increased from €400 to €719 as per the 2017 annual statement dated **3 April 2017**. It is not clear when this occurred, as very little documentation has been furnished by either party as to when and how this came about. I note that annual statements have not been furnished for 2015 and 2016. The Complainants have not submitted any evidence indicating that they did not agree and/or request this increase. In a letter dated **29 March 2017** from the Complainants to the Provider, the Complainants stated that Personal Accident Benefit was to be kept in place as it was. However, it is unclear what amount was being referred to at that time. In the complaint form to this Office, the Complainants stated that the First Complainant was entitled to €400 per week. I would also note the remarks of the First Complainant in a telephone call that took place with a member of Provider's complaints management team on **25 September 2017**:

> *"… Over the last couple of years I've noticed my payments going up. I also noticed that the pay out if I got injured went up … I noted on the last one that it was seven hundred and whatever euro. I noticed this and whatever and that was grand …*
> *[*First Complainant referring to his claim*] … this is great seven hundred and nineteen euro I'm covered … as far as I was concerned I was getting seven hundred and nineteen … euro per week … I thought seven hundred and nineteen was the minimum amount I was going to get, not the maximum amount I was going to get …"*

It is clear however, from the policy terms and conditions that the calculation of the benefits was set at a figure which was heavily reliant upon the policyholder's earnings at the time of any accident. It might have been more apparent to the policyholders if the benefit had been described as "*50% of weekly earnings up to a maximum of …*", rather than the details which were confirmed on the Policy Schedule and repeated annually, when Valuation Statements were issued to the Complainants.

I am satisfied that, as a matter of contract, dating from 2004, the First Complainant was entitled to recover only 50% of his weekly earnings at the time of any accident, up to a

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maximum of €350, and subsequently up to a maximum of €719 (if his weekly earnings had amounted to €1,438 or more.) Nevertheless, in the particular circumstances as detailed above, I am satisfied that the Provider has a case to answer to the Complainants for creating what I believe to have been a not unreasonable expectation on the First Complainant's part, from 2004 onwards, that he would recover benefit payments of €400 per week, were he to be injured, a figure which subsequently increased to a potential of €719.

In considering these issues, I am conscious that ***Section 60*** of the ***Financial Services and Pensions Ombudsman Act 2017***, prescribes at ***Sub-Section 2*** that a complaint may be found by this office to be upheld, substantially upheld or partially upheld on the grounds that:-

> *"(c) Although the conduct complained of was in accordance with a law or an established practice or regulatory standard, the law, practice or standard is or may be, unreasonable, unjust, oppressive or improperly discriminatory in its application to the Complainant."*

I take the view, bearing in mind these legislative provisions, that as a matter of fairness, it is appropriate to uphold this complaint.

I would also recommend that the Complainants now liaise directly with the Provider, to discuss the ongoing cost of this element of cover under the policy. This will enable them to decide whether they wish to continue paying a premium to continue to have Personal Accident Benefit available to the First Complainant, under the policy, now that the mechanics of the way in which the benefit is calculated under the policy, has been made fully clear to them, and in the knowledge as to how any future claim for that benefit will be calculated by the Provider.

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is upheld on the grounds prescribed in ***Section 60(2 (c) & (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 Complainants, in the sum of €5,000, to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants 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 Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

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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

1 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.