An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0269
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Lapse/cancellation of policy Dissatisfaction with customer service Failure to process instructions in a timely manner Failure to process instructions
Outcome:	Substantially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants, a husband and wife, held a health insurance policy with the Provider from 1 June to 31 December 2017, by way of the First Complainant's then employer's group scheme with the Provider. This policy was incepted in the name of the First Complainant, with the Second Complainant listed as the second insured.

The Complainants' Case

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

> *"I was employed until January 1st 2018, when I resigned. The health insurance plan was deducted at payroll and* [my Employer] *made a €500 contribution each year. I called* [the Provider] *in January and February* [2018] *and was told my policy was still active and not to worry as it may have been paid in a 3 month block. I received a letter on March 16th 2018 informing me that the policy had been cancelled and that I would be liable for a cancellation fee of around €380. I called* [the Provider] *and was told the policy had been retrospectively cancelled to 31st December 2017 and that I was liable for the fee unless I reinstated the policy.*

I was told on the 16th March call that I could have a plan at €86 [per month] *which would cover myself and my wife for 12 months. I agreed. I was then called back and was told it wasn't possible and that I would have to pay €800+ in April and a further €200+ in May to continue until my current policy expired in May 2018. I refused this.*

Some days later I called [the Provider] *and was informed that the policy had been set up and that the monies would be taken out in April and May. I questioned this and stated that I had not given any bank details. The person I spoke to said my wife's bank account details were on the file and that they had used these. I stated my wife's details were added for the purpose of* [the Provider] *sending payments for treatments received under the plan and not to have premiums taken out.* [The Provider] *stated they had only one bank detail on file and had used this. I cancelled immediately and was told I would then be liable for the €380+ cancellation fee. Despite my having sent several emails requesting proof that* [the Provider] *had been given permission to use the bank details, none has been received.*

I also raised other issues of concern such as how [the Provider] *had retrospectively cancelled a policy – the cancellation date of which left me with 2 weeks to arrange cover for both* [me and my wife]. *After pointing this out to the person on the phone I was told that* [the Provider] *would allow 13 weeks from the 16th March. This was useless to me as I had by then lost all faith in* [the Provider] *and wanted nothing more to do with them.*

The responses I have received [from the Provider] *have been incomplete and evasive at best …*

I would like the cancellation fee waived, an apology from [the Provider] *for the stress caused, and compensation for this stress"*.

In addition, in his later email to this Office dated 29 March 2019, the First Complainant also advised, among other things, as follows:

" … the policy was cancelled by a previous employer. However, [the Provider] *had confirmed on more than one occasion that my policy was still active between 31/12/17 and 15/3/18 during my calls with them and at no time indicated that the policy could be retrospectively cancelled … they have* [since] *waived said* [cancellation] *fees"*

There are two elements to the Complainants' complaint, as follows:

- The Provider cancelled the Complainants' health insurance policy on 16 March 2018 retrospectively, with effect from 31 December 2017, despite it having advised the First Complainant by telephone in January and February 2018 that the policy was still active at that time.

- The Provider, when offering to reinstate the Complainants' health insurance policy as a direct policy on 16 March 2018, advised the First Complainant of an incorrect

/Cont'd…

monthly premium amount and then reinstated the policy and used the Second Complainant's bank account details to set up a direct debit for premium collection, without first obtaining permission from the Complainants to do so.

The Provider's Case

Provider records indicate that the Complainants, a husband and wife, held a health insurance policy with the Provider from 1 June to 31 December 2017, by way of the First Complainant's then employer's group scheme with the Provider. This policy was incepted in the name of the First Complainant, with the Second Complainant listed as the second insured.

The First Complainant's employer made a €500 contribution towards the annual cost of his health insurance. The Provider invoiced this employer on a monthly basis for an amount equal to 1/12th (€201.52) of the annual premium and the employer made deductions from the First Complainant's salary. As it invoiced the employer directly, the Provider had no sight of how the employer applied its €500 contribution or whether the First Complainant benefited from the entire contribution, given that he ended his employment midway through the insurance policy year.

The First Complainant's former employer emailed the Provider on 8 March 2018 to advise that the Complainants' policy was to be cancelled with effect from 31 December 2017. As a result, the Provider wrote to the First Complainant on 15 March 2018, as follows:

> *"We have been informed that your group scheme…is no longer facilitating the payment of your policy …*
>
> *If you contact us within 13 weeks of the cancellation date* [30 December 2017]*, we can reinstate your policy from the date that cover ceased at the same premium with no gap in cover, until your next renewal …*
>
> *If we do not hear from you within 13 weeks of the cancellation date, your policy will remain cancelled in line with the terms and conditions of non-payment …*
>
> *Please note that a mid-term cancellation charge is payable…and we have enclosed an invoice detailing the amount due* [€394.80]*…If you decide to re-instate your policy within 13 weeks of the policy cancellation date, you will not incur the mid-term cancellation charge".*

Prior to this, the First Complainant had telephoned the Provider on 30 January, 31 January and 13 February 2018 and advised on each occasion that he no longer worked for the employer. The Provider acknowledges that during these telephone calls the First Complainant was advised that the Complainants' policy was still active, but notes that this was correct based on the information it had at that time as the employer had not yet advised the Provider of a cancellation date. In addition, the Provider states that it is satisfied that

/Cont'd…

each agent clearly advised the First Complainant to contact his former employer to ascertain the policy cancellation date and in addition, each offered to cancel the policy for him from the date he resigned and arrange replacement cover and he was provided with quotes for same, but the First Complainant took neither action at that time.
The Provider notes that during the telephone calls placed on 30 January and 31 January 2018, the First Complainant advised its agents that he had resigned on 2nd January but thought that the deduction taken from his December pay might cover his health insurance premium until 25th January. In this regard, the First Complainant was aware that the policy premium was being paid by way of salary deduction and that the final such deduction had occurred in December 2017.

The Provider submits that when a policyholder leaves the employment of a group scheme sponsor it is not unreasonable for them to conclude that they are no longer eligible to remain as part of the group scheme from the date employment ceased. In addition, the Provider notes that the First Complainant was advised by telephone on 30 January 2018 that the employer had the authority to amend the cancellation date and that typically a policy would be cancelled from the date the policyholder ceased working with the employer and that he should therefore contact his former employer's HR department, to confirm the date that it was cancelling his health insurance policy from.

Having received the policy cancellation notice dated 15 March 2018, the First Complainant telephoned the Provider on 16 March 2018. The Provider acknowledges that the Agent who dealt with the First Complainant on three telephone calls on 16 March 2018 made a number of errors that understandably frustrated the First Complainant in his dealings with the Provider and in this regard, the Provider notes that it has since taken the necessary actions with this particular agent internally.

The agent failed to advise the First Complainant during the telephone calls on 16 March 2018 that the actions that had been taken by the Provider thus far were correct and in line with the group scheme arrangements, but instead led the First Complainant to believe that numerous errors had occurred and offered an apology on behalf of the Provider. The agent then incorrectly advised the First Complainant that the monthly premiums for reinstating the Complainants' policy as a direct policy would be €89 and also, when he reinstated the policy, he failed to action preventative measures to avoid setting up a direct debit to collect premiums from the Second Complainant's bank account.

In this regard, the Provider notes that its IT platform can only hold one set of bank account details per policy and in this case, the Second Complainant's bank details had been added to the Complainants' record on 12 September 2017 to facilitate receiving claim payments. When changing a policy to a direct debit payment method for the first time, as the First Complainant was on 16 March 2018, the system prepopulates with any existing bank details that are on file. In this regard, in line with the standard process and scripting, the Agent ought to have advised the First Complainant that the Provider can only hold one set of bank details on file, and should have sought confirmation as to whether the existing bank details on file were correct to use for both premium debits and claim reimbursements.

/Cont'd…

This agent telephoned the First Complainant back later on 16 March 2018 when he realised he had incorrectly calculated the monthly premium to advise that the outstanding and remaining premium of €1,007.60 would have to be split over 2 months as there were only 2½ months left on the policy and the first payment of €806.08 would be collected in April, with the balance of €201.52 collected in May.

The First Complainant was understandably frustrated with this and the agent offered to have the matter investigated further, to which he agreed. The Agent then advised that he would try to have a call back arranged *"if not today* [Friday 16th March]*, it should be Tuesday"* (Monday being a public holiday), but he did not log the complaint on the Provider's system until 13:08 on 20 March 2018.

In addition, the summary of complaint that this agent then provided internally was incomplete and inaccurate, meaning that the Complaint Handler was unaware of the exact nature of the complaint when she first telephoned the First Complainant on 21 March 2018, leading to more frustration for him as following this call, further investigation had to be completed.

When the Complaint Handler telephoned on 21 March 2018, the First Complainant was surprised to learn that the agent had reinstated his policy on 16 March 2018, despite the First Complainant having advised that he would in no way be paying the outstanding and remaining premium of €806.08 in April and €201.52 in May. In addition, the First Complainant was also surprised to learn that the agent had set up a direct debit for the collection of this premium from the Second Complainant's bank account. As a result, the Complaint Handler deactivated the direct debit arrangement and cancelled the policy. The Provider notes that at this point, no premium payments had been collected from, nor were any attempts made to collect a payment from, the Second Complainant's bank account.

The Provider has conveyed its sincere regret at the confusion that was caused by the agent's comments and actions on 16 March 2018 and when submitting its formal response to this complaint in November 2018, it offered the Complainants the following:

- To amend the Complainants' policy cancellation date from 31 December 2017 to 15 March 2018 and waive the pro-rata premium from 1 January 2018 to 15 March 2018, that is, €244.94.

- To waive the cancellation fee, which based on the new cancellation date of 15 March 2018 would be €211.34.

- Pay any day-to-day claims that were incurred by the Complainants between 1 January and 15 March 2018, that is, €50, based on two chiropractor receipts.

The Provider noted that the total monetary value of this offer was €506.28 and that it was made on the assumption that the Complainants had obtained health insurance elsewhere prior to 15 June 2018, that being 13 weeks from the revised cancellation date of 15 March 2018.

/Cont'd…

The Provider also advised that if the Complainants' new health insurance policy had an inception date later than 15 June 2018, it would be happy to amend the cancellation date up to 31 May 2018, the date their policy with the Provider was originally due for renewal, so as to ensure that the gap between their old and new policy was less than 13 weeks in order to ensure continuous cover, as outlined in legislation.
The Provider has since noted that the First Complainant advised by email dated 29 March 2019 that *"myself and my wife took out health insurance with another provider so as to avoid any break in cover"*.

On 14 May 2019, the Provider noted that if the Complainants did incept a health insurance policy elsewhere on or before 2 April 2018 (13 weeks after 31 December 2017, that being the date that the First Complainant's former employer cancelled the Complainants' policy from) thereby ensuring that they do not have a break in cover of more than 13 weeks, then the Provider's previous offer may no longer be of value to the Complainants. As a result, it offered the Complainants the cash equivalent of the previous offer outlined above, that is, €506.28.

The Complaint for Adjudication

The complaint at hand is the poor customer service throughout the Provider's handling of the cancellation of their health insurance policy. In this regard, there are two elements to the complaint, as follows:

- The Provider cancelled the Complainants' health insurance policy on 16 March 2018 retrospectively, with effect from 31 December 2017, despite it having advised the First Complainant by telephone in January and February 2018 that the policy was still active at that time.

- The Provider, when offering to reinstate the Complainants' health insurance policy as a direct policy on 16 March 2018, advised the First Complainant of an incorrect monthly premium amount and then reinstated the policy and used the Second Complainant's bank account details to set up a direct debit for premium collection, without first obtaining permission from the Complainants 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 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.

/Cont'd…

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 20 June 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 issue of the Preliminary Decision, the Provider made a further submission by letter to this Office dated 11 July 2019, a copy of which was transmitted to the Complainants for their consideration. No further submission has been received from the Complainants.

Following consideration of the Provider's additional submission and all of the evidence submitted by the parties, I set out below my final determination.

In respect of the first element of this complaint, the First Complainant advises, among other things as follows:

> *"I was employed until January 1st 2018, when I resigned. The health insurance plan was deducted at payroll…I called* [the Provider] *in January and February* [2018] *and was told my policy was still active and not to worry as it may have been paid in a 3 month block. I received a letter on March 16th 2018 informing me that the policy had been cancelled … the policy had been retrospectively cancelled to 31st December 2017"*.

In this regard, the First Complainant's former employer emailed the Provider on 8 March 2018 to advise that the Complainants' policy was to be cancelled with effect from 31 December 2017. As a result, the Provider wrote to the First Complainant on 15 March 2018, as follows:

> *"We have been informed that your group scheme…is no longer facilitating the payment of your policy …*
>
> *If you contact us within 13 weeks of the cancellation date* [30 December 2017]*, we can reinstate your policy from the date that cover ceased at the same premium with no gap in cover, until your next renewal …*

/Cont'd…

If we do not hear from you within 13 weeks of the cancellation date, your policy will remain cancelled in line with the terms and conditions of non-payment …

Please note that a mid-term cancellation charge is payable…and we have enclosed an invoice detailing the amount due [€394.80]*…If you decide to re-instate your policy within 13 weeks of the policy cancellation date, you will not incur the mid-term cancellation charge".*

Prior to this, the First Complainant had telephoned the Provider on 30 January, 31 January and 13 February 2018 to advise that he no longer worked for the employer. I note that during each of these telephone calls the agents informed the First Complainant that the Complainants' policy was still active.

I accept the Provider's position that this was correct based on the information it had at that time as the employer had not yet advised of a cancellation date, and in this regard I note from the documentary evidence, that it did not do so until 8 March 2018.

In addition, I note that during the telephone calls placed on 30 January and 31 January 2018 the First Complainant advised that he had resigned on 2nd January but thought that the deduction taken from his December pay would cover his health insurance premium until 25th January. I am satisfied that this was a matter that the First Complainant could easily have clarified, by simply contacting his former employer to ascertain the policy cancellation date.

Recordings of the telephone conversations between the Complainant and the Provider have been provided in evidence. I have considered the recording of the telephone calls and I am satisfied that each agent clearly advised the First Complainant to contact his former employer to ascertain the policy cancellation date. For example, the agent advised the First Complainant during the telephone call on 30 January 2018, as follows:

agent: *One thing about the cancellation process as well, you have two options setting up yourself direct. One would be if you cancel this policy from the date that you left the Company – what I need to just advise you is that the Company would have the authority to ring us up and change the cancellation date if there was ever a reason to, so it normally has to be the date you leave …*

Similarly, the agent advised during the telephone call on 31 January 2018, as follows:

agent: *If you want me to cancel it back to the 2nd, reinstate it as a direct policy from then and then set up a direct debit from then until the end of the year then I can do that for you …*

… as I say, if you do want to keep on the insurance for the rest of the year I would cancel this one back to the 2nd of January, reinstate it from that date as well as a direct policy for you and

/Cont'd…

I can set up a direct debit for you, if you want to go with it that way?

In addition, I note the following exchange during the telephone call on 13 February 2018, as follows:

First Complainant: *Is there any way of checking that?*

agent: *I can't unfortunately, it would be the work you'd have to get on to see when they're going to pay it up until …*

It would have been prudent of the First Complainant to have contacted his former employer, as advised on three occasions by the Provider, to confirm the date that it was cancelling his health insurance policy from, particularly given that the First Complainant was also clearly advised by telephone on 30 January 2018 that the employer had the authority to amend the cancellation date and that typically a policy would be cancelled from the date the policyholder ceased working.

In this regard, the Complainants' health insurance policy was subject to the terms, conditions, endorsements and exclusions set out in the policy documentation and Section 8, '**Group Schemes'**, of the applicable Health Insurance Membership Handbook advises, among other things, at pg. 31, as follows:

"If your plan was started as part of a group scheme arrangement and the group scheme sponsor is acting on your behalf, you agree that the group scheme sponsor will have the following powers and responsibilities for the policy:

- *The group scheme sponsor may instruct us to start and cancel the policy …*

- *The group scheme sponsor may amend or cancel any or all of the plans listed under the policy …*

If your policy was arranged through a group scheme sponsor, your cover will continue as long as you fulfil the conditions for participation in the group scheme and the group scheme sponsor continues to pay your premium".

In addition, having considered the content of the telephone calls placed on 30 January, 31 January and 13 February 2018, I note that not only did each agent advise the First Complainant to contact his former employer to ascertain the policy cancellation date but each also offered to cancel the policy for him from the date he resigned and arrange replacement cover and he was provided with quotes for this, but the First Complainant took neither action at that time.

I am also mindful that as the First Complainant left the employment of a group scheme sponsor, it would have been reasonable for him to have concluded that he was no longer eligible to remain as part of the group scheme, from the date his employment ceased, but

/Cont'd…

in any event this was a matter that the First Complainant could have clarified by contacting his former employer to ascertain the policy cancellation date.

As a result, I accept that the First Complainant ought to have contacted his former employer to confirm the policy cancellation date, as he was advised on three separate occasions by the Provider to do so, or he could have cancelled the policy himself from the date he had resigned and arrange alternative cover for himself, as the Provider offered to do for him.

That said, I am concerned about the manner in which this policy was cancelled retrospectively. I note the Provider's agent informed the Complainant in the telephone call on 30 January 2018 "*the company would have the authority to ring us up and change the cancellation date if there was ever a reason to, so it normally has to be the date you leave…*".

I find it unacceptable that the policy was cancelled retrospectively on 16 March 2018 with effect from 31 December 2017. This is a period of some 11 weeks, just 2 weeks short of the 13 weeks which would have caused the Complainants to have a break in cover. While it would appear therefore, that, due to the fact that the Complainants managed to secure cover from another insurer before the 13 weeks expired, it did not have this effect on them. It could have had very serious consequences and the Provider's conduct certainly caused unnecessary inconvenience to the Complainants.

I note in an e-mail to the Complainant dated 23 March 2018, the Provider stated, among other things:

> *"… your policy has been correctly cancelled from 31st December 2017 and your cover has ceased from then. Please note that your break in cover begins from the point the policy is cancelled the 31st December 2017.*
>
> *As you were notified of the cancellation on the 14th March 2018 and you were in contact with us within 13 weeks of this date we had agreed that we can reinstate your policy from the 31st December 2017 however you would need to arrange payment of the arrears on the policy".*

The Provider goes on to state that it would normally seek the arrears, in this case €806.08 up front.

It then states:

> "*If the policy is not reinstated and arrears paid your policy will remain cancelled from the 31st December 201[2017]. This would mean that you have had a break in cover of longer than 13 weeks. This means you would be treated as a new member from the set up of any new policy with ourselves or any other insurer".*

I note that this correspondence was taking place with only one week left before the Complainants would find themselves being treated as new members.

/Cont'd…

I note in undated correspondence from the Provider to the Complainant it stated, among other things:

> "*I can also confirm that you have 13 weeks from the cancellation letter to reinstate the policy or take out a new policy with us".*

However, I note the cancellation letter dated 15 March 2018 from the Provider to the Complainant states, among other things:

> "*If you contact us within 13 weeks of the cancellation date, we can reinstate your policy from the date that cover ceased at the same premium with no gap in cover until you need renewal.*
>
> *…*
>
> *If we do not hear from you within 13 weeks of the cancellation date, your policy will remain cancelled".*

I have no doubt that the Provider's conduct providing confusing information and cancelling the policy retrospectively caused considerable inconvenience to the Complainants.

Therefore, I propose to direct the Provider to pay compensation to the Complainants and in addition in accordance with ***Section 60(4) (a)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, to undertake a review of this practice of allowing policies to be cancelled retrospectively or allowing the date on which a cancellation takes place to change. I also propose to bring this matter to the attention of the Central Bank of Ireland.

In my Preliminary Decision I had not contemplated directing compensation for this aspect of the complaint. However, having considered the matter further and in particular, the inconvenience caused to the Complainants by the manner in which the policy was cancelled and the fact that the Complainants had been informed that they had a valid policy, which later turned out not to be the case, I believe a sum of €500 in compensation is merited for this aspect of the complaint.

In respect of the second element of the Complainants' complaint, that is, that the Provider, when offering to reinstate the Complainants' policy as a direct policy on 16 March 2018, advised the First Complainant of an incorrect monthly premium amount and then reinstated the policy and used the Second Complainant's bank details to set up a direct debit, without first obtaining permission from the Complainants to do so, I note that the First Complainant submits, as follows:

> *"I was told on the 16th March call that I could have a plan at €86* [per month] *which would cover myself and my wife for 12 months. I agreed. I was then called back and was told it wasn't possible and that I would have to pay €800+ in April and a further €200+ in May to continue until my current policy expired in May 2018. I refused this.*

/Cont'd…

> *Some days later I called* [the Provider] *and was informed that the policy had been set up and that the monies would be taken out in April and May. I questioned this and stated that I had not given any bank details. The person I spoke to, said my wife's bank account details were on the file and that they had used these.*
>
> *I stated my wife's details were added for the purpose of* [the Provider] *sending payments for treatments received under the plan and not to have premiums taken out.* [The Provider] *stated they had only one bank detail on file and had used this. I cancelled immediately and was told I would then be liable for the €380+ cancellation fee"*.

I note that the Provider accepts that the agent who dealt with the First Complainant on three different telephone calls on 16 March 2018 made a number of errors that understandably frustrated the First Complainant in his dealings with the Provider.

Having considered the recording of these three telephone calls, it is clear to me that from the outset, the agent did not fully comprehend the First Complainant's situation regarding the cancellation of his policy.

The agent then proceeded to make a series of errors that began by his incorrectly advising the First Complainant that the premium for reinstating the Complainants' policy as a direct policy would be €89 a month for 12 months, when in fact the outstanding and remaining premium was €1,007.60, and this would have to be paid over 2 months (as there were only 2½ months left on the policy) with the first payment of €806.08 to be collected in April and the balance of €201.52 in May. In the resulting confusion, I note that the agent reinstated the policy despite the First Complainant advising that he would not pay this premium, and indeed, in doing so, he set up a direct debit to collect the premium from the Second Complainant's bank account, without confirming the Second Complainant's authority to do so.

I note the reason given by the Provider as to why it put in place a process that would collect the premiums from the Second Complainant's bank account without permission was that its IT platform can only hold one set of bank account details per policy, and in this case, the Second Complainant's bank details were associated with the policy to facilitate the payment of claims. I find this a most unacceptable situation. It is completely unacceptable that the Provider would set up a standing order or any other instrument to take money from the account of a person without that person's permission. It is clear that the bank account details were given to the Provider in order to receive payment of a claim.

The Provider had no authority to attempt to extract money from that person or that account. For this reason, I propose to uphold this aspect of the complaint and direct the Provider, under ***Section 60(4) (a) and (c)*** review its systems and put in place measures to require that permission is sought from a consumer prior to setting up a direct debit or standing order against that consumer's bank account.

/Cont'd…

In addition, as he did not fully comprehend the First Complainant's complaint regarding the cancellation of his policy, I note that that the agent then failed to log an accurate and detailed account of this complaint on the Provider's system, and that he also did not log the complaint in a timely manner.

I am mindful of the fact that when the error regarding the policy reinstatement and direct debit came to light, during the telephone call between the First Complainant and the Complaint Handler on 21 March 2016, the Complaint Handler immediately deactivated the direct debit arrangement and cancelled the policy. This was fortunate as otherwise the consequences could have been far worse.

I am also mindful that no premium payments had been collected from, nor were any attempts made to collect a payment from, the Second Complainant's bank account.

Nevertheless, it is clear to me that the errors made were very serious and constituted a particularly poor level of customer service and it is understandable that the First Complainant was confused, frustrated and inconvenienced by these errors.

As a result, I am satisfied that the Complainant was provided with poor customer service throughout the three telephone calls placed on 16 May 2018. The First Complainant ought to be able to rely on the expertise and administration of the Provider and its agents in his dealings with it, and the service he received on 16 May 2018 was clearly wanting.

I note that the Provider has apologised for the confusion that was caused by the Agent's comments and actions on 16 March 2018 and in November 2018, it offered the Complainants the following:

- To amend the Complainants' policy cancellation date from 31 December 2017 to 15 March 2018 and waive the pro-rata premium from 1 January 2018 to 15 March 2018, that is, €244.94.

- To waive the cancellation fee, which based on the new cancellation date of 15 March 2018 would be €211.34.

- Pay any day-to-day claims that were incurred by the Complainants between 1 January and 15 March 2018, that is, €50, based on two chiropractor receipts.

In this regard, the Provider noted that the total monetary value of this offer was €506.28 and was made on the assumption that the Complainants had obtained health insurance elsewhere prior to 15 June 2018, that being 13 weeks from the revised cancellation date of 15 March 2018. The Provider also advised that if the Complainants' new health insurance policy had an inception date later than 15 June 2018, it would be happy to amend the cancellation date up to 31 May 2018, the date the policy was originally due for renewal, to ensure that the gap between their old and new policy was less than 13 weeks in order to ensure continuous cover, as outlined in legislation.

/Cont'd…

I note that the First Complainant has since advised in his email to this Office dated 29 March 2019 that *"myself and my wife took out health insurance with another provider so as to avoid any break in cover"*.

In this regard, I note that if the Complainants did incept a health insurance policy elsewhere on or before 2 April 2018 (13 weeks after the 31 December 2017, that being the date the First Complainant's former employer cancelled the Complainants' policy from) thereby ensuring that they do not have a break in cover of more than 13 weeks, the Provider has acknowledged that its previous offer may no longer be of value to the Complainants and as a result, it has since offered the Complainants the cash equivalent of the previous offer outlined above, that is, €506.28.

While the Complainants did receive poor customer service on 16 May 2018, I am conscious that the mis-information they were given was corrected quickly. No money was taken from the account and most importantly, the Complainants did not suffer a break in cover in their health insurance. For this reason I believe that the Provider's offer of €506.28 in compensation is reasonable in the circumstances, and I do not propose to direct any further compensation for this aspect of the complaint.

The Provider made a post Preliminary Decision submission on 11 July 2019, focusing mainly on my Preliminary Decision in relation to the cancellation of the policy retrospectively.

The Provider, in its post Preliminary Decision submission, states as follows:

> "*By way of context, we have identified six findings of fact within the Preliminary Decision which appear to us to undermine the first aspect of the complaint [cancellation of the policy retrospectively]:*
>
> *(1) You have accepted that the information we provided prior to the cancellation was 'correct based on the information [we] had at the time'.*
>
> *(2) You have confirmed that you are satisfied that the Complainant could have easily established the correct cancellation date 'by simply contacting his former employer to ascertain the policy cancellation date'.*
>
> *(3) You have stated that 'I have considered the recording of the telephone calls and I am satisfied that each agent clearly advised the First Complainant to contact his former employer to ascertain the Policy cancellation date'.*
>
> *(4) You have acknowledged that '[It] would have been prudent of the First Complainant to have contacted his former employer as advised on three occasions by [our representatives']. Indeed, you have accepted that 'the First Complainant ought to have contacted his employer to confirm the policy cancellation date'.*

/Cont'd…

(5) *You have found that each agent offered to cancel the policy on behalf of the First Complainant and arrange alternative cover, but that the 'First Complainant took [no] action at that time'.*

(6) *You have agreed that 'as the First Complainant left the employment of a group scheme sponsor, it would have been reasonable for him to have concluded that he was no longer eligible to remain as part of the group scheme from the date his employment ceased'. This is a particularly important point, which we will revisit below.*

It appears from the Preliminary Decision that you propose to uphold this aspect of the complaint not pursuant to any facts specific to this particular case, but on the basis of your preliminary finding that it is generally impermissible for us to allow Group Scheme Sponsors the authority to cancel a health insurance policy backdated to the date a member left his or her employment. This will be the case even in circumstances where neither the sponsor nor the member in question has advised us of same immediately after the cessation of said member's employment".

The Provider's view in this regard is incorrect. I am upholding this complaint based on the facts of this complaint. In particular, I am concerned that the First Complainant was told on a number of occasions that the policy was still active only to find that it was later cancelled retrospectively. While I accept that the Provider's agent advised the First Complainant that he should contact his former employer, and indeed I agree it would have been prudent for him to have done so, it would equally have been prudent for the Provider to warn the Complainant that although it was informing him that the policy was still active, he could not in fact rely on this information as the Provider/employer might later cancel the policy retrospectively and that they may not in fact have cover at the very time when he was being informed that they were on cover. It is not at all clear what would have happened if the Complainants had a claim during the period when they were being told they were on cover when in fact they were not on cover.

Therefore, while I am concerned about the wider implications of the Provider's conduct, and am, for this reason drawing it to the attention of the Central Bank, I am upholding the complaint on the very specific conduct of the Provider in relation to the Complainants and this complaint.

The Provider, in its post Preliminary Decision submission of 11 July went on to state:

"Although this aspect of the complaint [cancellation of the policy retrospectively] was upheld, there appears to be no direction provided in the Preliminary Decision as to what action the company should take in future cases where a group scheme sponsor wishes to cancel a health insurance policy on a retrospective basis. It is significant that our practice of, in general, allowing group scheme sponsors the authority to cancel a health insurance policy backdated to the date a member left the company is the same practice that adopted by the other Health Insurance providers.

/Cont'd…

Therefore, the decision which you propose to make in respect of this aspect of the complaint will create systemic issues both for this company and Health Insurance providers generally. If Health Insurance companies could not backdate cancellations this would also lead to difficulties with dual insurance".

My direction to the Provider is to review the practice which leaves a customer in a situation where they are informed by the Provider that their health insurance policy is active only to later be told that their policy had been cancelled 11 weeks earlier. While I do not intend to make a prescriptive direction in relation to the matter, I would expect that any such review would result in measures that would ensure that policies are cancelled far quicker than 11 weeks and that would result in a system where a policyholder would not be told they have an active insurance policy that would later transpire not to be the case. I am directing the Provider to review a system that could leave customers incurring waiting periods on a new policy because their previous policy had been cancelled retrospectively.

It is not clear to me what period of retrospective the Provider is seeking to protect or indeed what period it believes to be reasonable. I believe cancelling a Health Insurance Policy in the manner in which it was done to the Complainants so close to the 13 week watershed is totally unreasonable.

The Provider, in its post Preliminary Decision submission of 11 July, stated:

"We cannot understate the effect that the proposed decision would have on an industry wide basis. It would have the effect that, even once an employee had left service, such employee would still be entitled to be provided with the specific employment related benefits, i.e. pension, car allowance, IP membership, effective up to the date when he or she – or the Group Scheme Sponsor – inform their service provider of the cessation of his or her employment.

It is common knowledge and universal practice that employment benefits are just that, and that benefits cease upon cessation of employment. As you acknowledge in your Preliminary Decision, as a matter of simple common sense any employee should know that his or her employment benefits will cease upon the cessation of employment".

I find the argument by the Provider that my direction somehow means that a former employee would continue to have pension benefits, car allowances etc., to be bizarre in the extreme.

My only concern is that the Provider's customers should know whether or not their policy of health insurance with the Provider is active and furthermore that having been informed that their health insurance policy is active the customer should not later be told that it has been cancelled retrospectively.

I fail to understand how the Provider has extended this to somehow bestow a range of employment rights on former employees.

/Cont'd…

For the avoidance of doubt, I am not concerned with the Complainants or any person's employments benefits or rights.

It is the conduct of the Provider in informing the Complainants that their insurance policy was valid and later cancelled the policy for the very period during which it had informed the Complainants it was valid that I am concerned about.

> **"***We are obliged to inform you at this stage that the Central Bank of Ireland [CBI] has previously been in correspondence with this company raising the query as to whether an employer can cancel a scheme without the consent of an employee. It was confirmed to the CBI that an employer can indeed cancel the group scheme without employee consent. However, we made it clear that – where this occurs – we will offer the employee the opportunity to take out a policy with us directly for the remainder of the policy year with the same terms and conditions that the member enjoyed as part of the Group Scheme. The CBI never in fact raised this as an issue again. It is, therefore, unclear what action the Financial Services and Pensions Ombudsman expects the CBI to take if the proposed decision is not notified to the CBI".*

Here again, the Provider seems to have misunderstood the issue. I have not raised any concern or commented with regard to whether an employer can cancel a scheme without the consent of an employee. I did not comment on this in relation to the Complainants or generally. Once again, I must point out to the Provider that my concern is in relation to the conduct of the Provider in relation to the information provided to the Complainants and the retrospective cancellation of a policy after 11 weeks.

It will be a matter for the Central Bank of Ireland to take whatever action it deems appropriate in relation to the matter.

In its post Preliminary Decision submission of 11 July, the Provider also states:

> ***"****If the proposed decision is carried through, it would pose the question as to whether the policies of directly insured members can be cancelled where they fail to make the agreed monthly payments of premium.*
>
> *Finding [Reference No. redacted] issued by the office of the Financial Services and Pensions Ombudsman [FSPO] rejected a complaint on 08/04/2019 on the basis that 'it was for [the insured] to ensure that the premiums were paid on time to the provider'. This is inconsistent in logic with the position adopted in the Preliminary Decision, which is in effect that members who are insured on a group scheme do not have the same responsibility to pay premiums. This is notwithstanding that – as you acknowledge – it is reasonable for an employee to conclude that his or her premiums will no longer be paid by the employer as he or she is no longer eligible to remain as part of a group scheme from the date of cessation of employment".*

/Cont'd…

Once again, the Provider appears to have misunderstood my concern. I have not queried the right of the Provider to cancel a policy where the premium is not paid. My issue is with the delay in cancelling the policy and the retrospective cancellation of the policy.

In its post Preliminary Decision submission of 11 July, the Provider also states:

> *"While [the Provider] does advise all Scheme Administrators of the importance of updating the company on the current status of their active employees on a monthly basis, and actively seeks up to date records on a monthly basis when the invoice for their scheme is issued, it is outside of our control as to whether or not the Scheme Administrators furnish us with the required information at the first available opportunity. As this office cannot under the terms and conditions of the policy instruct employers to become liable for the premiums falling due between the employee's departure and them notifying us of the cancellation, a direction whereby a health insurance company is now required to cancel a policy only from the date on which the cancellation request is received would mean either: (a) that the Group Scheme Sponsor would become liable for these premiums should the member fail to pay the arrears; of (b) that the premium for this aforementioned period of time would have to be waived by the insurer. Either way, the wholly anomalous and unfair situation would come about whereby health insurers would be required to bear a financial burden arising from somebody else's failure to notify us of the cessation of a policy.*
>
> *The above outcome would result in the direct impact of increasing costs for all contributors to a community rated industry. Not only would the pro rata premiums need to be borne by the insurer, but any claims incurred during this period of cover would need to be paid in line with the terms and conditions of the policy regardless of the fact that the member had not paid for the cover".*

The Provider's statement that "*any claims incurred during this period of cover would need to be paid in line with the terms and conditions of the policy regardless of the fact that the member had not paid for the cover",* goes to the heart of this matter.

It would appear to me that it is reasonable to infer from this statement by the Provider that if the Complainant had had a claim during the 11 weeks when he thought, based on information furnished to him by the Provider, that he was on cover when he clearly was not, that any claim he would have made during that period would not have been covered. I note, however, that this is not consistent with the fact that the Provider did in fact pay a claim for January 2018. The lack of clarity and risk of claims not being paid is one of the issues that concerns me most about this practice of cancelling policies retrospectively.

I do not believe it is acceptable or reasonable for the Provider to seek to absolve itself of any responsibility for its insured customers. It appears to want to have an open-ended system that will allow its customer's policy to be cancelled retrospectively without any limitation.

Perhaps one solution would be to notify its policyholders when their monthly premiums are not paid.

/Cont'd…

In its post Preliminary Decision submission of 11 July, the Provider also states:

> *"We must also point out that Section 1 of the membership handbook clarifies that it is either the policyholder that arranges and pays for the insurance, or the policyholder's employer that arranges and pays for the policy.*
>
> *Having a Group Scheme Administrator or a Group Scheme Sponsor does not change or impact who the policyholder is. However, it does mean that the additional rules of Section 8 Group Schemes also apply, as set out below:*
>
> *…*
>
> *If your policy was arranged through a group scheme sponsor, your cover will continue as long as you fulfil the conditions for participation in the group scheme and the group scheme sponsor continues to pay your premium. [Emphasis added].*
>
> *As is clear from the underlined section above, the terms and conditions make clear that there is no entitlement to continued cover under a group scheme where an employee's eligibility for participation in the group scheme has ceased and the Group Scheme Sponsor has ceased to pay the premium. As set out above, where we become aware that a member's participation in a group scheme has ceased, we will offer the employee the opportunity to take out a policy with us directly for the remainder of the policy year with the same terms and conditions that the member enjoyed as part of the Group Scheme. However, such cover will obviously depend on the member paying the applicable premium".*

Once again, I take no issue with the terms and conditions as outlined. My concern is with the retrospective cancellation of the policy after 11 weeks during which the policyholder was informed his policy was active.

The Provider, in its post Preliminary Decision submission of 11 July, also stated:

> *"We are committed to working to ensure we are continuously improving our service offering for our members. We respect inputs and opinions as to how we can improve. However, we feel that if the proposed finding is published in 2020 the only message it will send to Health Insurance customers is that there are no consequences to not paying a health insurance premium.*
>
> *It would also undermine the terms and conditions financial institutions employ to protect their businesses. As such, the proposed finding would have serious systemic effects. Fundamentally, the industry wide effect – which has been addressed in detail above – would result in the direct impact of increasing costs for all contributors to a community rated industry.*
>
> *Not only would the pro rata premiums need to be borne by the insurer, but any claims incurred during this period of cover would need to be paid in line*

/Cont'd…

with the terms and conditions of the policy regardless of the fact that the member has not paid for the cover.

In the vast majority of cases we receive timely notification from Group Schemes and work to ensure the member is made aware of the implications of not taking out a new insurance policy within a 13 week period. We work to minimise any negative impact on our customers. In situations where we have not been given ample notice we engage with the member to ensure there is little impact to their cover.

We urge you in the strongest terms to reconsider this aspect of the Preliminary Decision in light of the detailed information and context set out above. In the event that the office of the FSPO proceeds to uphold this aspect of the complaint in its final decision, we will have no alternative but to make the necessary submissions to Insurance Ireland and IBEC and to call upon the other Health Providers to make submissions also".

I would suggest that this response by the Provider is rather alarmist. I note the Provider has stated that "*in the vast majority of cases we receive timely notification from Group Schemes and work to ensure the member is made aware of the implications of not taking out a new insurance policy within a 13 week period*".

Perhaps the Provider would, on foot of my direction, reflect on how it could improve its process to ensure that all its customers would enjoy this basic protection. That is the underlying purpose of my direction to review its practice of allowing policies to be cancelled retrospectively or allowing the date on which a cancellation takes place to change.

For the reasons outlined above, I substantially uphold the complaint and direct the Provider to pay a sum of €500 in compensation to the Complainants and to review its practice in relation to allowing policies to be cancelled retrospectively and to review its systems and put in place measures to require that permission is sought from a consumer prior to setting up a standing order or direct debit against their bank account.

/Cont'd…

Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is substantially upheld, on the grounds prescribed in ***Section 60(2) (g).***

Pursuant to ***Section 60(4)(a)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to review its practice in relation to allowing policies to be cancelled retrospectively and pursuant to ***Section 60(4)(a) and (c)*** to review its systems and put in place measures to require that permission is sought from a consumer prior to setting up a standing order or direct debit against their bank account and 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 €500, 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.

For the avoidance of doubt, this €500 is in addition to the €506.28 offered by 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.***

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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

21 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.