An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0335
Sector:	Insurance
Product / Service:	Hospital Cash Plan
Conduct(s) complained of:	Rejection of claim
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint concerns an International Health Insurance Policy ("the Policy") held by the Complainants with the Provider.

The Complainants' Case

The first Complainant submits that on 21 July 2016, her son (the second Complainant), suffered a ruptured Achilles tendon when playing football in the UK. The second Complainant received emergency treatment under the National Health Service (NHS), and he was told that he required urgent surgery to repair the ruptured tendon. When the second Complainant attended the hospital for the surgery under the NHS, this did not go ahead as there were no medical records of his previous treatment.

The first Complainant states that she then reviewed the Provider's Policy and telephoned the Provider on 26 July 2016, to enquire whether the second Complainant was covered for the surgery under the Policy. She submits that she was told by the Provider that he was "*fully covered*", and therefore he decided to seek treatment privately.

The second Complainant attended a clinic in the UK for an initial consultation, scans and treatment plan on 27 July 2016, 29 July 2016 and 1 August 2016. The Complainants state

that following these appointments, there was a revised treatment plan (which was for the application of a special boot and concurrent physiotherapy).

The first Complainant states that she contacted the Provider on 2 August 2016 and communicated the revised treatment plan to the Provider.

The first Complainant submits that during the telephone call on 26 July 2016, she was "*assured by the support line that the treatment was fully covered in any medical institution in the UK and that they did not need to have or review any medical documentation to confirm this"*.

The first Complainant further submits that "*despite keeping [the Provider] informed with three previous calls to the support line, and one month after the private treatment had been authorised and commenced, [the Provider] said that, because treatment was now classified on an outpatient basis, a limit of €500 cover now applied"*.

The first Complainant submits that she contacted the Clinic in the UK, who clarified on 30 August 2016 (by way of email) that the medical treatment was carried out on a day patient basis and not an outpatient basis, however they re-classified the treatment as outpatient at a later date.

The first Complainant submits that "despite taking *every precaution to confirm full cover before embarking on a course of private treatment, [they] are now faced with total medical expenses running into thousands of Euro"*. The first Complainant also submits that the Provider delayed in verifying the type of treatment with the Clinic and that "*were it not for this delayed, re-designation we would have had the opportunity to consider other courses of action such as surgery and/or treatment in Ireland"*.

The Complainants are looking for the Provider to cover the full medical expenses "*as they had originally committed".*

<u>The Provider's Case</u>

The Provider submits that the claim was assessed within the terms of the Policy and the limit of €500 for outpatient benefits was correctly applied. It submits that the Clinic confirmed to the Provider that the treatment was classified as outpatient treatment.

The Provider submits that it has listened to the telephone calls with the first Complainant on 27 July, 28 July and 2 August 2016, and that "*there was no discussion about specific amounts of benefits, and the agents had no medical information to go on – they just gave general advice on what to do in the circumstances. They advise that he is entitled to private treatment on the policy but we need a medical report to review."*

The Provider submits that the first Complainant did not ask about monetary limits in these telephone calls and that in her call on 2 August 2016, she said that she had read the

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outpatient terms and conditions. The Provider also submits that all information given to the first Complainant during the telephone calls was correct.

The Complaint for Adjudication

The complaint is that Complainants were informed by the Provider on numerous phone calls that the costs of the second Complainant's treatment would be fully covered and that the issue of a €500 limit was only raised one month after the treatment began.

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 5 September 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, I set out below my final determination.

I have set out below the sequence of events relevant to this complaint. I have prepared this sequence of events on the basis of the evidence before me in making my decision, including recordings of telephone calls.

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Sequence of Events:

- **22 January** 2014, the Policy was incepted.

- **21 July 2016**, the second Complainant suffered a ruptured Achilles tendon when playing football in UK.

- On dates unknown (but before **27 July 2016**), the second Complainant received emergency treatment under the UK National Health Service (NHS), and he was told that he required urgent surgery to repair the ruptured tendon. When the second Complainant attended the hospital for surgery under the NHS, this did not go ahead as there were no medical records of his previous treatment.

- **27 July 2016**, the first Complainant telephoned the Provider to enquire whether the surgery would be covered under the Policy. The Provider informed her that the second Complainant was covered for private treatment and that he could find another facility in the UK or in Ireland for the surgery. The Provider informed her that flights to Ireland would not be covered and that he would only be covered for treatment in Ireland as he long as he did not stay for longer than 60 days. The first Complainant was advised that the second Complainant should see a Consultant and that a medical report and an estimation of the costs would be required for the Provider's medical team to review.

- **28 July 2016**, the first Complainant telephoned the Provider again to enquire as to whether the second Complainant was covered for surgery under the Policy. The first Complainant was advised that the Provider would require a medical report and an estimate of the costs, but that he was entitled to private treatment.

- **28 July 2016**, the second Complainant attended with the Consultant at a Clinic in the UK. The Provider has furnished this office with a copy of the letter from the Consultant dated 28 July 2016, which states that *"…he was placed with an Aircast boot with wedges…"*

- **29 July 2016**, the second Complainant attended at the Clinic for an Ultrasound. This can be seen from an invoice that was submitted with the claim (which I will refer to further in my decision below).

- **1 August 2016**, the second Complainant attended with the Consultant for a follow up appointment.

  The letter from the Consultant on this date states that "… [*The second Complainant] has read things in the literature himself including that surgery may give better clinical results although there is a tendency for people to steer away from surgery in favour of conservative management because results are also good. I am happy to offer conservative management for this with physiotherapy…."*

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- **2 August 2016**, the first Complainant telephoned the Provider to inform it that the second Complainant had been seen in a Clinic by a specialist and that he was put on a treatment plan which involved physiotherapy initially. The first Complainant told the Provider that she had read the terms and conditions for outpatient costs and enquired whether the physiotherapist was required to sign the claim form as well as the doctor. The Provider advised that the claim form only had to be signed by the doctor. The first Complainant also enquired whether the second Complainant should pay and claim, to which the Provider confirmed that this was the case. The Provider also advised that all expenses should be sent in within 3 months of treatment.

- **17 August 2016**, the Provider attempted to call the second Complainant. The Provider states that it emailed a claim form to him with a request for medical records. This office has not been furnished with a copy of this email.

- **26 August 2016**, the second Complainant telephoned the Provider in respect of the email sent to him. When the second Complainant raised a query about the costs of the treatment, the Provider informed him that there was a limit of €500 in respect of outpatient benefits.

  Later that day, the first Complainant telephoned the Provider in respect of the earlier telephone call with the second Complainant. The first Complainant was advised of the limit of €500 for outpatient benefits. In this call, the first Complainant referred to previous telephone calls with the Provider and she stated that "*I actually gave the name of the clinic. We talked about whether he should come back to Ireland for treatment because the NHS had bungled the whole thing and lost his notes. We discussed his coming back to Ireland I was assured he was fully covered to come back to Ireland apart from the flight that he would be covered to go to the clinic up in Dublin, the [named] clinic, which we had arranged an appointment for or he could attend in UK to the clinic in UK, full cover, total cover".*

  The Provider spoke to the first Complainant for a second time that day and informed her that there was a note on the Provider's system which stated that she had been advised of the €500 limit for outpatient benefit during the call on 26 July 2016. The first Complainant stated that she was not advised of this during any of the previous telephone calls.

- **30 August 2016**, a complaint was logged following a telephone call with the first Complainant.

- **15 September 2016**, the claim form in respect of the consultations at the Clinic was received by the Provider. There were four invoices from the Clinic submitted with the claim form in respect of the initial consultation and fitting of the aircast boot and heel wedge on 28 July 2016, the ultrasound on 29 July 2016 and the follow up appointment on 1 August 2016. This came to the sum of £940.00.

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In addition, an email from the Clinic dated 30 August 2016 was submitted with the claim form, which stated as follows:

> "*Dear [first Complainant],*
>
> *Thank you for your call just now.*
>
> *Please find attached all of [the second Complainant's] invoices which we have sent to your insurers [the Provider].*
>
> *I can confirm that all of [the second Complainant's] invoices are classed as day patient appointments. I hope that this helps [the Provider] assess the invoices"*.

- **20 September 2016**, the Provider telephoned the first Complainant. The first Complainant advised the Provider that the treatment was a on a day care basis and that there was an email from the Clinic to confirm this which was submitted with the claim form.

- **20 September 2016**, the Provider telephoned the Clinic to request the medical information in respect of the claim form received on **15 September 2016** and to enquire whether the treatment was on an outpatient basis. The Clinic confirmed that the treatment was on an outpatient basis.

- **10 October 2016**, the claim form for the physiotherapy treatment was received together with eight invoices from a Physiotherapy Clinic (for appointments between 3 August and 23 September 2016). The invoices for eight appointments came to a total sum of £693.00.

- **14 October 2016**, the Provider telephoned the Clinic again to enquire whether the treatment was on an outpatient basis or on a day basis, following their email to the first Complainant dated 30 August 2016 (outlined above). The Clinic confirmed that the treatment was on an outpatient basis.

- **14 October 2016**, the Provider received an email from the Clinic as follows:-

  > "*Many thanks for your email query regarding [the second Complainant]. I can confirm that [the second Complainant] was seen in the clinic …as a standard outpatient consultation…"*

- **20 October 2016**, the Provider sent the final response letter to the first Complainant. The complaint was not upheld. The letter states that "*we have reviewed the medical treatment [the second Complainant] has received as Out Patient and as discussed this treatment comes under the Outpatient's Benefit Limit of €500.*

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I realise from our conversation that this decision will be of disappointment to you, however we must apply the terms and conditions of the policy when reviewing any claims".

Policy Terms and Conditions

The Provider has furnished this office with a copy of the Policy. The terms and conditions include the following:

"…4) Words and phrases used in this policy
…

Day-Care

Medical treatment provided in a Hospital where an Insured Person is formally admitted but is not required, out of necessity, to stay overnight.
…

Out-Patient

Medical Treatment provided to the Insured Person by or on the recommendation of a Physician which does not involve an admission to Hospital either on an In-Patient or Day-Care basis…"
…

5) What is covered and what is not covered

We have set out below full details of what is covered as well as what is not covered. Attached to your policy you will find your table of benefits appropriate to the Plan Type you have selected which sets out a high level summary of the benefits together with their corresponding financial limits. Your Table of Benefits forms part of your Policy and should be read in conjunction with the terms, conditions and exclusions.
….

i) Out-Patient costs - We will pay medically necessary consultation fees for the services of a General Practitioner, Specialist, Physician, Physiotherapist, diagnostic tests and investigations including ECGs, X-rays, pathology, histology, MRI/CT/PET scans, radiotherapy, prescribed drugs and medicines and the hire or purchase of crutches, walkers, wheelchairs and basic orthopaedic prostheses and equipment.

Please Note: A Co-insurance will be applied to the cost of all out-patient prescribed drugs and medicines covered under this Section of the Policy, as stated on Your Table of Benefits.

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An Excess also applies to this benefit for Level 1 and Level 2, as stated on Your Table of Benefits.

We will pay for treatment and prescribed drugs for the following Complementary Medicines: Chiropractic, Osteopathic, Acupuncture, Homeopathic, Ayurvedic treatment including Herbal and Chinese medicines provided such treatment is given by a licensed practitioner and received following a written referral from your registered general practitioner.

We will pay for up to 3 Out-Patient psychiatric visits with a psychiatrist or clinical psychologist, oi maximum 60 minutes per visit, per Period of Insurance. A Co-insurance applies to this benefit, as stated on Your Table of Benefits. This benefit only applies if specified on Your Table of Benefits.

j) Out-Patient Minor Surgical Procedures requiring local anaesthesia undertaken in a GP/Specialist's consulting room..."

I have been furnished with a copy of the '*Table of Benefits – [Provider] International Level 1'* which accompanies the terms and conditions, and states as follows:

"…

This Table of Benefits must be read in conjunction with the [Provider] International Health Insurance Rules -Terms and Conditions. The plan type you have chosen is documented on Your Policy Details. If Your Policy Details specifies 'Level 1' then the following benefits apply.

All benefits apply on a per Insured Person per Period of Insurance basis unless stated otherwise in the [Provider] International Health Insurance Rules -Terms and Conditions….

	Benefit Provision	**Benefit Limit**
A	**Overall maximum benefit per insured person {refer to Sections 1 to 11 inclusive of your Rules -Terms and**	€3,000,000
B	**Medical & hospital benefits (refer to Section 2 of your Rules-Terms and Conditions)**…..	

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	Hospitalisation costs for in-patient or day-care admissions • Pre-hospitalisation consultations • Emergency department care • Hospital accommodation • Intensive care • Parent accommodation • In-patient rehabilitation…….	Full cover
	Out-patient costs including complementary medicine • Excess each medical condition • 20% co-insurance applies to all out-patient prescribed drugs, dressings and medicines • A maximum of 3 out-patient psychiatric visits will be covered within the overall out-patient benefit. The 20% co-insurance will apply.	€500 €45
	Minor surgical procedures requiring local anaesthesia undertaken in a GP/Specialist's consulting room	Full cover

Analysis

(1) The first issue to be determined is whether the first Complainant was informed by the Provider that the costs for the second Complainant's treatment would be "*fully covered*" during the telephone calls on 27 July, 28 July and 2 August 2016.

It is important to note at the outset that during the telephone calls on 27 July and 28 July 2016, the first Complainant made enquiries with the Provider in respect of the second Complainant having surgery. Having examined the terms and conditions attached to the Policy and the Table of Benefits, it is clear that such a procedure would be covered under the Policy. The Table of Benefits states that "*minor surgical procedures requiring local anaesthesia undertaken in a GP/Specialist's consulting room"* receives "*full cover"*.

However, I note that when the first Complainant spoke with the Provider on 2 August 2016, there was a revised treatment plan in place (where physiotherapy was required rather than surgery).

The second Complainant proceeded with this revised treatment. I accept that on the basis of the evidence before me, that this revised treatment was classified as outpatient treatment. The Table of Benefits states that outpatient costs has a limit of €500.

The Provider has furnished this office with a copy of the telephone recordings between the Provider and the Complainants. I have considered the content of all of these telephone calls.

Telephone call on 27 July 2016

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On 27 July 2016, the first Complainant spoke with two representatives of the Provider. The first representative was from the emergency department and the second representative was from the claims department.
In the telephone call with the first representative, the first Complainant enquired as to whether the second Complainant was covered under the Policy for the surgery. The representative informed the first Complainant that a medical report would be required for the medical team to review. When the first representative was asked whether a particular clinic in Ireland would be covered, she responded as follows:

> "*I can't answer that I'm afraid, that's with our claims team. We are actually the emergency line here so the fact that it's an outpatient surgery that needs to get booked in that's why I'm not a specialist and I've been referring to other departments they did confirm to me he would be covered in Ireland and they had said again you would need to do the same process as you would in the UK you need to find a hospital where he would have the treatment he would have to have a consultation before they even book you in for treatment so that would be the same in Ireland as it would be here, but whether a [particular clinic] is covered I don't know.*"

The first Complainant was transferred to the second representative in the claims department. The second representative advised that the Policy covered private treatment. The representative informed the first Complainant that as this was a "*planned procedure*", a medical report and an estimation of costs was required. The representative advised that once that was received, the medical team would review it and that the first Complainant would be given the "*yes or no go ahead*". The second representative asked the first Complainant to send the second Complainant's medical records to the Provider and she advised that this could be done by email.

I am of the view that the representatives were very clear that a medical report was required before confirming whether or not the treatment was covered, and on that basis, I cannot accept that the first Complainant was informed that the second Complainant was fully covered for treatment. The second representative referred to the medical report on at least two occasions during the telephone call. I note that the Complainants did not submit medical records to the Provider following this telephone call.

<u>Telephone call on 28 July 2016</u>

In this telephone call, the first Complainant enquired again about the second Complainant's cover in relation to private medical treatment in the UK. She states that "*[the second Complainant] has been told that the only treatment really is surgery by several doctors…*"

The representative advised that the second Complainant should see a Consultant and if it is decided that surgery is required, that he would need to contact the Provider straight away and get a medical report and an estimate of costs and that the Provider would deal with the facility directly. The first Complainant asked whether it was possible that the second Complainant would come out of the NHS system and then potentially not be covered, to which the representative appropriately responded by stating that "*I need to see, because I*

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have nothing to go on, on this, I need to see a medical report on it, but by all means he is entitled to go and see someone private anyway because he has his private health cover, you know, and we just take it from there with him".
I note that the representative advised that the second Complainant was entitled to private treatment, which was correct. I am of the view that the representative correctly advised the first Complainant that a medical report was required. I note that the Complainants did not submit a medical report or an estimation of costs following this call.

Telephone call on 2 August 2016

I consider that this is the most important telephone call relating to this complaint, as the second Complainant ultimately did not actually proceed with the treatment (that is, surgery) which was discussed during the telephone calls on 27 and 28 July 2016.

In this telephone call, the first Complainant telephoned to enquire about "*how to go about a claim…"* She informed the representative that the second Complainant had been seen by a Specialist in a Clinic and that the Specialist had put in place a treatment which involved physiotherapy initially. The first Complainant then stated that she had read the terms and conditions for outpatient costs and asked whether another claim form had to be signed by the physiotherapist. I accept that the representative responded appropriately and answered the question that she was asked, by confirming that the treating doctor was the only person who was required to complete the claim form.

The first Complainant also asked whether the second Complainant had to pay for the physiotherapy and claim. I accept that the representative responded appropriately and answered the question that she was asked, by confirming that it worked on a pay and claim basis. The first Complainant also asked when the expenses should be sent in. I accept that the representative responded appropriately and answered the question that she was asked, by confirming that all expenses must be submitted within 3 months of the treatment and that it was up the second Complainant whether he wanted to submit them weekly or monthly etc.

I accept that the representative did not inform the first Complainant during this telephone call that the treatment would be covered. The representative was asked specific questions in respect of the submission of a claim, to which the representative answered correctly and in line with the terms of the Policy. Whilst the first Complainant informed the representative that the second Complainant was due to have treatment with physiotherapy initially, she did not outline that this was a change in the treatment plan. The first Complainant did not enquire whether this treatment (which was materially different to what was discussed on the two previous calls) was covered under the Policy. I am of the view that it was the Complainants' responsibility to enquire whether the revised treatment was covered before embarking on the treatment. The first Complainant only asked general questions in relation to the submission of a claim and did not at any stage enquire whether this revised treatment was covered under the Policy.

I do not accept the first Complainant's submissions that she was informed that the treatment in which the second Complainant embarked on was "*fully covered"*. I also note

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that the first Complainant was informed on numerous occasions that a medical report was required before a decision was made in respect of cover, however the second Complainant embarked on treatment before providing a medical report and an estimation of costs.
I have been provided with no evidence to support the Complainant's contention that she was assured that the treatment would be fully covered. Furthermore, I accept that in each of these telephone calls, the Provider did not give any assurances to the Complainants to the effect that the costs of the treatment would be "*fully covered*".

Accordingly, I cannot accept the Complainant's submission that she was "*assured by the support line that the treatment was fully covered in any medical institution in the UK and that they did not need to have or review any medical documentation to confirm this*".

(2) The second issue to be determined is whether the Provider should have informed the €500 limit in respect of the outpatient benefit.

In respect of the telephone calls on 27 and 28 July 2016, I would not have expected the representatives to inform the first Complainant about the €500 limit in respect of outpatient costs, as the first Complainant made enquiries about cover in respect of surgery. There would have been no reason for the Provider to have informed the first Complainant about this limit during these telephone calls.

In respect of the telephone call on 2 August 2016, I note that the first Complainant said that she had read the terms and conditions in respect of outpatient costs. I am of the view that the terms and conditions clearly state that the table of benefits forms part of the Policy and should be read in conjunction with the terms and conditions. The Table of Benefits clearly state that the cover for outpatient costs is €500. On this basis, I accept that it was reasonable for the representative to assume that the first Complainant was aware of the €500 limit. The first Complainant did not raise any specific questions with the representative about whether the treatment was covered under the Policy or the level of cover.

Whilst it would have been best practice to mention about the limit of €500 when outpatient costs were referred to by the first Complainant, I note the agent addressed each of the questions that she was asked by the first Complainant. If the representative was asked about the level of cover, I would have expected the representative to outline the €500 limit, however this was not the case. I therefore do not accept that the Provider was obliged to inform the first Complainant about the €500 limit during this phone call. I am of the view that the representative was working on the basis that the first Complainant had reviewed the Policy as this was the information that the first Complainant gave to the Provider at the outset of the call. It appears that the Provider's representative proceeded to deal with the first Complainant's queries on this basis.

The first Complainant has made submissions regarding the email sent by the Clinic on 30 August 2016, which stated that the treatment was on a day care basis. It is important to note that the Table of Benefits outlines that day care admissions have "*full cover*" under the Policy. I do note that this email was sent after the Complainants became aware of the issue in respect of the €500 limit. It is unfortunate that the Clinic advised the first Complainant

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that the treatment was on a day care basis on 30 August 2016 when it confirmed to the Provider on 20 September 2016 and 14 October 2016 that the treatment was on an outpatient basis. It is important for the Complainants to be aware that this office investigates complaints against providers of financial services only. The conduct of the Clinic cannot be investigated by this office nor can I make any decision with regard to the Clinic's conduct. I have reviewed the telephone calls from the Provider to the Clinic on 20 September 2016 and 14 October 2016, and I can find no fault on the part of the Provider during these telephone calls. However, it is disappointing that when the Provider spoke with the first Complainant on 20 September 2016 (after speaking with the Clinic), that it did not inform the first Complainant about the Clinic's position in respect of the treatment being classified on an outpatient basis. I consider this to be a customer service failing on the part of the Provider.

It is not particularly clear from the documentation before me, however it appears that the Provider did not inform the first Complainant about this until either 10 or 14 October 2016 (some three weeks later).

In addition, in respect of customer service, the Provider accepts that the first Complainant was wrongly advised during the telephone call on 26 August 2016, when the representative stated that the first Complainant was informed of the €500 limit during an earlier phone call on 27 July 2016. The Provider accepts that the first Complainant was not advised of this and that the representative provided incorrect information. I accept that this will have caused frustration and inconvenience to the first Complainant. I consider this to be another customer service failing on the part of the Provider.

In conclusion, I accept that on the basis of the evidence before me, that the substantive complaint against the Provider cannot be substantiated. However, on the basis of the two customer service failings, I partially uphold this complaint and direct that the Provider make a compensatory sum to the Complainants in the sum of €300.

Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially upheld, on the grounds prescribed in ***Section 60(2)(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 €300, 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.

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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

4 October 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.