An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0354
Sector:	Insurance
Product / Service:	Term Insurance
Conduct(s) complained of:	Maladministration (life) Dissatisfaction with customer service
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint relates to a Term Life Assurance policy (the "Policy") which commenced on **24 October 1994**. The Policy was with a previous provider and was incepted by the first-named Complainant. The life assured was that of the second-named Complainant. The Policy (xxxxx369) had a 20 year term, and the first Complainant submits that she expected to receive a lump sum of £1,440 (Irish Punts) which was the sum assured, plus any bonuses due at the end of the term, or that the sum would be paid upon the death of the second Complainant, should this occur before the end of the term. It should be noted that in **September 2007**, the Provider acquired the business of the previous provider.

The Complainants' Case

The first-named Complainant submits that in **2014,** at the end of the policy term, she did not receive the sum assured or any bonuses that would have accrued at that time. She submits that she continued to pay the premiums in respect of the Policy until **September 2015.**

The first-named Complainant submits that when she queried this with the Provider, it informed her by letter that *"the policy came to an end in **June 2015,** and that it expired without value"*. There followed a series of letters between the Provider and the first-named Complainant, through her representatives, which point to some confusion, regarding the reference number of the policy held, the proposer of this policy and the number of policies held by the Complainants. The Provider also noted that a second Policy (xxxxx879) had been

incepted by the first Complainant on the same day as the Policy, which is the subject of this complaint.

During the course of correspondence between the Provider and Complainants, the Provider wrote to the first-named Complainant in August 2016 and stated that it had made "*an error in [its] earlier correspondence and [it] had confused two policy numbers – XXXXXX879 and XXXXXX369*." The Provider went on to say that the Policy had "*lapsed without any value before being taken on by [the Provider]".* The first-named Complainant submits that she was not advised by either Provider that there had been a change to the nature, term or name of the Policy that she took out and that she did not agree to any change. The first-named Complainant also says that she was never advised by either Provider that the Policy had lapsed. She continued to make payment on the Policy up to September 2015, which payments were accepted by the Provider.

The first-named Complainant "*believes that there have been numerous errors in the handling of [her] file by [the Provider] and believes that [its] records are not accurate".*

The Complainants want the Provider to *"pay the sum assured as per the policy"*. The sum assured was £1,440.00 (Irish Punts).

The Provider's Case

The Provider submits that policy number **XXXXXX369** was a policy *"(a form of with profits endowment)"* which commenced on 24 October 1994 with a 20 year terms and was due to mature on 24 October 2014. The Provider submits:

> "*this policy lapsed with no benefit prior to [the Provider] taking over the business of [the former Provider] in October 2007."*

The Provider outlines:

> "*this may have been because premiums were missed or ceased being paid and as a result the policy lapsed with no value. This means that you were not entitled to a pay-out when the policy expired*".

The Provider submits that in order for the Policy to have provided a return to the first-named Complainant at the end of the term, premium payments would have to have been paid for at least two years.

The Provider relies on the provisions of the Product Particulars for the Policy which state that:

> *Please note that if less than two years premiums have been paid, the policy will lapse, you will lose your right to receive the sum assured (and any bonuses allocated) under that policy and no surrender value will have accrued and therefore no sums will be payable to you.*

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The Provider also submits that there were elements of the Complainants' complaint where the Provider made errors, in that, correspondence which issued to the first-named Complainant contained inaccurate information and the Provider also sent the first-named Complainant a cheque which it later requested back because it should not have issued to her. The Provider apologised for these errors and offered €50.00 "*as recompense for poor service experienced*". The first-named Complainant did not accept this sum, and the cheque was returned to the Provider.

The Complaint for Adjudication

The complaint is that the Provider was guilty of maladministration, in that:-

1. The Provider failed to pay the first-named Complainant the lump sum payment, and bonuses believed to be due at the end of the term on policy in 2014;

2. The Provider continued to take premiums from the first-named Complainant despite its assertion that the policy had lapsed in October 2007;

3. The Provider has made "*numerous errors in the handling of the file" and the Complainants "believe [its] records are not accurate";*

4. The Provider failed to clarify to the first-named Complainant what policy she was paying premiums for, or to contact her regarding policy numbers being changed in October 2007;

5. The Provider issued a number of incorrect correspondences to the Complainants over a period of 18 months.

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

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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 17 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, the final determination of this office is set out below.

It has previously been confirmed to the Complainants that the FSPO cannot investigate a complaint of the mis-selling of the policy in 1994, owing to the period which elapsed between 1994 and when the complaint was made in 2018.

The Provider has furnished this office with a timeline of events, with respect to policies relevant to this dispute, as follows;

"24 October 1994	*Start date for policy number [XXXXXX368]* *Start date for policy number [XXXXXX369]*
Unknown date	*Policy number [XXXXXX369] lapsed without value*
26 June 1995	*Start date for policy number [XXXXXX879]*
24 October 2004	*Expiry of policy [XXXXXX368]*
30 September 2007	*The Provider acquired the [former Provider's] business* *Policy number [XXXXXX879] was renumbered as policy [XXXXXX309]*
26 June 2015	*Expiry of policy number [XXXXXX879]*
20 July 2016	*Refund of overpaid premiums to the value of €21.05 in respect of policy [XXXXXX879]*
4 November 2016	*Complaint received by the Provider from the first-named Complainant*
22 November 2016	*Final Response sent from the Provider to the first-named Complainant"*

It appears from the correspondence received from both parties, that there may have been some uncertainly on the part of the Complainants in relation to the number of policies held by them.

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The Provider responded to queries raised by this office by letter dated 11 February 2019 and noted that the Provider had records of three polices which has been incepted by the Complainants i.e. the Policy at issue (XXXXXX369) and two other policies XXXXXX368 and XXXXXX879.

The following should be noted:

1. **Policy number XXXXXX368**

The First Complainant held this Convertible Term Assurance Policy number XXXXXX368 which it seems was for a 10 year term which expired on 24 October 2004. This provided life cover benefit of €17,776.33 on the life of the first Complainant.

No issue in respect of this policy arises for adjudication.

I note that relevant screen shots from the previous provider's administration system have been furnished by the Provider as evidence of this policy's existence and expiry. I note that the premium on this policy was a monthly payment of €11.01.

2. **Policy Number XXXXXX879**

The Provider submits that;

> *"This is a Convertible Term Assurance policy number [XXXXX879]. This policy provided cover of €18,030.28 on the life of* [the Second Complainant] *for a premium of €11.01 per month. The policy ran from 26 June 1995 to 26 June 2015, when the policy expired"*

It is understood that when the Provider acquired the previous provider's business in 2007 Policy number [XXXXXX879] was renumbered, as policy [XXXXXX309]. The Provider submits that at the time that this policy was renumbered policyholders were advised of the renumbering, and were advised that the old number also remained valid.

The screenshots from the Provider's administration system show that the premium on policy number XXXXXX879 was €11.01 per month. It is understood that throughout the term of this policy the second-named Complainant made the payments, initially to the previous provider, and from 2007 to the Provider, by way of postal order.

3. **Policy XXXXX369** (which is the subject of this complaint)

The Complainants maintain that premiums in respect of the Policy (**policy number XXXX369)** continued to be paid and accepted by the Provider until September 2015. The Provider's records indicate that this policy was an "*Easisave*" policy with the sum assured of €1,828.42 on the life of the second Complainant.

The Complainants have not made available any documentation to show that premiums for the Policy continued to be paid until 2015. In this regard, this office wrote to the

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Complainants' representatives by email dated 20 March 2019 seeking clarification of the following:

1. Does the first-named Complainant have any proof/statements showing payment of the premiums on policy XXXXXX369, to the Provider from 1994 to the alleged expiry date of June 2015?
2. Please confirm how these payment were made to the Provider.
3. Do the Complainants agree that there were three polices incepted as stated by the Provider?

The Complainants' representatives responded by letter dated 14 May 2019 which stated that:

> *"*[The First Complainant] *cannot locate the receipts for the payments made since 1994. She did move house and she is still endeavouring to locate same. She states at the beginning of the policy* [the previous provider] *were based in* [location] *and a Mr [K.] collected the premiums for approximately 5 to 6 years. Then a man who she only knows as [M.] collected it for approximately 1 year or so. After that she states that she was sent 12 pre-addressed envelopes and she had to get a postal order each month and send it to a Dublin address".*
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> "*In relation to* [the Second Complainant] [the First Complainant's] *brother, she took the policy out in 1994 for 20 years. She states that there was ever [sic] one policy for him and she does not know why there was a second policy number for it. She states that the company was taken over by another company. She continued to pay as she was paying with the older company but she queried if they may have given it another number at that time but she is unsure of that".*

I note that the Provider submits that;

> "*I can confirm that you also held a Convertible Term Assurance policy with* [previous provider] *number XXXXXX368, and you continued to pay the premiums for this policy until it expired in October 2004 but you did not continue to pay the premiums for policy XXXXXX369*".

The Provider does not accept that premiums continued to be paid on the Policy until 2015 and states that prior to when it took over the business of the previous provider in 2007, the Policy had lapsed with no benefit.

The Provider has not furnished any correspondence that issued to the Complainants which confirms the date on which the Policy lapsed or the reasons why the Policy lapsed. The Provider merely offers a potential explanation as to why the Policy may have lapsed in its letter of 22 November 2016, being that "*This may have been because premiums were missed or ceased being paid and as a result the policy lapsed with no value. This means that you were not entitled to a pay-out when the policy expired*".

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I note that the Provider has furnished screen shots from the previous Provider's administration system (which the Provider states was decommissioned in 2007 when the previous provider's business was acquired by the Provider) in relation to the Policy XXXX369 which records the status of the Policy as "*Lapse No Benefit*". The monthly premium with respect to this policy is also noted to have been €11.01.

It is difficult to determine this dispute, in circumstances where the first-named Complainant cannot provide any evidence that the payments have been made and the Provider is in a position where it is relying on the records of a previous provider whose business it acquired. I must have regard however to the best evidence available, in the form of the screen shots from the previous provider's administrative system. These screenshots support the proposition that the Policy lapsed at some stage prior to 2007, albeit that the date of, or reason for, the lapse cannot be established. Furthermore, any correspondence which should or would have issued to the first-named Complainant regarding the lapsing of the Policy will have issued prior to the Provider taking over the business of the previous provider in 2007.

In those circumstances, I cannot find there to be any fault on the part of the Provider, in failing to communicate the lapse of the policy to the first-named Complainant at an undetermined point in time, prior to 2007.

I note that the Complainants have also raised issues with respect to correspondence issued to them in 2016. When the first-named Complainant raised an issue with respect to the policy number XXXXXX369, the Provider wrote to the first-named Complainant in July 2016 and made reference to the policy as

> "a *Legal Life Convertible Term Assurance which is only payable on death. This means that when the policy came to the end of its term, 26 June 2015, it expired without value*".

This was an error on the part of the Provider which it has accepted and explained in correspondence addressed to the Complainants' representatives dated 2 August 2016 which stated that;

> "*We can confirm that the [Provider] policy…is XXXXXX879 and not XXXXXX369 as advised in our letter dated 26 July 2016, please accept our apology for this error".*

In this regard, the Provider submits

> "*We essentially provided information in respect of the wrong policy*".

By letter dated 2 August 2016, the Provider wrote to the Complainants' representative enclosing a cheque in the amount of €21.05 for overpayment of premiums paid in respect of policy XXXXXX369. It is understood that the Provider subsequently wrote to the first-named Complainant requesting the return of the cheque because it should not have issued to the first-named Complainant, as the overpayment related to the second-named Complainant's policy XXXXXX879.

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In this regard, the Provider sets out in its final response to the Complainants dated 22 November 2016 that:

> *"Having reviewed your records, I conclude that you have not received the level of service we aim to provide. As recompense for the poor service experienced, I have requested a cheque for €50.00…"*

A cheque in the amount of €50.00 issued to the first-named Complainant on 6 December 2016. However, this was not accepted by the first–named Complainant and was returned to the Provider.

On the basis of the evidence before me, I am satisfied therefore that the Provider was entitled to maintain its position that no lump-sum payment was due to the Complainant in 2014 in circumstances where the records indicated that the policy had lapsed prior to 2007. The evidence also clarifies that the premium payments made by the Complainants during the period leading up to this complaint, were not paid in respect of the policy which is at issue and, instead, were payable in relation to an entirely different policy.

I am satisfied however, that the Provider has a case to answer in relation to the other elements of the Complainants' grievances. There were indeed a number of errors in the handling of this file and the communications from the Provider with the Complainants during 2016 merely served to add to the confusion regarding the Complainants' various policies.

In that context, I take the view that the compensatory payment of €50 which was offered to the Complainants by the Provider was inadequate to address the various errors and the confusion which ensued. Whilst I do not believe that the Complainants were at any financial loss as a result of any failure by the Provider to pay benefit pursuant to the policy which had previously been in place, nevertheless I believe that the Complainants are entitled to compensation for the misunderstanding and confusion caused throughout 2016. In those circumstances, I consider it appropriate to partially uphold this complaint.

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Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is 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 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.

- 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.

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION AND LEGAL SERVICES

9 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.