An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0361
Sector:	Insurance
Product / Service:	Dental Expenses Insurance
Conduct(s) complained of:	Rejection of claim Dissatisfaction with customer service
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint concerns the Complainant's health insurance policy with the Provider and relates to the Complainant's claim for dental treatment benefit which has been partially admitted by the Provider.

The Complainant's Case

The Complainant is retired. She submits that in **February 2017**, she upgraded her health insurance policy with the Provider to include cover for dental treatment. She says that on **12 May 2017**, she emailed the Provider for clarification regarding the level of cover for dental treatments under the policy and that, although her e-mail was responded to by the Provider, the query was not addressed.

The Complainant submits that in **June 2017**, her dentist referred her to a specialist dentist for extensive treatment and she again contacted the Provider via e-mail to query if this dental treatment would be covered under her insurance policy. The Complainant submits that the email was acknowledged by the Provider but that her query was not answered.

The Complainant says that in **December 2017**, she contacted the Provider for the fourth time to query if her dental treatment would be covered and in doing so she attached a detailed description of the treatment due to be carried out along with the estimated cost of

the treatment. The Provider replied to the Complainant's email in **January 2018** but, rather than addressing her query, it advised her that she had not submitted proper receipts and it would review her claim upon receiving the itemised invoices and receipts. The Complainant submits that she underwent the treatment and submitted the invoices and receipts to the Provider.

The Complainant maintains that the Provider wrote to her in **March 2018** to advise that a waiting period applied to her dental cover as she had changed the level of cover mid-year into the policy period. The Complainant submits that this is incorrect as her policy renewed unchanged in February 2018 and the dental benefit had been added to her policy in **February 2017**. The Complainant says that, due to the mid-year change in cover, the Provider partially admitted the dental claim.

The Complainant says that she emailed the Provider on **7 June 2018** to arrange a face to face meeting to discuss her complaint however the Provider advised that it did not have the facility to arrange such a meeting and advised her to log a complaint for investigation.

The Complainant says that despite her attempts in four separate correspondences to clarify the level of dental cover, to ensure her dental treatment would be covered under the policy, the Provider on each occasion neglected to read her correspondences properly. The Complainant submits that the Provider's lack of customer service is very frustrating. She says that the health issue pertaining to this complaint does not relate to dental problems but instead is related to a functional and medical condition and should be assessed as such.

The Provider's Case

The Provider maintains that it has paid out in full as per its liability under the policy.

In responding to this complaint in March 2019, the Provider furnished a very detailed timeline of the parties' interactions. The Provider says that the policy wording is both clear and unambiguous and it refers to the Table of Cover that was included in the Renewal Invitation and Renewal Confirmation documents both in 2017 and 2018, which outline that such must be read in conjunction with the Membership Handbook.

The Complaints for Adjudication

The first complaint is that the Provider dealt with the Complainant's queries pertaining to her proposed dental treatments in an unacceptable manner.

The second complaint is that the Provider has incorrectly or unreasonably declined the Complainant's full claim under the policy.

The Complainant wants the Provider to pay her claim in full.

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Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on12 August 2019, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter. Following the consideration of additional submissions from the parties, the final determination of this office is set out below.

Before embarking on my analysis, I consider it useful to set out the terms of the policy relied upon by the Provider as well as a chronology reproducing the content of certain relevant correspondence.

Policy Terms and Conditions

The Complainant's policy schedule or 'Table of Cover' provides for the following benefits:

Day-to-Day benefits (subject to excess)

Individual Day-to-Day excess *€1*

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Dentist Visits *€25 per visit, unlimited*

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The policy also provides for the following benefits:

Personalised Packages
…
Dental and Optical

Invisible cosmetic braces	*€450 point of sale discount*
Emergency Dental Care	*€350 contribution*
One hour teeth whitening	*50% point of sale discount plus 10% contribution*
Retainers & fitted gum shields	*€25 contribution*
X-ray, check-up, scale & polish	*€50 x 1 visit*

An *'Orthodontic Benefit'* of up to €100 per policy year was added to the policy upon renewal in **February 2018**.

The membership handbook, which forms part of the policy documentation, includes the following provisions:

Dentists/Oral surgeons/Periodontists

Your *in-patient benefit for consultant's fees also covers a limited number of dental/oral* ***surgical procedures*** *where they are performed by a* ***dentist, oral surgeon*** *or* ***periodontist****. (This excludes dental visits and emergency dental care which are covered under our Day-to-day Benefits and Out-patient Benefits).*

The dental/oral ***surgical procedures*** *that are covered under our In-patient Benefits are listed in the "Periodontal/Oral/Dental Surgery Ground Rules" section of the Schedule of Benefits. These* ***procedures*** *will only be covered where they are performed by the specified type of dental practitioner (i.e. a* ***dentist, oral surgeon*** *or* ***periodontist****). Please note many dental/oral* ***surgical procedures*** *require* ***pre-authorisation****. Your* ***dentist/oral surgeon/ periodontist's*** *fees will only be covered where your oral/dental* ***surgery*** *is performed in a* ***medical facility*** *covered under* ***your plan*** *or in your* ***dentist/oral surgeon/periodontist's*** *room.*

As with ***your consultant, your dentist, oral surgeon*** *or* ***periodontist*** *must be registered with* [the Provider]. *If they are not registered with us, you will not be covered (subject to cover prescribed under the* ***Minimum Benefit Regulations*** *if applicable).*

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*The extent to which **your oral surgeon/periodontist's** professional fees are covered will also depend on whether they have chosen to be a participating or a standard rate oral **surgeon/periodontist**. See the **consultant** section above for a full explanation on how **your** oral **health care provider's** status as participating or standard rate affects **your** cover. Please note that all **dentists** are classed as standard rate so **we** will only cover a limited portion of **your dentist's** fees for performing oral/dental **surgery**.*

Chronology

16 February 2012	Policy incepted
01 February 2017	Request from the Complainant to upgrade policy to include, *inter alia*, the 'Dental & Optical' package
16 February 2017	Policy renewed on upgraded basis to include dental benefits
12 May 2017	In an email to the Provider, the Complainant queried, solely, as follows: *"I am enquiring as to what cover is available to me for dental treatment?"*
12 May 2017	The Provider responded the same day indicating that, in circumstances where the Complainant upgraded her policy to include dental benefits in February 2017, the Complainant was serving *"an upgrade waiting period of 26 weeks*" before she could claim for enhanced benefit. The response went on to clarify that after this period was over, the Complainant could claim €25 per visit to a dentist. This email included the Complainant's policy number at the beginning.
12 May 2017	The Complainant in turn responded the same day as follows: *"Thanks for the prompt response to my query re dental benefits. If during the course of the yr. I have to have major dental repair work carried out can you clarify if that will be covered or is cover confined to specific dental practices?"*
12 May 2017	The Provider responded, again the same day, requesting details of the Complainant's membership number or date of birth so that it could locate the precise policy details. This was notwithstanding that the Complainant's policy number had been included in the original email.
27 June 2017	The Complainant emailed for the first time since the email of 12 May 2017 and, having cited her policy number, queried as follows: *"I have to have dental work carried out over the next period of time. I intend having this work done with* [dental practice named]. *As I have dental cover under the terms of my policy am I covered?"*

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28 June 2017 — The Provider responded reiterating that the Complainant was serving *"an upgrade waiting period of 26 weeks*" before she could claim for enhanced benefit, following which she would be in a position to claim €25 per each visit to the dentist.

28 June 2017 — The Complainant responded the same day as follows:

> *"Thank you for your prompt reply but unfortunately my query has not been answered. I have to have dental treatment in the near future will this be covered by my policy?"*

28 June 2017 — The Provider responded the same day indicating that "[a]*s advised for visits to a dentist you can claim €25 per visit unlimited once your 26 week upgrade is served*." This email also advised the means by which eligibility for particular procedures could be determined in advance on foot of the provision of certain identified information including the *"provision code (3 - 4 digit number specific to the exact procedure being carried out)".*

16 August 2017 — Expiry of 26 week upgrade waiting period.

21 December 2017 — Letter from the Complainant stating as follows:
"Enclosed is a detailed account of dental treatment required to maintain good health. As the treatment required is functional and not cosmetic I assume it will be covered under the plan."
The letter enclosed a letter from the Complainant's dentist dated 19 December 2017 referring to the broad outlines of a "*treatment plan*" together with an itemised estimate dated 19 December 2017 for extensive identified treatment in the total amount of €36,390. The estimate included the Complainant's name as the person being treated, the type of treatment required, the practitioner's qualifications and the cost of each treatment. No dates for the proposed procedures were included.

08 January 2018 — Letter from Provider stating as follows:

"Unfortunately, we are unable to accept the document we received for your proposed dental treatment. This document is an (estimate/invoice/quotation) and isn't a valid receipt.
To ensure your claim can be reviewed we need a valid receipt relating to the treatment which should include the following details;

- *The name of the person being treated*
- *The type of treatment*
- *The practitioner's full details including qualifications*
- *The date of each treatment dd/mm/yy*
- *The cost of each treatment*

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We would appreciate it if you could contact your practitioner and request new receipt with all of this information before resubmitting to us for review."

16 February 2018 — Policy renewed.

21 March 2018 — The Provider states that it received two receipts for treatment by post from the Complainant relating to treatment in the total amount €1,045. These receipts were comprised of €295 referable to **27 June 2017** and €750 referable to **23 January 2018**. The Provider then wrote to the Complainant on 21 March 2018 in the following terms:
"Regarding your ongoing dental treatment we will need a receipt of payment showing the date of each treatment in order to review your claim."

22 March 2018 — The Provider wrote to the Complainant stating "*Your claim has been paid"* and enclosing a cheque in the amount of €75.00. The enclosure to the letter recorded that the €75 was comprised of €25 for a dental visit on 23 January 2018 and €50 for an "*x-ray, check-up, scale & polish*" corresponding to the date 27 June 2017 and it was further noted that this represented "*maximum benefit paid*". The enclosure included a glossary of definitions that referred to a potential reason a shortfall in pay-out by reference to "*a change in cover mid-year*" for however this was not applicable or relevant to the Complainant's situation and appears to have given rise to confusion on her part.

01 April 2018 — Email from the Complainant:
"I received your correspondence dated 21/3/2018 [the content of the letter makes it clear that the Complainant was in fact referring to the letter of 22/3/2018] *in respect of my recent claim and am at a loss to understand as to why my policy did not cover these expenses?*
I earlier submitted a detailed schedule of treatment that my dentist has determined is necessary for me but your response was inadequate. I am now requesting again that since my dentist says I need mouth rehabilitation can you advise that this procedure which is very expensive will be covered under my policy? I am on a pension so my means are limited. I need to know definitely that the costs will be met, so do I need to make arrangements with my local credit union to pay initially submit the receipts and then await reimbursement to continue the treatment which will be ongoing?"

03 April 2018 — Response from Provider addressing the question of the earlier provision by the Complainant of the detailed estimate and stating:
"I can confirm that these receipts were not covered as they did not contain the date of treatment"

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10 April 2018	Letter from the Complainant providing a breakdown of treatment provided on 23 January 2018 which cost €750.00. This letter gave rise to the opening of a new claim which was declined on the basis that "*Receipt submitted and paid previously".*
17 April 2018	Phone call between the Complainant and the Provider during which the Provider reconfirmed that there was no further payment due on the receipt submitted by the Complainant in relation to dental cover. This prompted the Complainant to query what precisely she was paying dental cover for. The Provider then proceeded to cite certain of the specific matters covered as set out in the 'Table of Cover' part of the policy (reproduced above) before explaining that certain limited "*inpatient dental procedures … done in a day case*" are covered but hat a claimant must provide a procedure code for it to be covered. However, "*just routine dental work we don't really cover them in full*". The Complainant then queried whether she would be covered for the "*major work*" she had to have done. In response to a question as to what precise work was done, the Complainant stated "*mouth rehabilitation*" to which the Provider responded: *"If they didn't provide you with a procedure code, then we won't be able to check if it is a procedure that we cover. So, if you find out from the consultant and the dentist to see if there's a procedure code to the procedure that is done, if there is then you also have to give us the name of the consultant and then we can check. If both those details are covered, you might be able to send the claim then to* [the Provider]*, if not, then you won't be covered for anything."* The Complainant indicated that she would seek the relevant code but emphasised that she would be "*most annoyed*" if the insurance didn't cover the treatment.
15 May 2018	An invoice in the amount of €6,120 received by the Provider referable to treatment provided on 25 April 2018
20 May 2018	The Provider wrote to the Complainant stating "*Your claim has been paid"* and enclosing a cheque in the amount of €50.00. The enclosure to the letter recorded that the €50 comprised €25 for a dental visit on 25 April 2018 and €25 for 'retainers and fitted gum shields' on the same day. It was further noted that this represented "*maximum benefit paid*".
20 May 2018	Email from the Complainant querying why the cost of treatment was not covered and noting that the treatment was "*extensive, expensive and medical and in no way cosmetic*". This email again refers to a mid-year change in cover which I am again satisfied is a misunderstanding on the part of the Complainant.

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23 May 2018	Email from the Provider simply confirming that the plan allows the Complainant to claim back €25 per visit to the dentist.
29 May 2018	Email from the Complainant stating: *"I note that my claim was treated as a routine visit to the dentist when in fact it was a surgical procedure which entailed the carrying out of bone reconstruction."* This appears to be the first time that the procedure was described by the Complainant as 'surgical'.
30 May 2018	Email from the Provider stating that the policy "*does not provide cover for specialised dental treatment, therefore we could only process your receipt dated 25th April 2018 using the benefit for dental visits*." (This was not correct given the list of procedure listed in *"Periodontal/Oral/Dental Surgery Ground Rules"* section of the Schedule of Benefits).
07 June 2018	Email from the Complainant requesting a meeting with the claims manager.
08 June 2018	Response from the Provider indicating that such a facility not available.
08 June 2018	Response from the Complainant setting out various grievances.
17 June 2018	Formal complaint made by the Complainant.
21 June 2018	Provider's Final Response Letter.
27 August 2018	Further dental receipts received.
30 August 2018	The Provider wrote to the Complainant stating "*Your claim has been paid"* and enclosing a cheque in the amount of €100.00. The enclosure to the letter recorded that the €100 comprised three payments of €25 each for dental visits on 20 September 2017, 26 September 2017 and 09 November 2017 as well as a further €25 for an unrelated matter. The enclosure also noted that claims in respect of 3 earlier dates (the latest being July 2017) were declined as the waiting period had not yet been served.
04 January 2019	Further dental receipt received.
16 February 2019	The Provider wrote to the Complainant stating "*Your claim has been paid"* and enclosing a cheque in the amount of €25.00. The enclosure to the letter recorded that the €25 related to a dental attendance on 4 January 2019.

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Analysis

The development of the story of the claim in this matter was beset with confusion from the outset. The Complainant was seeking pre-approval for very costly treatment in circumstances where she had already expended only a small portion of the anticipated cost. The Provider did not appear to appreciate this (at the outset at any rate) and was seeking to be informed of the dates on which the treatment had been undergone. The Provider was seeking this information, it seems clear to me, on the basis that it intended to consider the claim by reference largely to the modest figures allowable on the policy referable to individual attendances with a dentist, namely €25 only for each individual visit.

There were certain other matters that contributed to further confusion that will benefit from clarity at the outset. The Complainant has repeatedly apprehended that one of the reasons advanced by the Provider for declining to pay out her claim in full is that she changed or modified her policy in the middle of the policy term therefore giving rise to a reduced pay-out. This is incorrect. The letters notifying the Complainant of the modest payments which were allowed included enclosures setting out the Provider's analysis which each included, at the end, a glossary to explain the various reasons that *might* be offered for a reduced payment. This glossary includes every possible reason that is typically relied upon by the Provider in any given situation. However, the relevant factor in this instance is the actual reason *in fact* relied upon by the Provider in the main body of the enclosures and in each instance here, the relevant reason was "*maximum benefit paid*". The Provider did not rely upon any 'change in cover mid-year'. Having stated the foregoing, it would be remiss not to point out that in my opinion, the Provider failed entirely, to clarify the matter for the Complainant or indeed to address her concern at all once she had raised the incorrect apprehension. I will return to this below.

The central confusion in this case however appears to have related to what was, and was not, covered under the policy. The Complainant believed, and indeed still does, that the policy should cover all non-cosmetic procedures or all procedures that are "*functional*" and/or medically advised. The Complainant clearly believes that by reference to this metric, the treatment she has required, and that she will require in the future, should be covered. Unfortunately, from the point of view of the Complainant, these are not the applicable criteria.

The policy documentation is the contractual framework between the parties which stipulates what is and is not covered. In this case, the dental part of the 'Table of Cover' document provides for modest cover (€25) in respect of each visit to the dentist. Certain other specific matters are also covered as noted above, at pages 3-4, where I have reproduced the policy terms, however these matters are largely irrelevant for the purposes of the present consideration. The treatment in respect of which the Complainant seeks cover is not expressly covered in the 'Table of Cover' document. It is not emergency treatment which would, in any event, be limited to another relatively modest figure.

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The Provider has however suggested on a number of occasions (both orally and in writing) that the treatment could possibly be covered by reference to a 'procedure code' and the Complainant has been asked to provide this code on a number of occasions along with the name of her 'consultant'. It is clear from the extract reproduced from the membership handbook above, that a certain number of specific "*dental/oral surgical procedures***"** are covered, providing always that the procedure is carried out by a dentist "*registered*" with the Provider. These specific procedures are said to be listed in the *"Periodontal/Oral/Dental Surgery Ground Rules"* section of the Schedule of Benefits. The Provider has not however furnished a copy of this document and I therefore assume that the Complainant has not had sight of it either.

The Provider points out that it sought the relevant information including the 'procedure code' from the Complainant in its email of 28 June 2017. The Provider further points out that the Complainant failed to respond to this email and this seems to me to be so. The Provider also relies on the fact that the 'procedure code' was sought during the phone call of 17 April 2018 and indeed that the Complainant undertook to furnish same. However, the fact that the Complainant and her dentist were unable to provide a 'procedure code' is entirely unsurprising given that the Complainant's dentist does not appear to be "*registered*" with the Provider.

In light of the fact that the Complainant's dentist is not "*registered*" with the Provider, it seems to me that the inevitable conclusion is that the Complainant will not be covered in respect of any treatment undertaken to date (other than by reference to the €25 daily attendance benefit), even in the event that the treatment *is* included in the list of dental/oral surgical procedures specified in the *"Periodontal/Oral/Dental Surgery Ground Rules"* section of the Schedule of Benefits.

Ultimately therefore, I am satisfied that the Provider has paid out on the claims made by the Complainant in compliance with the terms of the policy in the total amount, by my calculations, of €225. This obviously is but a small fraction of the cost faced by the Complainant however the fact of the matter is that the policy incepted by the Complainant simply does not provide cover for the treatment she has undergone to-date. Consequently, insofar as the Complainant complains about the amount of the payments made to her, this aspect of her complaint cannot be upheld.

That is not the end of the matter however. I am satisfied that the Provider in this case has contributed significantly to the unfortunate evolution of this situation. The Provider failed to engage with the Complainant in any meaningful way at the outset when it was clear that she was looking for guidance, prospectively, as to what might and might not be covered.

The Provider's first email of 12 May 2017, for example, made no reference to the list of dental/oral surgical procedures that are covered and listed in the "*Periodontal/Oral/Dental Surgery Ground Rules*" section of the Schedule of Benefits. This was clearly the relevant information required by the Complainant, so that she could ascertain whether substantial cover might be available in respect of the treatment required by her, and not just the modest daily attendance benefit.

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In the event that substantial cover *was* available, and in the event that the terms of the policy were satisfactorily explained to her, the Complainant might well have, at that point sought to change dentist to one "*registered*" with the Provider. (I might note that the Provider's second email of 12 May 2017 which was the last in the interaction, sought the Complainant's policy number however the Complainant had already provided this number in her first email of that day.)

The Provider's first email of 28 June 2017 (again in response to a specific query from the Complainant) once again failed to make any reference to the list of dental/oral surgical procedures that are covered on the policy. Whereas the Provider's second email of 28 June 2017 did refer to the 'procedure code', this email again omitted any reference to an actual list of dental procedures that are covered. It seems glaringly obvious to me that this is the information that the Complainant wanted and indeed, most needed.

The Provider's letters of 8 January 2018 and 3 April 2018 in response to the Complainant having provided an estimate for treatment, are also open to criticism in my view. The Provider intimated that insufficient information had been made available. However, of the specific items of information which the Provider indicated should have been included, the only item that was not included was the dates of treatment. However, given that the document provided by the Complainant was an estimate for future work, clearly it was not possible to give definitive dates. This is a further example in my opinion, of the Provider's failure to engage satisfactorily with the actual content of the Complainant's query.

The first occasion on which the Provider made any reference to a specific list of dental treatments which are covered under the policy was during the phone call of **17 April 2018**. In the course of this phone call, it was also clarified for the first time that the practitioner would also need to be registered with the Provider. This, in my view, was far too late in the process for this information to have been imparted (notwithstanding that it could have been gleaned from the details in the membership handbook).

In addition to the foregoing, the Provider entirely omitted to address the Complainant's admittedly incorrect apprehension (the mid-year change) as to the reason why her claim had not been admitted in full, as discussed above. The email of 30 May 2018 also imparted incorrect advice.

In light of the content of the previous several paragraphs, I consider it appropriate to partially uphold the Complainant's complaint regarding the Provider's maladministration, in particular the miscommunication, in the course of the claims process. I also consider it appropriate to direct the Provider to furnish the Complainant with a copy of the Schedule of Benefits with the pages addressing the '*Periodontal/Oral/Dental Surgery Ground Rules*' section, where the various procedures covered are listed, suitably highlighted and identified to her. This will enable the Complainant to ascertain whether any of the treatment she has undergone, or may require in the future, is covered (in this regard it would seem from the Complainant's submissions that in August 2019, she had already made payments totalling €26,000 towards the anticipated total bill of €36,390, with an additional €10,000 falling due in September.)

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In that event, she can take whatever action she deems appropriate in light of same. The Provider has noted that it will assess all and any future claims made by the Complainant and this of course should be the case. In the event that no further useful cover (from the Complainant's perspective) is available to her, over and above the daily attendance benefit, it is important to note that the Provider did not provide any advice to the Complainant in and around the purchase of the product (or in or around the time when upgrades were arranged). This advice was facilitated by a third party. As a result, any shortcomings in the cover, as perceived by the Complainant, cannot be ascribed to the Provider, and are a matter for the third party.

The Complainant also complains about the Provider's failure to facilitate her with a face-to-face meeting. Whilst I understand the Complainant's frustrations in this regard, there is no requirement on the Provider to facilitate such a meeting, either by reference to the terms of the policy or by reference to any relevant statutory or regulatory regimes. This aspect of the complaint cannot therefore be upheld.

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)(b), (c)*** *and* ***(f).***

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to rectify the conduct complained of, by furnishing the Complainant with a copy of the Schedule of Benefits to include the identified '*Periodontal/Oral/Dental Surgery Ground Rules*' and, in addition, to make a compensatory payment to the Complainant in the sum of €1,200, by way of electronic transfer into an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant 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

30 October 2019

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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.