An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0385
Sector:	Insurance
Product / Service:	Payment Protection
Conduct(s) complained of:	Lapse/cancellation of policy
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint relates to an alleged failure on the part of the Provider in **2012**, to execute the Complainant's instructions to cancel an insurance policy incepted in **2009**.

The Complainant's Case

The Complainant purchased, via an intermediary, an income protection policy in early **2009** which was administered by the Provider. In **May/June 2012**, following an unsuccessful claim on the policy, the Complainant states that he contacted the Provider seeking to cancel the policy. The Complainant states that he was advised to submit a request to that effect, in writing, which he maintains he did.

Thereafter, the Complainant states that he received a letter from the new underwriter of the policy in **June 2017** which made clear that the policy was still active. The Complainant states that he realised at this point that he had been paying €49 per month since his cancellation notice. The Complainant states that, in response to a query raised by him, the new underwriter communicated that it had no record of any oral or written request for the cancellation of the policy.

The Complainant states that at this point he requested "*a record of all details kept on file*" which, he maintains, when received, disclosed "*a lack of consistency in record keeping*" by the Provider.

The Complainant says:-

> "*Without prejudice, in making this request to your office, I do not question the integrity of any of the* [intermediary] / [Provider] *employees that I have dealt with, however, I do question the integrity of the record keeping on this account*."

The Complainant explains that:-

> "*For full disclosure, please note the policy acceptance letter from* [intermediary] *dated 2 February 2009. I have highlighted that the* [Complainant] *signature, is in fact me, working in my capacity of insurance sales manager for* [intermediary] *a sales agent for* [Provider]*] at that time. I can assure you, that the purchasing of this policy by me at the time was within the company guidelines and full disclosure was given to my employer at the time*."

The Provider's Case

The Provider states it has no record of the phone call made in 2012 nor of any subsequent letter from the Complainant. The Provider maintains that it did not receive a written request to cancel the policy until August 2017. The policy was cancelled promptly thereafter on 14 August 2017.

The Complaint for Adjudication

The complaint is that the Provider failed to execute the Complainant's instruction in 2012, to cancel the policy. The Complainant seeks a full refund of payments made from June 2012 until 2017, when the policy was actually cancelled. The Complainant calculates this amount to be €3,087.00.

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.

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

A Preliminary Decision was issued to the parties on 12 July 2019, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

Following the consideration of an additional submissions from the parties, the final determination of this office is set out below.

In considering this complaint, it is useful to set out an extract from the terms and conditions of the policy.

Policy Terms and Conditions

"***Section 8 – Cancellation Rights***" of the policy sets out the manner in which the policy can be cancelled:

> *You may cancel the* ***policy*** *at any time by advising* [the intermediary] *in writing.* [the intermediary] *will advise* [the policy administrator] *about cancellation of your insurance policy. If this is within 30 days of* ***your policy start date you*** *will receive a refund of any premium(s) paid. 30 days written notice is required for cancellation after the first 30 days.* ***We*** *will not refund any of* ***your monthly premiums*** *if notice to cancel is received after 30 days from the* ***start date****. Your instruction to cancel the policy must be sent to* [the postal or email address of the intermediary].

It is clear from these policy terms and conditions that to effect cancellation, it was appropriate for the policyholder to make contact with the intermediary. The policy provisions do not anticipate a direct communication with the Provider, but the Complainant has pointed out that the intermediary was not providing an Insurance sales service at that time, nor were they acting as an intermediary for the Provider. The Complainant points out that during a telephone conversation with a representative of the Provider, he was told that he would need to put his request to the Provider, in writing.

I am satisfied that any such notification in writing directly to the Provider, would have constituted sufficient and effective notice.

At the time when the FSPO issued its Preliminary Decision, some of the documentation dating from the time of a claim the Complainant made to the Provider in 2010, contained inaccurate information which led to a misinterpretation by this office. The claim form dating

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from June 2010, date-stamped received by the Provider on 14 Jul 2010, discloses that the Complainant had sought benefit for a period of disability arising from a required micro-discectomy at L5/S1. The Provider at that time elected not to pay the Complainant's claim for three separate reasons, confirmed in a letter dated **16 July 2010** as follows:-

> "*1.* [The Complainant] *consulted for your medical condition in the 12 months prior to the commencement date of your policy and therefore your claim is pre-existing.*
>
> *2. Your claim form was not received by us within the first 120 days of the date that your redundancy began.*
>
> *3. We have no written radiological evidence showing us the abnormality in your back which prevented you from working and led to your surgery*."

The Complainant's post preliminary submission takes issue with the reference to "redundancy" in this correspondence. He has made it clear that he has never been made redundant by the financial service provider for which he was working in 2012. Having pursued this issue with the Provider, it confirmed in August 2019 to this office, that not only was the reference to "redundancy" incorrect in that letter, in addition, the additional reference to "120" days was also incorrect. This is very disappointing. Any financial service provider writing to a claimant to explain why a claim is being declined, is under an obligation to ensure that the information it provides is accurate. I take the view in that regard that the Provider has a case to answer to the Complainant in respect of these significant errors in this correspondence.

Insofar as the substantive complaint is concerned, i.e. that the Provider failed to execute the Complainant's instruction in 2012 to cancel the policy, I note that the Complainant states that he contacted the Provider by phone in or around May 2012 seeking to make a claim on the policy "*in relation to a second operation*" on his lower back. This was the second claim made by the Complainant in respect of similar injuries (the first having been made and declined by the Provider in 2010). The Complainant says that he was advised by the Provider at this time that his second claim would "*not be approved*". The Complainant maintains that, arising from this, he indicated his wish to cancel the policy. The Complainant states that, in response, he was advised that a request in writing would be required. The Complainant maintains that he then made the request in writing, as instructed, and he asserts that he called the Provider back one week later, and he describes the exchange as follows:

> *When I called a week or so later, I was informed that the letter was received, but that it was too late to stop the Direct debit that was due at that time. Once that Direct debit was cleared, the policy would then be cancelled.*

It is certainly notable that the Provider has no records of any communication from the Complainant whatsoever in 2012, whether by telephone or in writing. If the Provider had received the letter of cancellation from the Complainant, as the Complainant recalls the Provider having confirmed to him over the 'phone, I would expect it to hold some form of a record, or a log of the event, even in the absence of the letter itself.

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It is similarly notable, in my opinion, that the Complainant himself, likewise, holds no records of any such communications with the Provider at that time. In 2012, the Complainant had been working in the financial services industry for a number of years. It is not unreasonable in such circumstances to have expected the Complainant to have kept some form of record, regarding his instruction to cancel his policy with the Provider, He holds no such records however and has also confirmed that he holds no records of any communications with the Provider in 2012 in relation to the second claim he wished to make in May/June 2012. The Complainant has a firm recollection that he was told that the cancellation instruction was required in writing and he recalls that he sent this. He does not however hold a copy of the letter which he sent, and equally there are no records of the first 'phone call or the second 'phone call which he made "*a week or so later*", when he says that he was informed that the Provider had received his letter of cancellation, but it was too late to stop the direct debit that was falling due, in or around that time.

Having reviewed and considered the submissions made by the parties to this complaint, I noted a significant conflict of fact, and considered the necessity for holding an Oral Hearing to resolve the conflict in the parties' evidence. I am conscious however that the Provider has no evidence to offer, other than the absence of records, and likewise, the Complainant can offer only his recollection of having made a telephone call, and having written a letter, followed by another telephone call, but with no objective evidence available to support this. I have taken the view in those circumstances that an Oral Hearing is unlikely to yield any resolution of the conflict in the parties' evidence.

The Complainant recalls that he was expecting one further direct debit only, to be actioned from his account, following his interactions with the Provider. In those circumstances, it is surprising that a period of some 5 years then elapsed without the Complainant, a Financial Services Manager, noticing the ongoing monthly debits of €49 from his account, contrary to the cancellation instruction he had given and which he says he understood would be actioned by the Provider. It is also surprising that, in the absence of any written acknowledgement from the Provider of the instruction to cancel the policy, or written confirmation that the policy was now ceased, that the Complainant did not follow the matter up with the Provider, to ensure that his instruction had been actioned, in accordance with his request.

In those circumstances, having considered this matter at length, I take the view on balance, given the notable absence of any contemporaneous records at all regarding the events of 2012, there is no basis upon which it would be reasonable to make a finding against the Provider that it failed to follow and implement the Complainant's instructions in 2012, to cancel the policy.

Whilst I appreciate that this will be disappointing for the Complainant, I take the view that there was some responsibility upon him in 2012, if he wished to cancel the policy, to ensure that his instructions were implemented. The Provider could not effect the policy cancellation without receiving the instructions in writing and if the Complainant believed that those instructions had been received, it would have been appropriate for him to have ensured that the direct debit which he expected to terminate, did in fact terminate, in accordance with his expectation.

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Accordingly, on the basis of the absence of evidence before me, I am satisfied that the substantive complaint cannot be upheld.

Since the investigation of this complaint has been commenced, the Complainant has suggested that he ought to have received additional communications from the Provider at the time when the existing policy was sold to another entity.

The Provider has however, confirmed that the policy itself was not sold and rather, it acquired the policy insurer in 2015, and it is confident that as part of the December 2015 acquisition, it met its regulatory requirements. It has pointed out however, that the underlying insurer of the policy remained unchanged. These comments have simply been noted by this office in circumstances where this element of the parties' dealings has only more recently been the subject of comment.

Insofar as the substantive complaint against the Provider is concerned however, for the reasons outlined above, I do not consider it appropriate to uphold the complaint that the Provider failed in 2012, to implement the Complainant's instructions to cancel the policy.

Be that as it may, I am satisfied that in the context of the parties' dealings, the evidence discloses a very significant error on the part of the Provider in communicating with the Complainant regarding the reason for declining his claim in 2010. Noting the erroneous information in the letter sent to him at that time, I consider it appropriate to direct the Provider to make a compensatory payment to the Complainant in the sum of €750, in order to conclude this matter.

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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 to make a compensatory payment to the Complainant in the sum of €750 to 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

6 November 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.