An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0401
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Rejection of claim- non-disclosure (life)
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant holds a Whole of Life insurance policy with the Provider, which was incepted in **January 2011** providing Life Cover of €50,000, and Critical Illness Benefit of €40,000. The Complainant submits that the Provider's agent filled out the application form which she then signed. In **March 2016** the Complainant made a claim under the policy. The Provider rejected the claim and declared the policy to be null and void on grounds of non-disclosure of material facts. The Complainant submits that the Provider's agent did not correctly record the information given to her when filling in the form, on her behalf.

The Complainant's Case

The Complainant states that she was sold life insurance by two of the Provider's agents. One of these agents filled in the application form for the Complainant and she signed it. The Complainant submits that *"I understood as I answered all questions correctly and truthfully she had filled in [the] forms as same."* The Complainant states that it was only when she was diagnosed with breast cancer and made a claim under the policy, that it was discovered that the Provider's agent had incorrectly filled out the application form and that the information recorded on the application form, did not reflect the answers given by the Complainant to the Provider's agents.

The Complainant submits that when asked in 2011, if she smoked, or had used any tobacco or nicotine products in the previous 12 months, she declared to the agents that she was a smoker and had given up within the previous 12 months. The Complainant states that the agent ticked 'No' to this question. The Complainant states that:

> *"I didn't question [the tied agent] as she works for [the Provider]. I understood she was right in filling in forms as she does work for [the Provider]."*

The Complainant states that she was also asked if she suffered from any illness. The Complainant states that *"I clearly stated I had thyroid and was taking ELTROXIN tablets. [The agent] said ok and ticked "No" again. I didn't question her as she is a staff member of [the Provider] and sells policies for a living."*

The Complainant further states that she *"understood in [the agent] filling in the forms she had given the information that was needed for my application, I never hid the fact I was an ex-smoker and clearly [the Provider] should have realised that, I claimed for critical illness as I was diagnosed with breast cancer, on my claim forms I did state I was an ex-smoker and had given up in July 2010 … if I had not told [the Provider's] 2 staff members on 12th January 2011 that I was as ex-smoker why would I have given the information on my claims application … I only signed the forms, which I was sure [the agent] had correctly filled in when she had been given the right information from me."*

The Provider's Case

The Provider's case is that its agents called to the Complainant for the purpose of discussing a protection policy. These individuals are no longer agents of the Provider having ceased their agency with the Provider in **April 2011** and **July 2011** respectively. The Provider states that before recommending and providing the policy to the Complainant, relevant information was requested from the Complainant and a full fact find was completed with the application form.

The Provider submits that following the recommendation to take out a Whole of Life Protection Plan, an application form was completed and signed by the Complainant. In line with standard practice, the answers provided by the Complainant were recorded on the application form by the Provider's agent. The questions on the form relate to medical and material facts. The Provider submits that full disclosure to the questions asked, was required by the Provider, to assess the Complainant's request for cover.

On receipt of the application form the answers provided were reviewed by the Provider's administration and underwriting departments. The Provider submits that the decision to provide cover was based on the information provided by the Complainant and recorded on the application form. Once the questions were answered by the Complainant, the Complainant signed a declaration as per section 9 of the form. The Provider refers to this declaration in its submissions. The Provider states that the policy is a contract between it and the Complainant and the documentation given to the Complainant constitutes and confirms the basis of that contract.

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The Provider outlined that the first agent who filled in the form was its agent from **August 2010** to **April 2011**. The second agent worked for the Provider from **August 2010** to **July 2011**. The Provider states in its submission that it has been unable to make contact with these agents for the purposes of obtaining a statement in respect of this complaint. The Provider states that both agents were trained and appropriately qualified to carry out their roles. It further states that there have been no previous issues raised in relation to the sale of any policies by these agents and there have been no complaints made in respect of these agents either.

The Provider points out that the procedures and safeguards in place in 2011 when the policy was sold face to face, is that the application form was posted back to the Complainant with her policy documents to provide her with a second chance to review it and advise of any changes she wished to make. The Benefit Guide was given to the Complainant at point of sale. This describes the important features of the policy. The Provider states that it is standard practice for all agents to go through this document at the point of sale with their clients. The Provider also refers to its Terms of Business which were provided to the Complainant at the point of sale. This document provides the Complainant with information about the Provider.

The Provider lists a number of policy documents issued to the Complainant and states that the cover letter enclosing these documents, asked the Complainant to read them carefully to ensure she understood the policy and that it met her requirements. A copy of the application form was enclosed with the policy documents. The Provider states that its agents were aware of its procedures and were aware that once the policy issued, a copy of the application form would be sent to the Complainant for her to review.

The Provider submits that contact details were provided to the Complainant should she wish to alter or clarify any information recorded on the application form. The Provider states that the Complainant was advised to contact its Client Services Department on a freephone number with any queries. The Provider states that it has no record of any such queries. The Provider refers to the Complainant's right of cancellation and the cooling-off period.

The Provider also points out that there were additional warnings on the application form in relation to smoking habits. The Provider states that it is satisfied that it explained to the Complainant the consequences of failure to make full disclosure and the importance of this was made clear in the Benefit Guide and on the application form.

Dealing with restrictions, conditions and general exclusions attaching to the policy, the Provider states that the Policy Provisions advised the Complainant of the exclusions under the headings "**Critical Illness Benefit**" and "**General Exclusions**". The Provider states that pre-existing conditions are not covered and this is referred to in section 3.2(b) of the Policy Provisions.

The Provider is satisfied that the policy was correctly sold and that it complied with the provisions of the Consumer Protection Code 2006. The Provider states that it would have been standard practice for the Complainant to be asked the questions posed on the application form and for her agents to record the answers provided. The Provider states that

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it is not in the interests of any party that any information provided be withheld from the application form. The Provider submits that the onus fell on the Complainant to ensure all medical and material facts were recorded on the application form.

On receipt of the application documents and following an assessment of these documents, the Provider states that it accepted that the information provided was true and correct and that it acted in good faith in issuing cover to the Complainant.

The Complainant suggests that it was only when making a claim under the policy that she became aware of the answers that were recorded on the form. She says that the answers recorded on the form were not the answers she provided to the agent.
The Provider submits that it is not correct or true that the Complainant was not made aware of the answers recorded on the application form prior to the assessment and cancellation of her claim. The Complainant was sent a copy of the completed form once the policy was issued and she was asked to review the answers given. The Complainant made no contact with the Provider to query or correct any details contained in the application form.

When it received the Complainant's claim form the Provider states that it wrote to the Complainant's GP and attending specialist on **10 March 2016** requesting details to help assess her claim. It received a report from the Complainant's GP and on review of the information provided, it became aware of non-disclosure of material facts in respect of the Complainant's application form.

It states that a letter was sent to the Complainant on **7 April 2016** advising her of this non-disclosure. The Provider states that the report confirmed that the Complainant:

> *"1. Had been a smoker within the previous 12 months of applying for cover.*
>
> *2. Had a history of raised cholesterol requiring medication.*
>
> *3. Had suffered with hypothyroidism requiring medication.*
>
> *4. Was aware of the severity of the raised cholesterol level and that there was major non-compliance with the prescribed treatment with the Complainant stopping medication, against medical advice …."*

The Provider states that there was further non-compliance in that the Complainant failed to disclose that she has a mammogram in **January 2006** and had a small cyst removed. The Provider states that the Complainant has failed to comment on her history of cholesterol and her cyst in her submissions to this Office.

The Provider states that had it been aware of the Complainant's full medical history in her application, the policy as proposed would not have issued. While the Complainant says that she did disclose some of her medical details to the Provider's agents, it found during the assessment of the Complainant's claim that there was significant non-disclosure of facts which she did not refer to when making her complaint to this Office.

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The Provider states that the Complainant committed a clear breach of the principle of utmost good faith and therefore, it had no option but to void cover and cancel her policy. The Complainant failed to disclose relevant medical and material facts at the point of sale, which would have enabled the Provider's underwriters to assess accurately the risk presented by the Complainant and this is the reason for the cancellation of her claim and why the policy was voided. The Provider submits that the medical details provided by the Complainant's GP clearly show:

1. A long and detailed history of cholesterol with failure to follow medical advice;
2. History of hyperthyroidism;
3. Smoking within the previous 12 months of applying for cover; and
4. A breast cyst being removed in 2006.

The Provider states that none of these issues were recorded on the Complainant's application form and the Complainant failed to refer to all of these non-disclosed issues, in her complaint. The Provider states that the Complainant was fully aware of her medical history and did not disclose this information to the Provider, rendering her policy null and void.

In an additional submission to this Office, the Complainant had inserted a handwritten reply beside the above-mentioned points. In relation to points 1 – 4, she states:

1. *Only off medication for a short period of time.*

2. *Not relevant to breast disease.*

3. [No response]

4. *Was drained. Did not realise it was relevant.*

The Complaint for Adjudication

The complaint is that the Provider wrongfully declined the Complainant's claim under the policy, and wrongfully declared her policy null and void.

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.

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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 on 1 November 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.

Documentary Evidence

By letter dated **18 January 2011**, the Provider sent a number of policy documents to the Complainant: the Policy Schedule, the Life Plan Provisions, Important Notice and "Your Benefit Guide". Referring to the enclosed policy documents this letter stated:

> *"… Please read these documents carefully to ensure you understand your policy and that it meets your requirements.*
> *A copy of your application form is also enclosed. You should review the information provided to ensure all questions have been answered correctly. If you would like to alter or clarify any information please contact us immediately as your policy has been issued based on the information provided."*

- ***Application Form***

The first page of the application form contains the following notice:

> *"**Important Notices***
>
> *Failure to disclose Material Facts, as referred to in Section 9.4 of the Declaration, may result in non payment of a claim and all cover under the policy being cancelled. The duty to disclose such facts remains in place from the date of signing the application to the date of issue of policy documents.*

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If a mistake is made, it should be crossed out, the correct word(s) inserted and the applicant should SIGN & DATE next to the correction. Please complete the application form in BLOCK CAPITALS using a blue or black ballpoint pen."

At Section 2 of the application form the Complainant was asked if she smoked or used any tobacco or nicotine product in the last 12 months. This box is ticked '**No**'.

Section 6 of the application form contains a number of medical questions and contains the following notice:

*"**Important Notices***

Failure to disclose relevant medical information may result in non payment of a claim and all cover under the policy being cancelled.

If you are in any doubt about whether to provide information when filling in the form, please provide the information.

If you are unsure about any information, you may wish to consult your doctor before completing the application. …"

Section 6.1(d) states:

*"**Within the last 5 years have you:***

- *Received medical treatment for raised blood pressure?*
- *Had any lump, cyst, growth or mole (naevus) of the skin that has bled, changed in appearance or become painful?*
- *Had or been advised to have any investigations or undergone tests or been referred to a specialist?*
- *Been admitted to a hospital or clinic?*
- *Suffered from any illness or condition that has required continuous medical treatment or prescribed medication for more than 4 weeks or requires you to attend for follow up review?"*

The boxes in respect of these questions were ticked '**No**'.

Section 9 of the application form contains the Declaration and states:

"1. I have read carefully through all the questions in this Application Form.

2. …

3. For the purpose of this Contract an application submitted to [the Provider] comprises any documentation completed by me, any oral or written

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statements made by me to the agents, employees or medical examiners acting on behalf of [the Provider].

4. *I understand I must disclose all Material Facts. (A Material Fact is one which is likely to affect [the Provider's] assessment or acceptance of your Proposal. If you are in doubt about whether a fact is material or not, you are, in your own interest, advised to disclose it.)*

5. *I understand that if I fail to disclose all Material Facts or if I fail to provide [the Provider] with full and accurate information about any aspects of my health, smoking habits, occupation or pastimes or about insurance policies with other insurance companies, that any subsequent claim may be rejected.*

6. *If I am applying for Non-Smoker rates, I declare that where I have stated that I have not consumed any tobacco products in the last 12 months, that I do not intend to consume tobacco at any time in the future.*

… [My emphasis]

9. *I declare that, to the best of my knowledge and belief, the following are true and complete: - all the information and statements given by me as part of this application*
- any statements written by me or at my dictation and signed by me
- any statements made or to be made to [the Provider's] medical examiner and signed by me

…

11. *I declare that all the information and statements as described in 9 above shall form the basis of the Contract with [the Provider]."*

This declaration was signed by the Complainant on **11 January 2011**.

- ***Policy Provisions***

The Life Plan Provisions (the **Provisions**) contains a definition of Material Facts in section 1.2 that is identical to the definition given in the application form.

Section 2.11 of the Provisions states:

"(a) The policy, the Application Form, all written and oral statements by you or the Life Assured in respect of the Application … will be the entire contract between you and us …

Failure to disclose all Material Facts could result in your claim being declined and the policy being voided. …"

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Section 3.2 deals with critical illness benefit and states under the section dealing with cancer:

"… For the above definition, the following are not covered:

- *All cancers which are histologically classified as any of the following:*
  - *pre-malignant;*
  - *non-invasive;*
  - *cancer in situ;*
  - *having either borderline malignancy; or*
  - *having low malignant potential …"*

Further to this at page 12 of the Provisions it states:

> *"b) No benefit will be payable if, in the opinion of our Chief Medical Officer, a claim is made for Critical Illness or disability which was known to exist, or for which symptoms were present, prior to the Commencement Date of the policy …"*

Section 4 contains some general exclusions that apply to the policy, in particular section 4.1(g) states:

> *"These benefits will not be payable if a claim arises in the following circumstances:*
> *…*
> *g) if the Life Assured failed to follow medical advice from a registered and appropriately qualified medical practitioner."*

<u>Claim for Critical Illness Benefit</u>

On foot of a claim form dated **7 March 2016**, the Complainant made a claim for Critical Illness Benefit under the policy. On the form the Complainant stated that she had ceased smoking in **July 2010**.

By letter dated **7 April 2016,** the Provider informed the Complainant that her policy was being declared null and void and all benefits under the policy were cancelled. The reason given for this course of action was non-disclosure of material facts on the Complainant's application form. The Provider stated, referring to a report obtained from the Complainant's GP:

> *"In this report [the Complainant's GP] advised that you have a history of raised cholesterol requiring medication and also hypothyroidism requiring medication. He also advised that you ceased smoking 6 weeks prior to October 2010.*
> *…*
> *As a consequence of this material non disclosure [the Provider was] not given the opportunity to fully assess your medical history. Also had we been made aware that*

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you were a smoker within 12 months of the commencement date of this policy, different rates would have applied."

The Complainant appealed the Provider's decision by letter dated **11 April 2016**. The Provider furnished the Complainant with its decision on her appeal by letter dated **5 May 2016**. This letter sets out the basis for the Provider's decision which is similar to the reasons given in its letter of **7 April 2016**. The Provider states that the Complainant should have answered 'Yes' to the question posed at section 6.1(d) of her application form as to whether or not she had smoked in the previous 12 months. The Provider also advised the Complainant that it contacted the agent who completed the form for her:

"We have investigated this matter thoroughly and as part of our investigation we contacted our former tied agent, … who left the company in April 2011. Unfortunately due to the passage of time she does not recall the specifics regarding the sale of your policy. However as part of her training [the agent] would have been very aware of the importance of recording all information disclosed by a client on the application form including smoking status and medical information."

Relevant Case Law

The test for materiality has been set out by the Supreme Court in ***Chariot Inns Ltd v Assicurazioni Generali S.p.a. and Coyle Hamilton Hamilton Phillips Ltd*** [1981] I.R. 199 at 226, as follows:

"What is to be regarded as material to the risk against which the insurance is sought? It is not what the person seeking insurance regards as material, nor is it what the insurance company regards as material. It is a matter or circumstance which would reasonably influence the judgment of a prudent insurer in deciding whether he would take the risk, and, if so, in determining the premium which he would demand. The standard by which materiality is to be determined is objective and not subjective. In the last resort the matter has to be determined by the court: the parties to the litigation may call experts in insurance matters as witnesses to give evidence of what they would have regarded as material, but the question of materiality is not to be determined by such witnesses."

This decision is generally accepted as the main authority relating to materiality and the duty of disclosure in Ireland.

In ***Earls v Financial Services Ombudsman*** [2015] IEHC 536, the High Court reviewed the case law on non-disclosure in insurance contracts and summarised the applicable principles as follows:

"1. Utmost good faith

(1) A contract of insurance is a contract of the utmost good faith on both sides. (Aro Road).

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2. Disclosure of material matters

(2) The correct answering of questions asked is not the sole duty of the insured. S/he must disclose all matters which might reasonably be thought to be material to the risk against which s/he is seeking indemnity. (Chariot, Aro Road).

(3) The duty involves exercising a genuine effort to achieve accuracy using all reasonably available sources. (To require disclosure of all material facts may well require an impossible level of performance). (Aro Road).

(4) The form of questions asked in a proposal form may make the applicant's duty to disclose more strict than the general duty arising; it is more likely, however, that the questions will limit the duty of disclosure. The acid test is whether a reasonable person reading the proposal form would conclude that information over and above that which is in issue is required. (Kelleher).

3. Test of materiality

(5) Materiality falls to be gauged by reference to the hypothetical prudent insurer. (Chariot).

(6) Absent a question directed towards the disclosure of a particular fact, the arbiter must give consideration to what a reasonable insured would think relevant; relevance in this particular context is not determined by reference to an insurer alone. (Aro Road).

4. Over-the-counter insurance

(7) In the case of over-the-counter insurance, of the type identified in Aro Road, the insurer is not entitled, in the absence of fraud, to repudiate on grounds of non-disclosure. (Aro Road).

5. Determiner of materiality

(8) The sole and final determiner of materiality is the arbiter, not the insurer. (Chariot, Aro).”

The Provider asserts that there were four instances of non-disclosure on the part of the Complainant. The Provider submits that the Complainant was smoking in the 12 months period prior to her application; had a history of hyperthyroidism; had a long and detailed history of cholesterol with failure to follow medical advice; and a breast cyst removed in 2006. In her complaint to this Office the Complainant addressed the smoking and hyperthyroidism aspects of the alleged non-disclosure and following a review of the Provider’s submissions addressed the remaining instances of non-disclosure. These reasons have been set out above.

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Smoking and hyperthyroidism

It is the Complainant's position that the Provider's agent asked her the questions contained on the application form and the Complainant answered these questions truthfully. When asked if she smoked within the last 12 months the Complainant states that she told the agent she had given up smoking in **July 2010** but that the agent ticked '**No**' on the application form. Similarly, the Complainant states that she was also asked if she suffered from any illness to which she replied she "*had thyroid and was taking ELTROXIN tables*." It is the Complainant's evidence that she placed significant reliance on the agent.

In its letter to the Complainant dated **5 May 2016** the Provider informed the Complainant that it contacted the relevant agent but she was unable to recall specific detail regarding the sale of her policy. Subsequently, in December 2018, in its submissions to this Office the Provider stated that it had been unable to contact the agents for the purpose of obtaining a statement for this complaint.

The Provider has submitted a copy of an internal email dating from 26 April 2016 which indicates that enquiries were pursued by the Provider in April 2016 with both of the agents in question, one of whom had advised that "*she has no recollection of this client so cannot comment on any aspect of the point of sale etc*." and the other of whom did "*recall completing one or two appointments with* [the Complainant]*…but she has no recollection of the specific client or what occurred during the point of sale as she was not the primary advisor."*

The Provider therefore points to the training the agents received; standard practice; what its agents would or should do; and the policy documents. The Provider asserts that it can only comment on the information recorded on the application form. This however does not address the instances of non-disclosure under the heading in question and furthermore, I do not accept that it is relevant to this particular complaint that no other complaints may have been made in relation to the Provider's agents in question. It is only the circumstances of this Complainant's interactions with the Provider's agents, which are relevant to this complaint.

Having considered the submissions of the parties on this aspect of the Complainant's suggested non-disclosure and given the absence of any recollection from the agents of the events of 2011, I believe that it is possible that the Complainant informed the Provider's agents of her smoking habits and her hyperthyroidism in **January 2011** and that the agents failed to record this information accurately on the application form.

While the Provider submits that the Complainant was advised to read the application form and was furnished with a copy of the form, I accept the Complainant's evidence that she relied on the agents when her application form was being filled in. Furthermore, there is a question raised as to whether the fact that the Complainant's smoking and hyperthyroidism were not accurately recorded on the application form, entitles the Provider to assert that there was a material non-disclosure, given the provisions of clause 3, clause 9 and clause 11 of the declaration signed by the Complainant on 12 January 2011, and clause 2.11(a) of the

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Provisions which effectively state that the contract between the Complainant and the Provider includes any oral statements, made to its agents. The Provider has been unable to demonstrate that these suggested statements by the Complainant in 2011 to its agents, confirming the accurate information regarding her smoking and hyperthyroidism, were not made by the Complainant at that time.

Cholesterol and cyst

The Provider submits that the Complainant's failure to disclose her cholesterol and cyst also constitutes material non-disclosure. The Complainant does not dispute that she did not disclose these details at the time of her application. In respect of her cholesterol the Complainant states that she was off her medication for a short period of time. In a telephone call which took place between the Complainant and the Provider's agent on **6 May 2016** the Complainant told the Provider's agent that she did not have cholesterol at the time of her application.

However, the medical records furnished by the Provider in respect of the Complainant suggest that the Complainant in fact had a high cholesterol level at the time of her application for cover and that her recollection in that regard is not reliable. In relation to the Complainant's cyst she states that at the time of completing the application Form, she did not realise that this was relevant.

In all of the circumstances, even if I accept the Complainant's evidence that she disclosed details of her smoking habits and hyperthyroidism to the Provider's agents in 2011, at the time of policy inception, the evidence confirms that she failed to disclose information at that time regarding her mammogram in 2006 (which had given rise to the removal of a cyst) and indeed that she also failed to disclose details of her high cholesterol, requiring medication.

I accept therefore that there was non-disclosure by the Complainant in respect of her cholesterol and cyst. Having considered the case law cited above and the application form (particularly the questions contained in section 6.1(d) and clause 4 of the declaration at section 9) I consider that details of the Complainant's cholesterol and the cyst which was removed in 2006, should have been disclosed to the Provider at the time of her application. As these disclosures were not made by the Complainant to the Provider, the Provider was not in a fully informed position when it made a decision to offer her the cover she sought. As a result the policy came into being on the basis of a false premise. Therefore, on the evidence before me, I accept that the Provider was entitled to reject the Complainant's claim and to declare her policy null and void on the basis of her material non-disclosure.

Finally, telephone conversations took place between the Complainant and the Provider on **11 April 2016** and **6 May 2016**. These calls appear to have been with the same agent of the Provider. Having listened to all of the calls and in particular these two, while the Complainant was clearly frustrated and annoyed with the Provider's decision to cancel her policy, I do not consider that this agent spoke to the Complainant in an appropriate or fair manner. Whilst this gentleman did his best to explain to the Complainant, why the policy had been cancelled, I am dissatisfied in particular with the way in which he ended each of these calls. I would suggest that the Provider review the recordings and turn its attention to any training

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requirements which would be beneficial to its staff. Any staff member in telephone contact with customers who are unhappy with the Provider, should be suitably trained to interact with a customer in a more professional manner. Insofar as the Complainant's grievance regarding the cancellation of the policy is concerned however, for the reasons set out above, I take the view that it is not appropriate to uphold this complaint.

Conclusion

My Decision is that this complaint is rejected, pursuant to ***Section 60(1)*** 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

25 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.