An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0416
Sector:	Insurance
Product / Service:	Dental Expenses Insurance
Conduct(s) complained of:	Claim handling delays or issues Dissatisfaction with customer service Rejection of claim – partial rejection
Outcome:	Substantially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint relates to a claim under a health insurance policy for dental work.

The Complainant's Case

In 2018, the Complainant had to undergo dental work that related to crowns and bridges. The Complainant had a health insurance policy that covered dental work which her employer paid for. On **20 October 2016** and **26 January 2017**, the Complainant called the Provider to seek information on the extent of her coverage in respect of crowns and bridges. After that phonecall, on **1 February 2017** the Complainant's policy was renewed and some of the terms of the policy relevant to her dental work were changed particularly insofar as coverage related to bridge work.

Throughout 2018 the Complainant underwent the dental work in different stages which cost €7,000.00 in total which the Complainant paid. On **17 November 2017**, the Complainant submitted her claim form in respect of the dental work. On 20 December 2017, the Complainant's claim was paid out in the sum of €1,200.00. The Complainant had thought that she would receive €3,000.00.

The Complainant queried why the claim was reduced as it was. She was told that the policy renewal had resulted in different terms applying which reduced her ability to claim. The Complainant queried why she had not been told when she renewed the policy.

The Complainant complained about that particular issue in addition to the delay in being paid, the delay in processing her claim and the length of the complaint handling process.

On **8 March 2018** and **9 March 2018**, the Provider sent its final response letter and on **15 August 2018** the complaint was received by this Office.

The Complainant asserts that the extent to which she was covered was not explained properly. In the phone call on **26 January 2017**, the Complainant specifically sought assurances about what coverage she has. During the call, the Provider's representative set out that the Complainant had coverage for 70% of the cost of one bridge and 70% of the cost of crowns up to a maximum of €600.00. As of **1 February 2017** - five days later - the Complainant's coverage changed such that there was also a maximum limit of €600.00 in respect of the bridge as well. The Provider's representative refers to the fact that the policy was up for renewal, but gives no indication that the relevant terms of the policy were due to change. The Complainant sets out in later phone calls that she would have managed her treatment differently if she had known this. The Complainant understood that her treatment would cost €7,000.00 and she thought that she would be able to claim €3,000.00. Instead the Complainant was paid €1,200 by the Provider. The Complainant asserts that all of the foregoing is unfair and misleading.

The Complainant asserts that the payment was made to the incorrect bank account. The Complainant says that this was due to an error on the Provider's part and the use of the incorrect bank details. The Complainant notes that this money was urgently needed for mortgage repayments and the failure to obtain it caused her great stress and involved borrowing money from others.

The Complainant asserts that there was a delay in processing the claim and also in handling and processing her complaint. On **17 November 2017**, the Complainant's claim form was submitted. After various phone calls concerning the extent of the treatment, on **20 December 2017**, the payment was erroneously sent to an incorrect account. On **4 January 2018**, the Complainant acknowledged receipt by phone call of the payment.

In relation to the speed of dealing with the complaint, the Complainant raised her complaint by phone call on **3 January 2018**, which was acknowledged by the Provider's representative. On **23 January 2018**, when a 20-day update e-mail was sent. On **28 February 2018**, a 40-day update e-mail was sent referring to the Complainant's right to refer the dispute to this Office. On **8 March 2018** and **9 March 2018**, the Provider responded with final responses to the complaint. The Complainant asserts that this was not done expeditiously and was an inadequate complaint procedure.

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The Provider's Case

The Provider maintains that the advice on coverage that it gave was correct and in accordance with the policy schedule at the time. The Provider states that the advice it gave in respect of the phone call on **26 January 2017** was, therefore, accurate and not misleading.

The Provider notes that the Complainant indicated that she was going to have the dental works done regardless and, therefore, that its advice cannot have any bearing on the Complainant's decision. In the phone call dated **20 October 2016**, the Provider notes that its representative expressly says to the Complainant that it cannot advise her unless she furnishes full information about the treatment. The Provider refers to the relevant policy schedules. The Provider also notes that the renewal forms require the insured to consider the enclosed table of benefits which indicates the extent of coverage.

The Provider accepts that there was an error in respect of the payment to the Complainant and accept that it was their fault. The Provider maintains that once it became aware of the error that it reacted expeditiously and called the Complainant to specifically query whether the payment went through.

In respect of processing the complaint, the Provider states that the claim form was received on **17 November 2017**, but that further details had to be requested from both the Complainant and the Complainant's dentist in order to establish what was covered and what was not covered. On **27 November 2017**, the Provider e-mailed the Complainant seeking this information. On **12 December 2017**, the Provider received an e-mail from the Complainant's dentist clarifying the treatment that the Complainant received. On **18 December 2017**, there was a phonecall from the Provider's representative for this purpose. On **20 December 2017**, an attempted payment was made, but as stated above it did not go through due to an error on behalf of the Provider.

In respect of the complaint handling, the Provider notes that it sent an acknowledgement in writing of the complaint on **5 January 2018**, but that it should have acknowledged the phone call on **18 December 2017** during the phonecall with the Complainant. The 20-day update letter was sent on **30 January 2018** and the 40-day update letter was sent on **28 February 2018**. The investigation concluded on **7 March 2018** and two letters setting out the position of the Provider were sent on **8 March 2018** and **9 March 2018**. The Provider says that this complies with the relevant provision of clause 10.8 and 10.9 of the CPC.

The Complaints for Adjudication

There are two complaints for adjudication.

> That the Provider acted unfairly or improperly in providing advice on coverage in the manner that it did to the Complainant, given that the coverage changed five days later.

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That the Provider failed in how it processed and handled both the claim and also complaint.

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 23 October 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 issue of my Preliminary Decision the following submissions were received:

1. Letter from the Provider to this Office dated 11 November 2019.

2. E-mail from the Complainant to this Office dated 12 November 2019.

3. E-mail from the Provider to this Office dated 22 November 2019.

The above submissions were exchanged between the parties.

Having considered these additional submissions and all of the submissions and evidence furnished to this Office, I set out below my final determination.

First, I will set out the relevant terms of the policy schedule. It is the case that the table of benefits that applied for the relevant period when the dental work occurred has a €600.00 limit on both bridges and crowns. It is also the case that the certificate of insurance refers to the fact that the table of benefits may have changed since the last renewal date. It is also

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the case that the advice given on the phone call dated **26 January 2017** was correct insofar as it related to the previous coverage that would have applied and the fact that the €600.00 limit did not apply to bridges at that time.

However, I believe it is highly unfair and misleading for the Complainant to not be told that this extremely relevant section of the table of benefits was due to change imminently. The Provider's representative referred to the fact that her policy was up for renewal in five days' time, but neglected to mention that the extent of coverage was due to change in a material way that would affect the extent to which the Complainant was covered on the policy.

It is disappointing that this happened and most disappointing that the Provider seems happy that this conduct is appropriate.

Recordings of the telephone calls between the Complainant and the Provider have been provided in evidence. I have considered the content of those calls.

In the phone call of **18 December 2017**, the Complainant specifically says that she was told that 70% of the bridge would be covered. She is correct. In the phone call dated **11 January 2018**, the Complainant says that she would have done the treatment differently had she known that her coverage was due to change. Later on in that phone call, the Provider's representative expressly states that the change in coverage should have been highlighted to the Complainant at that time. He was absolutely correct.

In all of the circumstances, therefore, I find that it was extremely unreasonable of the Provider to not inform the Complainant that her coverage was due to materially change, when she was planning an expensive and stressful treatment that clearly would not be completed in the following five days. When such material changes are due in five days and will have a significant impact on the Complainant's coverage, it is only fair and reasonable that the Complainant should have been properly apprised of this to allow her to make a properly informed decision.

With regard to the provision of information to a consumer the Consumer Protection Code states that a regulated entity must ensure that all information it provides to a consumer is clear and accurate, and that key items are brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information.

Provision 4.1 of the Consumer Protection Code 2012 (CPC) states that:

> *4.1 A regulated entity must ensure that all information it provides to a consumer is clear, accurate, up to date, and written in plain English. Key information must be brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information.*

I stated in my Preliminary Decision that I believed the Provider had not met the standard required of it under the CPC.

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In a post Preliminary Decision submission dated 11 November 2019, the Provider has put forward the argument that I incorrectly interpreted ***Section 4.1*** of the ***Consumer Protection Code 2012.***

The Provider *"submits that this provision was not quoted in the correct context in the [preliminary] decision"*. The Provider is of the view that as the section included the line *"and written in plain English,"* it is only applicable to written documents and states *"the renewal documentation highlighted what cover had changed from the previous year clearly".*

However, Section 4.1 is not limited to just written information, it states:

> *"4.1 A regulated entity must ensure that* ***all information*** *it provides to a consumer is clear, accurate, up to date, and written in plain English. Key information must be brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information". [My emphasis]*

I find it most disappointing and indeed disingenuous that the Provider would seek to suggest that only its written communications have to be clear. This, in my view, would be a perverse situation where a provider would be required to communicate clearly in writing, but not otherwise.

It is clear that 'Key information' was not brought to the Complainants attention at the time of the phone conversation of 26 January 2017. The Complainant was not informed of the significant change in relation to the very matter she was enquiring about that would occur within five days. As a result, she was unaware that the level of cover that she could expect was to be less than had been just stated during the call.

In respect of the customer service failings, I find that the Provider has accepted that it was at fault for the payment not being processed properly. It is therefore not necessary to analyse that aspect in detail. Once the Provider became aware of it, I find that it acted promptly and followed up with phone calls on **3 January 2018** and **4 January 2018**.

In respect of the other customer service failings, I note at the outset that the Provider's representatives apologised at length to the Complainant in the phonecalls in January 2018 and March 2018 and accepted that what happened was wrong and that the Provider had fallen below its own standards. In relation to the particular time line of handling the complaint, however, I find that the Provider acted within the time frames provided for in the CPC. The complaint was acknowledged by phone on **3 January 2018** and in writing on **5 January 2018**. The 20-day update letter was sent on **30 January 2018** and the 40-day update letter was sent on **28 February 2018**. The investigation concluded on **7 March 2018** and two letters setting out the position of the Provider were sent on **8 March 2018** and **9 March 2018**. I find that this complies with the provisions of the CPC insofar as timelines as concerned. I do note, however, that the Provider accepts that perhaps it should have acknowledge the complaint earlier.

In respect of the actual processing of the complaint, the relevant period was between the claim form being received on **17 November 2018** and the first attempt at payment being

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made on **20 December 2018**. In all of the circumstances, this is not a particularly long time for a claim to be assessed and either admitted or rejected. It is notable that in this time the Provider had to e-mail both the Complainant and the Complainant's dentist in order to establish the precise treatment that had occurred.

The Provider also called the Complainant to try and clarify further the treatment that she underwent. In all of the circumstances, I think that in the context of a dental claim that it is acceptable for the Provider to investigate the claim properly and thoroughly in order to determine if coverage applies or not. The Provider is entitled to assess the position correctly. While the payment should have gone through on **20 December 2018**, the Provider has already accepted responsibility for that. Insofar as the complaint relates to the time between the claim being lodged and the first attempt at payment, I find that was not unreasonable.

In my Preliminary Decision, I indicated my intention to direct the Provider to pay a sum of €3,000 in compensation.

I note the Provider has, in its post Preliminary Decision submissions, challenged my authority to direct the amount of €3,000 in compensation.

The Provider states that it *"...submits that the award of €3,000 in these circumstances is beyond the powers of the FSPO given by the Financial Services and Pensions Ombudsman Act 2017".*

The Provider refers to ***Section 60 (4) d*** of the ***Financial Services and Pensions Ombudsman Act 2017*** which states the Ombudsman may direct a provider to:

> *"(d) pay an amount of compensation to the complainant for any loss, expense or inconvenience sustained by the complaint as a result of the conduct complained of;"*

The Provider submits that *"the award of €3,000 in compensation is not compliant with this provision…"*

It is put forward by the Provider that under section 60(4) d of the Act compensation can only be directed where there was "*loss or expense caused"* or in order to *"account for the inconvenience caused"*.

The Provider is of the view that *"the advice given in that call did not cause the complainant any financial loss…"* or inconvenience.

In arriving at my decision to direct compensation I have considered all relevant aspects of the complaint and have fully considered the conduct of the Provider, and its impact on the Complainant in accordance with the relevant sections of the ***Financial Services and Pensions Ombudsman Act 2017.***

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The Provider submits that *"there would be no grounds to award compensation to cover the full amount the complainant states she was expecting on the circumstances, firstly this does not take into account the amount the complainant* [sic] *was paid in settlement of her claim".*

The Provider argues that the intended compensation "*…would be excessive & clearly disproportionate in the circumstances".*

Both the ***Financial Services and Pensions Ombudsman Act 2017*** and the ***Statutory Instrument no. 154 of 2018*** empower me to direct compensation.

Further ***Statutory Instrument no. 154 of 2018*** at ***Section 2(b)*** states the maximum I may direct in compensations is:

"(b) €500,000 in respect of all other complaints"

Therefore, I reject the Provider's assertion that my direction to pay €3,000 is somehow "*beyond my powers*".

The Provider submits in its post Preliminary Decision submission dated 11 November 2019 that:

> *"There is an error of fact in this judgement* [Preliminary Decision] *as the complainants actions would not have been altered had* [the Complainant] *been advised of the €600 limit for bridges that would apply…"*

The Provider has stated that while "*it is agreed that the complainant was not advised that the limit would be €600 for bridges to apply from the renewal on the 1st of February in this call", i*t believes [the Complainant] *"has not been financially detrimentally affected by this in relation to the treatment & financial outlay she had, as the course of action regarding the treatment would have been the same".*

Further to this the Provider has stated:

> "[The Provider] *notes in your [Preliminary] decision you referred to the complainant's call in January 2018 that [the Complainant] would have organised the treatment differently, but we were not provided with any explanation as to how it would have been different".*

I note the Provider in its post Preliminary Decision submission accepts that *"given the treatment was due to take place in the next policy year the agent could and should have checked the cover under the renewal and advised on that basis".*

However, having stated this, the Provider tries to mitigate its error by arguing it *"…did not materially change the complainant's position so would not have caused any loss or expense".*

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I am satisfied that the Provider should have advised the Complainant that the coverage was to materially change within days, so as to give the Complainant the most accurate information and allow for the Complainant to then decide on the best course of treatment.

In light of the failings of the Provider and, in particular, the failure to furnish full information to the Complainant in January 2017, I substantially uphold this complaint and direct the Provider to pay a sum of €3,000 in compensation to the Complainant for the loss, expense and inconvenience caused.

Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is substantially upheld, on the grounds prescribed in ***Section 60(2) (c) and (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 €3,000, 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.

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FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

17 December 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.