An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0422
Sector:	Investment
Product / Service:	Personal Pension Plan
Conduct(s) complained of:	Lapse/cancellation of policy Maladministration
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint relates to the administration of a company pension plan.

The Complainant's Case

The Complainant contends that the Provider has cancelled his disability insurance and his life insurance "*without notifying* [him] *beforehand*". Both of the aforementioned insurance benefits formed part of a company pension plan incepted in **1997**. The payments for this plan were paid by the Complainant's company for several years until the company ceased trading and payments were stopped in **November 2014**.

Thereafter, after a brief hiatus in payments, the Complainant "*transferred the payments to* [his] *own personal bank account*" and the plan was reinstated in **March 2015**. Following this, the Provider proceeded to accept the payments from this account until November 2016. The Complainant maintains that he subsequently became aware that the disability benefit was not in fact reinstated in March 2015 as he contends it should have been.

In **October 2016**, the Complainant sought to change the employer on the plan from the company which had ceased trading to a new company which he had incorporated. The Complainant maintains that, in processing this request, the Provider eventually responded indicating that the plan had been inappropriately funded since March 2015 (insofar as the

payments came from the Complainant's personal account) and that, in light of this, the premia were incorrectly received and would be returned rendering the insurance benefits terminated.

The Provider's Case

The Provider maintains that the payments made into the pension plan from March 2015 to November 2016 were made from an improper source, namely the Complainant's personal account and, consequently, the insurance benefits should be deemed not to have been reinstated. The Provider cites Revenue rules in support of its position.

The Complaint for Adjudication

The complaint is that the Provider was guilty of maladministration of the Complainant's pension plan. The Complainant seeks to have the insurance benefits reinstated and the policy transferred to his new company.

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 6 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.

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In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

It is useful to set out the terms of the policy relied upon by the Provider.

Policy Terms and Conditions

The disability benefit policy document provides the following definition of '**Insured Person**':

> *"Insured Person" means an employee of the Employer in respect of whom a proposal for an insurance under this Policy has been medically underwritten and accepted by the Company provided always that a person shall cease to be an Insured Person upon termination of employment with the employer.*
>
> [my emphasis]

Section 3 of the Policy entitled 'Premiums' provides as follows:

> (e) *If the Premium in respect of any Insured Person is not paid on the due date thereof or within 30 days of the due date, the Company's liability for payment of benefits as described in Clause 5 in respect of that Insured Person shall immediately cease, without any need for the Company to so notify the Employers.*
>
> …
>
> (g) *The receipt by the Company of any Premium after the expiry of the period of grace shall not constitute a waiver by the Company of the foregoing provisions and the company shall refund such Premium.*
>
> (h) *Notwithstanding sub-Clause (g) above the Company may allow the Policy (or the benefits thereunder in respect of an Insured Person) to be reinstated on such terms as it may determine.*

Analysis

A company pension plan was incepted in **March 1997** for the Complainant's personal benefit. The plan included a retirement benefit as well as 'risk benefits' in the form of disability cover and a life cover benefit. This plan was owned by the Complainant's limited company which was his employer.

On **7 November 2014**, the monthly payments to this plan, which had to that point been made by the Complainant's company, stopped. The Provider states that the reason made available by the paying bank for the failure of the payments was "*mandate blocked*". The Provider maintains that it wrote to the trustees of the retirement plan on **7 November 2014** to confirm the foregoing and that this letter was copied to the Complainant's professional pension advisor. I have been furnished with a copy of this letter addressed to the Complainant's limited company at the Complainant's home address, which states as follows:

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Your bank has advised us that it was unable to pay your last pension contribution of €121.56 due on 1st November 2014. They have returned the debit to us marked 'Mandate Blocked'.

As we are unable to collect your pension contributions we had to suspend the above scheme with effect from 1st November 2014. Any attaching risk benefits have ceased and may need to be underwritten when the scheme is reinstated.

In order to maintain the scheme member's valuable retirement (and attaching risk) benefits please complete and return the enclosed direct debit mandate to us within five working days. We will then collect the outstanding contributions at the next contribution due date.

A further letter in similar terms was sent on **27 November 2014**.

Neither the Complainant's employer, nor the Complainant appear to have responded with a repayment proposal until some months later, on **26 February 2015** when a completed direct debit mandate was supplied by the Complainant's professional pension advisor detailing a new bank account from which payments, including arrears, could be drawn. The account specified was the personal bank account of the Complainant. The payment of contributions into a company pension plan by an individual beneficiary is, however, prohibited by the Revenue.

The Provider maintains that it did not apprehend at the time (in February/March 2015) that the account details that had been supplied, related to the Complainant's personal account. The Provider states that it updated the Complainant's "*personal bank account details to the company plan … in error*" and that, in March 2015, it collected the arrears due since November 2014 (€729.36).

The Provider states that, at this point, the life cover benefit was reinstated but not the disability benefit. However, it is important to note that the letter of **16 March 2015** to the trustees of the pension plan, simply confirmed that

"*… the policy has been reinstated with effect from the 1st November 2014*".

There is no reference in the cover letter to disability benefit. The enclosure to the letter appears to have been a Statement of Reasonable Projection which did not include any reference to disability benefit, but which did include a reference to the life cover. An email of **13 March 2015** in relation to collecting arrears "*in order to keep the cover in force"* also omitted any reference to any cessation of the disability cover.

I have noted that the Complainant appears to have made a successful claim for disability benefit which was admitted in **March 2011**, but which was rescinded in **September 2012** upon the Provider discovering that the Complainant was, in fact, working. The Provider eventually sought to recoup certain of the payments made (€37.9K). A subsequent claim on the policy in **January 2013** was rejected. This is not directly relevant to this complaint except

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that the Complainant's professional pension advisor refers to certain correspondence issued in respect of these claims.

Following the reinstatement of the plan (minus the disability cover) in March 2015, the Provider continued to collect payments from the Complainant's personal account up until **November 2016**. At this point, the Provider realised the error following an application made on 3 October 2016 on behalf of the Complainant by his professional pension advisor to change the name of the employer on the pension plan from the original limited company to a new limited company also owned by the Complainant. (These companies are referred to below as the 'Old Company' and the 'New Company').

It is useful at this point to note some details in respect of the Old Company and the New Company. The Old Company, which had been registered in **1996**, was dissolved in **August 2016**. The New Company was registered in **May 2015**. In correspondence to the Provider dated **3 March 2015**, the Complainant confirmed that the Old Company was not trading and that it was intended to wind the company up. The letter also recorded that the Complainant was in receipt of no income from the Old Company or from any other source. The letter confirmed that the Complainant was not performing any work for the Old Company and had not done so for the past two years. In a later submission to the Provider dated 30 September 2016, the Complainant stated that he ceased employment with the Old Company in **April 2013**.

Having apprehended, in October/November 2016, that the payments being made into the pension plan were being made from an inappropriate source, the Provider emailed the Complainant's professional pension advisor on **8 November 2016** outlining a number of problems:

1) In the first instance, the Provider noted that the request to change employers on the pensions plan required, according to the scheme rules, the consent of the previous employer. In this instance however, the document signed by the Complainant on behalf of the Old Company was signed on a date (30 September 2016) after the date of the winding up of the Old Company. The Provider pointed out that it was not possible to change the employer, without a valid consent from the old employer.

2) Secondly, the Provider pointed out a fundamental problem regarding the fact that payments had been made since March 2015 from the Complainant's personal account in contravention of Revenue rules. The letter noted that the Provider would most likely have to seek guidance from Revenue on how to proceed.

At some point in and around this time (possibly 13 October 2016), the Complainant raised a complaint regarding the failure, in March 2015, to reinstate the disability benefit in addition to the life cover benefit which had been reinstated. The Provider eventually responded to this particular complaint (following a number of holding letters) on **15 March 2017** noting that its correspondence of 7 November 2014 had confirmed that the benefit had "*been*

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removed". The Provider went on to stipulate as follows (in which 'PHI' equates to disability cover):

> *The life cover benefit was the only risk benefit reinstated; PHI benefit was not. I must point out that at no point was it specified that the PHI benefit was to be reinstated and we did not confirm that the PHI benefit had been reinstated. All communication sent after this date confirmed life cover as the only benefit.*

The letter went on to advise that, as the Complainant had indicated that he was unemployed during the period in question, he would not have been in a position to benefit under the policy in any event.

The letter also repeated the proposition that contributions could only be properly collected from the company account and not from a personal account. The Provider concluded:

> *The correct process at the time would have been to advise that it was not possible to contribute from a company* [sic] *account.*
>
> *Had this process been followed, the plan and benefits would not have been reinstated. In order to rectify our error, as outlined above, we will be contacting Revenue shortly to determine how to proceed.*

I am satisfied that the foregoing passage contains a typographical error insofar as it should have read "*that it was not possible to contribute from a* personal *account*".

The Provider maintains that, in late 2017/early 2018, it received advice from Revenue indicating that it could refund the regular contributions collected from the Complainant's personal account in respect of the period November 2014 – November 2016. The Provider characterised the advice from the Revenue as "*supporting our position that the plan including any risk benefits should never have been reinstated when they were (as contributions for a company pension plan cannot be made from a personal account)*." Thereafter, the Provider refunded to the Complainant the contributions collected in respect of the period November 2014 to November 2016 in the amount of €2,917.44.

The Complainant's complaint in this case straddles a number of interconnected grievances. The Complainant essentially takes issue with the Provider's failure to reinstate the disability cover in March 2015 and he also takes issue with the decision to deem the payments from the personal account inappropriate and to discontinue all the risk benefits as a result. There is also a complaint about the failure to allow the plan to be transferred to the New Company. The main issue is the second issue, but I will return to the first and third issues in due course.

There is little factual dispute about several key issues regarding the second issue. It is accepted that there was a failure to make payments from November 2014 to March 2015. It is also accepted that when the payments resumed in March 2015, the payments came from the Complainant's personal account. In addition, I understand that the Complainant does not dispute the fact that Revenue rules disallow payments into company pension plans

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from personal accounts. The real essence of this aspect of the Complainant's complaint is as articulated in his email to this office of 26 January 2018 where he stated as follows:

> *The Provider agreed to the premium being paid for through my personal account but later reneged on the agreement*

This proposition is disputed by the Provider. This precise issue is agitated in a very relevant email exchange beginning with an email dated **8 February 2017** from the Complainant's professional pension advisor to the Provider which includes the following:

> *I have also checked my file and we wrote to* [the Complainant], *on your advices, that it was in order for him to pay from his personal bank account and have the risk benefits reinstated.*
>
> *There was a phone call between myself and* [the Provider] *on the morning of* ***12th November 2014*** *sometime between 9am and 10.18am to this effect. You might check your records here.*

The Provider's response to this email included the following:

> *However, I do feel it important to point out that I have checked our records for the date reference below (12 November 2014) and have located an email to you advising that as discussed during your telephone call, the direct debit needs to be set up on the company account. I have attached a copy of this email for your reference. There is no record of us confirming that it was in order for payments to be made from a personal bank account.*

The Complainant's professional pension advisor duly responded as follows:

> *As suggested, you might have a listen to phone records as I would not have advised the client to do this off my own steam.*

In correspondence of 15 March 2017, the Provider referred to this phone call:

> *We also confirmed during this telephone call that the Direct Debit had to be set up on a company account. We emailed you on 12 November 2014 and reconfirmed this information, as you had requested.*

A copy of the actual e-mail of 12 November 2014 is not available. The Provider has advised that:

> "*Unfortunately, the e-mail in question was sent to [the Complainant's professional advisor] prior to [the Provider] taking over the administration of the plan (from [the predecessor to the Provider]) in June 2015. Therefore, the format sent to you is the only format we hold on our records. However, I have attached a screenshot of our systems, showing it was sent on 12 November 2014 …*"

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The Complainant's professional advisor however remains firm that "*We, as an office, would not have undertaken to do so, in the first instance, without prior approval from [the Provider]*".

I have also noted the impression which seems likely to have been given to the Complainant by his professional advisor's letter of 22nd of May 2017, which stated the following to the Complainant (underlining added):

> *Firstly,* [the Provider] *advised that they removed the PHI (Income Protection Cover) Benefit from this policy when your income Protection Claim was terminated.*
>
> [The Provider] *advised that this occurred in April 2015. On being made aware of this we asked for the matter to be escalated to the* [Provider's] *complaints department.*
>
> *Secondly, on receipt of the Change of Employer Application,* [the Provider] *ceased collecting premiums from your personal bank account (even though they were in agreement with same at the time) and have now advised that, due to non-payment of premiums, they have removed your Life Cover Benefit from this policy.*

The contents of this letter appear to me to have been incorrect in two fundamental aspects. In the first part, it is incorrect to state that the Provider advised that it had removed the disability benefit when the income Protection Claim was terminated in April 2015. The correspondence from the Provider around this time simply advised that the Complainant should not have been paying for any income protection insurance in circumstances where he had no income to protect. There is no reference to any removal of the benefit. Secondly, the letter arguably misrepresented the Provider's position as to what had been communicated to the professional pension advisor. Certainly, there was a total failure to refer to the fact that the Provider disputed ever stating that payments could be made from the personal account.

Having considered all of the limited evidence made available, I can only conclude that some misunderstanding arose between the parties. Both parties are firmly convinced of their own respective position, but given the less than optimal records available and the regrettable typographical error in the Provider's letter of 15 March 2017, I can only conclude that there was a misunderstanding in the course of these communications.

It is also disappointing that no audio evidence has been made available of the telephone call which it seems took place on 12 November 2014, which would shine a clearer light on the discussions between the parties on that date.

Whichever of the parties was responsible for the provision by the Complainant of his personal account details for payment, certainly, the Provider made a mistake in accepting those account details. That being the case, I must turn to the Provider's response upon apprehending the problem.

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The Provider, in my view quite rightly, sought advice from Revenue regarding the problem. Revenue confirmed that the payments were improper. Revenue further confirmed that the payments since March 2015 could be returned. The Provider took the correct course of action in adopting this advice. Bearing in mind the Revenue rules, there are no grounds on which it would be appropriate for this office to direct the reinstatement of the plan as if proper payments had been made all along. The plan could only subsist if qualifying payments had been made throughout the period but this did not occur. The Complainant was clearly entitled to the return of the payments made from his personal account and he has received those. The Provider is entitled to treat the plan as if it had not been reinstated (noting that this does not have any adverse implications for the Complainant's retirement benefit). In light of this, I am not in a position to uphold this aspect of the complainant's complaint.

I am also conscious that once the Complainant ceased employment with the Old Company (which the Complainant has himself confirmed to have occurred in April 2013, he ceased to be an "*insured person*" within the meaning of the policy, and then was no longer eligible for disability benefit or life cover under the policy, in any event.

It is also worth noting that the terms and conditions of the disability benefit policy (as reproduced above), and in particular Sections 3 (e) and (g) thereof, entitled the Provider to deem the benefit to have ceased in the event that a payment was outstanding for more than 30 days. Payment was incontrovertibly outstanding for more than 30 days in this instance.

I have noted however that the correspondence from the Provider in March 2015 failed to make any overt reference to the removal of disability cover. Whereas Section 3(e) of the terms of the policy entitle the Provider to cease to provide cover without the need for notification, I am satisfied that in this case the correspondence was misleading insofar a reasonable reader would have assumed that the cover previously in place was being continued without change. In the circumstances, I am satisfied that the Provider should have explicitly noted that the disability cover had ceased. The fact that the Complainant may not have been in a position to benefit from the cover (by reference to his employment status or by reference to the decision taken later as regards the source of payments) does not absolve the Provider from its obligation in this regard to be clear and I am satisfied that the Complainant has substantiated his complaint to the effect that the disability cover was cancelled "*without notifying*" him.

There is one additional criticism I consider it appropriate to make in respect of the Provider. The Complainant appears to have raised his complaint about the reinstatement of the disability benefit on 13 October 2016. A substantive response was not provided until 15 March 2017. In my opinion, this represents an entirely unreasonable delay in dealing with the complaint. Certainly, the complexity of the matter did not, in my opinion, require anything like so long a period to generate a considered response.

Insofar as the Complainant complains about the failure to allow the change of employer on the plan, I am satisfied that the Complainant failed to comply with the Provider's lawful requirements that a valid consent be procured from the previous employer (the Old Company), and the Provider therefore has no case to answer in that respect.

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In light of the issues outlined above, it will be appropriate to partially uphold the Complainant's complaint as to the maladministration of the pension plan, to the extent only as outlined above. I direct in that regard that the Provider make a compensatory payment to the Complainant in the sum of €1,000, in order to bring a conclusion to the matter.

Conclusion

- My Decision is that this complaint is partially upheld, pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, 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 make a compensatory payment to the Complainant in the sum of €1,000 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.

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION AND LEGAL SERVICES

2 December 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.