An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0042
Sector:	Insurance
Product / Service:	Life
Conduct(s) complained of:	Mis-selling Failure to provide correct information
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint concerns the alleged mis-selling of a life and serious illness insurance policy which the Complainant took out with the Provider in **December 2014**. The primary complaint is that the Complainant was incorrectly given to understand by the Provider that the policy was a tax-deductible policy though it later transpired that this was not the case. The Provider denies that the policy was sold as a tax-deductible policy. The Complainant seeks a refund of all payments made under the policy between December 2014 and February 2016. The Provider denies that the policy was mis-sold and does not accept that the Complainant is entitled to a refund of the premiums paid. On the basis of the evidence, the total amount paid by way of premium during the relevant time, amounts to a figure of some €2,000.

The Complainant further asserts that when she telephoned the Provider in **January 2016** to confirm the tax status of the policy, a representative of the Provider attempted to sell her a new policy during the call. The Provider asserts that there is no record of any such call. The Complainant further says that the family history section of the medical questionnaire which formed part of the application for the policy contained inaccurate information. The Provider asserts that the medical questionnaire was completed by its representative at a meeting with the Complainant, in good faith, reflecting information provided by the Complainant. It says that the Complainant ought to have alerted it to any inaccurate information, on receipt of the relevant policy documentation.

Finally, the Complainant says that the Provider did not cancel the policy until **21 March 2016** notwithstanding that she had submitted the cancellation instruction to the Provider on **24 February 2016**. The Provider asserts that although the policy was not cancelled until March 2016, the cancellation was effective from **24 February 2016** and the premium deducted thereafter was refunded to the Complainant.

The Complainant's Case

The Complainant sent an email to the Provider dated 24 February 2016 requesting that the policy be cancelled with immediate effect as:

> "*This was sold as tax-deductible and it is not. I will be looking for a full refund*."

In a letter dated **24 February 2016**, the Complainant stated that she had just spoken to the Provider's customer service department and requested an immediate cancellation of the relevant policy. She stated that:

> "*When I took out the policy it was sold as a tax-deductible policy and it is not. This was verified today. I am requesting a full refund on this policy*."

In her complaint to this office, the Complainant says that she took out a [named] policy as she is a private business owner and she wanted a tax-deductible policy. She contends that when she filed her taxes, it became apparent that it was not a tax-deductible policy and she suffered financial hardship as a result. She states that when she called the Provider about the issue, it tried to sell her a new policy without solving her problem and she was completely bewildered by this. She states that she would never have taken out such an expensive policy if she had known that it was not tax-deductible. She seeks a refund of the premiums paid on the policy. She also states that the policy should have been cancelled from the date of her letter on 24 February 2016, not 21 March 2016.

A complaint in similar terms was made by letter dated **11 May 2017**. In this letter, the Complainant stated that she was advised by her accountant to take out a policy that was tax-deductible. She stated that she was advised by the Provider that she could not take out a policy over the phone and she had to go to meet a representative, which she did. She states that after the meeting, she thought she had signed up for a tax-deductible policy but in January 2016, she discovered that this was not the case. She states that when she called the Provider in January 2016 to investigate the tax status of the policy and discovered that she had been sold the wrong policy, she was dumbfounded when a representative tried to sell her another policy on the same call.

The Complainant states that having reviewed her file, she has also noted that the Provider ticked a box indicating that "*no person related to me died from cancer under the age of 60*". She states that this is not the case as her mother died from cancer at the age of 44. She states that she is aware of the Provider's non-disclosure clause and that this could have had a detrimental effect and caused monumental problems to any future claim.

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In an email dated 16 November 2017 in response to the Provider's submission dated 27 July 2017, the Complainant stated that she was advised by her accountant to review her old policy and advised that she should take out an illness policy with tax relief, as she is a business owner and she did not then have cover for illness. She further states that a close friend of hers had recently passed away leaving three young children and she wanted to put some protection in place in the event of her own illness and inability to support herself and young daughter.

The Complainant stated that the Provider would not arrange this over the phone and required her to meet its representative, Mr A. to discuss the policy. She stated that before she went to the meeting with Mr A., she knew that she wanted: (i) illness cover and (ii) a policy there was tax-deductible. She did not want to talk to Mr A. about her tax status as her accountant already done this. Later in this submission, the Complainant says that she did not review her policy "*until I discovered that my policy was not tax exempt*". She claims to have discovered that her mother's cause of death was inaccurate on the proposal. She states that she would never have taken out a policy for critical illness that did not cover her in the event of cancer. She says that she took out the policy in the utmost good faith that it covered critical illness and was a tax-deductible policy but the policy, effectively did neither and a full refund is due.

The Complainant states that her mother passed away from cancer when the Complainant was eight years old. She states that Mr A. completed her questionnaire during the meeting and she doesn't know why the information was incorrectly recorded. She states that she was not looking for a lower premium but rather a policy that would protect her and her daughter if she got sick, specifically from cancer. She states that she spent considerable time with Mr A. that afternoon, completing the application on a good faith basis but in fact she signed up to a policy that would never have paid out if she had been diagnosed with cancer. She felt that she and Mr A. had done a thorough review in his office and that a further review was not necessary. She accepts that the March 2016 refund was processed.

Many of the same points are repeated in a further email dated 9 December 2017. In addition to submissions previously made, the Complainant stated that she spent over an hour at the meeting in December 2014 with Mr A. where forms were completed for the new policy. She stated that at the time she was changing from a sole trader to a limited company. She says that if there is no record of her first call in January 2016, the problem is that the file is missing.

The Complainant states that she has never claimed that she did not enquire about a tax-deductible policy in February 2016 when she was trying to review her options and figure out how to get adequate cover. She states that when she did call in January 2016, the person on the other end of the phone started trying to sell her a replacement policy. She acknowledges that all of the documentation referred to by the Provider and submitted to this office were sent out to her for review. She thought that the forms were correctly completed by Mr A. in his office and she does not know how the box in relation to whether her parents had died of cancer was checked 'no'. She did not think she needed to go through the forms again with a fine tooth comb after the thorough meeting. She states that during the whole process she

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was trying to protect herself should she have gotten ill; she wished to have a tax efficient policy in place.

In a further submission to this office dated 12 January 2018, the Complainant reiterated many of the points already made in previous submissions. She argued that where a customer goes in to the Provider's office and meets a representative to complete paperwork for a policy, vital information such as the inaccurate recording of the death of one's parents should not happen. She argued that she should not be held responsible for this.

The Complainant also suggested that whether a policy is tax-deductible or not, should be more clearly stated on the front pages of application forms for relevant policies. The Complainant reiterates that the reason she met with Mr A. was to put in place a policy that was tax-deductible and covered critical illness, but it transpired that these things were not covered.

The Provider's Case

By letter dated 29 March 2016, the Provider responded to a complaint made by the Complainant over the phone, in which she stated that she believed that the policy sold to her when she met with insurance and investments manager, Mr A., in December 2014 was tax-deductible. The letter stated that the writer had raised the issue with Mr A. and he had confirmed that he advised the Complainant that, as a sole trader, the premiums were not tax-deductible. The letter stated that Mr A. had advised that he explained to the Complainant that only a limited company would benefit from corporation tax relief on executive key person insurance and that if she switched to a limited company, she should ensure to renew her life cover at that stage. Mr A. is also said to have confirmed that he advised her to speak with her accountant separately on the matter. The letter indicates that the writer had reviewed the file in detail and could not locate any notes recorded during the Complainant's meeting with Mr A. to indicate that he advised her that the policy was tax-deductible and, in the circumstances, the Provider was not in a position to honour her request for a refund of the premiums on the policy.

The Provider confirms that the policy has been cancelled since 21 March 2016 as per the Complainant's request. As part of the documentation submitted to this office, the Provider submitted a copy of an email dated 22 March 2016 from Mr A. to the writer of the said letter which reflects the details as set out in the letter of 29 March 2016 as per Mr A's recollection. In this email, Mr A. stated that

> *"there is no way whatsoever that I advised her that [named] policy was tax-deductible*."

In response to queries raised by this office, the Provider stated in a submission dated 27 July 2017 that the policy, was taken out by the Complainant following a meeting with Mr A., an insurance and investment manager, on **3 December 2014**. The policy had a term of 20 years, a monthly premium of €153.16 and life cover and accelerated critical illness benefit of €200,000 on a single life basis. The Provider notes that shortly before the Complainant cancelled the relevant policy in February 2016, the Complainant reduced the sum assured

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under the policy to €100,000 with a revised monthly premium of €79.68, by way of letter dated 19 January 2016 (though it is noted by this office that in fact the handwritten letter furnished in evidence by the Provider, bears no date).

The Provider states that the meeting with Mr A. was arranged by the Complainant as she wished to discuss an existing unit linked protection policy she had taken out with the Provider in **November 2002**. The Provider alleges that during the meeting, Mr A. completed a personal financial review with the Complainant.
Based on the information provided by the Complainant, a financial plan was generated which contained recommendations for the Complainant to consider, taking into account her circumstances at the time. A plan of action report generated at the meeting contained a note recorded by Mr A., which refers to the cancellation of the previous plan and its replacement with a mortgage protection policy and a separate life policy covering critical illness cover.

After the review, the Complainant signed a proposal form for the relevant life and serious illness policy confirming that she had been provided with an important information document. The Provider states that page 5 of this document states that "*premiums payable under the policy do not qualify for any tax relief*". The policy schedule, policy conditions and important information notice was issued to the Complainant on **5 December 2014**. The covering letter recommended that the Complainant should study the enclosed documents carefully to ensure that the policy met her requirements and drew her attention to her cooling off rights which permitted cancellation of the policy within 30 days.

The Provider states that it cannot accept the Complainant's assertion that the policy was sold as a tax-deductible policy. It suggests that she met with Mr A. to discuss her personal financial circumstances and not those of her business, and that Mr A. completed a personal financial review during the meeting, not a business review. The Provider states that a statement provided by Mr A. during the investigation of the complaint confirms that the Complainant asked him during the meeting if the premiums were tax-deductible and that he explained to her that, as the sole trader, they were not and that only a limited company would benefit from corporation tax relief on executive key person insurance. Mr A. denies having advised the Complainant that a [named] policy was tax-deductible. The Provider relies on this confirmation from Mr A. that he did not advise the Complainant that the policy was tax-deductible as well as the documentation furnished to the Complainant at point of sale, and on commencement, that no tax relief could be claimed on premium payments.

In relation to the Complainant's assertion that she had a telephone conversation with a representative of the Provider in January 2016 during which the representative attempted to sell her a new policy, the Provider states that it has no record of the Complainant placing a call to it in January 2016. It states that from its record of recorded telephone conversations between it and the Complainant (copies of which have been supplied to this office) it appears that the first telephone call the Complainant made to the Provider seeking information on the tax status of the policy was on **23 February 2016**. The Provider asserts that it is evident from this telephone call that it was the Complainant herself who enquired if there were alternative products available that were tax-deductible and that the

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representative in question advised that she would need to speak to an insurance and investment manager for further details.

As to the accuracy of information recorded on the health and lifestyle questionnaire, the Provider states that the Complainant was asked by Mr A. to respond to various questions in relation to her health and in relation to her family's medical history. The Provider argues that the responses to the questions on the application form were recorded by Mr A. in good faith, based on the information provided by the Complainant.
The Provider states that in signing the application form, the Complainant declared that she had read and understood the notes in respect of disclosure of material facts and also declared she had read and understood the replies to all the questions contained in the application form. Furthermore, the Provider states that following the meeting, a copy of the completed application form was posted to the Complainant with the covering letter asking her to read the documents carefully. The letter advised the Complainant that if any information recorded on the application form was incorrect or incomplete, she was obliged to notify the Provider within 10 days of the date of the letter. The Provider suggests the Complainant did not contact the company following receipt of the letter and enclosures and that the Complainant therefore accepted the accuracy of the information recorded on the application form. The Provider does not accept the Complainant's contention that information was incorrectly recorded on the medical questionnaire, as she was afforded an opportunity to rectify any errors or omissions and did not do so. The Provider argues that there was no detriment to the Complainant as a result of the information recorded and that the Complainant is likely to have benefited from a lower premium as a consequence.

In relation to the alleged delay in cancelling the policy, the Provider states that the cancellation instruction was received on 25 February 2016 and the cancellation instruction processed on 21 March 2016 with an effective date of 25 February 2016. It states that the premium that was debited from the account in respect of March 2016 premium was refunded to the Complainant on 29 March 2016.

In a letter dated 5 December 2017 in response to the Complainant's email of 16 December 2016, the Provider reiterates many of the points previously made by it in submissions to this office. The Provider submits that the Complainant would have been aware that the premiums under her old policy were not tax-deductible. The Provider reiterated its view that the Complainant was advised during the sales meeting that the proposed policy would not be a tax-deductible policy and that the documentation provided reflected that the policy was not tax-deductible.

It also asserts that all appropriate steps were taken to ensure that medical details recorded were brought to the attention of the Complainant and that the Complainant was afforded an opportunity to consider them. A submission in similar terms was made by letter dated 18 December 2017 in response of the Complainant's email of 11 December 2017 in which the Provider reiterated its understanding of what was said to the Complainant by Mr A. during the sales meeting and confirms that it has no record of receiving any calls from the Complainant in January 2016.

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The Complaint for Adjudication

The complaint is that the Provider was guilty of maladministration insofar as it:-

- Mis-represented in December 2014 to the Complainant that the cost of her life and serious illness policy was tax-deductible.
- Failed to correctly record the Complainant's family medical history.
- Delayed in cancelling the Complainant's policy upon request.

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 on 22 January 2020, 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. The Complainant believes that she was mis-sold the life and serious illness cover in December 2014. She says that she would only have taken out such an expensive policy on the understanding that it was tax-deductible. She is adamant in her written submissions to this office and in telephone conversations with the Provider in February 2016 that she only took out the policy on the basis that it was tax-deductible.

The Provider rejects this ground of complaint and submits that it was made clear to the Complainant both at the meeting with Mr A. and in the documentation made available to her at and after this meeting that the policy in question was not tax-deductible.

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A statement has been made available by Mr A. to the effect that he recalls discussing whether the premiums were tax-deductible with the Complainant and he explained that as a sole trader they were not. The Provider therefore does not accept that the product was mis-sold.

Documentary Evidence

The Provider has supplied this office with detailed records in relation to the application for life and serious illness cover. A fact find records the Complainant as being a self-employed company director. The fact find also records her assets, liabilities, income and expenditure, and savings and life cover shortfall. I note the inconsistency in this document between the Complainant's "employment status" being confirmed as "Employed", and nevertheless, the "Self-Employed" section of the document being completed noting the Complainant's occupation as "Company Director".

A financial plan was prepared for the Complainant by Mr A. recording his recommendations and I similarly note that although Mr A. recalls discussing the non-tax-deductibility of the premiums, because of the Complainant's sole trader status, her occupation is nevertheless recorded in this Financial Plan as "Company Director".

In a plan of action report detailing the recommendations made by Mr A. in the financial plan, Mr A. made a contemporaneous note of the recommendations as follows:

> *"[The Complainant] phoned me to set up this meeting to review her [old policy]. [The Complainant] currently has cover of €125,716 in this policy. It is protecting a mortgage of €38,000. [The Complainant] has no illness cover in place and I have strongly advised [the Complainant] to consider this. As a result of my financial review [the Complainant] is going to cancel her [old policy] and replace it with a basic mortgage protection policy for €38,000 for the next 15 years at a cost of €15 per month. [The Complainant] is also applying for a separate life cover and critical illness cover of €200,000 over the next 20 years. I have made [the Complainant] very aware that she is cancelling a whole of life policy and she is happy with this as the mortgage is still fully covered and she has a strong life cover and critical illness policy in place now. [The Complainant] is happy to proceed with replacing [old policy] at this time. [The Complainant] will also be encashing the full value of [old policy] which is currently €3,600*."

The plan of action report including the relevant note was signed by Mr A. and the Complainant on 3 December 2014. There is no mention in this contemporaneous note of any discussion having taken place at that time in the course of the meeting in relation to whether or not the life and serious illness policy premiums were tax-deductible. The Provider's representative confirms that the Complainant asked the question, during the course of the meeting as to whether the premiums were tax deductible (to which the answer was "no") but the recorded notes from this meeting do not include any detail of such discussions. This is disappointing, though I note that other critical elements of the discussions are captured by the notes i.e. that the intended policy was a replacement of an already existing policy.

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I note that a separate Statement of Suitability was signed by the Complainant and the Provider's representative on 3 December 2014 and I note that the reasons identified as to why the policy in question was most suitable for the Complainant were as follows:-

- *It is designed to provide cover throughout the chosen term, provided that an appropriate premium is paid.*
- *The policy offers a range of income on death, lump-sum on death and/or specified illness cover. Specified illness cover can be selected as a stand-alone benefit or as an acceleration of lump-sum on death benefit. You may also apply for hospitalisation payment, surgery payment, broken bones payment, accident payment and whole of life continuation if you wish. You may, subject to [Provider's] terms and conditions propose the type of cover which meets your financial needs.*
- *Subject to certain conditions you can vary the level and type of cover from time to time to suit your changing circumstances.*
- *You can opt at the outset for benefits and premiums to increase each year by a rate of 3%. This option helps maintain the "real" value of the benefits when inflation is taken into account.*

I note in that regard that of the reasons identified as to why this policy was suitable for the Complainant, the tax deductibility of premium payments was not one of those reasons.

In an application form for the [named] policy, a questionnaire has been filled out. Under a section entitled "concerning your family" the following appears:

> "*Have any of your biological parents, brothers or sisters had any of the following medical conditions before age 60:*
>
> (i) *Cancer of the breast, ovaries, colon, bowel, rectum, Polly poses of the colon or any other form of cancer?* ***NO*** "

This proposal form was signed by the Complainant by which she confirmed that she had read and understood the replies to all questions on the application and that all statements were true and complete and would form the basis of the proposed contract. By her signature, she further confirmed that Mr A. had provided her with an important information document.

In a cover letter dated 3 December 2014 enclosing the application and documentation containing important information regarding the proposed policy, the Provider stated as follows:

> "*If any of the information is incorrect or incomplete, you must notify us in writing within 10 days of the date of this letter. If you're satisfied that the information is correct and complete then there is no further action required from you at this time*."

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A further letter of 5 December 2014 enclosed a policy pack comprising the Complainant's policy schedule, policy documents and an important information notice which includes information as to her right to cancel the policy within 30 days.

The important information document detailed the protection benefits of the policy, the premium payable, and the term of the policy. On page 5 of 9 under a sub-heading entitled "**information on taxation issues**", the document stated as follows:

> "*The following is a general summary of taxation implications based on our understanding of current legislation. Owing to the individual nature of each case, we recommend that customers establish all tax implications with their professional advisors.*
>
> *The premiums payable under the policy do not qualify for any tax relief*."

In a further important information notice, taxation is dealt with on page 6 of 10 under the subheading "**taxation**". This notice is in comparable terms to the previous important information document and provides as follows:

> "*The following is a general summary of taxation indications based on our understanding of current legislation. All policies no taxation injured implications should be reviewed by customers with the professional advisers.*
> *…*
> *The premiums payable under the policy do not qualify for tax relief*."

Telephone Recordings

The Provider has supplied this office with recordings of several telephone calls between it and the Complainant with regard to the policy in question. The Complainant telephoned the Provider on 23 February 2016 and sought clarification as to whether or not the policy was tax-deductible. The Provider's representative confirmed during this call that the policy was not tax-deductible. The Complainant asked if there were any other products available that were tax-deductible. The representative indicated that he was unable to deal with this query and recommended that she speak to an insurance and investments manager, and gave her the details of one such person.

In a call dated 24 February 2016, the Complainant indicated that when her accountant had told her that the policy was not tax-deductible she was in complete shock. She states that the only reason she took out the policy was on the basis that it was tax-deductible. She stated that she was setting up a limited company at the time and that although the policy was expensive she bought it on the basis that it was tax-deductible. The Provider's representative assured the Complainant that her complaint would be thoroughly investigated.

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Tax Deductibility of Premiums

It is clear from recordings of telephone calls that the Complainant made to the Provider in February 2016, from her letters of complaint, and from her various submissions to this office that the Complainant is adamant that one of the primary reasons why she sought to change her insurance cover in December 2014 was so that future cover would be tax-deductible. She has stated that she was advised by her accountant to put in place a tax-deductible policy that would cover her in the event of serious illness and it was with this in mind that she met with Mr A. in December 2014.

In his email of 22 March 2016, Mr A. is also clear that he spoke to the Complainant during their meeting on 3 December 2014 about whether or not the policy was tax-deductible. He claims to have confirmed that the policy was not tax-deductible as the Complainant was a sole trader. He asserts that he informed her that it was possible to put tax-deductible executive key personnel insurance in place, in the case of a limited company and recommended that she discuss this with her accountant and review her cover if she did so.

This important aspect of the conversation however, is not included in any of the notes prepared by Mr A., and it is difficult to understand why, in the context of discussing the Complainant's sole trader status, he firstly did not record this detail within the documentation, and secondly, he was satisfied to record her occupation as "Company Director". Mr A. has confirmed that there is no way whatever that he informed the Complainant that the policy he was recommending for her was tax-deductible. Indeed, I note that the policy documents make it abundantly clear that the premium payments were not tax-deductible. The relevant entries appear on page 5 of 9 on one document and on page 6 of 10 in another document. It is also clear however, from the Complainant's own submissions that she didn't read the documents sent to her by the Provider. Had she done so, she would have been in a position to identify this issue much sooner.

I have also noted that the Complainant said in her 'phone call in February 2016 that in December 2014 she was setting up a limited company at the time. It is clear however, from the tax return details submitted to this office that during the following year, 2015, the Complainant continued to operate her business as a sole trader.

The Complainant says that she made a telephone call to the Provider in **January 2016** requesting information about whether or not the premiums on her life and serious illness policy were tax-deductible. She says that rather than dealing with her complaints, the representative with whom she was dealing instead tried to sell her an alternative policy.

The Provider has indicated that although it has recordings of several telephone conversations between the Complainant and its representatives in relation to the present complaint, the first such recording is dated 23 February 2016 when the Complainant telephoned to inquire about the tax status of the relevant premiums. On this call it was confirmed to her that the premiums were not tax-deductible. The Complainant herself inquired as to alternative tax deductible policies and the representative in question confirmed that he could not discuss alternative policies with her and instead recommended that she speak to a named insurance and investments manager.

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The implication from the Provider's response is that since there is no recording of a January 2016 telephone call, then the Complainant must be mistaken and the first telephone call took place on 23 February 2016. The recordings from 23 and 24 February 2016 make it clear that only the Complainant raised the possibility of alternative tax-deductible policies at this time. This is accepted by the Complainant who says that a previous call took place, which does not appear to have been recorded. I note in relation to the February 2016 calls that the Complainant indicated to the representative concerned, that she had been alerted by her accountant to the fact that the premiums were not tax-deductible and she was attempting to confirm whether or not this was the case. I would expect in those circumstances that this news had come to the Complainant's attention in the fairly recent past. In an email of 19 June 2019 to this office however, the Complainant made it clear that this information came from her accountant

> "*the first to second week of 2015 as* [named accountant] *told me when I was sending my tax receipts etc. to him for filing*".

This was a year before the Complainant's telephone call to the Provider. It is also unclear why the Complainant was sending receipts to her accountant in January, as it seems from the evidence she has submitted to this office, that her tax return falls due in October/November each year.

I also note that the evidence includes an email from the Complainant's accountant to her dated 27 June 2019 which confirms that:-

> *"I have checked the notes on this matter and in a conversation we had on per my records on 01/11/2016, we discussed a [Provider] life/illness policy which you believed had a tax deductible element to utilise against your tax liabilities. I had reservations that this was the case and I asked you to get clarification from the company to confirm if it was or was not allowable for tax relief. You subsequently advised me that this policy was not be used for tax relief purposes in your tax return…."*

The Complainant's accountant's records in that regard do not align with the Complainant's recollection of the relevant dates and his records refer to a conversation approximately 9/10 months after the relevant telephone conversations took place between the Complainant and the Provider.

There is, for the reasons outlined above, an absence of reliable evidence from both parties regarding the events of December 2014, and indeed regarding the subsequent interactions. I am also conscious that in one of the Complainant's submissions, she indicated that she had discovered that the policy was not "tax exempt". It is worth bearing in mind that tax-exemption is a concept which is entirely separate from the tax deductibility of premium payments.

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All in all, I consider that there was considerable confusion as between the parties in December 2014 regarding the Complainant's employment status/potential future status. There are conflicting details, and indeed the gaps in the information from the contemporaneous documents of 2014 are disappointing. Taking into account such issues, I believe that both parties share responsibility for the confusion which arose at the time that this policy was put into place and, bearing in mind the Complainant's confirmation that the tax-deductibility of the premiums was critical to her, as indeed was the nature of the cover she required, it is indeed disappointing that she did not take the time to read over the documentation sent to her by the Provider, once the policy was incepted. In all of those circumstances therefore, I am satisfied that this aspect of the complaint is one which should be partially upheld.

Medical History

It appears that the policy application form and the answers to the questions raised therein were completed by Mr A. in the course of his meeting with the Complainant on 3 December 2014. The Complainant has confirmed that her mother died of cancer at the age of 44. The Complainant therefore accepts that the answer that appears on this application form in response to the question of whether any of her family members were diagnosed with cancer before the age of 60 was answered incorrectly in the negative. She has quite fairly acknowledged that she does not know how this question was answered in the negative when it ought to have been answered in the positive. She has confirmed that there is no question that she would have knowingly provided a negative response to this question as she was very concerned that she would be covered in the event that she was diagnosed with cancer.

For its part, the Provider asserts that Mr A. filled in the responses to the questions raised in good faith in discussion with the Complainant at the relevant meeting. It also points to the fact that a copy of the application form was sent immediately following the meeting to the Complainant who was asked to review the information contained therein and to inform it within 10 days in the event of any inaccuracy.

The Complainant has expressed her belief that she was entitled to assume that all of the information had been accurately recorded, when she spent such a long period at the meeting with Mr A. She acknowledges that she did not review the relevant information until February 2016 when it became apparent that there was a larger problem with the policy, namely in relation to whether or not the premiums were tax-deductible. While I have sympathy for the Complainant's perspective in relation to this, and I accept that she did not knowingly provide inaccurate information in the course of the meeting, I do not accept that she was entitled to simply assume that all of the information recorded was accurate. There are many important questions raised in an application form for life and serious illness cover and it is plausible that in the course of answering these questions and selecting the relevant answers that either the Complainant or Mr A. could have made a mistake in relation to the relevant question, or indeed to any other question.

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I do not propose to single out either of them for this error, merely to point out that it could have been either one of them who made a mistake. It is reasonable in the circumstances that the Provider would request that an applicant for insurance review the medical information provided in the application form and confirm its accuracy and allow a period of time in which mistakes could be rectified. The cover letter of 3 December 2016 clearly requested that the Complainant do so and, on her own admission, she did not. As a result, the inaccuracy was not picked up for over a year; thankfully no damage in fact resulted from the error on this policy.

Bearing in mind this very serious issue of inaccurate information however, I wrote to the Provider in **February 2019** requesting a review of the Complainant's other policy which had been incepted in December 2014 in the context of her decision at that time to replace her existing policy with "*a basic mortgage protection policy for €38,000 for the next 15 years at a cost of €15 per month*". Noting that in the course of the investigation of this complaint, the Complainant had maintained that some of the answers recorded in response to the questions on the Medical Questionnaire were incorrect, I asked the Provider to review the inception of that separate mortgage protection policy, in order to establish whether the issue concerning the age and cause of death of the Complainant's mother, was an issue which also arose in respect of that separate mortgage protection policy.

The Provider subsequently confirmed at the end of March 2019 that the sales document relating to the policy in question disclosed no evidence that the Complainant's mother had died at age 44, from cancer. The Provider also confirmed nevertheless, that if the relevant information had been disclosed, the relevant cover would still have been offered to the Complainant at ordinary rates. Accordingly, while strictly speaking it was open to the Provider to declare the policy void for non-disclosure, the Provider confirmed that it did not propose to do so on the basis of the failure to disclose the date of death of the Complainant's mother. The Provider has therefore confirmed that provided the Complainant continues to maintain her monthly premium, cover under the mortgage protection policy will remain in place for the remainder of the selected term. This is a very welcome confirmation to the Complainant, that this cover remains valid, notwithstanding the incorrect entry on the proposal.

Insofar as the life and serious illness insurance policy is concerned (i.e. the policy which was cancelled by the Complainant in February 2016) I take the view that while it is unclear who was to blame for the inaccurate information that was recorded, it was nevertheless incumbent upon the Complainant, upon request, to review the accuracy of the answers provided in the application form. Although Mr A. recorded her answers to the questions raised, on the basis of the information made available at their meeting, the Complainant had the ultimate responsibility for ensuring the accuracy of the information provided by her in her application for life and serious illness cover. Furthermore, she has accepted that she understands the potential ramifications of non-disclosure in this context and appreciates the importance of the provision of accurate medical information.

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Delay in Cancellation of Policy

The Complainant says that although she sent a letter requesting the immediate cancellation of the policy dated 24 February 2016, the cancellation was not effected until 21 March 2016. The Provider accepts that the policy was not in fact cancelled until March 2016 but it has confirmed that at that point, it was cancelled effective from 25 February 2016, i.e. from when the cancellation letter was received by it. The Provider accepts that the March 2016 premium was deducted after the cancellation letter was received from the Complainant but it has also confirmed that this premium was refunded. Indeed the Complainant now accepts that this is the case. I therefore do not consider there to be any real dispute between the parties in that respect.

Having considered all of these issues at length, I take the view that in all of the circumstances, on the basis of the evidence available, the complaint against the Provider should be partially upheld, to the limited extent which I have outlined above. I am conscious that the overall cost of the premiums paid by the Complainant during the relevant period was approximately €2,000 and in those circumstances, to mark that decision, I consider it appropriate to direct the Provider to make a compensatory payment to the Complainant of €1,000, in order to conclude.

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 €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

13 February 2020

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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.