An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0056
Sector:	Insurance
Product / Service:	Payment Protection
Conduct(s) complained of:	Rejection of claim - fit to return to work
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint relates a mortgage payment protection insurance policy. In **January 2016** the Complainant submitted a claim under his policy in respect of a shoulder injury he sustained in **June 2015**. The Provider allowed the Complainant's claim for the period **10 June 2015** to **6 November 2015**. The Complainant is dissatisfied with the manner in which the Provider assessed his claim in that the Provider refused to access the Complainant's tax clearance certificate (**TCC**) and also failed to request medical records from his consultant when assessing his claim.

The Complainant's Case

The Complainant states that he made a complaint to the Provider on **16 July 2016** in respect of the manner in which the Provider dealt with his claim under his mortgage protection policy. In a submission dated **30 August 2016**, the Complainant outlines the first aspect of his complaint as follows:

> *"1. [The Provider] persistently refused to access my tax clearance cert. The tax clearance cert access number was furnished to [the Provider] on numerous occasions but they repeatedly claim they were unable to access my Tax Clearance Cert. This is incorrect"*

The Complainant states that his accountant contacted the Provider's claims department in early **June 2016** and as a result of this call, the Provider was immediately able to access his tax clearance certificate.

The Complainant points out that following this call, the Provider paid four monthly payments in respect of his claim on **2 June 2016** for the period **10 June 2015** to **7 October 2015**. The Complainant submits that he received treatment from his consultant after the payment of his claim.

The second aspect of the complaint relates to the Provider's failure to seek medical records from the Complainant's consultant when assessing his claim. The Complainant summaries this aspect of his complaint in a submission dated **15 February 2018** as follows:

> *"2. [The Provider] failed to take up my medical notes from [the Complainant's consultant] over a ten (10) months period, from January to October, 2016. This was despite being repeatedly advised, that it was [my consultant], who had treated me for my injury and not my GP …"*

In his submissions dated **30 August 2016**, the Complainant also states:

> *"I pointed out to [the Provider] that the consultant I attended in relation to my injury was [consultant]. I had previously been a patient of [consultant] and I therefore I (sic) did not need a referral from my GP … as I had direct access to [consultant]. [The Provider] have persistently ignored this point and never consulted [my consultant] in relation to my medical records.*
>
> *[The Provider] contacted my GP … but [my GP] was not the medical practitioner who treated me. [The Provider] should have contacted [my consultant] and have persistently refused to do so."*

The Complainant states that the Provider advised him that he attended his consultant on **10 June 2015** and **13 April 2016** and there was no evidence on any further visits. The Complainant disputes this and identifies six further occasions on which he attended his consultant between **June 2015** and **July 2016**.

In a submission dated **29 April 2019**, the following points are raised:

> *"Please note that [the Complainant] reached his 65th birthday on [date]. On this date, the contract for PPI Insurance between [the Complainant] and [the Provider] came to an end.*
>
> *[The Provider] continued to charge monthly interest for his PPI Insurance to our Mortgage Account in [the Mortgage Provider],*
>
> *[The Mortgage Provider] facilitated this and paid the insurance each month, from [date] up to and including 1st August 2018 [totalling €409.15].*
>
> *…*

/Cont'd…

*[The Mortgage Provider] wrote to me on 9th November 2018 advising that they had made a **mistake** on our monthly payment protection insurance, which they continued paying after the contract for the product was terminated …*

Both [the Provider] and [the Mortgage Provider] are in breach of contract in relation to this matter."

The Provider's Case

The Provider states that it received a sickness claim from the Complainant on **19 January 2016**. The Provider submits that it reviewed the Complainant's medical records and *"… in his medical records he did not consult, receive treatment or medication from his GP during the period of his claim from the 10th June 2015 to 03rd June 2016."* It is because of this, the Provider submits, that the Complainant's claim was stopped.

The Complaint for Adjudication

The complaint the subject of this adjudication is contained in the Complainant's complaint form dated **5 September 2016** and is further elucidated on in the accompanying submissions. The conduct complained of in the submission dated **29 April 2019** occurred quite some time after the date of submission of the complaint form. I consider this conduct to be unrelated to the conduct the subject of this complaint. Furthermore, I note that it also involves another financial services provider. Therefore, this conduct does not form part of this complaint. It is open to the Complainant to make a separate complaint to this Office in relation to that conduct.

Therefore, the complaint that I am adjudicating is that the Provider:

1. wrongfully and/or unreasonably refused and/or neglected to access the Complainant's tax clearance certificate; and

2. failed to request the Complainant's medical records held by his consultant between **January 2016** and **October 2016**.

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.

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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 9 January 2020, outlining my preliminary determination 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 Complainant made a further submission under cover of his e-mail to this Office dated 16 January 2020, a copy of which was transmitted to the Provider for its consideration.

The Provider did not make any further submission.

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

Mortgage Payment Protection Plan

Section 1 of the policy defines *disability* as follows:

> *"A state of incapacity due to accidental bodily injury or illness as certified by a registered medical practitioner in consequence of which the insured person is totally disabled from attending to the occupation at which he/she was gainfully employed immediately prior to disability or any other occupation for which he/she is fitted by knowledge or training"*

Section 2 deals with eligibility and states:

> *"A borrower is eligible for this insurance provided that on the effective date of the insurance, such borrower*

/Cont'd…

…

(ii) is in permanent gainful employment … including self-employment and has been so employed continuously for the 6 months immediately prior to such date …"

Section 3 of the policy outlines the duration of the benefits provided under the policy:

*"**C) Benefit Payments***

Benefit will be payable at monthly intervals during the period of the claim until

i) the insured person returns to work, or
ii) the maximum number of 12 monthly benefit payments has been made in respect of any one period of claim, or
iii) …

Periods of disability for the same cause not separated by at least 6 consecutive months full time employment will be considered as a continuous period of disability for the purpose of determining the maximum benefit. …"

Section 5 sets out certain obligations relating to the provision of information:

"B) The insured person must supply at his/her own expense all information, evidence and medical certificate required by the insurer …"

The Provider sent the Complainant a claim form under cover of letter dated **25 November 2015**. The Complainant submitted his completed claim form under cover of letter dated **16 January 2016** and advised that his consultant was still treating him in respect of his injury.

By letter dated **26 January 2016**, the Provider wrote to the Complainant requesting the following information:

"Your accounts section of the claim form to be completed
Or

A copy of your 2015 accounts as submitted to the Revenue Commissioners."

The Complainant replied on **31 January 2016** providing certain information in respect of his employment. At the second paragraph of this letter the Complainant states:

"I am enclosing Employers Statement which my accountants would not be able to complete,

My accountants would be unable to furnish the information requested in the Employers Statement in relation to the following questions …"

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The Provider wrote to the Complainant on **9 February 2016** advising (in the context of meeting the definition of *disability* as contained in the policy):

> *"… In order for us to validate this we require evidence that you were working immediately prior to your last date worked on 28 May 2015. To date we have not received any confirmation of this. Can you please provide us with evidence to show that you were working prior to May 2015. This can be in the form of your 2015 year end accounts or evidence that you were paying VAT to the Revenue Commissioners for the first half of 2015. Unfortunately we cannot assess your claim without evidence that you were working prior to your recent injury. …"*

On **11 March 2016**, the Complainant replied stating:

> *"Please note that my Annual Year End Returns for 2015 to Revenue Commissioners as a self-employed person are not due to be filed with Revenue until the 31st October 2016. Revenue returns for 2015 in my case, are due, to be filed, by the third week in November 2016, as I use ROS*
>
> *…*
>
> *In relation to my work, prior to the 28th May 2015, I was engaged by … to supervise the refitting of their showrooms …*
>
> *Enclosed correspondence from … confirming my position in relation to work carried out on their behalf.*
>
> *Your request for VAT details to Revenue for the first half of 2015, will not apply."*

On **21 March 2016**, the Provider wrote to the Complainant in the following terms:

> *"Whilst we appreciate that it is difficult to provide proof of working immediately prior to the period of disability commencing on 10 June 2015 I am sure that you will also appreciate that we must be able to validate all claims in line with the terms of the policy.*
>
> *We will be happy to accept a copy of your 2015 Tax Clearance Certificate that would have been issued by the Revenue Commissioners or a copy of the Subcontractors Relevant Tax letter that would have been issued when … registered you as a subcontractor …*
>
> *Please note, in order to prevent any further delays we have also written to your GP … to request up to date medical notes to assess your claim."*

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The Complainant emailed his accountant on **24 March 2016** requesting that his accountant apply for a TCC on his behalf. In reply, the Complainant's accountant advised:

> *"We applied for a tax clearance certificate as requested. It has been refused on the following grounds:*
>
> - *Employers P35 for 2015 is outstanding*
> - *[Partnership] Firm 1 for 2009 and 2010 is outstanding.*
>
> *You might confirm the above as nil and I will file and reapply."*

The Complainant confirmed the above by email dated **29 March 2016**. The Complainant's accountant informed him on **30 March 2016** that he had successfully re-applied for a TCC and provided the Complainant with the relevant access details. The Complainant responded the same day advising:

> *"Could you contact revenue with access number to forward onto to us, a copy of the TCC*
>
> *As we are not registered with ROS."*

In reply, the Complainant's accountant advised him that the Revenue Commissioners no longer issued paper TCCs. The Complainant responded stating that he *"… wanted site of the TCC for my own records."*

The Complainant furnished the Provider with details of his tax number and access number by letter dated **31 March 2016**. In this letter the Complainant also confirmed that he was receiving ongoing treatment for his shoulder and was attending his consultant. The Provider wrote to the Complainant on **7 April 2016** informing him that:

> *"Unfortunately tax clearance certificates can only be read on the computer that they are downloaded to so we would be unable to access your certificate.*
>
> *We ask that you please forward a copy of the certificate to us at your earliest convenience …"*

The Complainant replied on **11 April 2016** stating that he was advised by his accountant that the Revenue Commissioners do not issue paper TCCs. The Complainant also provided contact details for his accountant who would be able to assist the Provider in relation to accessing his TCC.

The Complainant also wrote to this accountant on **11 April 2016** stating:

> *"As we are registered with ROS through [the Complainant's accountants], we are unable to access this information ourselves of (sic) our computer.*

/Cont'd…

Could you access an email copy of our TCC 2015, and forward it onto to us, so as we can forward it onto the party that requires it."

The Provider wrote to the Complainant on **19 April 2016** as follows:

"Please forward a copy of your tax clearance certificate. This should be available for you to print on your Revenue Record online. We cannot proceed with the assessment of your claim without this."

The Complainant replied to the Provider on **25 April 2016** outlining that:

"Revenue have confirmed to me that [the Provider] can access my Tax Clearance certificate through their own ROS account … Please see Revenue Website to clarify this point.

Have [the Provider] accessed my Tax Clearance Certificate on Line (sic) as they have the facility to do so

…

I am scanning a copy of my tax clearance which I have printed on the 22nd April 2016 from Revenue as well as Verification of Tax Clearance Certificate."

Minutes after sending this email, the Complainant again wrote to the Provider:

"Please ignore that attachment I just sent you in error. This attachment is for you in relation to Tax Clearance Certificate …"

In an email to the Complainant dated **29 April 2016**, the Provider advised the Complainant that:

"As previously requested we need you to send us a copy of your 2015 tax certificate.

The email you sent us confirmed that your tax certificate had been sent and did not give us any information. …"

In an email dated **13 May 2016**, the Complainant sought clarification from the Provider that it was unable to access his TCC online using its ROS facility. On **18 May 2016**, the Provider explained to the Complainant that:

"Please be advised that we tried to log into the Revenue Online Service Secure Login.

An error message advised that 'No certificates are loaded in this browser', therefore we are unable to view any Tax Certificate.

To date we have not received your actual Tax Certificate.

/Cont'd…

We would be grateful if you please log into your Revenue account and print the certificate and post it to us, or alternatively scan it and email it to us."

In a letter to his accountant dated **24 May 2016**, the Complainant sets out the position as follows:

"[The Provider's] correspondence dated the 19th April 2016, requires me to PRINT my Tax Clearance Certificate, which I cannot do, as [you] are the registered accountant.

I emailed [the Provider] on the 25th April 2016, in relation to accessing my Tax Clearance Certificate on line. The response I received was a request for my 2015 TCC.

I emailed [the Provider] on the 13th May 2016, with a number of questions in relation to accessing my TCC … I received correspondence 18th May 2016, advising me that they are unable to view my Tax Clearance Certificate.

[The Provider] have requested that we 'Log into our Revenue Account' and print the certificate and post it to them, or alternatively scan it and emailed to them.

Can you please print out a copy and put it in the post."

By letter dated **2 June 2016**, the Provider wrote to the Complainant to inform him that:

"We received a telephone call from [the Complainant's accountant] this morning to discuss your Tax Clearance certificate, and he explained how one can check and confirm your tax clearance verification online.

Based on this, along with a full claim review carried out by the claims manager, a decision has been made to commence payments on your claim.

… we will write to [your GP] today to confirm that you have been under his regular care to date to enable us to issue further payments."

Request for Medical Records

The Provider wrote to the Complainant's GP on **21 March 2016** requesting the following:

"1. Copies of any medical records relevant to this claim …

2. Copies of clinical consultations, surgery notes, investigations and associated results, treatments, referrals, outpatient appointments and any repeat prescriptions from 25 September 2014 to date.

3. Evidence (if any) that you were under the care of a specialist or consultant …

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All the information we receive from you is for the purpose of validating your patients claim …"

The Provider notified the Complainant on **2 June 2016** that is was admitting his claim for the period **10 June 2015** to **7 October 2015**. A letter in similar terms was sent to the Complainant on **7 June 2016** which also stated:

"To continue receiving payments until your cover runs out you will need to send us your continuing claim documents each month after 06 November 2015. Please see attached guide/continuing claim form."

The Provider again wrote to the Complainant's GP on **2 June 2016** requesting:

"Copies of clinical consultations dating from 10/06/2015 to 03/06/2016.

All the information we receive from you is for the purpose of validating your patients claim …"

The Provider wrote to the Complaint on **14 June 2016** advising that

"… we have written to [the Complainant's GP] to confirm that you have been under his regular care to date to enable us to issue further payments."

The Provider wrote to the Complainant on **21 June 2016** requesting that he complete the attached disability self-assessment form. The Complainant retuned the form under cover of letter dated **24 June 2016** and also advised the Provider of the following:

"I received treatment in [name of hospital redacted] Hospital on the 10th November 2015 from my consultant … I assume that you have secured my medical records from [my GP] and [my consultant] …"

The Provider wrote to the Complainant on **30 June 2016** declining his continuation claim on the basis that:

"Having reviewed your medical records you did not consult, receive treatment or medication from your GP during the period of your claim from 10/06/2015 to 03/06/2016. Therefore, we are unable to continue with payment on your claim because you do not meet the above definition of disability as outlined in your policy terms and conditions.

Retrospective letters written by your GP cannot be accepted as evidence of disability because there is no evidence of ongoing consultation and review by your GP during this period.

Also, there is no evidence to suggest that the injury to your shoulder would prevent you from carrying out your role as [job description]."

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The Complainant wrote to the Provider on **7 July 2016** taking issue with the Provider's decision to decline his claim. The Complainant informed the Provider that he had been receiving treatment for his shoulder injury from his consultant and not from his GP as his GP did not possess the necessary medical expertise to treat such an injury. The Provider wrote to the Complainant on **12 July 2016** stating:

> *"… Letters written in retrospect will not suffice and therefore writing to your consultant or indeed the consultant's secretary would not provide us with this information.*
>
> *…*
>
> *Having reviewed all of the information that we have received from both your GP and your consultant to date, we are unable to overturn our decision on your claim."*

The Provider wrote to the Complainant's consultant on **26 September 2016** requesting:

> *"Copies of any clinical consultations/surgery notes, investigations and associated results, treatments, referrals, outpatient appointments and any repeat prescriptions from 08/10/2015 to 10/06/2016."*

The Complainant's consultant replied on **25** and **26 October 2016** enclosing the requested information.

The Provider wrote to the Complainant on **3 November 2016** advising:

> *"We wish to confirm that we have received your medical records from [the Complainant's consultant] which confirm evidence of disability up to 10/11/2015.*
>
> *The next entry after the 10/11/2015 is dated April 2016, therefore, we do not have sufficient evidence to confirm that you had an ongoing disability. We have issued another payment of €1065.72 and closed your claim."*

Complaint and Final Response

The Complainant made a complaint to the Provider on **16 July 2016** in respect of the manner in which his complaint was handled. The Provider issued a Final Response on **9 August 2016** to the effect that:

> *"Your claim form was received on 19/01/2016 and the claim form had not been fully completed. The Employment section was blank. The Claims Department requested further self-employment details to confirm that you were working at the onset of the illness for which you were certified. I note that you forwarded correspondence from … but this correspondence was not sufficient to confirm that you were still registered with Revenue for self-employment purposes.*

/Cont'd…

This was a requirement as the Claims Department had to confirm that you returned to work since your previous 12 month claim.

Following on from this, a copy of your 2015 tax clearance certificate was requested from you on 21/03/2016. When you provided the Claims Department with your log in details for Revenue On-line Service, they tried to log in to view, but the tax clearance certificate could not be accessed. Individual claims handlers do not have access to Revenue On-line Service.

A call from [the Complainant's accountant] to the Claims Department on 02/06/2016 confirmed that [the Provider's] Accounts Department would be able to view the tax clearance certificate and the document cannot be printed. Based on this, your employment details were accepted.

I do apologise for the delay in the acceptance of the employment details for your claim. It appears that Revenue have amended their process, in that they are no longer issuing paper tax clearance certificates.

Your claim was accepted on 02/06/2016 and four monthly payments were issued to [the Complainant's bank]. At that point, further evidence to confirm that you continued to meet the definition of disabled was requested from [the Complainant's GP], because you were making a back-dated claim. This was requested by the Claims Department on 02/06/2016, and they notified you in writing that they were requesting such documentation on 02/06/2016. (The Claims Department first notified you that they were going to request medical records (in the first instance) from [the Complainant's GP] in a letter dated 21/03/2016).

The Claims Department did not request any medical records from [the Complainant's consultant]; some of his letters were included in the medical records which [the Complainant's GP] provided.

When the medical records were received from [the Complainant's GP] on 14/06/2016, it was noted that you visited your GP once in 2015 and the visit was not related to your shoulder injury. It was also noted from these records that you visited your consultant … on 10/06/2015 and 13/04/2016 and there is no evidence of any further visits.

On receipt of your Disability self-assessment forms by the Claims Department, a further medical review was carried out by the Medical Risk Team. With the information provided to the Claims Department to date, there is no evidence that your shoulder injury would prevent you from carrying out your occupation …

Should you wish to provide sufficient evidence of consultation and treatment for the duration of the claim period, we would be happy to have the claim re-assessed."

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The First Complaint

The Complainant asserts that the Provider *persistently refused* to access his TCC. Under the terms and conditions of the Complainant's policy, the Provider is entitled to verify the employment status of the Complainant when assessing his claim. In so doing, the Provider wrote to the Complainant on **26 January 2016** requesting certain information regarding his employment. The Complainant was unable to provide this information. On **21 March 2016**, the Provider advised the Complainant that a copy of his TCC would be an acceptable form of proof of employment. The Complainant furnished the Provider with details of his tax number and access number by letter dated **31 March 2016**. It was a further two months before the Provider was able to access this Complainant's TCC.

It appears to be the case that accessing an individual's TCC is not necessarily a straightforward exercise. During the telephone conversations which took place between the Complainant's account and the Provider, it was explained to the Provider that the Revenue Commissioners had recently introduced a new online system for viewing TCCs and that the Revenue Commissioners were no longer issuing paper copy TCCs. However, in order for an organisation such as the Provider to access a TCC it is necessary to download certain computer certificates. Once downloaded, these certificates are not available organisation wide and can only be used on the computer to which they are downloaded.

I am satisfied that neither the Complainant nor the Complainant's accountant were able to furnish the Provider with a copy of the TCC. Furthermore, I accept that the Provider experienced certain difficulties accessing the Complainant's TCC. I am not satisfied, however, that there is any evidence to support the Complainant's contention that the Provider persistently refused to access his TCC. While the Complainant's TCC was not successfully accessed by the Provider until **2 June 2016**, I do not consider the circumstances giving rise to the delay or inability in accessing the Complainant's TCC constitutes a persistent refusal.

Therefore, I do not uphold this aspect of the complaint.

The Second Complaint

The Complainant submits that the Provider failed to request medical records held by the Complainant's consultant when assessing his claim. It is important to emphasise that, for the purpose of assessing this aspect of the complaint, it is not the role of this Office to comment on or form an opinion as to the nature or severity of the Complainant's injury or condition. It is the duty of this Office to establish whether, on the basis of an objective assessment of the medical evidence submitted, the Provider has adequately assessed the Complainant's claim and whether it was reasonably entitled to arrive at the decision it did following its assessment of the medical evidence submitted.

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The correspondence outlined above demonstrates that the Complainant advised the Provider from the date he submitted his claim form and on numerous occasion subsequent to this, that he was attending his consultant in respect of his shoulder injury and not his GP. Furthermore, the *Doctors Statement* section of the claim form was completed by the Complainant's consultant. However, despite this, the Provider did not seek any medical records from the Complainant's consultant prior to its acceptance of his claim on **2 June 2016**. It was not until **26 September 2016** that the Provider wrote to the Complainant's consultant to request his medical records.

It is clear that the Provider's assessment of the Complainant's claim predominantly centred on the records maintained by the Complainant's GP and the Complainant's attendances with his GP. Furthermore, no records were sought from the Complainant's consultant prior to **26 September 2016** and there is no evidence to indicate that Complainant was independently examined as part of the Provider's assessment of his claim.

While the Provider did seek information from the Complainant's GP in respect of any consultants/specialists attended by the Complainant and that certain records from the Complainant's consultant were in fact provided as part of the documents furnished by the Complainant's GP, no attempts were made to communicate with the Complainant's consultant to determine if all medical records and information that were relevant or potentially relevant to the Complainant's claim were sought. While it is likely to be the case that any of the consultant's records furnished by the Complainant's GP formed part of the Provider's assessment of the Complainant's claim, I do not accept that the Provider sought or had in its possession all relevant or potentially relevant medical records in respect of the Complainant's claim. Furthermore, the Provider did not take any action to obtain any records from the Complainant's consultant despite the Complainant advising the Provider that it did not possess complete records in respect of his injury and that he was under the care of his consultant in respect of his injury.

I am satisfied that the Provider did not take cognisance of the fact nor did it properly appreciate that the Complainant was being treated by his consultant in respect of his injury. I am also not satisfied that the Provider assessed the Complainant's claim in an adequate or reasonable manner as it did not seek any records from the Complainant's consultant until **September 2016**: 9 months after the Complainant submitted his claim, almost four months after the Provider allowed the claim and three months after the Provider declined to continue the claim. Following receipt of the records from the Complainant's consultant in **October 2016**, the Provider made a further payment to the Complainant. This is very suggestive of the fact that there was relevant information in the possession of the Complainant's consultant. Taking these matters into consideration, I am not satisfied that the Provider adequately assessed the Complainant's claim.

Therefore, I uphold this aspect of the complaint and direct the Provider to pay a sum of €2,000 in compensation to the Complainant for the inconvenience caused.

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Conclusion

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

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

27 February 2020

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,

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(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.