An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0087
Sector:	Insurance
Product / Service:	Payment Protection
Conduct(s) complained of:	Rejection of claim - late notification
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant, now a retired civil servant, was a member of a Group Income Continuance Plan, via his Trade Union, the policyholder. The policyholder's financial services broker is the Scheme Administrator. The Provider was the Insurer of this Scheme from **April 1990** until **August 2009**, responsible for the underwriting of applications for cover and assessing claims.

The Complainant's Case

The Complainant, having been medically certified as unfit for work due to *"work-related stress"*, was placed on reduced pay on **4 July 2001** and later took early retirement due to ill-health on **29 November 2002** as *"I was severely mentally and physically ill"*.

He later suffered [details of illness redacted], *"which has left me physically disabled"*.

The Complainant states that in 2011 a former colleague reminded him of the Group Income Continuance Plan, which prompted him to contact the Provider in October 2011 to ascertain if he was entitled to make a claim, to which it subsequently advised that he was not eligible to make a claim dating back to 2001 due to late notification and that his membership of the Scheme had ceased when he stopped paying premiums in 2001.

The Complainant sets out his complaint, as follows:

> *"I contributed to an Income Protection Plan from 1983 to July 2001.*
>
> *I was severely ill mentally and physically for over a year and a half, so much so that I had to leave a [role redacted] job & retire in my early 50's in 2002.*

I was so ill that I was not fit mentally to make a claim under the policy until October 2011.

[The Provider] *has disallowed my claim without reasons &…have a responsibility in this regard"*.

In addition, in his correspondence to this Office dated 24 May 2018, the Complainant further sets out his complaint, as follows:

"In short the position is;

1. *I retired from my job as [role redacted] in* [Employer] *in 2001/2002 due to serious medical conditions both health related and mental related.*

2. *I underwent multiple rigorous medical examinations arranged by my employer in accordance with the strict criteria in place to establish my suitability to perform my work duties.*

3. *In 2012 following a life review and after a social meeting with a former work colleague I was reminded about the existence of* [a Group Income Continuance Plan] *for the benefit of* [Employer] *staff members*

4. *I contacted* [the Provider] *the underwriters of the scheme…to establish;*

    a. *Whether I was a fully paid up member of the Scheme in July 2001 (the date when I was reduced to less than fully paid sick pay by my employer)*

    b. *What the terms and conditions of the Scheme were on July 2001; and*

    c. *Whether I was entitled to claim under the Plan.*

Amazingly [the Provider has not] *kept records of my contribution record and I had to resort to my ex-employers to get that record.*

Amazingly also [the Provider has not] *kept records of updated terms of the Master* [Policy] *Documents as they changed from time to time and in particular as at the date relevant to my position – July 2001.*

And despite having no grounds whatsoever for making any reasonable decision to bar my claim [the Provider] *have done so anyhow, without reasonable foundation"*.

In this regard, in the absence of the Group Income Continuance Plan policy document that applied in 2001, the Complainant relies on the Scheme Administrator's 'Income Continuance Plan of [the Policyholder] Explanatory Booklet – 2000', which in his letter to the Provider dated 30 July 2017 he notes *"places no time limit in the making of claims"*. As a result, the Complainant seeks for the Provider to admit his income continuance claim.

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The Complainant made a data access request to the Provider by way of letter dated 27 August 2013 and he notes that its response to him in October 2013 made no reference to telephone calls that had taken place between the Provider and the Scheme Administrator in May 2012 and which the Scheme Administrator was later able to furnish recordings of to this Office in 2018. In this regard, the Complainant may raise any concerns he has in this regard with the Data Protection Commission. However, in his letter to this Office dated 15 April 2019, the Complainant refers to these recordings, as follows:

> *"This goes back to phone calls* [on 17 May and 18 May 2012]*, where the representatives of the relevant firms* [the Provider and the Scheme Administrator] *jeered and colluded to deny me my valid claim, agreed inter se to send me an irrelevant copy plan, fed me false information, through the failure of* [the Insurer] *on 2/10/2013 to mention the phone calls in which the author has debased me and right up to 24/7/2017 when* [the Insurer's Head of Claims, Mr P.] *amused the lady from* [the Scheme Administrator] *by telling her that he has told me to "bugger off", to her great amusement"*.

The Complainant's complaint is that the Provider wrongly or unfairly declined to assess his income continuance claim.

The Provider's Case

The Complainant, now a [role redacted] was a member of a Group Income Continuance Plan until **2001**, via his Trade Union, the policyholder. The Provider was the Insurer of this Scheme from April 1990 until August 2009, and thereby responsible for the underwriting of applications for cover and for assessing claims. The Scheme Administrator is the Policyholder's financial services broker, responsible for the collection of premiums from individual members and submitting these in bulk to the Insurer.

Provider records indicate that it first received a letter from the Complainant dated 9 October 2011 on 24 April 2012 advising that he had suffered [details of illness redacted] and that he had been making contributions to the Group Income Continuance Plan prior to his retirement on ill-health grounds. The Provider advised the Complainant by telephone and by letter dated 25 May 2012 that it could not consider his claim due to the late notification policy provisions contained in the Group Income Continuance Plan which state that a claim must be notified before the end of the deferred period and in the event of late notification, a claim can only be considered from the date a claim was actually notified, in this instance, April 2012.

In addition, the Provider telephoned the Complainant in May 2012 to advise that it would not send him a claim form as this might unfairly give rise to an expectation that a claim would be considered. The Complainant has therefore not completed an income continuance claim form and the Provider has not sought any supporting medical information from him to consider a claim, however the Provider does not dispute that the Complainant was and is ill.

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In this regard, the Complainant was not eligible to make an income continuance claim due to his delay in notifying the Provider of a potential claim until some 11 years after his former employer had placed him on reduced pay due to long term illness absence in July 2001 and some 10 years after he had retired on ill-health grounds in November 2002. The Provider also referred the Complainant to the Scheme Administrator regarding his premium payments and membership up to 2001, as it no longer held such data.

The Complainant later made a data access request to the Provider by way of letter dated 27 August 2013 seeking copies of the Group Income Continuance Plan policy document that applied at the time his former employer had placed him on reduced pay in July 2001, and a record of his premium payments up to then. The Provider wrote to the Complainant on 2 October 2013 to advise that it did not hold any historical data on him as it does not hold data for longer than 6 years (at this time it was 12 years since the Complainant had ceased to be a member of the Scheme). It also explained that as this was a Group Scheme, the Provider did not hold individual premium details on members and that any such data would have been held by the Scheme Administrator. As the Complainant subsequently replied to the Provider that it was unclear to him as to whether it still held this data, the Provider contacted the Scheme Administrator itself by email and asked that it provide any relevant information it had to the Complainant, which it confirmed it had done in February 2014.

In addition, the Provider notes that in 2018 the Scheme Administrator was able to furnish this Office with recordings of telephone calls that had taken place in May 2012 between the Provider and the Scheme Administrator and which the Provider could not give the Complainant details of in October 2013 when responding to his data access request. In this regard, the Provider notes that it held no policy details for the Complainant in May 2012 as he had had no claim with the Provider and no file existed where any correspondence or notes of telephone calls could be stored or centralised. In addition, the Provider notes that the technology to record telephone calls was only first installed in its Claims Department in July 2012.

The Provider next received a letter from the Complainant in June 2017 complaining that it would not consider his income continuance claim. The Complainant states that his former employer placed him on reduced pay due to long term illness absence in July 2001, however notification was not received by the Provider of his intention to submit an income continuance claim until 11 years later in April 2012 (with the Provider having ceased insuring the Scheme in August 2009). In refusing to assess the Complainant's claim, the Provider relies upon the following policy provision (set out in the policy document applicable from 1 April 2004):

> *"5.9.4. Written notice of a claim for Benefit shall be given to the Company at least two months prior to the expected expiry date of the Deferred Period. Where written notice of a claim is received later than two months prior to the expected expiry date of the Deferred Period, the Company reserves the right to deem the Deferred Period to expire two months after the date that written notice is received unless evidence, satisfactory to the Company, is provided showing Disability existed at the end of the Deferred Period"*.

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The Provider accepts that some Scheme members may be too ill to meet the claim notification deadline, that is, *"two months prior to the expected expiry date of the Deferred Period"*, but it submits that it would show flexibility and compassion where a claim is notified a few months late due to severe chronic illness. In this case, however, the Complainant notified the Provider of a potential claim some 11 years after his former employer had placed him on reduced pay due to long term illness absence in July 2001 and some 10 years after he had retired on ill-health grounds in November 2002.

The Provider accepts that the Scheme Administrator's '**Income Continuance Plan of [the Policyholder] Explanatory Booklet – 2000**' does not place any upper limit on when a claim must be submitted by, however it notes that this is only an explanatory booklet produced by the Scheme Administrator and not by the Provider itself and in any event, the Booklet does not contain nor purport to contain all of the terms and conditions of the Scheme. In this regard, pg. 2 of this Explanatory Booklet clearly advises, *"you should bear in mind that this booklet contains only an outline of the Plan and does not create or confer any rights"*.

In addition, the Provider notes that Complainant ceased paying policy premiums in 2001 and thus he was no longer a member of the Scheme beyond that date. In this regard, in refusing to assess the Complainant's claim, the Provider relies upon the following policy provision (set out in the policy document applicable from 1 April 2004):

> *"Cessation of Insurance*
>
> *4.4 The insurance of any Member shall immediately terminate upon the happening of any one of the following events:-*
>
> *(a) discontinuance of payment of Premiums by the Member under this Policy except as provided for in Provision 3.3".*

The Provider is citing from the Group Income Continuance Plan policy document applicable from 1 April 2004 as it unable to produce a copy of the Group Income Continuance Plan policy document that applied in 2001. In this regard, as this Scheme has not been insured with the Provider since August 2009, old records have been destroyed. Nevertheless, the Provider can confirm that this policy provision regarding claim notification has applied to all of its group income continuance schemes since at least 1994.

From the information provided, it appears to the Provider that the Complainant took ill-health early retirement in November 2002 following a recommendation from his GP, which was accepted by his former employer's Chief Medical Officer. There is no evidence suggesting that the Complainant attended or was treated by a psychiatrist at that time or that he was incapable of handling his affairs. Had his condition been so severe at that time that he could have met the policy definition of disability, that is, that he was *"totally incapable by reason of illness or injury of following his normal Occupation"*, the Provider would have expected that the Complainant would have been under the care and treatment of a psychiatrist.

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To assess a claim of this nature, the Provider would require contemporaneous medical reports from the member's GP and treating specialist(s), and it would typically refer the member for an independent medical examination with an appropriate specialist in order to substantiate any claim that the member was disabled under the Scheme. From the reports furnished by the Complainant, there is no indication that he was attending a specialist doctor in 2001 for treatment. In addition, it is not possible for the Provider to now refer the Complainant for an independent medical examination with an appropriate specialist in order to seek an opinion as to his fitness to work in 2001 as any medical examination conducted at this time will be obviously unable to verify his eligibility to claim under the Scheme, some 17 years ago.

In addition, whilst it acknowledges that the Complainant retired early on ill-health grounds in November 2002, the Provider notes that the requirements for obtaining ill-health early retirement from the Civil Service are different from those required under the Scheme, so acceptance of his ill-health early retirement claim by his former employer and its Chief Medical Officer at that time does not automatically mean that his income continuance claim under the Group Income Continuance Plan would have been similarly valid at that time.

In conclusion, the Provider is satisfied that the provisions of the Group Income Continuance Plan of which the Complainant had been a member, requires that a claim be notified before the end of the deferred period to allow the Insurer assess the claim, and where a claim is notified late, benefit can only commence (subject to the member meeting the policy definition of disability) from the date of notification. The Complainant first notified the Provider of a potential claim in April 2012, some 11 years after his former employer had placed him on reduced pay due to long term illness absence in July 2001 and some 10 years after he had retired on ill-health grounds in November 2002, and his membership of the Scheme had ceased in 2001.

Accordingly, the Provider is satisfied that it correctly and fairly declined to assess the Complainant's income continuance claim.

The Complaint for Adjudication

The Complainant's complaint is that the Provider wrongly or unfairly declined to assess his income continuance claim.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

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In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint. Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on **9 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.

Following the consideration of additional submissions from the parties, the final determination of this office is set out below.

The complaint at hand is, in essence, that the Provider wrongly or unfairly declined to assess the Complainant's income continuance claim. In this regard, the Complainant, now a retired civil servant, was a member of a Group Income Continuance Plan until 2001, via his Trade Union, the policyholder. The Provider was the Insurer of this Scheme from April 1990 until August 2009, responsible for the underwriting of applications for cover and assessing claims.

The Complainant, having been medically certified as unfit for work due to *"work-related stress"*, was placed on reduced pay on 4 July 2001 and he later took early retirement due to ill-health on 29 November 2002 as *"I was severely mentally and physically ill"*. He later suffered[details of illness redacted], *"which has left me physically disabled"*. The Complainant states that in 2011 a former colleague reminded him of the Group Income Continuance Plan, which prompted him to contact the Provider to ascertain if he was entitled to make a claim.

The Provider states that it first received a letter from the Complainant dated 9 October 2011, on 24 April 2012 advising that he had suffered [details of illness redacted] and that on reviewing his affairs he had noted that he had previously made contributions to the Group Income Continuance Plan. The Provider subsequently advised the Complainant that he was not eligible to make an income continuance claim due to his delay in notifying the Provider of this potential claim until some 11 years after he had been placed on reduced pay due to illness absence in July 2001 and some 10 years after he had retired on ill-health grounds in November 2002, and that his membership of the Scheme ceased in 2001 when he ceased paying premiums, in accordance with the policy terms and conditions.

In this regard, in refusing to assess the Complainant's income continuance claim, the Provider has relied upon the following policy provisions set out in the Group Income Continuance Plan policy document applicable from **1 April 2004**, as follows:

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"Cessation of Insurance

4.4 The insurance of any Member shall immediately terminate upon the happening of any one of the following events:-

(a) discontinuance of payment of Premiums by the Member under this Policy except as provided for in Provision 3.3

…

5.9.4. Written notice of a claim for Benefit shall be given to the Company at least two months prior to the expected expiry date of the Deferred Period. Where written notice of a claim is received later than two months prior to the expected expiry date of the Deferred Period, the Company reserves the right to deem the Deferred Period to expire two months after the date that written notice is received unless evidence, satisfactory to the Company, is provided showing Disability existed at the end of the Deferred Period".

The Provider has advised that it is citing from its Group Income Continuance Plan policy document that was applicable from 1 April 2004 as it is unable to locate a copy of the earlier Group Income Continuance Plan policy document that applied in July 2001, when the Complainant was placed on reduced pay due to illness absence. In this regard, I note that the Provider has not been the Insurer of this Scheme since August 2009 and it has advised that its old records have since been destroyed. I note the Provider has confirmed that the claim notification clause it cites from its Group Income Continuance Plan policy document that was applicable from 1 April 2004, has applied to all of its group income continuance schemes since at least 1994.

Whilst it is regrettable that the Provider is unable to locate a copy of the Group Income Continuance Plan policy document that applied in July 2001, I am satisfied that income continuance policy provisions regarding claim notification and scheme membership, such as those citied by the Provider from its Group Income Continuance Plan policy document applicable from 1 April 2004, are relatively standard within the income protection insurance industry, and I am satisfied that the wording relied upon in this instance is consistent with what this Office would expect and which it would consider to be the norm.

In my opinion, it is unlikely that the wording of such standard terms would differ greatly, if at all, between the Group Income Continuance Plan policy document that applied in July 2001, and the one applicable from 1 April 2004; there is no evidence before me indicating otherwise. Moreover, the inability of the Provider to locate the earlier document arises from the delay on the part of the Complainant in seeking to pursue a claim. I do not believe that it is appropriate to criticise the Provider for its inability to produce the earlier document, given that the document ceased to be the correct version in 2004, more than 15 years ago and indeed, given that the Provider ceased to be the insurer of the Scheme, more than a decade ago.

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In the absence of the Group Income Continuance Plan policy document that applied in July 2001, the Complainant relies instead upon the Scheme Administrator's 'Income Continuance Plan of [the Policyholder] Explanatory Booklet – 2000', which he notes in his letter to the Provider dated 30 July 2017 *"places no time limit in the making of claims"*. Whilst this Explanatory Booklet does not set out any upper limit on when a claim must be submitted by, I am satisfied that this booklet is an explanatory booklet only that is produced by the Scheme Administrator and not by the Provider itself and, in any event, it does not contain nor purport to contain all of the terms and conditions of the Scheme. In this regard, pg. 2 of this Booklet clearly advises,

> *"you should bear in mind that this booklet contains only an outline of the Plan and does not create or confer any rights"*.

Regardless of whether the Complainant first notified the Provider in October 2011 as he contends, or that the Provider was first notified in April 2012 as it contends, this notification, some eleven years after the potential claim arose, can in my opinion, be reasonably and rightly regarded as late notification. It is understandable that income continuance policies require a claimant to provide timely notice of a potential claim. Late notification can hinder an insurer in its efforts to retrospectively assess whether any such claim would have satisfied the policy terms and conditions at the time the potential claim first arose. In this instance, as the Complainant did not notify the Provider of a potential claim until some eleven years later, I am satisfied that this late notification would greatly impede its ability in 2011/2012 to retrospectively assess whether such a claim would have satisfied the policy terms and conditions in 2001. As a result, I do not consider the Provider's refusal to assess the Complainant's income continuance claim to be unreasonable or unjust.

In addition, as the Provider ceased being the Insurer of the Scheme that the Complainant was a member of in August 2009, it is understandable that it would not retain outdated policy documents (from 2001) on schemes it no longer insured. Furthermore, as the Complainant had been a member of a Group Scheme, I accept that the Provider itself would not have held individual premium details on members and that any such data would have been held by the Scheme Administrator which was responsible for the collection of premiums from individual members and submitting those in bulk to the Insurer.

I note the Complainant asserts that the fact he retired early in November 2002 due to ill-health should be sufficient evidence for the Provider to conclude that he was entitled to claim income continuance benefit at that time. In this regard, the Complainant submits,

> *"I underwent multiple rigorous medical examinations arranged by my employer in accordance with the strict criteria in place to establish my suitability to perform my work duties."*

He considers that the medical information he has since provided, the GP notes and occupational health reports dating from 2001 and 2002 that his former employer relied upon to approve his application for early retirement, should suffice.

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I note, however, that an ill-health early retirement application is determined according to the specific criteria of the employer's own pension/ill-health retirement scheme, whilst income continuance is assessed according to the Insurer's specific policy definition of disablement. There is very often a difference between the two sets of criteria and a person may be eligible and accepted for ill-heath early retirement but not for income continuance, or vice versa. The occupational health provider assessing an ill-health early retirement application on behalf of the employer may, for example, take into account the employee's attendance record, performance, motivation and subjective symptoms, in addition to the nature of the illness and the specific work place and role. Income continuance insurance decisions are, however, based on objective medical evidence and the job demands of the occupation, to ascertain whether the claimant meets or continues to meet the policy definitions for a valid claim.

As a result, I am satisfied that the fact that the Complainant applied for and was granted ill-health early retirement in November 2002 does not automatically nor necessarily mean that he would have satisfied the Group Income Continuance Plan definition of disablement at that time, or since. In this regard, the late notification of his claim prevented the Provider from forming its own contemporaneous opinion as to the Complainant's fitness for work in 2001, when his potential claim first arose, in accordance with the relevant policy terms and conditions, as it is entitled to do.

I note from the documentary evidence before me that the Complainant was medically certified as unfit for work in 2001 due to *"work-related stress"*. In this regard, as part of his complaint, the Complainant advises, *"I was so ill that I was not fit mentally to make a claim under the policy until October 2011"*. I note, however, from the documentary evidence before me that in his handwritten letter to his former employer dated 23 April 2002, the Complainant applied for early retirement on ill-health ground, as follows:

> *"I have been on sick leave, related to my employment, for a considerable time on the advice of my doctor …*
>
> *He advises me that there is little prospect of recovery. Accordingly, I am formally applying for early retirement on health grounds"*.

It is not unreasonable to suppose that if the Complainant was capable of applying to his former employer for early retirement due to ill-health, he would also have been capable of applying to the Provider at that time for income continuance benefit, and in this regard the Provider's position in this matter has been prejudiced by the Complainant's failure to do so.

Finally, I note that in his letter to this Office dated 15 April 2019, the Complainant refers to the recordings of a telephone call that took place between the Provider and the Scheme Administrator on 17 May and of a second call that took place on 18 May 2012, as follows:

> *"…the representatives of the relevant firms* [the Provider and the Scheme Administrator] *jeered and colluded to deny me my valid claim, agreed inter se to send me an irrelevant copy plan, fed me false information"*.

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Having listened to a recording of these two calls, I do not share the Complainant's view.

The Provider telephoned the Scheme Administrator on 17 May 2012 as the Complainant had recently made contact with the Provider to ascertain whether he was entitled to make an income continuance claim dating back to 2001, and it was seeking details of his membership of the Scheme. The Provider Representative and the Scheme Administrator both expressed surprise at the extreme and unprecedented length of delay of the claim notification at hand and in the absence of any protocol for such a case, a conversation based largely on opinion ensued between the two as to the possibility of the claim proposed being considered at such a late stage. Whilst the Provider Representative was clearly surprised at the length of delay of the claim notification at hand, I do not consider that her expression of such surprise, or anything else that she said during the course of these telephone calls, in any way made fun of or jeered the Complainant.

In addition, the Complainant also refers to the recording of the telephone call that took place between the Provider's Head of Claims, Mr P. and the Scheme Administrator on 24 July 2017, as follows:

> *"*[The Provider's Head of Claims, Mr P.] *amused the lady from* [the Scheme Administrator] *by telling her that he has told me to "bugger off", to her great amusement"*.

Having listened to a recording of this telephone call, I note the following exchange:

> "Provider Representative: *I've seen a couple of emails from one of your people … em, but I hadn't replied because I was waiting for confirmation that it was ok to bung the letter off, em, from the claims committee, which I since got and the letter went out last… last…*[indecipherable] *Friday before that -*
>
> Scheme Administrator Representative: *And what's your position?*
>
> Provider Representative: *I just told him to bugger off -*
>
> Scheme Administrator Representative: [laughs] - *in a nice way?*
>
> Provider Representative: *In a nice way, yeah. Basically explaining that he had an obligation to tell us …."*
>
> [the two Agents then discuss the case in detail for a further 6 minutes]

It is fair to note that this telephone call was between two people who, it is obvious from the recording, have regular contact with each other regarding different matters arising between the Provider and the Scheme Administrator, and in this context I take the view that the Provider Representative's use of the expression *"bugger off"* whilst far from ideal, and certainly not a term for professional use, was nevertheless in the particular circumstances what might be termed over-familiar/conversational.

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Certainly, I do not accept that this regrettable phrase was used in an offensive tone or manner. Rather I believe that Mr. P. allowed his familiarity with the Scheme Administrator Representative, to permit his level of professionalism to fall well below standard. In my opinion, the use of this unprofessional language, whilst far from ideal, does not result in the Provider being in any way obliged to admit and assess the Complainant's claim under the Scheme, in the circumstances of the delay which are outlined above.

Accordingly, it is my Preliminary Decision that this complaint cannot be upheld.

Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017*** is that this complaint is rejected.

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

12 March 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,
(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.