Decision Ref:	2020-0088
Sector:	Insurance
Product / Service:	Term Insurance
Conduct(s) complained of:	Lapse/cancellation of policy Delayed or inadequate communication Dissatisfaction with customer service
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The background to the complaint is that the Complainants took out three products with the Provider (through its tied agent – a Bank). A Term Life Insurance – 1186**1, a Mortgage Life Insurance 1176***8 and (in respect of the First Complainant) a Regular Investment Product 118***6.

The Mortgage Life Insurance was incepted in 2014. The Term Life Insurance and Regular Investment Product were set up in December 2015.

A Specified Illness claim was made under Policy 1186**1. However, the Company voided the policy for non disclosure, and likewise voided the Mortgage Life Insurance for non-disclosure. The complaint concerning the Regular Investment Product is that it was unsuitable to the First Complainant's needs.

The complaint is that the Provider's representative incorrectly advised the Complainants when setting up the insurance and investment polices, in particular in relation to the need to disclose aspects of the Second Complainant's health history.

The Complainants' Case

As regards the complaint about the savings account, the Complainants state that the First Complainant wanted to open the account to be able to put away an amount of €100 per month for 5 years. The Complainants state that the intention was to accumulate a little

lump sum amount at the end of the 5 year period by having a savings account that was safe and flexible to access, that allow the First Complainant to have an immediate access to her funds if and when required.

The Complainants state that on 11 November 2015 the First Complainant visited the Bank (a tied agent of the Provider) where the customer service representative suggested that she meet with one of the Provider's financial advisors. The meeting was arranged and in or around 16 November 2015 the First Complainant met with the Provider's financial advisors — Mr B.

The Complainants state that Mr B recommended that the First Complainant take out a Savings Plan. The Complainants state that the Advisor also provided an additional recommendation for a Critical Illness Plan. The Complainants state that as it turned out the Plan number 1186***6 that was sold to the First Complainant was completely unsuitable for her needs, investing her money in volatile markets instead of allocating it into a safe deposit account.

The Complainants state that it was only when a Provider representative contacted the First Complainant two months into the plan, that they were advised what it really was. The Complainants state that the money was being invested in equities and not a cash fund. The Complainants state that to their surprise the Provider's representative agreed that the plan that was sold to the First Complainant was completely unsuitable for her needs. The Complainants state that they are sure that the Provider has a recording of this phone conversation as they suggest that all the telephone calls are now recorded. The Complainants state that during this telephone call, the First Complainant immediately cancelled the plan and subsequently received the money back. The Complainants state that this was very disappointing to say the least. The Complainants state that they did not make a complaint at the time as they received the original payments back.

The Complainants state that in addition to the savings plan, the First Complainant was also offered a Critical Illness plan, this time to cover both Complainants. The Complainants state that they met with Mr B on 16 December 2015 to receive advice on such insurance. The Complainants submit that Mr B advised that people at their stage in life should have an additional security in a form of critical illness cover so that, in the very unlikely event of serious illness occurring, they would be protected and receive some money to cover any medical and other expenses. The Complainants state that even though they thought that Hospital cover would be sufficient for them in case of an emergency, Mr B advised that it would be too expensive and that the Critical Illness type of cover would be more suitable for them. The Complainants' position is that Mr B did not provide them with a quotation to prove that Hospital cover is in fact more expensive, but his explanation seemed reasonable so they decided to go with his advice and take out Critical Illness cover instead.

The Complainants state that Mr B's original recommendation for the level of Critical Illness cover was €340,000 for the First Complainant & €344,800 for the Second Complainant. The Complainants state that they could never afford this level of cover, so they asked for the lowest level of cover possible as this type of benefit is, as it turns out, is very expensive. The Complainants state that they asked for the lowest level of cover just so (as

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recommended) they had some sort of cover in place for the future. It was meant to protect them if required to a small degree at least.

The Complainants say that ultimately, they were offered €25,000 & €30,000 levels of cover for the First Complainant and the Second Complainant respectively, which they say they could afford. The Complainants' positon is that at that stage both of them were in a very good health and they would have never even thought that they would have to use the Critical Illness cover so soon.

The Complainants submits that Mr B asked them a series of questions and he noted the answers on his tablet. It is the Complainants' position that they answered all the questions honestly and disclosed all relevant material facts and information to him — in particular details of the Second Complainant's then recent visit to Dr L. The Complainants state that they understand how important these things are and they took it very seriously, advising that in the end of November 2015 the Second Complainant had a routine check up with Dr L when it was advised that a mass in the right kidney was incidentally found. The Complainants state that Dr L assured them that there was nothing to be worried about and said that a few tests are required to be sure that it was nothing serious, but that they were only precautionary.

The Complainants submit that on that information Mr B advised them that this was nothing and that it was alright to have routine check-ups and that it was not necessary to include this in the insurance proposal form. The Complainants state that Mr B asked them to sign the form on his tablet and did not ask that they read through all the answers.

It is the Complainants' position that they felt that this "financial advice" / "financial review" meeting was rushed to say the least and that Mr B was only interested in getting the business done. The Complainants say that they do not even know how much Mr B was paid for selling them first the savings and then insurance plans, but they assume that he received some sort of remuneration for the plans he sold and the "advices" he provided them with.

The Complainants state that they then received documents in respect of the new plan number 1186***1 (Term Life Insurance) dated 16 December 2015 in post.

The Complainants submit that unfortunately, the Second Complainant was diagnosed with cancer in February 2016. The Complainants state that when they received the dreadful news, they were heartbroken and were left wondering about their future. The Complainants state that they did not even remember that they had the insurance plan in place and it was only when the Second Complainant's brother asked if they had a life cover that they remembered the plan they took out in December 2015. It brought a sense of hope and relief, which was very short lived, because after submitting the Critical Illness Claim to the Provider the Complainants were advised that the claim has been declined due to non-disclosure of material facts.

The Complainants say that they believe that this would not have happened if Mr B had diligently noted all of the details they advised him of and took more interest in them as his

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customers at the meeting in December 2015. The Complainants state that they believe that had Mr B done his job as a "qualified financial advisor" properly they would not be in this position now. The Complainants state that they also believe that Mr B failed to identify their financial needs offering completely unsuitable savings plan to the First Complainant first and then trying to sell them very expensive insurance of €340,000.

The Complainants submit that when they received the letter declining the Critical Illness Claim from the Provider they wrote to the Provider advising of the advice that they were given by Mr B and that all questions Mr B had asked were answered honestly and truthfully by them and were all true at the time of signing the proposal. The Complainants state that these are the questions the Provider advised they did not answer truthfully:

- *"Have you ever suffered from or had treatment or advice for any growth, lump, tumour, abnormal mole or cancer?"* — the answer recorded was "No". The Complainants state in this regard that they never knew that the "mass" on the Second Complainant's kidney would ever be considered as any of the above, and that they did acknowledge the existence of it to Mr B at their meeting.

- *"Have you ever suffered from or had treatment for any other illness, injury or condition for which you have had medical advice in the last five years?"* – The Complainants states that yes, the First Complainant suffered a neck pain, and yes, the Second Complainant suffered a fractured rib (the Complainants advised of that and this was noted by Mr B on the application form).

- *"Have you in the last five years had or been advised:*

  To have any special investigations, scans, blood or laboratory tests or have a surgical operation. Seen by any specialist as an in-patient or out-patient at any hospital or clinic"

The Complainants state that in regard to the above at the time of completing the form they did advise Mr B that the Second Complainant needed tests done to confirm that the mass on his kidney was not something to be concerned about. The Complainants state that at least that is what they were told. At this point Dr L did not give the Complainants any impression that the mass was cancerous. The Complainants say that on 27 November 2015 Dr L advised the Second Complainant that a test will be done for peace of mind and that it would be no harm to see a urologist (for a consultation only). There was never a suspicion of cancer.

The Complainants state that then the Provider advised that the Term Life Insurance number 1186***1 was cancelled and returned all the payments made back to the Complainants by cheque. The Complainants' position is that the Provider had no right to cancel the whole plan, as the First Complainant was also insured for Life and Critical Illness and she was completely healthy and that she should still be on cover.

The Complainants submit that in the Provider's letter it also advised that they were cancelling the plan that was protecting their Mortgage — Plan number 1176***8

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(Mortgage Life Insurance). The Complainants state that the Provider returned payments they made since September 2015 by cheque. The Complainants' argument is that the Provider had no right to cancel this plan. It was originally taken out by the Complainants in 2008 to protect their mortgage against death. The Complainants state that it was then subsequently replaced by plan 1176***8 in 2013 for a lower amount of cover and therefore lower cost as the mortgage was partially repaid at that point. The Complainants state that they were both healthy in 2008 & 2013. The Complainants submit that the Second Complainant's health problems began in February 2016 when he was diagnosed with kidney cancer.

The Complainants state that the Provider's excuse for cancelling the mortgage plan was that they had not paid the premiums in August 2015 and the plan was cancelled as the Provider would not have given them the cover if it knew their health was poor at the time. It is the Complainants' position that neither the First Complainant nor the Second Complainant's health was poor in August 2015. The Complainants state that they always paid on time and have receipts to prove it. The Complainants say that slight delays with payments occurred due to the Provider's errors alone. The Complainants submit that the Provider's apology letter dated 26 November 2015 as well as multiple phone conversations with their customer service will clearly confirm this.

The Complainants state that they have never been advised by the Provider that the 117***4 mortgage plan had come out of force and that at any point they were off cover. It is the Complainants' position that they would never allow the plan to come off cover as they needed it to cover their mortgage. The Complainants say that they returned the cheque the Provider sent to them and requested that the payments were re-applied, that the plan be put back in force immediately and that the direct debits continue to be debited from the nominated bank account.

The Complainants state that they made an official complaint to the Provider and the Bank in November 2016. The Complainants say that upon the receipt of their letter dated 20 November 2016, they received a telephone call from a Provider's representative advising that she would investigate the complaint and would keep them updated. The Complainants state that they had not heard from her until the letter dated 21 December 2016, which they assert had not addressed any of the main points they made in their complaint.

In the Complainants' subsequent complaint letter they requested that the Provider confirm immediately that the plan has been put back in force and that the Provider provide them with a detailed payment history along with all documentation they sent to, and received from, the Provider. The Complainants state they also asked for all phone call transcripts to show how incompetent the customer service is and the way the Provider's representatives spoke to them on several occasions, which the Complainants state was just horrible and disrespectful.

The Complainants submit that in response they received a letter advising that they would receive information from the Provider by 30 January 2017. On 30 January 2017, a telephone call was received to say that the Provider was not ready and they would get

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another phone call the following week. The Complainants state that the 30 January 2017 was the Provider's own deadline which it failed to keep. The Complainants state that to-date they have received no confirmation that the mortgage plan is back in force and that their mortgage is covered.

The Provider's Case

In relation to the Complainants Regular Invest Plan (11877***), the Provider sets out a brief summary of its understanding of the issues raised and the Provider's response to these issues. The Provider states that it understands that the conduct complained of relates to the suitability of the plan.

The Complainants state that they were unaware that their funds were exposed to risk and not invested in a Safe Deposit Account as they state that they requested.

The Provider's response is that on 16 December 2015, the Complainants met with the Financial Adviser Mr B to discuss their financial arrangements. The Provider says that during this meeting, a Portrait Personal Financial Review was completed, where the Complainants' existing financial arrangements and financial needs were discussed. It is the Provider's position that a copy of this report was sent to the Complainants following the meeting.

The Provider refers to the "Planning your savings" section which stated the following:

> *"[First Complainant and Second Complainant]*
>
> *How much would you like to save at the moment? €100*
> *How many years do you want to save for? 5"*

This section of the Personal Finance Review noted that the Complainants wished to save an amount of €100 over a term of five years. The Provider states that based on the information provided, it was established that the Complainants met the profile of a customer whose attitude towards risk was Careful.

The Provider states that based on this it was recommended that the Complainants invest in Multi Asset Portfolio 3 . The Provider says however that having discussed these options with Mr B, the Financial Advisor, the Complainants chose to invest in the Multi Asset Portfolio 2. The Provider refers to page 20 of the Planning your savings" section which stated:

> *"[The First Complainant], you have asked to go against the recommendation of …3 in favour of …2 as you consider …2 to be less risky. I can confirm that …2 is 1 risk category lower than. …3. I have also explained that after charges …2 could*

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> *potentially perform less well than a deposit account. I also explained that this product does not provide capital protection and this means that you could get back less than you invested, I gave you the range of returns document and explained it to you".*

It is the Provider's positon that it is clear from this that the Complainants were made fully aware of the fact that this was an investment and not a deposit account, and that it was possible to receive back less than what was originally invested.

The Provider states that this was also included in the documentation sent after the plan had started.

The Provider says that following a conversation with Mr B, the Complainants opted to cancel this plan within the Cooling Off Period, and received a full refund of payments made (€202).

The Provider submits that while the Complainants state that they were unaware that their monies were invested in funds that were exposed to risk, it is noted from its response and from the documentation that this was not the case. The Provider submits that it was clearly noted in the Personal Financial Review that this plan would not perform as well as a deposit account. The Provider says that all of the documentation provided to the Complainants also confirmed the risks associated with this plan, and that there was the potential to receive back less than the Complainants invested.

As regards the Term Life Insurance Policy (No. 11867**1) the Provider states that it understands that the conduct complained of in respect of this plan relates to the Providers decision to decline a Specified Illness Claim, and withdraw cover and cancel the plan. The Provider states that as a result of this, the Complainants have raised issues with the sale of the plan.

The Provider states that it would first like to point out that the decision to decline the claim was based on non-disclosure by the Complainants in December 2015 when they initially applied for their Term Life Insurance plan.

The Provider submits that on the application form completed by the Complainants when they applied for their plan in December 2015, they advised on the completed medical questions section that the Second Complainant had only suffered a fractured rib. The Provider states however, that when assessing the Specified Illness Claim submitted by the Complainants in June 2016 in respect of the Second Complainant, the medical evidence received indicated the following:

In August 2015, [the Second Complainant] underwent cardiac review in [a] Hospital which included a CT angiogram and cardiology follow up. [The Second Complainant] was noted to be started on medication in the form of Rosuvastatin and to be on Atenolol. A plan for an ultrasound referral was noted. On 25 August 2015 [Dr L] noted that [the Complainant] had asked for a referral to [a] Hospital for the ultrasound. She confirmed she would send a letter to [the Hospital].

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On 26 November 2015, [the Complainant] had a liver ultrasound scan in [a] Hospital which showed an incidental finding of a mass in the right upper pole of the right kidney.

On 27 November 2015, [the First Complainant] attended [Dr L] who discussed the results of the scan with him and sent a referral to Urology in [the] hospital and arranged an MRI. An appointment for blood tests was also made at this time.

On 15 December 2015, [the First Complainant] requested that his appointment with [Dr L] on 17 December 2015 be rescheduled as an appointment had become available for him with [a], Consultant Urologist, on that date.

On 16 December 2015, [the Complainant] attended [Dr L] to discuss the results of his blood tests taken on 04 December 2015. It was noted at this appointment that [the Second Complainant's] MRI was still pending at that time. [The Second Complainant] confirmed that he had an appointment with [Consultant Urologist] the following day.

It is the Provider's position that the medical history outlined above should have been disclosed by the Second Complainant under the following medical questions on the application for cover on 16 December 2015:

- Have you ever suffered from or had treatment for high blood pressure, high cholesterol, any disorder of the heart, rheumatic fever, stroke, diabetes
- Have you ever suffered from or had treatment for any other illness, injury or condition for which you have had medical advice in the last five years?
- Have you in the last five years had or been advised:

- To have any special investigations, scans, blood or laboratory tests or have a surgical operation.
- Seen by a specialist as an in-patient or out-patient at any hospital or clinic.

The Provider considers that this constitutes non-disclosure of material facts. The Provider states that the importance of disclosing all material facts was noted on the application, and on the summary of questions and answers sent to the Complainants following their meeting with Mr B. The Provider refers to the following extracts:

> *"Important — Telling [the Provider] about material facts*
> *We now need to ask you about your health. The answers you give will be used to assess your request for cover. If you do not give us true and complete information, or withhold any facts or details, any future claim on this plan may not be paid. If this were to happen it could have a severe financial impact on you or your family. If you are not sure whether something is relevant, you should tell us anyway. Failure to disclose this information may result in difficulty obtaining cover with another company".*

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Life 2 Material Facts [Second Complainant]

"I understand the note concerning material facts and agree to disclose all relevant information. "Yes"

I understand that all my answers will be recorded and I will be asked to sign a declaration confirming my answers are true and complete. "Yes"

I understand that if I do not disclose all relevant material facts any future claim on this plan may not be paid. "Yes"

> *"Product Declaration (Protection)*
>
> *We understand that this declaration, together with the other declarations and consents made by us in this application (online or otherwise) given by us to [the Provider] is our application for cover under [the Provider's] normal conditions.*
>
> *We understand and agree that our contract with [the Provider] will be based on the declarations and consents in this form, our application form completed (online or otherwise), any supplementary questions answered, any statements made to [the Provider's] underwriting team in response to any phone calls received, any information we give to a medical examiner acting for [the Provider] and all terms and conditions furnished to us by [the Provider].*
>
> *We have read and understand the important information concerning our obligation to tell The Provider about all material facts in connection with the application and we understand that if we do not tell The Provider all material facts, this contract could be void. If this happens, there will be no cover under the plan and [the Provider] will not refund our premiums. In these circumstances, [the Provider] will not pay a claim".*

The Provider submits that the Complainants signed the Product Declaration confirming that they had read and understood the details that had been recorded on the application and that all of the information outlined was true and complete.

The Provider states that in addition, the Terms and Conditions of the plan state the following:

> *"We have issued this plan to you on the understanding that the information given in the application is true and complete and that we have been given all relevant information. If this is not the case we will be entitled to declare the plan void. If this happens, you will lose all your rights under the plan, any claim will not be paid and we will not return any payments. If we do decide to refund any payments made, we may deduct any associated medical evidence, administration or sales costs we have incurred under the plan. If the cover is voided on one life on a dual cover plan all cover will cease under that plan for both lives. Information is 'relevant' if it might*

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> *influence the judgement of a reputable insurer when fixing the level of payments or benefits, or when deciding whether to provide cover at all".*

It is the Provider's position that had the Provider been aware of the medical history at application stage, it would have postponed its underwriting decision pending the conclusion of the investigations.

The Provider states that as the investigations confirmed that the Second Complainant was diagnosed with renal cell carcinoma, its underwriters would not have been in a position to offer cover under this plan.

The Provider states that it is for these reasons that it was unable to admit the Specified Illness Claim and found it necessary to void the plan from the outset and cancel all cover attaching to the plan. The Provider says that a full refund of payments made to the plan was also issued by cheque to the Complainants (€1,409.78) on an *ex gratia* basis.

The Provider notes that the Complainants state that they answered all questions honestly and disclosed all relevant information and facts to their financial adviser Mr B.

The Provider states that having contacted Mr B for comments, he has advised that the only disclosures made at the time of application related to previous neck/back injuries, and he recorded details of any and all disclosures made by the Complainants.

The Provider says that Mr B also confirmed that he ensures that customers are made aware of the importance of disclosing material facts at application stage.

The Provider submits that a copy of the questions and answers was sent to the Complainants following their meeting with Mr B. In the accompanying letter, the Provider asked that if any of the information in the application was not true and complete, that the applicants contact the Provider in writing as soon as possible.

It is the Provider's position that it received no communication from the Complainants following this letter. The Provider states that furthermore, it believes it is important to highlight the fact that two months prior to completion of the application form with Mr B, the Complainants completed a Declaration of Health Form in respect of plan number 11768***8 where they did not disclose material facts. The Provider contends that this is therefore the second instance of non-disclosure by the Complainants.

As regards the Mortgage Life Insurance (11768***8) the Provider says it understands that the conduct complained in respect of this plan relates to the decision to cancel the plan and withdraw cover. The Provider summarises specific concerns that the Complainants have raised in respect of this plan as follows:

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- The Complainants allege that the decision to cancel the plan was due to missed payments in 2015;
- The Complainants state that all payments for this plan were always received on time and any delay in payment was due to the fault of the Provider;
- The Complainants state that they were never made aware that the plan had been cancelled and they were no longer covered at any time; and
- The Complainants have requested that this plan be put back in force and payments recommence immediately.

The Provider states that it is very important to point out that the reason for the cancellation of the plan and withdrawal of cover was not specifically due to missed payments in August 2015; but due to non-disclosure on a Declaration of Health Form completed by the Complainants in September 2015.

The Provider says that this decision was made during the assessment of the Specified Illness Claim that was submitted on plan number 1186***1. The Provider states that when assessing the claim, it came to light that there had been material non-disclosure in September 2015 when a Declaration of Health Form was completed for the reinstatement of plan number 11768***8 following a period of non-payment of premiums.

The Provider explains when a plan is out of force for longer than 90 days, it requires a Declaration of Health Form to be completed to ensure that the customer's health status has not changed in the previous three months.

The Provider submits that the Declaration of Health Form completed by the Complainants had no disclosures on it. The Provider states however, that the Second Complainant answered "No" to a question that should have been answered "Yes":

> *"Have you been admitted to hospital, attended or been advised to attend a specialist, hospital or clinic?"*.

The Provider states that there is an important note on the Declaration of Health Form, outlined below:

> *"Important Note: Please remember that you must tell us everything relevant in answer to these questions on this Declaration of Health Form. If you do not or if any of these answers are not true and complete, The Provider could treat the policy as void. If this happens, there will be no cover under the policy and we will not refund any premiums. In these circumstances, we will not pay a claim".*

It is the Provider's contention that had it been made aware that the Second Complainant was due to go for an ultrasound, its Underwriters would have postponed the reinstatement of the plan, pending the results of this test. The Provider says that as the

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eventual diagnosis was renal cell carcinoma, its underwriters would not have been in a position to reinstate this plan.

The Provider explains that it was for this reason that the plan was cancelled, and all cover under the plan ceased. The Provider states that a full refund of payments made by the Complainants to the plan was returned to the Complainants by cheque (€1,104).

The Provider has submitted a summary on how the plan initially lapsed due to non-payment and why a Declaration of Health Form was requested.

Following a telephone call of 30 January 2015 to the Provider's Customer Service Department, the direct debit on the plan was suspended as the Complainants advised that they wished to make their monthly payment by telephone instead of direct debit.

The Complainants made two months payments by telephone in February 2015, three months payments by telephone in April 2015 and one month's payment in June by telephone.

The Provider wrote to the Complainants on 6 June 2015 to confirm that their most recent payment had been received, and that the plan was paid to 7 June 2015.

The Provider points out that when a customer opts to pay their monthly payment by telephone, the onus is on the customer to ensure that they telephone each month to pay for their plan.

The Provider states it does not issue monthly reminder letters to advise of an outstanding payment, as its system is set up to facilitate monthly direct debit payments and not monthly payments by telephone. It is for this reason that no letters were sent to the Complainants in July or August 2015 to advise that there were payments due.

The Provider received no communication from the Complainants until a telephone call to its Customer Service Department on 28 August 2015. During this telephone call, the Complainants were advised that there were three payments outstanding. The Complainants were unable to make the full payment that was outstanding at this time and confirmed to the Provider's Customer Service Department that they would telephone the following day to make a payment for their plan.

The Provider wrote to the Complainants on 29 August 2015 to advise of the following:

<u>Billing Letter 29 August 2015</u>

> *"We previously wrote to you to tell you that your Mortgage Life Insurance plan is paid to 7 June 2015 and that we have not received payment since that date.*
>
> *As this has not changed your plan has now gone out of force and your benefits have been cancelled".*

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It is the Provider's positon that it again received no communication from the Complainants until a telephone call to its Customer Service Department on 28th September 2015 where the Complainants were advised that their Plan had lapsed due to non-payment. It was confirmed that a Declaration of Health Form was required in order to reinstate the plan, and this was posted to the Complainants on 28th September 2015.

The Complainants returned their completed Declaration of Health Form to the Provider's Head Office on 30 September 2015, along with a payment of €207. The plan was reinstated, and paid to 7 September 2015.

The Provider submits that as outlined previously, it was during the Specified Illness Claim that was submitted on plan number 1186***1 that the non-disclosure on the Declaration of Health Form came to light. The Provider says that as outlined in this form, if any answers were not true and complete the Provider could treat the plan as void, and all cover would be withdrawn and that this is what happened in this case.

The Provider rejects the claim that all payments for this plan were always received on time and any delay in payment was due to the fault of the Provider.

The Provider's positon is that that since commencement of the plan, payments have been irregular and missed on multiple occasions. The Provider says that in fact, from commencement of the plan there have been issues with the monthly payment.

The Complainants have stated that apologies documented in the Providers previous response letters confirm that it was the fault of the Provider and not the fault of the Complainants for any missed payments on this plan.

The Provider submits that this was not the case. The Provider says that the apology documented in previous communication was in relation to poor service that the Complainants received and errors that occurred in updating their Direct Debit Mandate. The Provider says that it did not confirm to the Complainants that their bank account details had been updated, and it applied to their bank account for payment on dates that they had not specified and therefore were not expecting.

The Provider also notes the Complainants suggestion that they were not made aware at any point that the plan had been cancelled and they were no longer covered. The Provider's response to this is that it wrote to the Complainants on 29 August 2015 to advise that their plan had lapsed due to non-payment and their benefits had been cancelled.

The Provider states that when it wrote to the Complainants on 5 January 2017 to advise that it was not in a position to pay their claim on plan number 1186***1 and that it was withdrawing cover and cancelling their plan, it also confirmed that plan number 1176***8 had been cancelled and cover withdrawn. The Provider points out that the Complainants included a copy of this letter with their completed Complaint Form.

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As regards the Complainants' statement that this plan was a replacement of a previous plan taken out in 2008 to cover their mortgage, it states that plan number 1176***8 commenced on 7 May 2014. While it was noted on the application that this was a replacement for the Provider plan (1152***4), the Provider states that plan number 1152***4 had previously lapsed due to non-payment. It is the Provider's position that it confirmed this in writing to the Complainants in a letter dated 12 October 2013.

The Provider notes the Complainants' preferred resolution as follows:

Reinstatement of plan number 1176***8
Payment of Specified Illness Claim for the Second Complainant on plan number 1186***1
Reinstatement of plan number 11867571 for the First Complainant.

The Provider states that it was not in a positon to accede to the requests for the reasons stated.

The Provider states as the Complainants did not disclose relevant information on the application form, the plan was declared void and cancelled. A full refund of payments made to the plan was also made to the Complainants. The Provider points out that in the event of non-disclosure it is not obliged to refund any payments.

The Provider states that it is satisfied that its letter and enclosed documentation clearly explains the reason for declining to pay the Specified Illness Claim for the Second Complainant.

The Provider submits that it is not in a position to reinstate plan number 1186***1 for the First Complainant. The Provider says that the Terms and Conditions of the plan state that in the event of cover being voided on one life on a dual cover plan, all cover will cease under that plan for both lives. The Provider's position is that it is legally entitled to, and has no alternative but to void the policy as a whole which includes cover on the First Complainant as the second life assured.

<u>Evidence</u>

<u>The Provider's retrospective underwriting opinion for Plan No. 1176***8</u>

The Provider looked at the medical information that should have been recorded on the application forms, and retrospectively assessed that information to see would it have met its underwriting criteria for acceptance of the policy from the outset.

> "In force from 8/5/2014
> Disclosed broken ribs
> Accepted at o/r
> DOH [Declaration of Health] to reinstate the plan signed on 29/9/2015

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"Within the past 12 months:
Have you been admitted to hospital, attended or been advised to attend a specialist, hospital or clinic?"

He attended A&E in June 2015 with chest pain.

He had been referred for an ultrasound in August 2015

His GP advised him that he would send a referral letter to …. Hospital in respect of the ultrasound.

Had we been aware of his pending investigation, we would have postponed the reinstatement for 6 months.

On diagnosis of renal cell carcinoma in February 2016, the reinstatement would have been declined.

Retrospective underwriting opinion: Postpone reinstatement for 6 months and then decline".

Retrospective underwriting opinion on 1186***1

"Had [Second Complainant] disclosed that he had a history of high blood pressure, high cholesterol and cardiac investigations, and that he had been referred to Urology OPD, we would have obtained medical evidence.

Had we been aware that his ultrasound scan on 26/11/15 was abnormal, and that he had been referred to Urology OPD for further investigations, we would have postponed his application.
The eventual diagnosis was renal Cell Carcinoma pT1a(Feb 16)

Life: Postpone for 2 years
SIC: Postpone for 8 years
Retrospective underwriting opinion:
Postpone for 6 months initially pending investigation and then postpone Life for 2 years and SIC(Serious Illness Cover) for 8 years following diagnosis of Renal Cell Carcinoma pT1a (Feb 16)".

<u>Report from the Provider's representative Mr B</u>

"When conducting underwriting I always ask all the questions listed and include all information given by the customer. As you can see in this case, several medical disclosures were made during our meeting and I included them all. If the customer told me he attended the GP he would have also told me the reason for this and this would have been included on my report".

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The Representative states that *the point the Complainant's make:* ***"That [the representative] asked them to sign the form on [his] tablet and did not ask that they read through the answers"*** *is definitely a lie without a doubt as the questions would have been on the desktop screen right in front of them the whole time as this is the process I use in every meeting (unless a customer is'nt present and I use the paper application but this was'nt the case here)".*

"Before the medical questions are asked there is a section of the application that makes clear " the importance of disclosing material facts". This is shown to the customer on the screen and I also explain it. .. I met both customers and completed the medical underwriting with them going through all the questions both verbally and visually using the desk top monitor. There were a few disclosures made at the time of the application that if I'm not mistaken related to neck / back injuries the customer had had previously. These along with any other disclosures the customers would have made would have been included on the report".

The Provider states that when applying for plan number 1186***1 the Complainants did not disclose any medical history that would have prompted a PMAR [Private Medical Attendants Report] to be requested. They were therefore accepted automatically based on the disclosures they made on their application.

Letters of 07/05/2014 & 16/12/2015 – from the Provider to the Complainant

"Please find enclosed a summary of all questions and answers submitted, including underwriting questions and answers, in relation to this application.

Please study this document carefully to make sure that all the information is correct. Please note that we will use your date of birth and smoker status to work out the premium we will charge you for your cover. We will use the answers provided to the medical questions to work out whether to accept your application and if so on what terms. If any of the information in the enclosed application form is not true and complete you must contact us in writing as soon as possible, correcting any inaccurate information. We will acknowledge receipt of these details within 10 working days. If you do not hear from us within 10 working days, please contact us on … However, if the information in the application form is true and complete then you do not need to contact us or take any other action".

16/12/2015 – Provider to the Complainant

"If any of the information in the enclosed application form is not true and complete you must contact us in writing as soon as possible, correcting any inaccurate information. We will acknowledge receipt of these details within 10 working days. If you do not hear from us within 10 working days, please contact us on ….

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However, if the information in the application form is true and complete then you do not need to contact us or take any other action".

<u>16/12/2015 – Letter from the Provider's representative to the Complainant</u>

"The rest of the report includes all the information that I gathered during the review. For example the "Your Needs" section shows the information that I used as the basis for my recommendations.

If there is anything in the report that you do not agree with, or if you have any questions about the content, please do not hesitate to contact me. You can also contact our .. service team on …"

The Complainants therefore had a copy of the answers recorded by the Provider's representative to medical questions that were put to them at their meeting in December 2015.

<u>Specified Illness Cover Claim Form dated 22 August 2016</u>

Q.3. When did you first suffer symptoms of this illness ?

Answer recorded: *"11/02/2016"*

Q. 4. (a) "Please describe the first symptoms?

Answer recorded: *"incidental finding of Right Renal Lesion"*

(b) How long were these symptoms present?

Answer recorded: *"29/12/2015"*

Q.5 When did you first seek medical advice in connection with these symptoms?

Answer recorded: *"11/02/2016"*

<u>The Complaints for Adjudication</u>

The complaints are (i) that the Provider's representative incorrectly advised the Complainants when setting up the investment policy (ii) that the Provider incorrectly voided the Term Life Insurance Policy (with Serious Illness benefit attached) due to non disclosure by the Complainants of the Second Complainant's health history and (iii) the Provider incorrectly voided the Complainant's Mortgage Protection Policy.

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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 Complainants were 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 **24 February 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.

A Submission dated **9 March 2020** was received from the Complainants by this Office after the issue of a Preliminary Finding to the parties. This submission was exchanged with the Provider and an opportunity was made available to the Provider for any additional observations arising from the said additional submission. There was no additional observations made by the Provider.

The content of the Complainants' submission has not persuaded me to alter my previous preliminary determination and, consequently, my final determination is set out below.

The issues for investigation and adjudication is whether the Provider (i) correctly and reasonably recommended the Savings Plan to the Second Complainant (ii) correctly and reasonably rejected the Illness Claim, on the basis of the Complainants alleged non disclosure of material facts and voided the policy and (iii) correctly and reasonably voided the Life and Mortgage policies.

The Complainants submitted a Specified Illness Cover claim to the Provider in respect of the Second Complainant on 22 August 2016.

In order to assess the claim, the Provider requested medical information from the Second Complainant's medical professionals, and a copy of his medical records from the Hospital

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he was attending. The medical information received during the assessment of the claim indicated the following:

- In August 2015, the Second Complainant underwent a cardiac review in a Hospital.

- On 25th August 2015, Dr L noted that the Second Complainant had asked for a referral to a named hospital for an ultrasound. The doctor confirmed that she would send a letter to the hospital.

- On 26th November 2015, the Second Complainant had a liver ultrasound which showed an incidental finding of a mass in the right upper pole of the right kidney.

- On 27th November 2015, the Second Complainant attended Dr L who discussed the results of the scan with him and sent a referral to Urology in the hospital and arranged an MRI.

- On 15th December 2015, the Second Complainant requested that his appointment with Dr L on 17th December 2015 be rescheduled as an appointment had been arranged with a Urologist on that date.

- On 16th December 2015, the Second Complainant attended Dr L and confirmed that he had an appointment with the Urologist on the following day.

An Application Form which was signed on 16th December 2015. A copy of the completed Application Form was sent to the Complainants along with a copy of the Welcome Pack that was issued to the Complainants on 16th December 2015. The only recorded disclosure by the Second Complainant on the application was that he had suffered a fractured rib.

The Provider's position is that the medical history outlined should have been disclosed by the Second Complainant on the application for cover, in response to the following question:

> *'Have you ever suffered from or had treatment for any other illness, injury or condition for which you have had medical advice in the last five years?'*
>
> *'Have you in the last five years had or been advised:*
> - *to have any special Investigations, scans, blood or laboratory tests or have a surgical operation*
> - *seen by an specialist as an in-patient or out-patient at any hospital or clinic'*

The Provider submits that this constitutes non-disclosure of material medical facts.

There were warnings on page five of the application for cover concerning the disclosure of material facts and the consequences of not doing so:

> *'A material fact (relevant information) includes anything that a reputable insurer would treat as likely to influence the assessment and acceptance of an application*

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for cover. If you are not sure whether something is relevant, you should tell us anyway. This includes details of tobacco consumption.

We will rely on what you tell us and you must not assume we will automatically clarify or confirm any information you provide. You can provide any highly confidential information directly to [the Provider's] Chief Medical Officer in a sealed envelope with your name, date of birth and application number. In these circumstances you must refer to this information when answering your health questions.

You should not tell us about any genetic test (that is, any analysis of chromosomes, DNA or RNA to detect genetic abnormalities in individuals) which you may have had You must however, tell us if you are having treatment for or experiencing symptoms of a genetic condition. You will also be asked to give us full information about your family history, including all genetic conditions. '

The Product Declaration (Protection) on the Application Form states:

'We understand that this declaration, together with the other declarations and consents made by us in this application (online or otherwise) given by us to [the Provider] is our application for cover under [the Provider's] normal conditions.

We understand and agree that our contract with [the Provider] will be based on the declarations and consents in this form, our application form completed (online or otherwise), any supplementary questions answered, any statements made to [the Provider's] underwriting team in response to any phone calls received, any information we give to a medical examiner acting for [the Provider] and all terms and conditions furnished to us by [the Provider].

We have read and understand the important information concerning our obligation to tell [the Provider] about all material facts in connection with the application and we understand that if we do not tell [the Provider] all material facts, this contract could be void. If this happens, there will be no cover under the plan and [the Provider] will not refund our premiums. In these circumstances, [the Provider] will not pay a claim.

We declare that all statements recorded in answer to the questions in our application form (online or otherwise) including those about tobacco consumption (together with any statements written down for us) are true and complete. We understand that we will receive a copy of the application form questions and our answers for our own records. We understand that we must tell [the Provider] in writing about any changes in our health or circumstances between the time we applied for cover and the date our application is accepted.

We understand that this plan will not start until [the Provider] has accepted us for cover and we have paid the first payment. We understand that if we have used the application form for Data Capture in order for the application to be later completed

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online, that the information captured will be retained by our Financial Adviser and not passed to [the Provider]. We acknowledge that a printed record of the online application will be sent to us and agree to notify [the Provider], in writing, if:

- *we do not receive the printed record*
- *any information in this record is, false, incorrect or incomplete*

We consent to [the Provider] obtaining information from or sharing information with any doctor who at any time has attended us concerning anything which affects our physical or mental health any health professional for the purpose of processing our application or any insurance company where we may have applied or may make a claim. We authorise [the Provider] to access and receive this information. We agree that this authority will stay in force after our death. We agree that this information (including any medical data) can be held for six years. '

The Complainants signed the application form on 16 December 2015 indicating their understanding and acceptance of each of the declarations.

In addition, the Term Life Insurance Terms and Conditions notes the following:

'We have issued this plan to you on the understanding that the information given in the application form and any related document is true and complete and that we have been given all relevant information. If this is not the case we will be entitled to declare the plan void. If this happens, you will lose all your rights under the plan, any claim will not be paid and we will not return any payments. Information is 'relevant' if it might influence the judgement of a reputable insurer when fixing the level of payments or benefits, or when deciding whether to provide cover at all.

If we do decide to refund any payments made we may deduct any associated medical evidence, administration or sales costs we have incurred under the plan. If cover is voided on one life on a dual cover plan all cover will cease under that plan for both lives'.

The Provider submits that had its underwriters been aware of the Second Complainant's medical history and pending investigations as outlined above at the time of his application, they would have postponed a decision on whether to offer cover pending the conclusion of the investigations. The Provider states as the investigations confirmed the Second Complainant's diagnosis of renal cell carcinoma, its underwriters would not have been in a position to offer the Complainant cover under plan 1186***1.

The Provider states that it is for this reason, that it cannot admit the claim and find it necessary to void plan number 1186***1 from the outset. This means that the plan has been cancelled and no cover remains. A refund amount of €1,409.78 in respect of all premiums paid to plan number 1186***1 was issued to the Complainants on an *ex-gratia* basis.

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The Provider notes the Complainants comments regarding the cancellation of cover and states that had the full details of the Second Complainant's health history been disclosed, as they should have been, it would not have accepted the Second Complainant for life assurance or issued the policy. Therefore, the policy would not have gone into force and there would be no life cover in existence with the Provider for either Complainant.

The Term Life Insurance plan is a dual life contract and was set up as such on 16 December 2015 with dual life cover for both Complainants. The Provider's position is that therefore, in accordance with paragraph nine of the Terms and Conditions which state: *"If cover is voided on one life on a dual cover plan all cover will cease under that plan for both lives"*, the Provider was contractually entitled to void the policy as a whole which includes cover on the First Complainant as the second life assured.

With regard to plan number 1176***8, the Provider states that this plan went out of force on 29th August 2015 due to the non-payment of premiums. The Provider explains that in order to reinstate the cover on the plan, both Complainants were required to complete a declaration of health. This was received on 30th September 2015.

The Second Complainant answered 'No' to all the questions on the declaration of health. The Provider states however that given the Second Complainant's medical history, it was evident he should have answered 'yes' to the following question:

"Have you been admitted to hospital, attended or been advised to attend a specialist, hospital or clinic".

The Declaration of Health states:

> *"Important Note: Please remember that you must tell us everything relevant in answer to these questions on this Declaration of Health Form. If you do not or if any of these answers to the questions are not true and complete, [the Provider] could treat the policy as void. If this happens, there will be no cover under the policy and we will not refund the premiums. In these circumstances we will not pay a claim"*

The Provider's positon is that had it been aware that the Second Complainant was advised to attend for an ultrasound, its underwriters would have postponed the reinstatement of the plan until all investigations were complete. The Provider states that the eventual diagnosis following these investigations was renal cell carcinoma, its underwriters would not have been in a position to reinstate the cover under plan 1176***8.

The Provider submits that it is for this reason, that it found it necessary to cancel plan number 1176***8. This meant that the plan had been cancelled and no cover remained. A cheque for the amount of €1,104.00 in respect of all premiums paid since the reinstatement of plan number 1176***8 was issued to the Complainants on an *ex-gratia* basis.

The Complainants' Mortgage Life Insurance (plan number 1176***8) started on 7 May 2014.

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The Provider sent the Complainants a Welcome Pack dated 8 May 2014 including the Terms and Conditions document (which explains the workings of the plan).

The Terms and Conditions document provided important information about the Provider's Non-Disclosure policy, and information about making payments for the Mortgage Life Insurance.

Section 2 Basis of Cover, explains the legal basis on which cover was given to the Complainants, as follows:

> *"2.1. We have issued this plan to you on the understanding that the information given in the application form and any related document is true and complete and that we have been given all relevant information. If this is not the case we will be entitled to declare the plan void. If this happens you will lose all your rights under the plan, we will not pay any claim and we will not return any payments. Information is 'relevant' if it might influence the judgement of a reputable insurer when fixing the payment or level of benefits or when deciding to provide cover at all.*
>
> *If we do decide to refund any payments made we may deduct any associated medical evidence, administration or sales costs we have incurred under the plan. If cover is voided on one life on a joint life cover plan all cover will end under that plan for both lives".*

This extract from the Terms and Conditions document explains that the information provided by way of an application for cover must be true and complete, and if this is not the case, the Provider will consider the plan to be void.

Section 2 Basis of Cover

> *"2.2. If your cover ends but is reinstated under section 3.4, we will reinstate it on the understanding that the information given in the evidence of health form and any relevant document is true and complete and that all relevant information has been provided.*
>
> *If this is not the case, we will be entitled to declare the plan void. If this happens, you will lose all your rights under the plan, we will not pay any claim and we will not return any payments. If we refund payments, we are entitled to deduct appropriate costs incurred as a result of the setting up and administration of this plan. Information is 'relevant' if it might influence the judgement of a reputable insurer when fixing the level of payments or benefits; when deciding to reinstate cover at all; or when deciding whether to attach conditions".*

This extract from the Terms and Conditions document explains that evidence of health for the purpose of reinstatement of the Mortgage Life Insurance plan must be true and complete, or the Provider will consider the plan void.

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The Terms and Conditions document also explains that the policyholder must keep up payments in order to maintain the Mortgage Life Insurance, and explains what will happen if the policyholder does not maintain payments.

Section 3 Making payments

This section explains the customer's obligations making payments and explains what happens if payments fall behind.

> *"3.1 Although each payment is due on the payment dates shown in the plan schedule, we give you 30 days to make the payment unless you make payments monthly, in which case we will give you 10 days to make the payment. (The time allowed is known as a 'period of grace'.) If you become entitled to a benefit during a period of grace, we will take from your benefit any payment that you have not made.*
>
> *3.2 If you have not made a payment by the end of the period of grace, your cover under the plan will end immediately. A payment is not made until we have received it. It is up to you to make sure that we receive your payment We are entitled to pass on to you any charge we have to pay because all or part of your payment (for example, a direct debit) is dishonoured.*
>
> *3.3 If your cover under the plan ends as described in section 3.2, you can restore your cover within 90 days from the date the first missed payment became due. You must make all the payments which would have been due if your cover had not ended. You will not be entitled to benefits for anything that happens between the end of the period of grace and the date we receive all missed payments.*
>
> *3.4 If, after 90 days and before 180 days of the first missed payment being due, you ask for cover to be restored, the life assured must fill in an evidence of health form and all the payments, which would have been paid if cover had not ended, must be made. If the information on the evidence of health forms shows that the health of the life assured is now different to that declared on the application form, we may refuse to restore cover or restore the cover:*
>
> *Without any change*
>
> *With an Increased payment; or*
>
> *With new conditions".*

This section from the Terms and Conditions document explains that the Mortgage Life Insurance will be cancelled if the policyholder does not make a payment due, within the period of grace.

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This section from the Terms and Conditions document also explains that the Provider will require evidence of health from the customer if the customer asks to reinstate the Mortgage Life Insurance after 90 days.

The Complainants' Mortgage Life Insurance was initially paid by direct debit. However, the direct debit was suspended further to a telephone conversation between the First Complainant and the Provider's Customer Service Department on 30 January 2015.

During this telephone conversation on 30 January 2015, the First Complainant queried whether the payments for the Mortgage Life Insurance could be paid by way of card payments.

It was agreed between the Customer Service Representative and the First Complainant on 30 January 2015 that the direct debit (former method of payment) would be suspended.

Payments for the Mortgage Life Insurance was paid by way of card payments which were paid during telephone conversations with the Provider's Customer Service Department between January and May 2015.

The Provider sent a letter dated 6 June 2015 to the Complainants explaining that it had applied a payment to their Mortgage Life Insurance, and that their plan was now paid until 7 June 2015.

The Provider cancelled the Mortgage Life Insurance from 7 June 2015 due to non payments of premiums since this date. The Provider sent the Complainant a letter dated 29 August 2015 which explained that it had cancelled the plan. The letter stated:

> *"We previously wrote to you to tell you that your Mortgage Life Insurance plan is paid to 7 June 2015 and that we have not received payment since that date,*
> *As this has not changed your plan has now gone out of force and your benefits have been cancelled. To restore your plan benefits, please send us the amount due of €207.00 in the prepaid envelope provided, together with the payment slip from the bottom of this letter".*

The above letter dated 29 August 2015 explained that the Provider had not received payment from since 7 June 2015, and outlined its then requirement for reinstatement.

It is the Provider's positon that it is clear that the Mortgage Life Insurance was cancelled from 7 June 2015, due to non-payment of premiums, and not due to any Provider errors. The Complainants position is that the Provider did not correctly present for payments from their bank.

The Complainants contacted the Provider's Customer Service Department by telephone on 28 September 2015. During this telephone conversation, it was explained that the Provider would require evidence of health for the reinstatement of the Mortgage Life Insurance. A letter dated 28 September 2015 was sent to the Complainants by the Provider, which

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included a Reinstatement Declaration of Health for reinstatement of the Mortgage Life Insurance. The Reinstatement Declaration of Health included the following information.

> *"Important Note*
> *Please remember that you must tell us everything relevant in answer to these questions on the Declaration of Health form. If you do not or if any of the answers to these questions are not true and complete, [the Provider] could treat the policy as void. If this happens there will be no cover under the policy and we will not refund the premiums in these circumstances we will not pay a claim.*
>
> *A material fact i.e. relevant information includes anything which a reputable insurer would regard as likely to influence the assessment and acceptance of an application for insurance. If you are not sure whether something is relevant you should tell us anyway".*

The Provider received the completed Reinstatement Declaration of Health form for revival of the Mortgage Life Insurance on 30 September 2015. There were no disclosures included on the completed form.

The Provider also received payment for €207 from the Complainants on 30 September 2015. The Provider then reinstated the Mortgage Life Insurance, and applied the payment for €207. This payment paid for cover from 7 June 2015 until 7 September 2015.

The Provider then sent the Complainants a letter dated 1 October 2015 which explained that it had applied the payment, and the Mortgage Life Insurance had been paid until 7 September 2015.

The Provider's letter also explained that there was an outstanding payment for €69 due to bring the payments to the Mortgage Life insurance up to date.

The Provider received a completed SEPA Direct Debit Mandate from the Complainants on 27 October 2015. The completed Direct Debit Mandate indicated that the payment date be the first of each month.

The Complainants notified the Provider of a complaint during a telephone conversation with its Customer Service Department on 20 November 2015, as the Provider had attempted to collect payments from the Complainants on 6 November 2015 and 18 November 2015, (having had previously requested that the Provider collect payments on the first day of each month).

The Provider's Response Letter dated 26 November 2015 outlined its position towards this concern. In that letter it explained that it had applied a monthly payment for €69 to the Mortgage Life Insurance by way of an apology for poor service. This letter also explained that it had enclosed a One4All voucher for €50.

During telephone conversation on 26 November 2015, the Provider explained to the Complainants that it would enclose a new SEPA Direct Debit Mandate with its Response

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Letter, for the Complainant's completion, as the Complainants had previously indicated that they intended to pay the premium payments from a different bank account.

The Provider received a completed SEPA Direct Debit Mandate from the Complainants on 13 January 2016, and the Complainants paid the premium payments to the Mortgage Life Insurance monthly by direct debit from January 2016 until January 2017.

It is the Provider's position that further to its assessment of the claim on plan number 1186***1 it identified that the Complainants did not disclose information about a change to the Second Complainant's health circumstances by way of a completed Reinstatement Declaration of Health which it received for plan number 1176***8 on 30 September 2015.

The Provider sent the Complainants a letter dated 5 January 2017 which explained that it had cancelled their Mortgage Life Insurance in light of the alleged non-disclosure. The Provider also sent the Complainants a cheque for €1,104 representing a refund for payments paid to plan number 1176***8 since September 2015. The Complainants returned the cheque for €1,104 to the Provider's office.

From the above it can be seen that the Mortgage Life Insurance had previously been cancelled from 7 June 2015, due to non-payment of premiums.

It can also be seen from the above that the reinstated Mortgage Life Insurance was cancelled by the Provider due to the alleged non-disclosure in the completed evidence of health form received on 30 September 2015, (in accordance with the Terms and Conditions document which was provided to the Complainants when they started their plan).

Analysis

The Investment Policy

As regards the First Complainant's investment policy the evidence shows that the Provider's representative had discussed the different types of fund that were available and recommended a fund with a greater risk than was eventually chosen by the Complainant. It is noted that on page 20 of the "Planning your savings" section of the Personal Financial Review it stated:

> *"[The First Complainant], you have asked to go against the recommendation of …3 in favour of …2 as you consider …2 to be less risky. I can confirm that …2 is 1 risk category lower than ….3. I have also explained that after charges …2 could potentially perform less well than a deposit account. I also explained that this product does not provide capital protection and this means that you could get back less than you invested, I gave you the range of returns document and explained it to you".*

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I accept that it is evident from this that the First Complainants was made aware of the fact that this was an investment and not a deposit account, and that it was possible to receive back less than what was originally invested.

It is noted that this was also included in the fund documentation sent after the plan had started.

The First Complainant opted to cancel this plan within the Cooling Off Period, and she received a full refund of payments made (€202).

I accept that the information supplied to the First Complainant clearly advised that the monies invested in the fund were exposed to risk. The Personal Financial Review also stated that the plan would not perform as well as a deposit account. I accept that all of the documentation provided to the First Complainant confirmed the risks associated with the plan, and that there was the potential to receive back less than what was invested. I consider that the First Complainant had the right and opportunity to step back from the investment by availing of the Cooling off provision, and receive back the amounts invested. The Complainant did exercise her cooling off rights and received back the monies she invested and I am satisfied that this ensured that she was not at a loss and I do not uphold this aspect of the complaint.

<u>The cancellation of the Term Life Insurance Policy and the Provider's rejection of the Serious Illness Claim that was made under that policy.</u>

I must assess whether there was a full disclosure to the Provider of the Complainant's medical history. In this regard, I am mindful of the decision in <u>*Chariot Inns Ltd v Assicurazioni Generali spa [1981] IR* 199</u> wherein the Supreme Court stated that the test for materiality is:

> *"...a matter or circumstance which would reasonably influence the judgment of a prudent insurer in deciding whether he would take the risk, and if so, in determining the premium which he would demand. The standard by which materiality is to be determined is objective and not subjective."*

I am further mindful of the well accepted principle that a contract of insurance is a *"contract of utmost good faith on both sides"* and I note the dicta of Mr Justice Barrett in <u>*Earls -v- The Financial Services Ombudsman & Anor [2015] IEHC 536*</u> in relation to this duty wherein he outlined that;

> *"The duty of utmost good faith requires a genuine effort to achieve accuracy using all available sources; to require disclosure of all material facts which are known to an insured may well require an impossible level of performance"*

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The Complainants argue that they did disclose information to the Provider's representative (MR B), but that he is said to have advised that the disclosures were not something of relevance that needed to be recorded on the application form.

With regard to this offices assessment of whether the facts that were not disclosed on the application form were material facts, the High Court in Earls (cited above) decided that this office should not proceed on the basis that if a material fact was not disclosed then, *ipso facto*, there has been a breach of the duty of disclosure. Rather in the Court's opinion, this may not always be the case, as the duty arising for an insured in this regard, is to exercise a *"genuine effort to achieve accuracy using all reasonably available sources"* and on the facts of the case in Earls it was noted the proposers *"memory and experience"* in the characterisation of the event was relevant.

Consequently, it is evident that the test for materiality is an objective one and the proposer is required to disclose every matter which a reasonable person would consider to be material to the risk against which indemnity is being sought.

Furthermore, I note this general duty may be limited in particular circumstances by reference to the form of questions asked in the proposal form. Consequently, I must consider whether the particular questions that were asked of the customer on the Application Form had limited that general duty.

In this regard, it is recognised by Finlay CJ in *Kelleher v Irish Life Assurance Company [1993] 3 IR 393* Finlay CJ that the test is as follows:

> *"whether a reasonable man reading the proposal form would conclude that information over and above it which is in issue was not required"*

Consequently, the question at issue is also to be assessed by reference to the reasonable person.

Having examined the documentation in relation to the policy that gives rise to this complaint, I accept that, a **"material fact"** was correctly defined and the consequence of a non-disclosure of a material fact was also set out, that is it could render the contract void. It was stated on the proposal form (a copy of which was provided to the Complainants after their completion of the proposal form) that:

"Important – Telling [the Provider] about material facts

We now need to ask you about your health. The answers you give will be used to assess your request for cover. If you do not give us true and complete information, or withhold any facts or details, any future claim on this plan may not be paid. If this were to happen

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it could have a severe financial impact on you or your family. If you are not sure whether something is relevant, you should tell us anyway.

Material Facts

I understand the note concerning material facts and agree to disclose all relevant information "Yes"

I understand that all my answers will be recorded and I will be asked to sign a declaration confirming my answers are true and complete". "Yes"

I understand that if I do not disclose all relevant material facts any future claim on this plan may not be paid" "Yes"

The obligation placed on the Insured was to answer questions on the application form fully and it was specifically set out on the application form that if in doubt whether a fact was material such facts were to be disclosed. The Complainants declared by their signatures on the application that they understood the need to fully disclose material facts.

I accept that the questions on the Proposal Form, were not ambiguous or open-ended, and having regard to the Second Complainant's health history that the questions were not answered correctly on the application form.

In order to assess the claim, the Provider requested medical information from the Second Complainant's medical professionals, and a copy of his medical records from the Hospital he was attending. The medical information received during the assessment of the claim indicated a number of medical examinations / medical reviews.

The Application Form was signed on 16th December 2015. A copy of the completed Application Form was sent to the Complainants along with a copy of the Welcome Pack that was issued to the Complainants on 16th December 2015. The only recorded disclosure by the Second Complainant on the application was that he had suffered a fractured rib.

I must take issue with the Provider's representative's choice of words when asked to respond to the allegation that he did not ask the Complainants to read though their answers at application stage. The representative stated in his reply, that the Complainants' allegation, was: *"definitely a lie without a doubt"*. I consider that this was an inappropriate comment for the representative to make. This is particularly so, as the Provider's representative's evidence is that he could not recall the specifics of the particular application process, but where he gave an account of what would have typically have happened at such meetings.

That said, I accept that the medical history outlined above should have been disclosed by the Second Complainant on the application for cover, in response to the following question:

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'Have you ever suffered from or had treatment for any other illness, injury or condition for which you have had medical advice in the last five years?'

'Have you in the last five years had or been advised:

- *to have any special Investigations, scans, blood or laboratory tests or have a surgical operation*
- *seen by an specialist as an in-patient or out-patient at any hospital or clinic'*

As I accept that the material facts not disclosed on the application form would have reasonably operated on the mind of a prudent insurer assessing the risk, I find that the Company did not act unreasonably or outside the terms and conditions of the policy in arriving at its decision in relation to the claim.

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

The cancellation of the Mortgage Protection Policy

As regards the Provider's cancellation of the Mortgage Protection Policy, I note the following:

- The Complainants' premiums were paid up to 7th June 2015. In a letter dated 6 June 2015, the Provider advised that: *"We have updated this payment to your plan and it is now paid to 7 June 2015. Your next payment will be due on that date".*

- It is only when a plan is out of force for longer than 90 days *"from the date the first missed payment became due"* that a Declaration of Health is required to be completed by the policyholders.

- The Provider advises that its system did not allow for reminder letters to issue where payments were being made over the telephone. Therefore, it did not remind the Complainants when the July and August payments were not received.

- The First Complainant contacted the Provider on 28th August 2015 to make a payment. Payment was not made then, due to a problem with the debit card. The Frist Complainant had requested that she receive a call back from the Provider the following day to make payment, but was advised that this would not be possible, but that she could telephone directly herself to make payment. The Complainants did not arrange payment until September 2015.

I note that in the telephone call of 28th August 2015 no advice was given by the Provider to say the policy was out of force. I also note that there was no advice given by the Provider about the requirement for the completion of a Declaration of Health, should the policy be in excess of 90 days out of force.

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- The Provider then sent a letter to the Complainants on 29th August 2015 to advise that the plan was paid to 7th June 2015 and that the policy had been cancelled. This letter makes no reference to the 90 days grace period before a Declaration of Health was required.

- At the date of the First Complainant's telephone call of 28th August 2015 and at the date of the Provider's letter of 29th August 2015 the Complainants' policy was still within the 90 days grace period.

Having regard to the above I consider that:

(a) it would have been reasonable if the Provider had in place a system for reminding a policyholder of overdue payments, where premiums were being paid over the telephone. Where the policyholder had a practice of paying in this manner, it would be reasonable that there would be a reminder notice from the Provider, as it does provide for other payment methods.

Alternatively, I consider that the Provider could have specifically advised the Complainants that where premiums were paid over the telephone, it would not be sending payment reminder notices to policyholders.

I do not find any communication from the Provider to advise the Complainants that it would not be sending payment reminder notices where payment are made over the telephone.

(b) it would have been reasonable if the Provider had highlighted to the First Complainant in the telephone call of 28th August 2015 that the life cover had gone out of force and that there was still time to avail of the grace period available for reinstatement of the cover without the need for the completion of a Declaration of Health.

(c) it would have been reasonable if the Provider had outlined to the Complainants in its letter of 29th August 2015, that there was a 90 day grace period for reinstating the policy without the need for the completion of a Declaration of Health Form.

The Provider did none of the above steps regarding the provision of this important information. It is particularly disappointing that this crucial information was not provided to the Complainants by the Provider either during the telephone call of 28th August 2015 or in the letter of 29th August 2015.

In addition I note that the Provider attempted to debit the outstanding premiums prior to receiving the Declaration of Health Form from the Complainants.

As regards the provision of information to a consumer the Consumer Protection Codes require that a regulated entity must ensure that all information it provides to a consumer is clear and comprehensible, and that key items are brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important

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information. A regulated entity must supply information to a consumer on a timely basis. In doing so, the regulated entity must have regard to the following: (a) the urgency of the situation and (b) the time necessary for the consumer to absorb and react to the information provided.

In light of the above failings by the Provider, in not clearly putting the Complainants on notice that they could have reinstated their policy, by paying the premiums prior to the expiry of the 90 day grace period, having had a number of opportunities to do so, I uphold this aspect of the complaint and direct that the Provider reinstate the Complainants' mortgage policy, waiving any outstanding arrears of premiums. The premium payments by the Complainants are to recommence only from the date of this Legally Binding Decision. The Complainants are to thereafter pay the premiums in the manner agreed with the Provider.

I also direct the payment of a compensatory payment of €1,000 (one thousand euro) to the Complainants for stress and inconvenience caused to them over the past number of years, when they did not have this mortgage protection cover in place.

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 (i) reinstate the Complainants' Mortgage Protection policy, waiving any outstanding arrears of premiums (the premium payments to recommence only from the date of this Legally Binding Decision) (ii) make a compensatory payment of €1,000 (one thousand euro) to the Complainants.

- The Provider is to make the compensatory payment to the Complainants in the sum of €1,000, to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants to the Provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

- The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.

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GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

30 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.