Decision Ref:	2020-0091
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Rejection of claim
Outcome:	Substantially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint relates to the benefit payable following a disability claim under a Group Scheme Income Protection policy, in particular the application of a 3% annual indexation increase on the benefit.

It is the Complainant's complaint that the Provider is incorrect when it states that the maximum benefit payable is 75% of his defined income. The Complainant considers that the 3% indexation of benefit should apply even where the 3% indexation brings the benefit payment beyond an amount which is in excess of 75% of his defined income.

The Complainant is a member of his employer's group scheme for Income Protection benefits. The Provider was the Underwriter for the period from 1998. The Complainant became a member of the scheme from August 2004. The date of his claim is February 2006. The Provider and the Complainant's employer are the contractual parties to the Income Protection Policy. The Complainant's employer is the policy owner.

In circumstances where the Complainant is an actual or potential beneficiary of the Income Protection Policy being contractually entitled to benefit from a long-term financial service, he falls within the definition of "complainant" as set out in the **Financial Services and Pensions Ombudsman Act 2017 (as amended**). Therefore, while not the policy owner, the Complainant can bring a complaint to this office in respect of his benefits under the policy.

The Provider advises that these group schemes are usually renewed every 3 years and new Terms and Conditions then become applicable for future claims. The version of Terms and Conditions that were in place prior to the date of claim notification is the 2003 version. It is therefore the 2003 group scheme Terms and Conditions that apply to this claim and dispute.

As the scheme owners are the Complainant's employers, the Provider states that communications are formally with the scheme owner and the scheme owner's appointed brokers in respect of this contract.

The deferred period under this group scheme is 26 weeks of a consecutive period of disability that must expire before a claim can be paid. The date of the Complainant's claim event was February 2006 and benefit payments commenced in August 2006.

The claim payment commenced from 17th August 2006. The Provider states that a Limitation of Benefit was incorrectly applied from August 2015. This resulted in the same benefit being paid but a 3% p.a. increase was not applied. This was corrected in a payment made in April 2017.

The claim is still in payment but subject to medical and financial review.

The complaint is that the Provider is not correctly administering the policy in relation to payment of benefit.

<u>The Complainant's Case</u>

The Complainant contends that Section 4 of the Policy (Limitation of Benefit Section) is an independent clause. The Complainant contends that in the alternative the "Limitation of Sum Insured" terms only apply "at the end of the Deferred Period" (26 weeks from February 2006). The Complainant's position is that the base weekly rate was set then and the 3% compound annual increase should apply thereafter and should not have ceased in August 2015. The Complainant states that while the Provider did re-adjust its figures and is applying the 3%, the Provider considers that the limitation will apply in the future and the 3% indexation will cease then. The Complainant considers that it should not cease, but continue for as long as he is in receipt of the policy benefit.

The Complainant returned to work in 2008 for a short period, but the Provider states that benefit continued. Benefit payments stopped between June 2011 and December 2012 as the Complainant was deemed medically fit to return to work following a claim review per the medical file submitted at that time. The Provider re-admitted the claim upon an appeal of its decision. The Provider back dated payments to the date it ceased paying benefits. The Complainant wants the Provider to recalculate his benefit based on his declared salary in 2008 of €31,000.

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The Provider's Case

The Provider states that there are two parts to this complaint, the first part relates to whether the policy condition for the Limitation of Benefit applies to this claim after the Deferred Period. The Provider states that this is still in dispute. The Provider says that the second part relates to the Provider's error in calculating the maximum benefit applying under this condition from August 2015. The Provider states that the claim benefit continued to be paid but no indexation increases applied from August 2015. The Provider submits that the second part of the complaint was corrected with back payments paid and the correct benefit has been paid since.

The Provider states that the matter in dispute here relates to Condition 4 - Limitation of Benefit under the group scheme. The Provider states that it does not agree with the Complainant's interpretation of this Condition and referred him back to the Scheme Owner for further clarification as it contends this would be the normal channel for such communications under this group scheme.

The Provider asserts that the Scheme Owner and its appointed broker are interested parties here as any retrospective change to such a condition would have an impact on the premiums charged. The Provider states that it is noted that neither the Scheme Owner nor the Scheme Broker have raised any issue in respect of this Condition. The Provider is firmly of the view that it has correctly applied this condition. It is the Provider's view that this Condition applies not just on the date of the end of the Deferred 26 week period as suggested but also applies for the duration of the claim when there is a change in a member's financial circumstances.

The relevant condition is under Section 3 of the group policy Terms & Conditions from 2003. In the box at the start of this section it states:

> *"There are, however financial limits on the maximum benefit payable and situations for which Members are not covered".*

Condition 4 Limitation of Benefit states:

> *"At the end of the deferred period the amount of the Disability Benefit in respect of any member under this policy will be the sum of the amounts calculated in A and B below. The maximum total benefit, unless otherwise agreed with [the Provider] will be limited as follows".*

Section A refers to the 'Income of the member' and is a general limit of 75% of the member's earned income less other detailed income and Section B is in respect of *'Ordinary Pension Contributions'* and has a general limit of 30% of Earned Income.

The Provider states that the Complainant is of the view that the section 4 Limitation only applies at the end of the deferred period and at no future date. The Provider says that this, in its view, is in direct contradiction to the actual policy wording and its intention. It also states in Section 4:

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> *"[The Provider] will repeat this calculation whenever there is a change in a member's financial circumstances. If so, it will update the member's Earned Income to reflect changes since the beginning of the Deferred Period in the Consumer Price Index and use revised figures for, A(1) (a), (b) and (c) as appropriate".*

It is the Provider's position that it has therefore correctly applied this Condition when there was a 'Change in a members' financial circumstances'. The Provider says that the 3% per annum benefit increase does not apply without reference to the Limitation of Benefit condition as suggested by the Complainant. The Provider's position is that the 75% overall maximum claim benefit under this group scheme is a fundamental basis for the group premium paid.

The Provider states that this Limitation Condition must also be read in the context of the whole Group Policy Terms & Conditions for this scheme. The Provider states that this claim is subject to medical & financial review for the duration of the claim. The Provider points out that if for example the Complainant was in receipt of other income whilst on claim the Provider reserves the right to adjust the benefit paid under this claim to the maximum 75% allowed under the group policy Terms & Conditions. The Provider submits that the basis of its income protection product is to provide protection, but the protection is only to a maximum of 75% of the defined income.

As regards the Error in Calculation the Provider advises that in August 2015 it limited the benefit payable under the claim and the 3% benefit increments per annum did not apply from this date. This it says was the initial disputed point.

The Provider states that in dealing with this complaint it discovered an error in the calculation of this Limitation. The Provider states that it apologised for this error, corrected and paid the underpayment amounting to €589.93 in April 2017. The Provider states that it calculated that it would take another 5 to 6 years for this Limitation of Benefit clause to apply assuming there is still a valid and medically supported claim upon any reviews. The Provider also offered an ex-gratia payment of €750 for the trouble and inconvenience caused.

The Provider states that in correspondence there is a suggested difference in what is contained in the policy Terms & Conditions and that what was communicated by the employer to its staff members in respect of the 3% p.a. increase in benefits. The Provider states that it has checked this matter and is satisfied that it has correctly applied the 3% annual increase in benefit and the Limitation of Benefit condition in accordance with the group policy Terms and Conditions. The Provider's position is that it is not responsible for third party communications and has suggested that the Complainant refers this matter to his employers. The Provider states that the communication from the employer is also clearly a 'general outline' of staff 'Pension, Life and Income Replacement Scheme' and 'cannot overrule the Trust Deed and Rules governing the Scheme' as set out in the Important Note at the end of the Staff information provided by the employer and included in the Complainant's submission.

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The Provider notes that the Complainant has stated three areas on the Complaint Form where he wants things put right. The Provider's response to them are as follows:

1. In relation to the 3% indexation increase, the Provider states that it has already adjusted the income for a 3% increase from August 2015 to March 2017. The current weekly benefit is €259.63 and is within the maximum benefit calculation of €311.88, so the 3% increase will continue to apply for the coming years. It is estimated that it will be another 5 to 6 years before the actual benefit will reach the maximum allowed.

2. In relation to the Complainant's request for *"such costs as considered appropriate"*, the Provider states that there are no costs here. The Provider says it made an error in the initial Limitation calculation and offered an Ex-gratia payment in the sum of €750 for the trouble and inconvenience caused. The Provider reiterates its sincere apology for this error to the Complainant. The Provider is of the view that if this Limitation calculation was done correctly in 2015 the Provider probably would not have this dispute now, but the issue may have arisen in 4 or 5 years' time.

3. In relation to the Complainant's request for certified policies for 2003 & 2006, the Provider states that the original policy documents are with the Scheme Owner. The Provider states that any member enquiries are usually directed to the Scheme Owner or Scheme Broker on its behalf. The Provider states that these Documents in particular the Policy Schedule contain confidential information to the scheme Owner. The Provider states that therefore usually it only provides a copy of the Terms & Conditions in dispute situations. The Provider refers to the employer's email dated 25th October 2016. The Provider says that the employer as scheme Owner does not want the Policy Schedule disclosed. The Provider states that it notes that the Complainant / his advisor have already received full copies of the 2003 and 2006 group scheme policy Terms and Conditions and the Provider enclosed 'Certified' copies as requested by this office.

The Provider asserts that this matter was initially brought to its attention by the Complainant's employers on 4th August 2016. There was an initial response on 9th August 2016 with a further response on 24th November 2016. The Provider states that its letter dated 30th March 2017 deals with all matters.

The Provider concludes that the Limitation of Benefit condition applies to all claims under this employer group scheme. That the Condition applies for the duration of any claim when there is a change in financial circumstances and not a one off calculation after the Deferred Period at the commencement of the claim benefit as it has been interpreted by the Complainant.

<u>Some further submissions from the Parties</u>

9 March 2019 – Complainant's Summary of issues

> ***"Summary.***

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1.Between August 2006 and December 2013 the insured was underpaid €21,223 representing an underpayment of €4,900 p.a.in benefits and non payment of 3% p.a. increment. Also in 2015 the 3% was wrongly stopped without notice. Additionally in 2011 his salary was not paid for c.12 months due to a medical misdiagnosis.

[The Provider] seeks to deflect blame to the employer and medical personnel for some of those but this is contested. It was in a position of power and should have been questioning and insisting on correct data. In the correspondence received there is nothing contrite in the replies. Also "Limitation of the Sum Insured" with supporting figures is a confusing mantra when clearly from para. 2 herein there is no limitation. Also the issues of basic salaries of €28,560 and €31,000 is not dealt with.

Issues.

*2. The basic €28,000 increases by 3% p.a. but the insurer states this 3% p.a is limited by policy terms to €32,012 p.a. plus CPI est.@€2,600. This could be reached by the years 2022/23 . This limiting formula is disputed. (**Under policy no. … it states under increasing sum Insured at Para. 4 "During any period of entitlement to Benefit the Sum Insured will increase at a rate of 3% p.a. compound**"). This is what "Limitation of Benefit" means in correspondence. My point is that the 3% p.a. should continue.*

*3. **What are the other issues here;***

a.. The actions (as outlined @1 above) by [the Provider] in relation to financial dealings with an insured who suffered .. injuries. He was never provided with any policy details directly by the insurer until issues were raised going back to 2006 and involved discovery under S. 4 of Freedom of Information legislation. Instead he was subjected to multiple medical examinations which questioned his infirmity even though, from early on, it was known that he suffered life changing injuries.

b. The "capping" of the 3% pa annual compounding (see above).

c. The basic salary of €28,000 p.a. was agreed in an e mail dated 19th November 2013 between [the Provider representative] and [the Employer's representative] (.. a wages clerk not a HR person and very busy). It is possible that the initial salary given to [the Complainant] in 2006 of €23,000 p.a. (subsequently increased as above) was obtained in the same non professional manner and for which [the Provider is] blaming [the Employer]. Besides it seems to me the salary in the November e-mail should have been €28,560. Absence from work due to illness should not invalidate the committed 2% increase.

d. [The Complainant] returned to work in 2008. His salary was certified at €31,000 pa. [The Provider was] advised of this increase. Unfortunately [the Complainant] had a relapse but [the Provider] instead of recalibrating the basic income from

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€28,000 (or €28,560) to €31,000 ignored this. The €31,000 p.a. salary was revealed through discovery. I have raised this in my e-mails but [the Provider] has chosen to ignore it.

e. The response in clause 17 in the discovery is wrong. An adverse inference can be inferred from this.

f. [The Complainant] was never advised that under the policy he was entitled to claim expenses.

The Complainant submits that it was never advised that he was eligible to have his expenses covered and suggested an attendance figure of €150 for every visit made at the insurers request.

20 March 2019 – The Provider's further submission:

"It is our opinion that the Limitation of Benefit clause has been correctly applied to this income protection claim and currently does not apply but may do so in the future. It has been acknowledged with apology that the calculation figures initially used were in error and, in our view, an appropriate redress was offered in previous correspondence. …

I'm of the opinion that the €150 expenses requested for attending a medical examination within less that 10k inside Dublin is a little excessive but will accede to this request".

Evidence

I will now set out some of the relevant Terms and Conditions from the Policy governing this dispute.

Group Income Protection Insurance Plan Schedule

"Income Protection Benefit: Salary Continuance Benefit:

66.67% of salary less once the social welfare benefit (currently €6490)

Deferred Period: No disability Benefit is payable during the first 26 weeks of disability.

Claim Payment Indexation: 3%"

Policy Provisions

"Section 1 – Contract and definitions

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Deferred Period
The first number of consecutive weeks of any period of disability as set out in the policy schedule(s) that must expire before a claim can be paid.
..

Period of Disability
A period throughout which a member is totally unable to carry out his Normal Occupation due to a recognised illness or accident and during which the Member is not involved in carrying out any other occupation for profit, reward or remuneration of any kind what so ever whether sedentary or otherwise and whether or not entirely different from his Normal Occupation.
…
Disability Benefit
The sum insured, subject to the limits where appropriate set out in Section 3, in respect of a Member as set out in the policy schedule(s).
..
Earned Income
In respect of a Member means gross earned income for the period of one year immediately prior to the commencement of the Period of Disability or such other period as [the Provider] may agree.
..
Section 3 – Benefits, exclusions, restrictions and limitations
The main purpose of the Policy is to provide Members with an income in the event of their becoming unable to carry out their Normal Occupation.

There are, however financial limits on the maximum benefit payable and situations for which Members are not covered. This section describes maximum benefits, standard exclusions, restrictions and limitations. ….

3. Benefit
The Benefit in respect of Members will be determined initially on the date of their inclusion in the Policy and may change with effect from subsequent Renewal Dates of the Policy or, if insured, from the date of any subsequent movement in Plan Salary.

4. Limitation of Benefit
At the end of the Deferred Period the amount of the Disability Benefit in respect of any Member under this Policy will be the sum of the amounts calculated in A and B below. The maximum total benefit, unless otherwise agreed with [the Provider], will be limited as follows:

A. Income to Member
The Benefit (Income to Member) as set out in the policy schedule(s) limited where necessary so that when aggregated with the annual rate of any amounts

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payable at that time under any other insurance against disability in respect of the Member the total does not exceed any of the following limits:

(i) 75% of the Member's Earned Income, less:

(a) The annual rate of any continuing salary, commission, pension or other income, and

(b) The Social Welfare Benefits at that time which will be taken as zero in the case of a Member who would not qualify for Social Welfare payments in Ireland or equivalent benefit in other member states of the European Union, and

(c) The weekly equivalent amount of any compensation for loss of earnings either by virtue of a Court Award or by way of settlement in respect of a claim for loss due to the Member's disablement such weekly equivalent amount shall be calculated by the Actuary of [the Provider]. ..

B. Ordinary Pension Contributions

…

[The Provider] will repeat this calculation whenever there is a change in a Member's financial circumstances. If so, it will update the Member's Earned Income to reflect changes since the beginning of the Deferred Period in the Consumer Price Index and use revised figures for A (i) (a), (b) and (c) as appropriate".

Section 4 – Making a claim and benefit payments

..

The payment of benefit is not guaranteed and will at all times be subject to regular review.

..

8. Increasing Benefit

During any period of entitlement to Benefit the Benefit may increase.

The rate of increase applicable is as set out in the policy schedule(s). The first increase will take place on the first anniversary of the expiry of the Deferred Period and subsequent increases will be made at yearly intervals thereafter for so long as payment of Benefit continues. When payment of Benefit ceases the Benefit will revert to the level determined by Section 3.3 as at the commencement of the Period of Disability".

..

Section 5 – General Conditions

..

3. [The Provider's] right to change Policy Conditions

"[The Provider] will have the right to vary these Policy Conditions on the Premium Review Date or on any subsequent Premium Review Date provided that written notice has been given by [the Provider] to the Employer at least two months prior to the Premium Review Date. Any such alteration in these Policy

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Conditions will apply only to new Benefits for new Members and to increases in Benefits for existing Members which take effect on or after the Premium Review Date".

The Complaint for Adjudication

The complaint is that the Provider is not correctly administering the policy in relation to payment of benefit.

It is the Complainant's complaint that the Provider is incorrect when it states that the maximum benefit payable is 75% of his defined income. The Complainant considers that the 3% indexation of benefit should apply even where the 3% indexation brings the benefit payment beyond an amount which is in excess of 75% of his defined income.

Decision

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

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

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

A Preliminary Decision was issued to the parties on 15 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.

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Post Preliminary Decision submissions

The Provider made a post Preliminary Decision submission dated **4 February 2020**. In this submission the Provider states that as regards the Complainant's return to work in 2008, the return to work was on a trial basis without remuneration. The Provider states that it correctly used the 2005 P60 salary for the benefit calculation. As regards the cessation of benefit in June 2011, the Provider states that following an appeal of its decision to stop payments, the benefit was reinstated in November 2012 with payment backdated to June 2011. The Provider concludes that in circumstances where the Complainant's principal complaint was not upheld by this office and where there is no requirement to recalculate the benefit payable to the Complainant, bearing in mind the corrections made to date, it is submitted that a "substantially upheld" finding is not warranted.

The Complainant made a post Preliminary Decision submission on **9 February 2020**. In his submission the Complainant refers again to the 3% indexation issue. The Complainant states the summary of the scheme was supplied by the Broker which included the indexation. The Complainant considers that the Provider should produce a signed and dated copy of the 2003 Policy.

As regards the Complainant's return to work in 2008, the Complainant states:

> *"The facts are that the insured did return to work part time in December 2007. This went well and on 9th May 2008 it was confirmed to [Employer] that [the Complainant] could work "a full 5 day week". On or about 12th May 2008 the complainant's salary was agreed @ €31,000 plus a bonus of €10,587 and confirmed to the Insurer. Unfortunately within 24 hours of starting work the Insured had a [relapse in his health]".*

The Complainant highlights the efforts and challenges involved in having the payment restored.

As regards the operation of the policy, the Complainant states that the Provider did not provide information, for example no information was supplied in relation to expenses that could be claimed when attending the Provider's doctors.

The Complainant does not consider that the Preliminary Decision should alter ("weaken") but that it should be greater upheld to take account of the Complainant's entitlement to a bonus in May 2008. The Complainant submitted evidence that shows that the Complainant's employer did communicate to the Provider the salary details of €31,000.

The Provider responded to the Complainant's submission of 9 February 2020 by way of letter dated **21 February 2020**. In this submission the Provider states that there is no basis for the Complainant's assertion that the policy terms are being adapted / inserted to suit the Provider's positon. As regards the return to work in 2008, the Provider states that there is no evidence, nor is it submitted by the Complainant, that he received the salary or bonus. The Provider maintains that the applicable payment calculation relates back to February 2006, that is the end of the deferred period. The Provider does not consider that

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an increase should occur on a notional salary. As regards any consideration of bonuses, the Provider states that bonuses are only taken into account in the calculation of the Limitation of Benefit.

The Provider maintain the position that the return to work in 2008 and the cessation of benefit in 2011 have no bearing on the calculation of benefit. The Provider states that as the primary complaint has not been upheld, consideration should be given to whether it is appropriate to make a “substantially upheld” finding.

The Complainant’s response of **24 February 2020** to the Provider’s submission of 21 February 2020. In this submission the Complainant notes the absence of certification of the original policy.

The Complainant states that there was a return to full time work in May 2008. The trial period had ended earlier. The Complainant states that the salary was not notional, but actual as certified by the Complainant’s employer. The Complainant submits that the €10,000 bonus should be included, limited as necessary because the insured could not earn it due to illness.

The Provider made a submission on **5 March 2020** in response to the Complainant’s submission. The Provider’s position is that there is no dispute as to the applicable Terms and Conditions of the Policy and this did not form part of the preliminary decision. The Provider accepts that the Complainant returned to work in May 2008 but unfortunately within 24 hours of his return he suffered a relapse in health. The Provider states that there is no evidence, nor is it submitted that the Complainant received a salary or bonus in respect of his return to work. The Provider states that if a member suffers a relapse within 6 months of a return to work, the benefit recommences on the same basis and salary upon which it was initially calculated at the outset of the claim.

The Provider states that the reference to a consideration of a bonus only related to the calculation of the limitation of benefit rather than the calculation of benefit at the end of the deferred period. The Provider accordingly states that in line with the policy there is no basis for using the declared salary of €31,000 (and bonus) in 2008 for the purpose of calculating the benefit where the benefit was calculated in 2006 in accordance with the policy and was paid without interruption until June 2011.

The Complainant’s last submission of **6 March 2020** was that he was not in agreement with the Provider.

These submissions were exchanged between the parties and an opportunity was made available to both parties for any additional observations arising from the said additional submissions. I have taken into account the content of those submissions and all the submissions and evidence in arriving at my final determination, as set out below.

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Analysis

I accept that the date of the Complainant's claim is from February 2006, so the September 2003 group policy Terms and Conditions apply.

I accept that the 3% per annum indexation increase only applies with reference to the Limitation of Benefit condition. I also accept that the 75% overall maximum claim benefit under these group schemes is a fundamental basis for the group premium being paid.

It is correct to say that the Limitation Condition must be read in the context of the whole Group Policy Terms & Conditions for this scheme. Income protection claims are subject to medical & financial review for the duration of the claim. I accept that whilst benefit is being paid the Provider has the right to adjust the benefit being paid to the maximum 75% allowed under the group policy Terms & Conditions. The Provider is correct when it states that the protection is only to a maximum of 75% of the defined income. Any increases to the member's Income, as a result of indexation, must stay within the maximum limits allowed. This 75% limit is clearly set out in the Terms and Conditions of the policy governing the Scheme and is also the general and accepted way that these policies operate. Therefore, I do not propose to uphold this aspect of the complaint.

As regards whether the income benefit payable to the Complainant has been correctly paid by the Provider, the policy provisions make it clear that the Provider will repeat the initial calculation of benefit *"whenever there is a change in a Member's financial circumstances. If so, it will update the Member's Earned Income to reflect changes since the beginning of the Deferred Period in the Consumer Price Index and use revised figures for [continuing salary, social welfare benefit and any other payments]".*

In the Provider's post Preliminary Decision submission the Provider states that if a member suffers a relapse within 6 months of a return to work, the benefit recommences on the same basis and salary upon which it was initially calculated at the outset of the claim.

The relevant policy provisions in relation to a "linked Claim" states:

> *"If a Member suffers a relapse caused by the same injury or illness and which starts within six calendar months of the end of a period during which the Member was receiving Disability Benefit or a Proportionate Benefit, Benefit may recommence without the imposition of a further Deferred Period if, in the opinion [of the Provider], having regard to all the information available to it, the Member is suffering a Period of Disability".*

It must be noted that the Policy Terms and Conditions do not, as the Provider submits, state that the benefit would recommence on the same basis. However, what the Policy does state in relation the recalculation of benefit is that:

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> *"[The Provider] will repeat this calculation whenever there is a change in a Member's financial circumstances. If so, it will update the Member's Earned Income to reflect changes since the beginning of the Deferred Period…".*

The evidence shows that the Complainant's financial circumstances would have possibly been altered on two occasions during the time that benefit was being paid, that is, in 2008 when the Complainant returned to employment and 2011 when the Provider ceased payment of benefit. I accept that when the Provider becomes aware of such changes it should seek salary verification from the Employer. The post Preliminary Decision submission show that there is still disagreement between the parties on the level of benefit that should be paid. Therefore, I am substantially upholding the Complainant's complaint in respect of the figures being used by the Provider when calculating his benefit from 2008. In that regard I direct that the Provider now seek verified figures from the Complainant's employer for the time that he returned to work during the period 2008. It is noted that the employer had confirmed for the Provider a salary of €31,000 in 2008 and I consider that this should now be further clarified by way of payment details for the relevant year. The Provider should then make the appropriate adjustments to the Complainant's income benefit (if any).

As regards the communication issues that arose, I accept that the brochure provided to the Complainant by the Broker to the scheme or by his employer was provided to give an overview of the workings of the Income Protection Policy. It merely provides a basic summary of the Income Protection Policy and is not a legally binding document. The contract that was agreed between the Provider and the Complainant's employer is the legally binding contract. That said, I consider that the Provider cannot distance itself from the documentation prepared by the Broker to the scheme or any prepared by the employer, which is intended to explain the workings of the scheme. The Provider should reasonably ensure that the documentation being prepared for members of the Scheme which it administers are in line with what the scheme policy contains.

Of particular note here, I would have expected to see some explanation of the indexation and how it operates. In particular I consider that it should have been clearly set out that any increases to income benefit, as a result of indexation, must stay within the maximum limits allowed. I would also have expected to see some explanation of why there was a 75% limitation of benefit.

I accept that at the time the Complainant was considered to have reached the maximum benefit allowable in 2015 (although this was reviewed and corrected by the Provider), he should have been automatically advised of this position. The Complainant had to bring this to the Provider's attention before he was advised of the positon. It was not until 2017 that the Provider corrected the identified indexation error on the Complainant's benefit.

While I accept that the contractual parties are the Employer and the Provider, where a claim arises and benefit becomes payable to an employee, that employee should be given access to as much information to assist with their understanding of what they are entitled to under the scheme. That information ideally should include the policy documentation. While the Provider is correct that such information and advices should come from the

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Broker to the Scheme, the Provider should also ensure that the fullest information is made available to the member.

Having regard to all of the above it is my Legally Binding Decision that the complaint is substantially upheld and I direct that: (i) the Provider financially reassess the Complainant's claim for benefit having regard to any changes occurring when the Complainant returned to work in 2008 and when benefit ceased for a time in 2011 (ii) for the identified communication issues noted above, the Provider is to pay the Complainant the compensatory payment of €2,500 (two thousand five hundred euro), this payment includes the €750 already offered by the Provider.

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is substantially 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 rectify the conduct complained of by financially re-assessing the Complainant's benefit and pay the Complainant the compensatory payments of €2,500 to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the Provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

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

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

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GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

10 March 2020

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Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that—

(a) ensures that—

(i) a complainant shall not be identified by name, address or otherwise,

(ii) a provider shall not be identified by name or address,

and

ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.