An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0093
Sector:	Insurance
Product / Service:	Payment Protection
Conduct(s) complained of:	Rejection of claim - late notification
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant, now a retired civil servant, was a member of a voluntary Group Income Continuance Plan via his Trade Union, the policyholder. The Provider, in its capacity as the policyholder's financial services broker, is the Scheme Administrator.

The Complainant's Case

The Complainant, having been medically certified as unfit for work due to *"work-related stress"*, was placed on reduced pay on **4 July 2001** and later took early retirement due to ill-health on **29 November 2002** as *"I was severely mentally and physically ill"*. He later suffered a severe stroke in **2009**.

The Complainant states that in **2011,** a former colleague reminded him of the Group Income Continuance Plan that he had contributed into from 1983 to 2001, which prompted him in 2012 to contact the firm that had been the Insurer of this Scheme at the time of his potential claim in 2001, to ascertain whether he was now entitled to make an income continuance claim. The Insurer, which had ceased underwriting the Scheme in August 2009, advised the Complainant that it was not in a position to consider a claim due to the time limits involved and as he was no longer a Scheme member.

Following contact from the Insurer on this matter, the Provider wrote to the Complainant on 31 July 2012. It noted that the Complainant was seeking a copy of the policy document that had applied in 2001 when his membership of the Scheme had ceased but it advised that as it had not become the Scheme Administrator until 2006, it did not hold a copy of this particular policy document and instead it enclosed the policy document applicable from April 2004.

Similarly, the Provider also advised that it was unable to furnish him with a record of the premiums he had paid into the Scheme as it had not received any payments from him as he had left the Scheme in 2001, five years prior to it becoming Scheme Administrator in 2006.

The Complainant later wrote to the Provider on 18 March 2013, requesting the following:

> *"(A) That you furnish me with a copy of the policy applicable when I retired.*
>
> *(B) That you furnish me with a copy of my contribution record.*
>
> *(C) …whether* [the Provider] *will assist me…by first of all sending me a claim form and secondly pursuing any such claim vigorously"*.

The Provider advised the Complainant by letter dated 24 May 2013 that it was attempting to locate the policy document that had applied in 2001, as well as ledger records of his contributions into the Scheme and in that regard, it would *"keep* [him] *updated"*. In addition, the Provider also noted that the Insurer had already separately confirmed to the Complainant that *"due to extreme late notification they cannot consider a claim"* but that in order for the Provider to understand his case, it asked the Complainant to explain why he had not pursued an income continuance claim through the former Scheme Administrator in and around 2001.

The Complainant was not satisfied that the Provider's letter of 24 May 2013 adequately addressed his queries and as is had failed to keep him updated thereafter, as it had advised, he wrote to the Provider on 27 August 2013, making a data access request. The Provider responded to the Complainant on 7 October 2013 regarding *"your request for a copy of all data held by* [the Provider] *relating to you*. *Please find all documentation we hold enclosed"*.

Some 2½ years later, by way of correspondence dated 2 June 2017, the Complainant submitted a complaint to the Provider, as follows:

> *"I am making a formal complaint to be handled expeditiously and exhaustively by your internal complaints procedure in relation to the matters outlined below …*
>
> *My correspondence with* [the Provider] *began in July 2012 …*
>
> *In particular your officers failed to;*
>
> 1. *Inform me that I was in fact a contributing member of the Plan in 2001 when I suffered a severe meltdown and had to retire early on grounds of disablement. I only discovered this as a result of data disclosed under the Data Protection Act 1988 and later from data produced by my former Employers …*
>
> 2. *Keep a record of my contributions to the said Income Continuance Plan.*
>
> 3. *Update me as promised in your* [correspondence] *of 24/5/2013.*

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4. *Deal with the matters raised in the first and final paragraph of* [my correspondence] *of 27/8/2013.*

5. *Failed to produce a copy of the Income Continuance Plan that applied to my situation in July 2001 when I went off half pay due to disability, which failure has resulted in the denial of benefits due to me under the Plan*

6. *Obtain and process a Claim Form to progress my valid Claim.*

7. *Failed to produce any explanatory booklets pertaining to the Plan which would protect my position …*

In short, [the Provider] *failed me in pursing the benefits due to me and I have suffered severe financial loss as a result"*.

Having investigated his complaint, the Provider sent the Complainant its Final Response Letter dated 16 August 2017, wherein it acknowledged that it had overlooked and failed to answer a number of the queries he had raised in 2013 and *"as a tangible measure of apology for our shortfalls"*, it enclosed a cheque in the amount of €300. The Complainant was not satisfied with the Provider's Final Response but *"accepted the €300 totally without prejudice and feel that it would in no* [way] *recompense me for the number of hours and distress caused me by* [the Provider's] *negligence"*, and he made a complaint to the then Financial Services Ombudsman (hereafter, 'this Office') in November 2017.

The Complainant notes that as part of this complaints process, the Provider then furnished this Office with information it held in relation to his case that it had not previously provided to him when it responded to his data access request in 2013, noting in his letter to this Office dated 28 September 2018 that the Provider

> *"failed to disclose to me at least three audio tapes vital to my case after I made a data access request on 27/08/2013 and only disclosed them after a request by the Ombudsman on 16/08/2018, 5 years after they ought have produced them to me"*.

This Office does not investigate complaints relating to data access, but the Complainant may raise any concerns he has in this regard with the Data Protection Commission.

In particular, the Complainant refers to a recording of a telephone call that the Insurer made to the Provider on 17 May 2012, as follows:

> *"Tape 1 of the series of audio tapes includes a conversation between two ladies, one from* [the Provider, Ms E.] *and the other from* [the Insurer] *in which they mock my application, laugh at me and agree on "gut instinct" to deny my legitimate claims and confirm my view that they conspired to "nip me in the bud" and demonstrate that they will speak uno voce on the matter.*

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> *Instead of acting in good faith with me, knowing full well that each owed me distinct and separate contractual rights, they acted conjointly to deny my rights. I don't know what codes of ethics govern these institutions, if any, but my "gut feeling" is that they have driven a coach and fours over them …*
> *I am hugely insulted and hurt at the manner in which I was derided, insulted and laughed at* [during this telephone call]*"*.

In addition, in later correspondence to this Office dated 21 November 2018, the Complainant considers that the recording of this telephone call shows that the Provider

> *"plotted cheek by jowl* [with the Insurer] *to frustrate my legitimate claim and deny me what is legally mine"*.

In his correspondence dated 28 September 2018, the Complainant notes, *inter alia*, as follows:

> *"There is nothing complex about the matter in hand. From 1983 at the latest until July 2001 I contributed to an Income Continuance Plan. Because of ill health I was placed on less than full pay in July 2001 and the Income Continuance Plan I had…ought to have kicked in but didn't.*
>
> … [the Provider did not keep]...
>
> A. *An updated copy of the terms and conditions applicable to the Plan as at July 2001, the relevant date in my case.*
>
> B. *Particulars of my premium payment record.*
>
> *I have had to gather and supply evidence of my cover and supply evidence of my contributions because of the absolute failure of* [the Provider] *to keep it and produce it to me*
>
> *I am astounded that* [the Provider] *have been so deficient in their record keeping"*.

In addition, in correspondence to this Office dated 21 November 2018, the Complainant submits, *inter alia*, as follows:

> *"Premiums were deducted from my salary with* [my former employer] *from 1983 until June 2001 to insure myself against disability, which would kick in when sick pay with my employer was reduced to less than full pay.*
>
> *This happened in June 2001 when I went on half pay, having been continuously out on sick leave from 17/3/2001.*
>
> *From 22nd September 2001 my sick pay was reduced further to pension rate pay and this persisted until I was eventually retired in November 2002 on grounds of disability.*

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> [My former employer] *ceased to deduct my premiums in June 2001 …*
>
> *Of course had I been well enough to make a claim at the time I would have been in receipt of benefit since then and deduction of the premiums after that date would not have been an issue then nor should they be now"*.

In this regard, the Complainant sets out his complaint, as follows:

> *"I feel that* [the Provider] *failed me on a number of fronts, namely; -*
>
> *A. I feel that* [the Provider] *were more apologists for* [the Insurer] *than facilitators in processing my claim, which appears to be their primary function …*
>
> *B. I feel that* [the Provider] *utterly failed to keep me appraised of changes in the terms of the Scheme in the viduity of my membership of the Scheme.*
>
> *C. I feel that* [the Provider] *ought to have alerted me to the possible making of a claim under the Scheme when they ought to have noticed that my contributions ceased well before retirement age.*
>
> *D. I feel that* [the Provider] *ought to have kept copies of policy changes to the Scheme and copy of Explanatory Booklets from 1994 to 2000, particularly as a change in the terms of making a claim was introduced in 1994, which in my view made the making of claims possible even up to the present.*
>
> [The Provider's] *failure in these tasks adversely affected my ability to make a successful claim thus far"*.

In addition, in his letter to this Office dated 22 May 2018, the Complainant submits, *inter alia*, as follows:

> *"I have also been badly served by* [the Provider] *in that they ought to have presented my claim to* [the Insurer]*, irrespective of what* [the Insurer] *said in that regard and that they are equally negligent in their failure to publish, prepare and notify to me such changes to the Master Policy as were implemented over the years"*.

The Complainant seeks for the Provider to present, on his behalf, his income continuance claim to the Insurer for its assessment, so that he can claim the benefit of the Group Income Continuance Plan from 4 July 2001, when he was first placed on reduced pay due to illness absence, until 16 August 2016, his 65th birthday.

The Complainant's complaint is that the Provider wrongly or unfairly failed to present, on his behalf, his income continuance claim to the Insurer for its assessment, and that the Provider failed to retain records of his membership of the Scheme and copies of the policy documents that applied throughout his membership.

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The Provider's Case

The Provider understands that the Complainant, now a retired [profession], was a member of a voluntary Group Income Continuance Plan via his Trade Union, the policyholder, until 2001. The Provider, in its capacity as the policyholder's financial services broker, is the Scheme Administrator.
The Scheme commenced on 1 July 1980 and aims to pay a member who satisfies the policy definition of disablement an income of up to 75% of his or her salary, less any other income that he or she may be in receipt of, such as half pay, temporary rehabilitation remuneration or early retirement pension, or any State Illness Benefit to which the member may be entitled to.

The Provider notes that the Complainant was placed on reduced pay due to illness absence on 4 July 2001 and that he later took early retirement due to ill-health on 29 November 2002. The Complainant did not, however, contact the firm that had been the Insurer of this Scheme at the time his potential claim arose in 2001, until some 11 years later, in 2012 to ascertain whether he was entitled to make an income continuance claim. Having been advised by the Insurer that it was not in a position to consider a claim due to the time limits involved and as he was no longer a Scheme member, the Complainant then directly raised the matter with the Provider as a Scheme Administrator, in March 2013.

In this regard, the Provider notes that a different firm, [Z.Z.Z.], became Scheme Administrator in 1986 and that the Provider itself only became Scheme Administrator in 2006, when it acquired this firm. As a result, at the time the Complainant's premium payments to the Scheme ceased in 2001, and when he retired on ill-health grounds in 2002, the Provider was not the Scheme Administrator.

The Complainant's former employer was able to confirm to the Provider that premium payments had been made on behalf of the Complainant from 1997, which is as far back as its records go, until 2001. As the requirements in terms of record keeping were not as robust as they are now, the Provider is unable to source any proposal form, acceptance letter or other further evidence relating to the commencement of the Complainant's membership of the Scheme but it accepts that it is likely that his membership and premium payments began before 1997.

The Provider collects and reconciles premiums and maintains the membership database for a number of different group income continuance schemes and is therefore the primary source of confirmation to an insurer as to whether an individual is a member, prior to it considering a claim. Ordinarily, when a member of a scheme contacts the Provider to advise that they are absent on sick leave, it will issue the member a claim form without referral to the insurer. Most, if not all such schemes carry some form of late notification clause, and for this reason, where there is late notification, the Provider must refer to the relevant insurer before issuing a claim form to a member. The Provider has had experience of dealing with late notification claims in the past, though it is not aware of any case being considered or proposed to be considered, so long after the fact, in excess of 10 years, as was the case here.

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In June 2017, the Complainant submitted to the Provider along with his complaint a number of letters from his GP and occupational health reports, all dating from 2001 and 2002. Whilst the Provider is not involved in or a party to the medical assessment of income continuance claims, its experience has been that depending on the circumstances, the insurer may agree to consider a late notification claim where there is clear undisputable medical evidence that the member was disabled from working during the period being claimed for, for example, a broken leg.

Conversely, in other circumstances where the medical condition is more subjective in nature, such as a mental health condition, the insurer may be unable to retrospectively assess whether the member was disabled from working during the period, and therefore it will refuse to consider a late notification claim. In this instance, the Insurer advised in 2012 that it would not be in a position to consider the Complainant's income continuance claim due to the passage of time. It further set out in 2017 that there was insufficient evidence available to enable it to medically assess the claim, in particular it noted that there was no evidence of referrals to specialists or treatments in 2001 and 2002. With this in mind, the Provider did not gather a completed income continuance claim form from the Complainant, as to do so would have suggested that the Insurer would consider his claim, thus creating an unrealistic expectation for him.

In relation to General Principles 2.1, 2.2, 2.6 and 2.8 of the Consumer Protection Code 2012, the Provider notes that from the beginning of its dealings with the Complainant in 2012, it understood that his requirement was to claim from the Scheme retrospectively, having retired on ill-health grounds some 10 years previously. Given the passage of time involved, the fact that the Scheme the Complainant was a member of, was one which the Provider had only acquired in 2006 after his membership had ceased in 2001, and as that the Insurer had in 2012 confirmed that it was not in a position to consider his claim, this was a particularly complex case to deal with and it was challenging for the Provider to gather the relevant information.

Initially in its dealings with this matter in 2012, prior to receiving any submissions from him directly, the Provider informed the Insurer that the Complainant was not at that time a current member of the Scheme as it could confirm that no premiums had been received from him since at least 2006, when it had acquired the Scheme through [Z.Z.Z.], and it wrote to the Complainant on 31 July 2012 relaying the Insurer's position that it was would not consider his claim due to the timeframes involved. Information pertaining to his previous membership was not available to the Provider at that time, though it confirmed in this letter to the Complainant that his membership of the Scheme had ceased in 2001.

The Complainant first wrote to the Provider on 18 March 2013 setting out specifically his requirements and the Provider undertook efforts to gather the information requested from various sources, including the Complainant's former employer, the policyholder and the former Insurer, and from the files of the previous Scheme Administrator. In this regard, the Provider wrote to the Complainant on 24 May 2013 to advise that it was attempting to locate the policy document that had applied in 2001, as well as ledger records of his contributions into the Scheme and in that regard, it would *"keep* [him] *updated"*.

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In addition, in response to his request for a claim form, the Provider noted that the Insurer had already separately confirmed to the Complainant that *"due to extreme late notification they cannot consider a claim"* but that in order for the Provider to understand his case, it asked the Complainant to explain why he had not pursued an income continuance claim through [Z.Z.Z.], the former Scheme Administrator, in and around 2001.

Subsequently, the Complainant wrote to the Provider on 27 August 2013 with a data access request and at the start of this letter stated,

> *"For the record the reason I did not make a claim through* [Z.Z.Z.] *at the time I retired was because I was in no fit condition to do so"*.

Regrettably, it appears that the Provider overlooked this statement at the time, a fact that it later addressed when dealing with the Complainant's complaint in 2017 and sought to rectify by determining whether this information, had it been made available to the Insurer in August 2013, would have changed its stance.

In relation to General Requirement 3.1 of the Consumer Protection Code 2012, the Provider confirms that it was its Salary Protection Claims Team that dealt with the Complainant's case. This team is experienced and adept at dealing with income continuance claimants, bereaved family members and other vulnerable individuals. Given the Complainant's circumstances and the complexities of the situation, a senior member of this team was appointed to handle his case in 2013 and her direct contact number was provided to the Complainant at that time.

In relation to General Requirement 3.3 of the Consumer Protection Code 2012, the Provider notes that the requirements for firms in terms of record keeping at the time when the Complainant's membership of the Scheme ceased in 2001, was not of the same standard as it is today. With this in mind, the Provider notes that there was very little information readily available to it in relation to the Complainant and his membership of the Scheme when it was dealing with his case in 2013, and therefore it took a number of weeks for it to respond to his queries. In addition, when he submitted his complaint to the Provider in June 2017, it was accompanied by a significant volume of supplementary information, which took the Provider a number of weeks to work through before it was in a position to respond on 16 August 2017.

In relation to Provision 7.6 of the Consumer Protection Code 2012, the Provider confirmed to the Insurer that the Complainant was not a current member of the Scheme, when the query was first raised in 2012, and the Insurer subsequently confirmed that it was not in a position to consider his claim. The Provider notes that had the claim been submitted, it would not have been for the Provider to verify its validity in terms of whether the policy definition of disablement has been satisfied.

In relation to Provisions 10.7, 10. 9, 10.10 and 10.11 of the Consumer Protection Code 2012, the Provider can confirm that when it received the Complainant's complaint dated 2 June 2017, these stipulations were complied with.

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In relation to the Complainant's assertion that the Provider *"were more apologists for* [the Insurer] *than facilitators in processing my claim, which appears to be their primary function"*, the Provider notes that as Scheme Administrator it does facilitate claim processing once it has been determined that the member is eligible to make a claim. In this instance, the Insurer had confirmed in 2012 that the Complainant was not eligible to make a claim. Essentially, the Insurer position was that due to late notification of the claim, coupled with the fact that it was unable to perform a retrospective medical assessment using the evidence supplied, that there was no claim to answer under the Group Income Continuance Plan terms and conditions; therefore the Provider was not in a position to facilitate the processing of the Complainant's claim.

In relation to the Complainant's assertions that the Provider *"utterly failed to keep me appraised of changes in the terms of the Scheme in the viduity of my membership of the Scheme"* and that it is *"negligent in their failure to publish, prepare and notify to me such changes to the Master Policy as were implemented over the years"*, the Provider notes that during his membership, the practice for informing members in relation to the Scheme was via the policyholder, the Trade Union that the Complainant was a member of, with its members' newsletter in particular being the means for such updates.

In relation to the Complainant's assertion that it *"ought to have kept copies of policy changes to the Scheme and copy of Explanatory Booklets from 1994 to 2000"*, the Provider notes that it was not the Scheme Administrator during this period. In this regard, [Z.Z.Z.] became the Scheme Administrator in 1986 and the Provider itself did not become Scheme Administrator until 2006, when it acquired this firm. The Provider confirms that as part of its search it did search the files of the previous Scheme Administrator, however it was unable to locate the documents requested by the Complainant.

In relation to the Complainant's assertion that the Provider *"ought to have alerted me to the possible making of a claim under the Scheme when they ought to have noticed that my contributions ceased well before retirement age"*, it is the Provider's experience that in general, a member of a voluntary group income continuance scheme will instigate claim proceedings when facing into a period of long term sick leave or when their income is affected by sick leave, either by their own propensity to do so, or following a prompt from their employer or trade union. When his premium payments ceased in 2001, the Provider understands that [Z.Z.Z.], the then Scheme Administrator, did not reconcile batch premiums received from employers down to individual contributions, therefore it is unlikely that any communication would have issued to the Complainant at that time from [Z.Z.Z.]. Currently, the Provider does reconcile premiums down to individual contributions, and where it identifies that a premium is missing, it writes to the member alerting them to this fact. This process can prompt members to make a claim.

In relation to the Complainant's assertion that the Provider *"ought to have presented my claim to* [the Insurer]*, irrespective of what* [the Insurer] *said in that regard"*, the Provider received correspondence from the Complainant dated 27 August 2013 with a data access request and at the outset of this letter he stated, *"For the record the reason I did not make a claim through* [GMG] *at the time I retired was because I was in no fit condition to do so"*.

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On receipt of this letter, whilst it processed the data access request, the Provider did not approach the Insurer with the Complainant's explanation as to why he had not submitted a claim when he retired. The Provider should have done so, and it was an oversight that it did not. Had it done so, this would have allowed the Insurer to consider in 2013, whether the Complainant's explanation for the late notification of his claim would change its stance.

The Provider sent the Complainant a Final Response Letter dated 16 August 2017, wherein it apologised for its failure to transmit his explanation to the Insurer in 2013. Before doing so, the Provider gave that explanation to the Operations Manager of the Insurer's Claims Department, asking him whether if it had been provided this information in 2013, the Insurer would have changed its stance, to which he confirmed it would not. In this regard, the Operations Manager advised that the medical evidence supplied by the Complainant (a number of letters from his GP and occupational health reports from 2001 and 2002, as opposed to specialist referrals or treatment information) was insufficient to enable the Insurer to determine that a valid claim existed in 2001. As a result, the Provider is satisfied that its failure in 2013 to present the Complainant's explanation for late claim notification to the Insurer did not prevent the claim from progressing.

When instances arise whereby a member is being refused a claim on grounds, either from an eligibility or medical evidence perspective, which it believes merits challenging, the Provider will advocate strongly on the member's behalf to the Insurer, and the Provider has a long track record of obtaining successful outcomes through its interventions. The Complainant included GP and occupational health reports from 2001 and 2002 with his complaint letter to the Provider in June 2017. Though it is not involved in the medical assessment of claims, it was apparent to the Provider upon reading through these reports that the condition the Complainant was suffering with at that time was work-related stress. In this regard, the Provider knows from experience, how difficult it is to prove retrospectively that an individual met the policy definition of disablement when it is significantly after the fact; more so with a condition such as work-related stress. In such cases, there would be a need for strong contemporaneous medical evidence to enable the Insurer to separate a workplace or employment matter from an individual's medical disablement from working, and thus determine whether a valid claim exists.

With this in mind, and the fact that the Insurer had confirmed that it could not consider a claim for the Complainant based on the medical evidence supplied, the Provider did not believe it had a strong case to make to the Insurer to compel it to consider his request to claim, any more than it had already done. Additionally, it did not want to set an unrealistic expectation for the Complainant when the Insurer had clearly confirmed that it was not possible for it to consider the claim.

During its investigation into his complaint in 2017, the Provider identified that oversights on its behalf occurred during its dealings with the Complainant in 2013, in particular, it did not pass on to him information it had received from his former employer, pertaining to his premium contributions to the Scheme, it did not provide him with updates as promised in its letter dated 24 May 2013, and it did not approach the Insurer with his explanation provided in his letter dated 27 August 2013 as to why he had not submitted a claim in and around 2001.

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Having completed its investigation in 2017, it was apparent to the Provider that whilst these oversights meant that the service it provided to the Complainant fell short of the standard it would expect from itself, they did not have any material effect on his core issue, which was to have his income continuance claim assessed and paid by the Insurer and the Provider does not believe that the Insurer would have considered and paid the Complainant's claim, had it not been for these oversights.

Nevertheless, the Provider accepted in 2017 that its oversights would have certainly caused inconvenience and frustration to the Complainant, and in recognition of this it awarded him the sum of €300 (€100 for each oversight) in August 2017, which it considered commensurate and which he accepted payment of.

The Provider notes that telephone calls took place between the Insurer and the Provider in May 2012. These call recordings were not accessed or considered by the Provider when it issued its Final Response Letter to the Complainant in August 2017, nor were they provided to him in October 2013 in response to his data access request in August 2013. In this regard, the Provider submits that is it not practical for it to search the content of all call recordings between the Provider and an Insurer when handling individual data access requests. It does, however, search for those calls where there is a note on the file detailing the time and date of the call. In this case, as the Complainant had not yet made contact with the Provider at the time of these calls in May 2012, there was no file for it to note the calls on.

The Provider notes that these telephone calls only became evident in the course of preparing a timeline for its submission to this Office, when it became apparent that the Insurer's letter to the Complainant dated 25 May 2012 referenced a previous contact it had with the Provider that was not noted on file. This enabled the Provider to identify a limited timeframe during which these calls could have transpired, meaning its search criteria could be reasonably narrowed, allowing the recordings to be retrieved from its archives. The Provider has since had an opportunity to consider the contents of these calls in the context of the Complainant's complaint and this dispute.

As the membership administrator for such voluntary group schemes, the Provider was and still is the primary point of reference for insurers as to an individual's eligibility in terms of membership at point of claim, which would have been the motivation for the Insurer to telephone the Provider on 17 May 2012.

The Provider notes that the circumstances presented by the Complainant in 2012 were, for both the Provider and the Insurer, unprecedented, and in the absence of any protocol for such a case, a conversation based largely on opinion ensued on 17 May 2012 between the Provider Representative and the Insurer as to the possibility of the claim proposed being considered at such a late stage. Both felt that it was not a reasonable prospect, given the timelines involved. The Provider notes that this was by no means a typical exchange, rather it reflected the highly unusual nature of the claim being proposed.

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Whilst it appears from the recording of this call that the initial attitude of the Provider Representative to the Complainant's request to make a claim was dismissive, the Provider notes that its Representative was a very experienced and capable claim administrator, who stated that this was her own *"gut instinct"* on the matter. The notion of any Insurer considering a claim such a long time after the fact was unheard of, but notwithstanding this, the Provider would have preferred its Representative to have taken a more sympathetic and open-minded approach at the outset of this case, despite the fact that she felt there was no prospect of a claim. Whilst this Representative made her views known to the Insurer, the Provider is satisfied that ultimately the decision not to consider the claim, was made by the Insurer.

The Provider understands and apologises for the fact that the Complainant may have felt *"insulted and hurt"* by what was said in the telephone call recordings provided. The phraseology used was without doubt regretful, but not material to whether an individual can reasonably expect to be deemed to have met the definition of disablement pertaining to an illness that transpired some 10 years previously, which would be necessary in order to claim income continuance retrospectively. The Provider prides itself on the level of service it offers to members claiming from a scheme, providing guidance and support throughout the process, advocating on their behalf when it believes there are grounds for it to do so.

Considering that the Complainant's request to claim came so significantly after the fact, together with the fact that the Insurer had advised that the medical evidence submitted was not sufficient to prove a valid claim existed at the time, the Provider remains of the opinion that there were and are no grounds for it to urge the Insurer to consider the Complainant's claim. In conclusion, with regard to the failings on its part which it identified and apologised for in its Final Response letter dated 16 August 2017 and on reflection of the contents of the recording of the telephone calls from May 2012, and finally as a gesture of goodwill, the Provider offers the Complainant, in addition to the €300 it previously issued to him in August 2017 in relation to his matter, the further sum of €300. This offer remains open to him to accept.

The Complaint for Adjudication

The Complainant's complaint is that the Provider wrongly or unfairly failed to present, on his behalf, his income continuance claim to the Insurer for its assessment, and that the Provider failed to retain records of his membership of the Scheme and copies of the policy documents that applied throughout his membership.

Decision

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

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

A Preliminary Decision was issued to the parties on **9 January 2020**, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

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

The complaint at hand is, in essence, that the Provider wrongly or unfairly failed to present, on the Complainant's behalf, an income continuance claim to the Insurer for its assessment, and that the Provider failed to retain records of his membership of the Group Income Continuance Plan and copies of the policy documents that applied throughout his membership.
In this regard, the Complainant, now a retired civil servant, was a member of a voluntary Group Income Continuance Plan via his Trade Union, the policyholder, until 2001. The Provider, in its capacity as the policyholder's financial services broker, is the Scheme Administrator.

The Complainant was placed on reduced pay due to illness absence on 4 July 2001 and he later took early retirement due to ill-health on 29 November 2002. The Complainant did not, however, contact the firm that had been the Insurer of this Scheme at the time his potential income continuance claim first arose in 2001. He did not do so until 2012 when he then sought to ascertain whether he was entitled to make a claim. Having been advised by the Insurer that it was not in a position to consider a claim due to the time limits involved and as he was no longer a Scheme member, the Complainant then directly raised the matter with the Provider himself in March 2013.

The Complainant has set out his complaint at length to this Office. In summary, his complaint is that the Provider wrongly or unfairly failed to present, on his behalf, an income continuance claim to the Insurer for its assessment. In this regard, in his letter to this Office dated 22 May 2018, the Complainant submits, *"I have…been badly served by* [the Provider] *in that they ought to have presented my claim to* [the Insurer]*, irrespective of what* [the Insurer] *said in that regard"*.

The Complainant also complains that the Provider failed to retain records of his membership of the Scheme and copies of the policy documents that applied throughout his membership, in particular a copy of the policy document that applied in 2001.

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In addition, the Complainant makes particular reference to a recording of a telephone call wherein the Insurer had telephoned the Provider on 17 May 2012 and in his letter to this Office dated 28 September 2018 submits *"I am hugely insulted and hurt at the manner in which I was derided, insulted and laughed at* [during this telephone call]*"*, and in later correspondence dated 21 November 2018 he considers that the recording of this telephone call shows that the Provider *"plotted cheek by jowl* [with the Insurer] *to frustrate my legitimate claim and deny me what is legally mine"*.

With regard to the Complainant's complaint that the Provider wrongly or unfairly failed to present, on his behalf, an income continuance claim to the Insurer for its assessment, I note from the documentary evidence before me that the Complainant first contacted the Insurer in and around May 2012 as to the possibility of his submitting a claim, which dated back to 2001 and that the Insurer advised him that it was not in a position to consider a claim due to the time limits involved and as he was no longer a Scheme member.

In this regard, I note from the recording of the telephone calls between the Insurer and the Provider on 17 May, 18 May and 29 May 2012 that the Insurer had confirmed to the Provider that it was not in a position to consider a claim from the Complainant. In addition, though he had not yet made contact with the Provider in relation to this matter, I note that following its contact from the Insurer, the Provider wrote to the Complainant on 31 July 2012 advising, as follows:

> *"I understand that* [the Insurer] *advised you that they are not in a position to consider a claim for you because of time limits involved and as you are no longer a member of the Plan"*.

I am thus satisfied that the Provider was aware, from the outset of this matter in May 2012, that the Insurer was not in a position to consider a claim from the Complainant, dating back to 2001 and confirmed this position to the Complainant. The Complainant later wrote to the Provider on 18 March 2013 asking

> *" whether* [the Provider] *will assist me…by first of all sending me a claim form and secondly pursuing any such claim vigorously."*

In this regard, in correspondence to the Complainant dated 24 May 2013, the Provider responded, as follows:

> *"… as I understand,* [the Insurer] *has already confirmed that due to the extreme late notification they cannot consider a claim.*
>
> *Before* [*Assistance from* [the Provider] *in pursuing a claim*] *can even be considered and to try and understand your case, I would appreciate if you could explain why did you not pursue a claim through* [Z.Z.Z.], the then Scheme Administrator] *around the time you retired on ill health grounds"*.

/Cont'd…

I note that the Complainant later advised the Provider by letter dated 27 August 2013 that *"for the record the reason I did not make a claim through* [Z.Z.Z.], the then Scheme Administrator] *at the time I retired was because I was in no fit condition to do so"* and that the Provider acknowledges that it ought to have presented this explanation to the Insurer at that time, to see if it would change its stance on the matter, but that it had failed to do so.

When this failure was first brought to its attention by the Complainant in his correspondence dated 2 June 2017, I note that the Provider then gave this explanation to the Insurer, asking whether if it had provided this information to it in 2013, the Insurer would have changed its stance, to which it confirmed it would not.

In this regard, I also note that the Insurer advised that the medical evidence supplied by the Complainant to the Provider in June 2017, namely letters from his GP and occupational health reports from 2001 and 2002, was insufficient to enable it to determine that a valid claim existed in 2001. As a result, I am satisfied that the failure of the Provider in August 2013 to present to the Insurer the Complainant's explanation for the late notification, whilst unprofessional, did not prevent the claim from progressing at that time.

In his letter to this Office dated 22 May 2018, the Complainant submits, *"I have…been badly served by* [the Provider] *in that they ought to have presented my claim to* [the Insurer]*, irrespective of what* [the Insurer] *said in that regard"*. I note again the fact that the Insurer had previously confirmed to the Provider in May 2012 that it could not consider the claim. In addition, I note the Provider position that the medical evidence the Complainant submitted to it in June 2017 (GP and occupational health reports from 2001 and 2002) indicated that the Complainant was at that time diagnosed with work-related stress, which the Provider knows from its experience is particularly difficult to prove retrospectively when it is significantly after the fact.

I am thus satisfied that it was reasonable for the Provider not to issue the Complainant with an income continuance claim form and pursue a claim on his behalf, as to have done so may have raised unrealistic expectations for the Complainant that his claim may be admitted by the Insurer, when the Provider itself had no reason to consider that it would or could be.

I note from the documentary evidence before me that in his letter to this Office dated 28 September 2018, the Complainant stated,

> *"Because of ill health I was placed on less than full pay in July 2001 and the Income Continuance Plan I had…ought to have kicked in but didn't"*.

Similarly, in his correspondence dated 21 November 2018, the Complainant stated

> *"Premiums were deducted from my salary with* [my former employer] *from 1983 until June 2001 to insure myself against disability, which would kick in when sick pay with my employer was reduced to less than full pay"*.

/Cont'd…

The Group Income Continuance Plan which the Complainant was a member of, aims to pay a member who satisfies the policy definition of disablement an income of up to 75% of his or her salary, less any other income that he or she may be in receipt of at that time, such as half pay, temporary rehabilitation remuneration or early retirement pension, or any State Illness Benefit, which the member may be entitled to. In this regard, it is important for the Complainant to note that income continuance claims do not *"kick in"* or automatically pay out a benefit when a member is placed on less than full salary. Rather a claim must be made and the insurer must be satisfied that the policy definition of disablement has been met by a claimant before any such claim can be admitted, and as part of its claim assessment, the insurer will typically refer a claimant for independent medical examinations with relevant specialists. In addition, an income continuance claim that is then admitted remains subject to regular review, regardless of whether or not the member may have retired early on ill-health grounds.

I note that in his letter to the Provider dated 2 June 2017, the Complainant states that the Provider failed to

> *" inform me that I was in fact a contributing member of the Plan in 2001 when I suffered a severe meltdown and had to retire early on grounds of disablement."*

As the Scheme is a voluntary group income continuance plan, I am satisfied that the Complainant, in the first instance, would himself have completed an application in order to join the Scheme and that the resulting premium payments were then deducted from his salary by his former employer, up to 2001. In this regard, I am satisfied that the Complainant himself ought to have been aware that he was contributing into the Scheme at that time. Furthermore, in terms of the Provider later confirming to him his membership of the Scheme in 2001, I note that notwithstanding that he himself had not yet contacted the Provider at that time, the Provider wrote to the Complainant on 31 July 2012 stating,

> *"I am aware that you left the Plan in September 2001"*.

The Complainant also complains that the Provider failed to retain records of his membership of the Group Income Continuance Plan. The Complainant's membership of this Scheme ended in 2001 when he ceased paying premiums, in accordance with the relevant policy terms and conditions. At the time his membership ceased, I note that it was a different firm, namely [Z.Z.Z.], which was the Scheme Administrator and that the Provider itself only first became the Scheme Administrator in 2006, when it acquired this firm.

I therefore accept that the Provider is correct when it states that it did not receive any premium contributions on behalf of the Complainant, as it seems likely that his scheme membership had ended in 2001/2002, four to five years before the Provider became the Scheme Administrator, in the context of the Complainant's reduced pay situation and his ultimate retirement in 2002. As a result, it is understandable that the Provider would have no detailed records of the Complainant's previous membership of, or contributions to, the Scheme.

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In addition, the Complainant also complains that the Provider failed to retain copies of the policy documents that applied throughout his membership of the Scheme, and in particular a copy of the policy document that applied in 2001. In this regard, in his correspondence to the Provider dated 2 June 2017, the Complainant submits that the Provider

> *" failed to produce a copy of the Income Continuance Plan that applied to my situation in July 2001 when I went off half pay due to disability, which failure has resulted in the denial of benefits due to me under the Plan."*

It is not at once clear to me how the Complainant considers that the failure of the Provider to furnish him with a copy of the policy document that applied in 2001, 5 years before it became the Scheme Administrator, *"resulted in the denial of benefits due to* [him] *under the Plan"*. In this regard, the Complainant first notified the Insurer in 2012 of a potential claim from 2001, which the Insurer then confirmed it was not in a position to consider due, *inter alia*, to the time limits involved.

It is of course important to bear in mind that even if the Provider in 2012 or anytime thereafter was able to furnish the Complainant with a copy of the policy document applicable in 2001, this would not alter the fact that he had not notified the Insurer until 2012 of a claim dating back to 2001. Likewise, given the standard late claim notification clauses that apply to income continuance plans in general and the Insurer's stated difficulty to establish retrospectively that the Complainant would have met the policy definition of disablement back in 2001, neither would the production of this document at that time, been likely to have altered the Insurer's position in 2012, to the late claim notification.

In any event, I note from the evidence before me that the Provider did make efforts to locate the information the Complainant required, both by making contact with his former employer, the policyholder and the former Insurer, and from searching through the files of the previous Scheme Administrator, [Z.Z.Z.]. It is unfortunate that despite its efforts it has been unable to locate a copy of the policy document that applied in 2001, however I am mindful of the fact that the Provider was not the Scheme Administrator in 2001 and that when , in 2006, it acquired the firm that had been the Scheme Administrator in 2001, the 2004 policy document was already in place and the Provider would only have acquired whatever records [Z.Z.Z.] had seen fit to retain, and I do not consider that the Provider can be reasonably deemed responsible for the extent of those records.

Finally, the Complainant makes particular reference to a recording of a telephone call wherein the Insurer telephoned the Provider on 17 May 2012. In this regard, in his letter to this Office dated 28 September 2018 the Complainant stated

> *"I am hugely insulted and hurt at the manner in which I was derided, insulted and laughed at"* [during this telephone call]

In later correspondence dated 21 November 2018 submits that the recording of this call shows that the Provider *"plotted cheek by jowl* [with the Insurer] *to frustrate my legitimate claim and deny me what is legally mine"*. Having listened to the recording of this telephone call, I do not accept this.

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The Insurer telephoned the Provider on 17 May 2012 as the Complainant had recently made contact with the Insurer to ascertain whether he was entitled to make an income continuance claim dating back to 2001 and it was seeking details of his membership of the Scheme. I accept the Provider position that a delay in claim notification of over 10 years was unprecedented and that in the absence of any protocol for such a case, it was somewhat understandable that a conversation then ensued, based largely on individual opinion, as to the possibility of the claim proposed, being considered at such a late stage.

It is clear from listening to the recording of this call that both the Provider Representative and the Insurer believed that there was not a reasonable prospect, given the timelines involved. In this regard, I note that the Provider Representative remarked,

> *"I don't think* [the claim] *can be looked at, this would be my gut instinct"*.

In addition, the Provider Representative remarked

> *"I think* [the claim] *is way too late and the Ombudsman isn't even going to look at it."*

I am satisfied that this comment (which refers to the time limits that apply to this Office in having jurisdiction to investigate complaints) was to put in context, the considerable delay of the claim notification at hand.

Whilst the Provider Representative made her views known to the Insurer, I do not consider that she was in any way colluding with the Insurer at that time. I accept the Provider's position that ultimately the decision whether or not to consider the Complainant's income continuance claim in 2012, was one made by the Insurer. In addition, whilst the Provider Representative was clearly surprised at the length of delay of the claim notification at hand, I do not consider that her expression of such surprise was intended to insult or make fun of the Complainant and I don't accept that it did so.

Nevertheless, having reflected on the contents of the recording of this telephone call and as a gesture of goodwill, the Provider has offered the Complainant, in addition to the €300 it previously issued to him in August 2017, the further sum of €300. In this regard, it is now a matter for the Complainant to advise the Provider directly if he wishes to accept this offer. Should he wish to do so, he should advise the Provider accordingly, without undue delay, as the Provider cannot be expected to hold that compensatory offer open, indefinitely.

Insofar as the substantive complaint against the Provider is concerned however, for the reasons outlined above, I do not believe that it would be reasonable to uphold the complaint. I do not accept that the Provider has been guilty of any wrongdoing such as would make it appropriate to uphold that complaint against it.

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Conclusion

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

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

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION AND LEGAL SERVICES

12 March 2020

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

(a) ensures that—
(i) a complainant shall not be identified by name, address or otherwise,
(ii) a provider shall not be identified by name or address,
and

(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.