An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0097
Sector:	Investment
Product / Service:	Cash Investment
Conduct(s) complained of:	Mis-selling Delayed or inadequate communication Dissatisfaction with final fund value
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant incepted a life assurance policy with the Provider through her financial adviser in **2011**. Sometime later, the Complainant was advised by her financial adviser that her policy had been mis-sold to her. The Complainant's financial adviser sought to have her policy rewritten by the Provider. It subsequently transpired that the policy was not rewritten causing it to lapse. The Complainant became aware of this towards the end of **2016**.

The Complainant's Case

In her complaint to this Office, the Complainant states that she *"… was mis-sold a plan by [the Provider] back in October 2012, this matter was finally resolved in December 2013 with a new policy being issued."* However, when the Complainant contacted the Provider on **21 September 2016**, to advise it of her recent marriage she was informed that her policy had lapsed as she had not made her monthly contributions. The Complainant explains that *"[t]his policy was a one off paid up front policy with no monthly contribution."* The Complainant advises that she registered a complaint with the Provider on **21 September 2016** and under its own complaints procedure, 40 business days lapsed with no communication from the Provider since **3 November 2016** when she was advised that her complaint was being reviewed as a priority.

In a submission to this Office dated **12 January 2018**, the Complainant explains her complaint as follows:

> *"My main complaint is with [the Provider] as having agreed that the first policy was mis-sold (in 2012) they then issued a further policy of a similar nature when they held documents on file stating that I wanted a fixed lump sum investment and not a monthly contribution policy.*
>
> *During which time from the acknowledgement of the mis-selling of the re-issue of the new policy my money was held with them and I could not access it, nor was given any interest or compensation as a result of this.*
>
> *I therefore believe that in regards to the second re-written policy [the Provider] are both responsible for the mis-selling as they had reviewed documentation from myself (and the broker) stating that my initial investment is for a lump sum only, and they still put in a monthly contribution scheme, doing the same as the first policy, in which they held on to the lump sum and drip fed a monthly saver until the maximum contribution would of (sic) been reached.*
>
> *…*
>
> *I have never received any direct mail or communication from [the Provider] regarding that the policy was not 'maintained' with funds. …*
>
> *They told me on initial contact that the policy had been 'frozen' due to the contributions not been (sic) continued. At no point did [the Provider] contact me to advise me of this …"*

In a submission dated **26 August 2018**, the Complainant states:

> *"… I had all of the paperwork processed regarding the re-write and had no communication to state that this had not progressed, so when I received my 2015 valuation, I read that the premium was 'paid-up', suggesting as the policy I requested be re-written had been completed and was all in order."*

Referring to the payment instruction section of the policy application form signed on **27 October 2011**, the Complainant explains:

> *"On the payment instruction to my bank, none of the details are written or completed by me, it was for a one off transfer of £22,000, the signature on this looks fake and it is not my writing again on the date under the signature.*
>
> *"[From] (P4 onwards) on the whole document none of this is my writing."*

/Cont'd…

The Complainant continues by stating that:

> *"Having known that the original policy was miss-sold and the reason for this, which was the length of the term and that it was monthly payments instead of the one off lump sum I requested, so having this information they have never made any attempts to rectify this having admitted I was miss-sold. On the same note they have never (still to this date), even offered to 'transfer' my money into the exact policy I requested. Instead they offered for me to be able to continue with the policy, which at £1,000 a month I cannot, and could never, maintain."*

The Complainant concludes this submission stating that the Provider has acted contrary to the provisions of the ***European Communities (Unfair Terms in Consumer Contracts) Regulations, 1995*** (the **Regulations**) in that the Provider has breached the good faith provisions and has acted recklessly and negligently in relation to her policy.

In resolution of this complaint, the Complainant wants *"… to retrieve my money, the last statement I have (dated 30.06.14) valued the policy at £24612.56 …"*

The Provider's Case

The Provider states that its explanation for the conduct complained of in this complaint was included in the Final Response letter issued to the Complainant which is dated **6 December 2016**. This is set out in detail below.

In addressing the lack of communication with the Complainant during **2015** and **2016**, the Provider states in a submission dated **13 September 2018** that the policy lapsed in **2015** as the value in the policy fell below the minimum required level. It was the Provider's practice to send the lapse information and letter to the financial advisor appointed by the Complainant to allow them the opportunity to advise the Complainant as to her options. The Provider submits this is why the Complainant did not receive any information during this period. The Complainant's policy was later marked as *paid up* in an attempt to address the issues that were presented by the Complainant.

Responding to the Complainant's submission that she did not complete the application form and bank details section of this form, the Provider acknowledges that this is a very serious matter and if the Complainant believes that she has been the subject of a criminal act then it is strongly recommended that she make a formal complaint to the relevant law enforcement authorities. The Provider states that it is not in a position to comment further on this allegation.

Dealing with the mis-selling of the Complainant's policy, the Provider submits that the sale of the policy was undertaken by the Complainant's financial adviser and not the Provider. The Provider is of the view that the Complainant should make a complaint in respect of the financial adviser who sold the policy.

/Cont'd…

The Provider wishes to clarify for the avoidance of any doubt, that it did not acknowledge that the policy was mis-sold. The Provider explains the position as follows:

> *"… a former employee of [the Complainant's] appointed financial adviser requested in 2012 that we re-structure the policy from a 25-year term to a 15-year term. At the time of this request, the employee in question had moved to a new Financial Advisor and was no longer an employee of [the Complainant's] appointed Financial Advisor.*
>
> *…*
>
> *Such a request therefore required the consent of [the Financial Advisor firm] which was not received by us; and the request was accordingly not subsequently processed by us."*

The Provider submits that this does not equate to an instance where a product has been mis-sold or an admission that a product has been mis-sold. The Provider explains that what occurred, as outlined in a letter to the Complainant dated **6 December 2016**, was that the Provider agreed, *ex gratia*, to restructure the Complainant's policy in accordance with the above request to a 15 year term. The Provider advises that this offer was rejected by the Complainant.

The Provider does not accept that it is in breach of the Regulations. It states that the policy was provided to the Complainant in accordance with her instructions which were communicated to the Provider through the application form from **December 2011**. The Provider states that the Complainant's explicit instructions reflect that she understood and acknowledged the policy functioned at the time of her initial application. The Provider advises that it does not dispute that the Complainant is entitled to the most favourable construction possible of any contractual term, the meaning of which may be the subject of doubt, however, the Provider rejects the Complainant's blanket assertions that it acted in a reckless and negligent manner and breached its duty of good faith in the provision of the policy to her. The Provider submits that the Complainant chose this particular policy through her financial adviser which she then tailored to her specific needs and requirements in respect of premium contribution term and contribution period which the Provider then supplied.

<u>The Complaint(s) for Adjudication</u>

The complaints are that the Provider:

Re-issued a life assurance policy to the Complainant on similarly incorrect terms to a policy that had been previously mis-sold to her and is therefore responsible for mis-selling her policy, failed to inform the Complainant that her policy had lapsed, and unreasonably delayed in its investigation of the Complainant's complaint regarding the policy.

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Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The 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 18 February 2020, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

Following the issue of my Preliminary Decision, the Complainant made a further submission under cover of her e-mail to this Office dated 27 February 2020, a copy of which was transmitted to the Provider for its consideration.

The Provider has not made any further submission.

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

Application Form

A copy of the application form dated **27 October 2011** purportedly signed by the Complainant has been furnished as part of this complaint. The first page of the form contains details of the Complainant's financial adviser and outlines the sections that have been completed by the Complainant and the sections that have been completed by her financial adviser. Sections 1 and 2, and 4 to 12 are marked as having been completed by the Complainant; while sections 13 and 14 are marked as having been completed by her financial adviser. Both of these sections have been signed by the Complainant's financial adviser.

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Section 6 of the form deals with the amount to be invested. There are two option contained on the form: a regular premium or a single premium. The sum of £1,000 has been inserted into the *Regular Premium* box with the monthly *Regular Premium Payment Frequency* option also being selected. Section 7 selects the *Premium Payment Term* as 25 years. Section 11 contains a number of declarations. Section 12 contains the Complainant's payment instruction which was to be by way of a monthly standing order of £1,000 commencing on **28 November 2011**. The form contains a signature representing to be that of the Complainant.

Terms and Conditions

I have reviewed the terms and conditions of the Complainant's policy and I note the following provisions.

Section 4.3 deals with the *Initial Periods* of the policy as states:

> ***"4.3 Initial Periods***
>
> *The first 100% of Regular Premium Unit allocations during the Initial Period are set aside in order to fund the administration fees due over the duration of the Premium Payment Term. The Initial Period is shown on your Policy Statement and depends on the Premium Payment Term of your Policy. …"*

The table contained in section 4.3 attributes an *Initial Period* of 23 months to a policy with a Premium Payment Term of 25 years.

Sections 13 to 15 of the policy state:

> ***"13. Paid-Up Policy***
>
> *If premium payments have ceased and you have not chosen the premium holiday option … and your Policy had a Surrender Value of at least … GBP1,050 … then the Policy will become paid-up. However, we reserve the right to fully surrender your Policy if the Surrender Value falls below … GBP1,050 … and the proceeds of any such surrender will be forwarded to you. No further premiums will be due.*
>
> …
>
> *Charges continue to be deducted on a paid-up Policy.*
>
> ***14. Lapsing Your Policy***
>
> *If premium payments have ceased and the Policy has a Surrender Value of less than … GBP105 or if after the Initial Period, mortality deductions or other charges exceed the Surrender Value, the Policy will lapse without value and all benefits will cease.*

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15. Reinstatement of Your Policy

Lapsed Policies can be reinstated up to one year after the due date of the first unpaid premium subject to the payment of all outstanding premiums. Paid-up Policies can be reinstated up to one year after the due date of the first unpaid premium. We reserve the right to refuse to reinstate a Policy after this time has elapsed. …"

Section 22 deals with *Charges*. Section 22.1 states in respect of the *Administration Fee* as follows:

*"**22.1 Administration Fee***

This fee relates to Regular Premium payments and is deducted on each Policy Anniversary. Each administration fee will continue for 30 years or until the end of the Premium Payment Term, whichever is earlier.

…

This fee is taken from Units credited during the Initial Period by virtue of the first 100% of premium allocation including associated dividend Units.

…

In the event of full surrender before the end of the Premium Payment Term, [the Provider] will deduct, from the Surrender Value, any administration fees which would have otherwise been deducted had the Policy not been surrendered."

Policy Schedule

The Complainant's policy schedule sets out a number of important details about the Complainant's policy. In particular, under the *Policy Details* section it describes the policy as comprising a regular premium of £1,000 payable on **9 December 2011** and monthly thereafter for 25 years.

The section page of the schedule contains the following information in respect of the administration fee:

"Policyholders are reminded that if you reduce or stop paying your premiums, we continue to deduct the administration fee as if you had continued investing the full amount until the due date of the final premium. …"

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While the policy schedule is dated **8 June 2018**, it was enclosed with Provider's submissions sent to this Office on **12 June 2018**. It is most likely that this date reflects the date the schedule was printed by the Provider when compiling the schedule of documents it was submitting to this Office in respect of this complaint. I accept that this schedule is representative of the original policy schedule furnished to the Complainant and/or her financial adviser.

Policy Illustration

The Provider has submitted a policy illustration dated **15 February 2012** and signed by the Complainant. This illustration contains details of the policy similar to those outlined in the policy schedule and also provides information as to projected policy values.

Correspondence with the Financial Adviser

Over the course of a number of emails dated **26 September 2016**, the Complainant forwarded to the Provider email correspondence with her financial adviser from **2012** and **2013**. The Provider's agent acknowledged receipt of this on **27 September 2016**.

In response to this, the Complainant informed the Provider on **27 September 2016** that:

> *"I have contacted my bank who can if requested, provide evidence that at no point ever since me having the account has a regular payment (direct debit/standing order) ever been taken from my account in regards to this policy (by company name or amount).*
>
> *Also at no point have I ever received any written communication at this address in regard to the policy."*

While a number of emails were forwarded to the Provider, I note that the Complainant wrote to a third party on **24 October 2012** explaining:

> *"I have had my meeting with [my financial adviser] … and things did not go well.*
>
> *They have agreed that my policy was mis-sold to me …*
>
> *The chap who sold it to me has been sacked …*
>
> *The company are telling me that I have to continue the policy until August 2013 – paying an additional 10k, and can not access the funds until I am 65 years. …"*

In an email dated **3 October 2013**, the Complainant's financial adviser informed the Complainant that he was moving to a new firm and that he would be *"… maintaining all of my clients … within the region and I can continue to help and support you."*

/Cont'd…

On **1 November 2013**, the Complainant's financial adviser wrote to her from a new firm advising:

> *"Many thanks for such a prompt reply.*
>
> *I will get this sent out to [the Provider] straight away.*
>
> *I will work on the documents required to get everything required resolved …*
> *I will call you on Monday to arrange a time … to complete the paperwork. …"*

Following on from this, the financial adviser wrote to the Complainant on **6 November 2013** to update her that:

> *"I have rewritten on the documentation that is needed to change your term and policy, I have sent this to our compliance department to sign off.*
>
> *Once they have approved this and have confirmed that nothing else is required I will contact you …"*

In an email dated **12 December 2013**, the Complainant's financial adviser informed her as follows:

> *"I understand that you are now have (sic) all the documentation that is required to change your policy?*
>
> *I have agreed everything with … and [the Provider], so I just need you to return the signed documents.*
>
> *Are you going to courier these to us?*
>
> *[The Provider] will be closing for 20th for new business, so I am keen to get this resolved for you. We then know moving forward in 2014 you have the term that you wish."*

The Provider's submission to this Office contains a timeline of events, I note the following comments:

> *"21/02/2014 I reverted to [named individual] to advise that the rewrite had not progressed as we had not received clarity from both brokers about clawing back commission from outset*
>
> *24/02/2014 I emailed [the financial adviser] to clarity (sic) the rewrite had not progressed and that commission was clawed back because the policy was 'paid-up'*
>
> *NO FURTHER FEEDBACK ON THIS CASE UNTIL CLIENT CALLED THE OFFICE ON 22/09/2016."*

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While the Provider has prepared a timeline of events, copies of the correspondence referred to in the above passage have not been submitted in evidence.

The Complainant then received a valuation prepared by the Provider in respect of her policy from her financial adviser's new firm under cover of email dated **1 July 2014**. I note this valuation is addressed to the office of the Complainant's financial adviser. When forwarding this email to the Provider on **26 September 2016**, the Complainant explains that:

> *"I have not received any other communication (email or written letter) since this valuation, therefore I (wrongly) assumed all was fine with the policy …"*

Complaint to the Provider

It is not entirely clear from the correspondence provided by the parties to this complaint when the Complainant first reported the matter to the Provider. However, in an email dated **21 September 2016**, an agent of the Provider advised the Complainant that she had *"… escalated your policy to my manager who is going to investigate this for you."* As noted above, the Provider's agent acknowledged receipt of the forwarded email correspondence on **27 September 2016**. In this email, the Complainant was advised that her case would be reviewed and the Provider would revert to her with its findings as soon as possible.

The Complainant wrote to the Provider seeking an update on its investigation on **7 October 2016**. The Provider replied on **19 October 2016** informing the Complainant that her case was being investigated and that the Provider was currently trying to contact the originating broker. Following this, the Complainant sought updates from the Provider as to the status of its investigation.

In response to these requests, the Provider wrote to the Complainant on **26 October 2016** advising that it had contacted the originating broker and were awaiting its response. The Provider acknowledged the Complainant's further requests for a response on **8 November 2016** stating that this was a complex query and getting a response from the originating broker was proving time consuming.

The Provider wrote to the Complainant on **25 November 2016** advising her that:

> *"… it has been agreed to uphold the previous agreement made with [the financial adviser] and rewrite this policy with a premium of 1000 GBP per month for a revised term of 15 years. If we proceed on this basis we will transfer the funds (totalling 22,000 GBP) from [policy number] as 22 advance payments on the new policy. …"*

The Complainant rejected this offer on **28 November 2016** and requested that the £22,000 be refunded to her. The Provider responded on **29 November 2016**, stating that:

> *"… this is the only option we have available to you, we are not in a position to refund premiums paid into the plan.*

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What we spent time trying to work on for you was a restructuring of the plan based on an agreement with [the financial adviser] some years back. This was not actioned and [the financial adviser] has since moved from the original Brokerage where the plan was sold making this a more complicated process. …"

Final Response Letter

The Provider advises that the explanation for the conduct complained of in this complaint can be found in its Final Response letter dated **6 December 2016**. I will now set out what I consider to be the pertinent parts of this letter.

*"**Policy Details***

You applied for the above policy in December 2011. The premium contribution term you selected was for a 25-year contribution period at a predefined contribution level of £1,000 per month, totalling £300,000 over the life of the contract.

The cost structure of the Policy was therefore established in accordance with your instructions at that time in accordance with the Details Guide and Terms and Conditions.

Suitability and Advice

For clarity, [the Provider] is the product provider and neither we nor our employees are authorised to give investment advice. Furthermore, we cannot take responsibility for investment advice given to you by your Financial Advisor as they do not act as our agent.

[The Financial Adviser firm], the firm that you appointed, are an independent firm of Financial Advisors, who are able to place business with whichever provider they believe has the product most suited to the requirements of each of their clients. By electing to engage [the Financial Adviser] at [the Financial Adviser firm] you thereby appointed them as your agent, a relationship which is outside the remit of [the Provider]. [The Financial Adviser firm] are therefore responsible for any advice provided on their behalf.

In 2012 we received a request from [the Financial Adviser] to rewrite the plan to a 15-year term from a 25-year term, we understand this request was after a meeting he had with you. At this time [the Financial Adviser] had moved to a new Brokerage and was no longer affiliated with [the Financial Adviser firm].

That request to rewrite required the written consent of the originating broker, [the Financial Adviser firm] which was not subsequently received and therefore not progressed.

We would surmise that you must have been aware of this given there was no new contributions of premium to your policy.

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As there was no rewrite of the plan it continued on the original term which was a 25-year policy with a 23-month initial period meaning the first 23 months' premium was being used to fund the Administration fees due on each policy anniversary over the 25-year term. You will be aware that we only received 22 months premium so the contributions made into the plan were not sufficient to meet the initial period and the plan subsequently lapsed with no value.

If you reduce or stop paying your premium which is permitted, we continue to deduct the Administration Fee as if you had continued investing the full amount until the due date of the final premium. This is consistent with the Principal Brochure, Details Guide and Terms and Conditions issued at the time. As the policy was established to meet a required planning objective over a 25-year term it is very much in the interests of the Policyholder to continue with premiums at the level contracted throughout the life of the contract. This will mean that it is more realistic that the financial goals will be met at the end of the investment period, as no doubt was discussed with your financial advisor at outset.

The request to rewrite raised again this year through more recent correspondence from you when you were inquiring on the status of the policy which had lapsed with no value.

While not obliged to do so and after much internal consultation, [the Provider] had agreed to rewrite the plan to a 15-year term plan and to transfer the 22 premiums over to a new plan. This offer of goodwill was subsequently rejected by you in an email dated 28th November 2016. Your position was that you wanted a return of all premiums paid which we are not willing to offer.

Product Literature

Whilst [the Provider] is not responsible for the provision of financial advice, we do accept ownership for the quality, clarity and accuracy of the product literature which are required at the time of application.

Compliance Obligations

In accepting new applications for policies with us, our administration department complies with our internal due diligence controls in respect of each application that we receive. Amongst others, these include the stipulation that each applicant is provided with copies of the promotional literature and fund information and that they acknowledge as part of the application process, their receipt of these and also confirm that they have read and understood this information.

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Prospective applicants are also required to sign an illustration of Benefits Document linked to the contribution term they have specified, which makes clear what the likely return will be, particularly it the policy is surrendered in the early years. The company is required to include on this illustration wording which makes clear that the applicant should only invest in the product if he or she intends to maintain the premium for the whole of the payment term. The text must also caution that should the plan be terminated early, the applicant may suffer a loss, as shown by the figures provided.

Finally, prospective applicants must again sign to confirm that they have read and understood the information provided in the illustration and also that they have received the Principal Brochure.

Contract Validity

On review of your file [the Provider] have found that our staff did satisfy the compliance obligations in place at the time you affected your policy, as evidenced by your signature against the application form.

We in turn established in good faith the contract exactly in accordance with the instructions that you provided to us.

…

Summary

[The Provider] have maintained the Policy in adherence to the original contract terms noted in the application form and as such are not in a position to alter the conditions of the Policy nor comply with your request to return premiums paid into the Policy.

If you therefore had a grievance concerning the advice you have received, these complaints should be referred to your Financial Adviser. …"

Analysis

In the timeline outlined by the Provider it is stated that the Provider was aware in **October 2012** of the alleged mis-selling of the Complainant's policy and that a request was made by the Complainant's financial adviser that the policy be rewritten. The timeline further discloses that in order for the rewrite to proceed, the Provider required clarification in relation to the clawback of commission paid in respect of the original policy and a commitment that the Complainant pay the premium for the full term of the policy on rewrite. The Provider has referred to correspondence and communications throughout its submission to this Office. However, I note that this correspondence has not been furnished in evidence. This is very disappointing.

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The evidence in this complaint suggests that while the Complainant's financial adviser attempted to have the policy rewritten, it was not fully progressed and the rewrite did not occur. Consequently, the Provider continued to administer the Complainant's original policy in accordance with the policy terms and conditions. Taking these matters into consideration, I accept that the Complainant's policy was not rewritten and/or reissued by the Provider contrary to the submissions made by the Complainant.

While the Provider has not furnished copies of any correspondence with the Complainant's financial adviser or the original financial adviser firm outside of the valuation referred to above, the valuation suggests that the Provider was in fact corresponding with the relevant financial adviser in respect of the Complainant's policy. However, due to the lack of documentation furnished by the Provider, I am unable to ascertain and/or understand the precise nature and extent of the correspondence and communications between the Provider and the financial adviser/the financial adviser firm in respect of the rewrite of the Complainant's policy.

I have not been provided with evidence that the Complainant's financial adviser carried out her instructions regarding the rewrite of her policy. However, the Complainant's financial adviser is not being investigated as part of this investigation. The evidence demonstrates that the Provider was aware that there was mis-selling associated with the Complainant's policy. I am satisfied that, in the circumstances of this complaint, the Provider ought to have contacted the Complainant directly to notify her of the stage which the rewrite of her policy had reached and/or the status of her policy.

The evidence provided to this Office indicates that the Complainant made a complaint to the Provider in or around **21 September 2016**. The Complainant wrote to the Provider on a number of occasions subsequent to this looking for an update as to the status of her complaint. I have outlined the Provider's replies to these requests above. On **25 November 2016**, the Provider offered to uphold the Complainant's original instructions in respect of the policy however, this offer was rejected by the Complainant. The Provider issued a Final Response letter to the Complainant on **6 December 2016**. While this is longer that the 40 day period advanced by the Complainant in her submissions, I am not satisfied that the time taken by the Provider to investigate and respond to the complaint was unreasonable.

Provider's Response to Complaint

This Office wrote to the Provider on **8 February 2018** enclosing the complaint file requesting that the Provider furnish an explanation for the conduct complained of and all relevant documentation and information to assist in the adjudication of the complaint within 20 working days. The Provider did not respond to the foregoing request and this Office wrote to the Provider on **12 March 2018** advising that the Provider's response was overdue. Almost one month later, the Provider acknowledged its submission was overdue by email dated **9 April 2018** and advised this Office that it was in the process of compiling certain files. Following this, the Provider indicated on **11 May 2018** that it wished to offer the Complainant a sum of money in order to settle this complaint. An offer of €3,000 was made by the Provider which was communicated to the Complainant by this Office on **16 May 2018**.

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This offer was rejected by the Complainant on **18 May 2018** and communicated to the Provider on **25 May 2018**. The Provider's submissions were then received in two tranches: the first on **31 May 2018** and the second on **12 June 2018**. While there was further correspondence in the intervening period, I am disappointed with the length of time it took the Provider to deliver its response in respect of this complaint.

The Provider was furnished with additional submissions from the Complainant under cover of letter dated **15 January 2019** and was invited to respond within 10 working days. The Provider did not respond to this correspondence. Letters were then sent to the Provider on **18 February 2019**, **11 April 2019** and **10 May 2019** requesting that the Provider indicate whether or not it intended to submit any further submissions. No response was received in respect of any of this correspondence. I find it totally unacceptable that this series of correspondence was ignored by the Provider.

I am aware that telephone conversations took place between the Complainant and the Provider on **22 September 2016** and **28 November 2016**. Recordings or transcripts of these calls have not been furnished in evidence by the Provider. In its submission to this Office, the Provider states, in respect of the second telephone call, that it is not being provided as the Provider is not seeking to rely on it in response to this complaint.

The Provider's refusal to furnish recordings or transcripts of the above-mentioned telephone call recordings is completely unacceptable. Simply because the Provider does not intend to rely on these telephone calls does not exempt them from disclosure. It is not for the Provider to determine the relevance of these telephone calls.

I would point out to the Provider that it is not a matter for the Provider to determine whether it will cooperate with this Office. In that regard, I would draw the Provider's attention to Section 47 of the ***Financial Services and Pensions Ombudsman Act 2017*** which provides the basis on which I can require the Provider to submit evidence at Section 59 of the Financial Services and Pensions Ombudsman Act 2017 dealing with obstruction of the work of the Ombudsman.

Because of the failings in communication by the Provider, particularly in relation to the lapsing of the Complainant's policy, I partially uphold this complaint and direct the Provider to re-offer the Complainant the opportunity to re-write the plan to a 15 year term, by transferring the 22 premiums into a policy as a lump sum in the manner which was proposed in the original offer. I also direct the Provider to pay a sum of €5,000 in compensation to the Complainant.

Conclusion

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

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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 re-offering the Complainant the opportunity to re-write the plan to a 15 year term by transferring the 22 premiums into a policy as a lump sum in the manner which was proposed in the original offer. I also direct the Provider to pay a sum of €5,000 in compensation to the Complainant, to an account of the Complainant's choosing. Both directions to be completed within a period of 35 days of the date of this Decision.

I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

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

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

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

31 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.