An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0112
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Lapse/cancellation of policy
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant and his family had a health insurance policy with the Provider, against which this complaint is made. In **2016**, the Complainant's wife purported to cancel the policy by sending a letter to the Provider. The Provider did not receive this letter and continued to debit the Complainant's account. The Complainant and his family changed to a new health insurance provider at this time after deciding that it would be a more attractive deal.

In 2018, the Complainants realised that the Provider had not cancelled the policy and had continued to deduct the premiums. In **May 2018**, the Complainants formally cancelled the policy and contended that the Provider should repay €7,840.69 in premiums that had been paid from 2016 to 2018.

The Complainant's Case

The Complainant and his wife assert that a letter was sent in June or July of 2016 cancelling their health insurance policy with the Provider. The Complainant says that they realised that they could get a better deal elsewhere and, therefore, made the decision to not renew with the Provider. From that date onwards, the Complainant and his wife state that no documentation was received from the Provider. In 2018, the Complainant realised that the direct debit to the Provider was still active and, therefore, immediately took steps to cancel their cover.

The Complainant noted that there was a medical procedure carried out on **12 April 2017** which they claimed benefit for, on their new health insurance policy and not on their policy with the Provider. The Complainants note that it would be illogical to have held a policy with two providers with the same cover.

The Complainant's wife indicated that she is responsible for all issues to do with household and family matters and that she has kept a file of all correspondence received in relation to those matters. The Complainant's wife notes that there is no correspondence from the Provider after she states she sent the cancellation letter. The Complainant accepts that there was one phone call which the Complainant answered, but that a follow up was requested which never materialised.

The Complainant seeks the repayment of €7,840.69 for the premiums paid since the date of purported cancellation.

The Provider's Case

The Provider states that it did not receive the purported letter of cancellation. On that basis, the Provider did not cancel the policy and continued to debit from the Complainant's account. The Provider notes various communications that it says are inconsistent with the cancellation of the policy.

On **2 June 2016**, the Provider says it wrote to the Complainant stating that his policy was due for renewal from **1 July 2016** to **30 June 2017**. This letter states that if there was no contact, then the policy would be renewed.

On **3 June 2016**, the Provider says that it called the Complainant and that he indicated his intention to renew. The Complainant indicated that his wife should be contacted and the Provider states that two attempts were made to do so on **3 June 2016** and **15 June 2016**, but that she did not answer these attempts. Three text messages issued to the Complainant after that date on **30 June 2016, 6 July 2016** and **8 July 2016** informing him that he had missed a call from the Provider and that his cooling off period was due to expire on **14 July 2016**.

The Provider says that in 2017, it renewed the Complainant's policy again, as it had not heard from him. On **22 May 2017**, a pre-renewal notice pack was sent to the Complainant's house noting that his policy was again due for renewal. The Provider said that it received no communication and, therefore, the policy was automatically renewed.

The Provider states that it sent further correspondence such as an update regarding legislation concerning public bed charges and GDPR compliance. On **2 May 2018**, the present issue arose when the Complainant's wife contacted the Provider stating that the policy had been cancelled back in 2016. The Provider did not agree to repaying the Complainant's premiums from 2016. The Provider noted that cover was validly in place and if a claim had been made during the period of cover, then the Provider would have been obliged to pay it. Consequently, it would not agree to a retrospective cancellation of the policy and a refund of the premiums paid.

/Cont'd…

The Provider noted that the cancellation in 2018 was during the course of the contract year, and the Provider said that it would not seek payment of the remaining premiums left on the contract from the Complainant.

The Complaint for Adjudication

The complaint is that the Provider failed to cancel the Complainant's health insurance policy in 2016 and wrongfully continued to renew the cover thereafter, debiting the Complainant's account until 2018.

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 26 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.

In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

I note that the relevant contractual terms are set out at clause 3 and 4 of the terms and conditions of membership. Clause 3 provides that each policy shall last for one year and clause 4 provides that the policy will automatically renew on the date set out in renewal documentation, unless the insured contacts the Provider cancelling their policy in advance of the renewal date, or within 14 days after that date. Accordingly, the entire dispute hinges on whether or not the letter of cancellation was in fact sent by the Complainant's wife and received by the Provider.

/Cont'd…

It is important to note that there is no copy of the purported letter of cancellation. It is necessary therefore to assess all of the surrounding circumstances.

On the one hand, it is clear that the Complainant arranged for alternative health insurance policy with another provider in and around the time of the suggested cancellation. In April 2017, the Complainant underwent a medical procedure and claimed on his new health insurance policy, as opposed to the policy with the Provider.

Both of these pieces of evidence point towards the Complainant being under the impression that the policy had been cancelled.

On the other hand, the Provider states that it kept sending various correspondence to the Complainant even after the date of the purported cancellation. If this correspondence was received, then it would naturally indicate that the policy was still in existence, and had *not* been cancelled. For example, the receipt by the Complainant of the May 2017 renewal documentation was wholly inconsistent with the policy having been cancelled in 2016. Similarly, the text messages and attempted calls are indicative of the fact that there was an existing policy in place with the Provider.

Finally, records of phone calls have been furnished in evidence. The Complainant answered the phone call from the Provider on **3 June 2016** and indicated that he probably would be renewing the policy. This supports the Provider's position. The Complainant further said, however, that his wife would deal with any further query and provided her number to the Provider's representative.

There is a further phone call dated **2 May 2018** where the Complainant's wife rang the Provider to complain about the matters which are the subject of this complaint.

There is a further phone call **3 May 2018** where the Complainant's wife set out their understanding that the policy should have been cancelled in July 2016. The Complainant's wife reiterated that they have not received any documentation since July 2016. The Complainant's wife confirmed that the Provider had the correct address and phone numbers for both her and her husband.

In all of the circumstances, I am satisfied that the Complainant's wife more than likely did send the letter seeking to have the insurance policy with the Provider cancelled at some point in June or July 2016, although it remains unclear whether such was in fact received by the Provider. I am also satisfied that the Complainant and his wife, however, more than likely did receive the renewal documentation in 2017, copies of which were submitted in evidence to this office.

Consequently, I take the view that the Complainant's policy should have been cancelled in 2016, the Complainant and his wife were on notice in 2017, that something had gone wrong and they should have taken further steps to cancel the policy at that point, and indeed should have examined the direct debit payments which would have drawn their attention to the fact that those payments were in fact still ongoing.

/Cont'd…

On that basis, I am mindful that there is simply no evidence available of the suggested copy letter which it is suggested the Complainant's wife sent to the Provider. I note the Complainant's contention that his wife keeps a file of all correspondence received in relation to those matters. I would have expected in those circumstances that even if a photocopy of the letter was not kept for the purpose of the file, that the Complainant or his wife would have followed up with the Provider in the event that the letter in question had gone unacknowledged.

It is surprising that not only was no action taken after mid-2016, to follow up with the Provider in relation to the suggested cancellation in question, but in addition, having received the renewal documentation for 2017, it seems that similarly, the Complainant and his wife again took no action.

In those circumstances, I take the view that the Complainant must share responsibility for the premium payments made by him to the Provider. I am mindful however, that the premium paid both in 2016 and 2017, will have included a health insurance levy which will in fact already have been paid to the Government via the Complainant's health insurance policy incepted with the other provider.

In the circumstances, it would appear that the Complainant was genuinely of the view that he did not have a policy of insurance with the Provider and would not therefore have made a claim on the policy. This is evident by the fact that he actually made a claim on the other policy he had incepted.

Accordingly, I believe that in order to do justice between the parties, some refund is appropriate to the Complainant, in recognition of these unusual circumstances.

I am mindful of the provisions of ***Section 60(2)(c)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, which prescribe that the FSPO can find a complaint to be upheld, substantially upheld or partially upheld on the basis that:-

> "*Although the conduct complained of was in accordance with a law or an established practice or regulatory standard, the law, practice or standard is, or may be, unreasonable, unjust, oppressive or improperly discriminatory in its application to the Complainant;*"

Accordingly, in the particular circumstances, it is my decision to partially uphold this complaint and I direct the Provider to make a compensatory payment to the Complainant by way of refund of a portion of the premium payments which are at issue, in the sum of €4,000.

/Cont'd…

Conclusion

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

- Pursuant to ***Section 60(4)(d)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** that the Respondent Provider make a compensatory payment to the Complainant in the sum of €4,000.

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

20 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.