An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0148
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Lapse/cancellation of policy
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns a Life Term Cover policy which was incepted on **1 August 2010.** The policy was cancelled by the Provider on **23 December 2017.**

The Complainants' Case

The Complainants held a Life Term Cover policy with the Provider. The First Complainant states that he attended the Provider's offices on **2 October 2017** *"with an amount of €102.62 to pay for October and November".* The Provider took the payment and issued a receipt to the First Complainant.

The First Complainant states that in **January 2018,** the money in his bank account to pay the policy amount had not been collected. The First Complainant states that when he enquired about this, he was informed that the policy had been cancelled since **23 December 2017.** The Complainants state that they did not receive any correspondence from the Provider regarding missed payments or any correspondence at all.

The Complainants state that having pre-paid a cash amount on **2 October 2017**, they were not expecting to pay further premiums until the end of December 2017. The First Complainant states that he *"never cancelled the direct debit to the Provider"* and that he *"understood the importance of keeping this payment going".*

The First Complainant states that in **January 2018** he became aware that his policy was not paid up to date. The First Complainant was informed by the Provider that if he failed to make a payment before **1 February 2018** that he would be required to complete an evidence of health form.

The First Complainant states that he had funds in his account and lodged a further €170 into his bank account on **31 January 2018.** The payment was not taken from his bank account by the Provider. The First Complainant states that he enquired with his bank on **26 February 2018** and was told *"the only date the Provider went into his account was 2 October 2017, there was no further request showing up to February 2018".* The Complainant states that he was told the cash payment could not be accepted as the policy was cancelled since **December 2017.**

The Complainants are unhappy with the Provider's suggestion that they complete an *"evidence of health"* form to restart the policy. The First Complainant states that he is willing to pay the outstanding premiums and would like to have the policy reinstated without submitting an *"evidence of health" form.*

The First Complainant states that he *"is very distressed over this whole issue and feels he has been a loyal customer for the past eight years".*

The Complainants seek for the Provider to reinstate the policy.

The Provider's Case

The Provider states that the Complainants had not paid all premiums due on the policy up to **31 December 2017.**

The Provider states that as the Complainants' method of payment for their policy was via direct debit, the monthly payment is requested from their bank account each month. The Provider requests the monthly payment five days in advance of the chosen debit date.

The Provider states that the outstanding payment of €102.62 due on **2 October 2017** was already requested from the Complainants' bank account when the cash payment was made on **2 October 2017.**

The Provider states that it appeared that they had paid €205.24 into their plan which was more than the required €102.62.

The Provider states that the bank returned the payment of €102.62 as unpaid due to insufficient funds in the Complainants' bank account on **4 October 2017.**

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The Provider states that it requested the normal monthly payment of €51.31 on 1 November 2017 as the Complainants had not overpaid in October as the direct debit in October had been returned. The Provider states that the bank returned the November payment to the Provider as unpaid as the direct debit had been cancelled.

The Provider states that it wrote to the Complainants on **28 October 2017** informing them that their monthly payment of €51.31 was not paid as they cancelled their direct debit. The Provider further informed the Complainants that their plan would *"automatically go out of force if we do not receive this payment before 23 December 2017"* and that they would need to complete an *"Evidence of Health"* if it did not receive payment before **1 February 2018.**

The Provider states that no response was received from the Complainants in relation to this letter. The Complainants' policy went out of force and their benefits were cancelled on **23 December 2017.**

The Provider states that it wrote to the Complainants on **23 December 2017** informing them that as it had not received the outstanding payments their benefits were now cancelled. The Provider further states that it advised the Complainants that it needed the outstanding balance of €153.93 and if no payments were received before **1 February 2018** an *"Evidence of Health"* form would be required. The Provider states that no response was received from the Complainants in relation to this letter.

The Provider states that it is possible to reinstate their plan, but it requires the Complainants to complete an *"Evidence of Health" form.* The Provider needs this information as its underwriters need to approve restarting the plan. The Provider further states that as it has not received any payment since **1 November 2018** the outstanding amount would be required. This amount needs to be paid to reinstate their plan.

The Complaint for Adjudication

The complaint for adjudication is that the Provider cancelled the Complainants' policy on **23 December 2017** without the Complainants' knowledge, failed to request direct debit payments for November and December 2017 from the First Complainant's bank account, and has failed to accept the First Complainant's payment on **31 January 2018** to bring the policy payments up to date and reinstate the policy. The Complainant further complains that the Provider is requesting him to complete additional documentation to reinstate the policy.

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.

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The Complainants were given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

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

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

A Preliminary Decision was issued to the parties on 24 March 2020, outlining my preliminary determination 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.

The Complainants incepted a Life Term Cover policy on **1 August 2010.** This was maintained for seven years before the policy was cancelled by the Provider on **23 December 2017.**

I note from the documentary evidence before me that the Complainants are very distressed by the cancellation of their policy on **23 December 2017.** The Complainants state that the policy was paid up to **December 2017** and further state that they have a receipt confirming this payment. The Complainants state that policy premiums of €51.31 were paid monthly by direct debit through the First Complainant's bank account.

The Provider states that it did not cancel the Complainants' plan because the bank cancelled the First Complainant's direct debit. The Provider further states that the Complainants' plan went out of force as the Complainants ceased making the payments required.

I note that Section 3 of the Provider's Terms and Conditions deals with *'Making Payments'*

> *"3.1 Although each payment is due on the payment dates shown in the plan schedule, we give you 30 days to make the payment unless you make the payments monthly, in which case we will give you 10 days to make the payment. (This time allowed is known as period of grace.) If you become entitled to a benefit during a period of grace, we will take from your benefit any payment that you have not made.*

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3.2 If you have not made a payment by the end of the period of grace, your cover under the plan will end immediately. A payment is not made until we have received it. It is up to you to make sure that we receive your payment. We are entitled to pass on to you any charge which we have to pay because all or part of your payment (for example, a direct debit) is dishonoured.

3.3 If your cover under the plan ends as described in section 3.2, you can restore your cover within 90 days from the date the first missed payment became due. You must make all the payments which would have been due if your cover had not ended. You will not be entitled to benefits for anything that happens between the end of the period of grace and the date we receive all missed payments.

3.4 If, after 90 days and before 180 days of the first missed payment being due, you ask for cover to be restored, the life assured must fill in an evidence of health form and all the payments which would have been made if cover had not ended must be made"

I further note that the Complainants did not contact the Provider until 118 days from the first missed payment on 1 November 2017.

From the documentary evidence before me, the Provider sent letters to the Complainants dated 3 October 2017, 28 October 2017 and 23 December 2017 informing the Complainants that their direct debit had not been paid and that their policy would go out of force if the Provider did not receive payment before 23 December 2017. The Complainants state that they did not receive any correspondence from the Provider.

While I accept that this had caused distress to the Complainants, it is unfortunate that the Complainants delayed in contacting the Provider in relation to the missed payments. I do not believe that the conduct of the Provider was unreasonable in the circumstances.

For the reasons set out above, I do not consider that the Provider's conduct has been in any way wrongful. Indeed, the Provider has stated that it is possible to reinstate the Complainants' plan, however, the Complainants must complete an evidence of health form before this is possible.

For the reasons outlined above, I do not uphold this complaint.

Conclusion

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

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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

16 April 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.