Decision Ref:	2020-0172
Sector:	Banking
Product / Service:	Multiple Products/Services
Conduct(s) complained of:	Dissatisfaction with customer service
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint concerns the Provider Bank's alleged role in having the Complainant's Critical Illness Policy cancelled. The Complainant states that she had a Critical Illness policy in place in case of serious illness since December 2002. The Complainant states that in 2009 she had to re-mortgage the family home. The Complainant says that the Bank agreed to re-mortgage even though she advised the Bank that she had a medical condition and family history of a serious illness. The Complainant states that her ability to pay was stress tested by the Bank. The Complainant was given a mortgage, but then her wages were severely cut. The Complainant states that she worked with the Bank to agree a lesser repayment plan and the advice of the Bank was to cut back on and terminate a critical illness policy and other insurance policies. The Complainant's position is that this was done to pay a larger portion towards the repayment of the mortgage. The Complainant says that she fell victim to a serious illness in 2013 and her income was further cut and due to the advice she was given by the Bank she had no Critical / Serious Illness cover to rely on. The Complainant says that it seems she would have been in a better position if she had never attended meetings with the Bank.

The Complainant states that she had an exemplary record for paying her mortgage for the previous 15/16 years, and feels that she was given a mortgage when the banking crisis had set in and later deprived of her critical / serious illness policy by the Bank.

The complaint is that the Bank incorrectly and unreasonably required / allowed the Complainant to cancel her Serious Illness Policy.

By way of resolution the Complainant wants the Bank to provide compensation for her being unable to pay her mortgage due to what she describes as its poor advice.

The Complainant's Case

The Complainant states that she believes the Bank, has wronged her on several levels. Specifically, having fallen victim to a serious illness and in reference to her critical illness policy (which she had paid into for over 10 years) terminated due to the pressure she states was placed on her by the Bank in 2010 / 2011.

The Complainant says that she considered the Bank to be her financial advisors, more so in recent years. The Complainant states that during the time of the banking collapse, all media and Government institutions were advising that borrowers engage with their bank. The Complainant states that likewise, the Bank in turn purported to do so with her best interests foremost. The Complainant submits that the Bank's directives proved to be wrong at every level and left her in a dangerously vulnerable position financially. The consequences of which she says has, without doubt, negatively affected every aspect of her life thereafter.

The Complainant states that in the 32 years prior to the collapse of Irish banks, she had never not repaid a loan. She says that in fact, her record had been exemplary throughout her engagement with the Bank. The Complainant states that she has always taken the Bank's direction on financial planning matters.

The Complainant states that due to concerns surrounding a close family history of a serious illness, she took out critical illness cover in 2002. The Complainant says that when instructed by the Family Court to re-mortgage, the relevant documents at the time show her concerns regarding a serious illness she had, and she clearly indicated on the applications that she had a medical condition. The Complainant states that this in itself is proof that she had no intention of cancelling any such policy, as this would later result in serious financial consequences.

The Complainant's position is that employees at the Bank were fully aware of her concerns.

The Complainant says that the evidence shows she repaid full mortgage payments until the 16th of August 2010. During this period, conversations and discussions took place both at branch and at senior level, as an interest only repayment plan was discussed and agreed. The Complainant says that notably the first 6 months review falls in line with the cancellation of the policy.

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The Complainant's position is that during the latter half of 2010 mortgage payments became increasingly difficult to maintain. The Complainant says that this was due to cuts in pay, overtime, the introduction of USC, and Government Pay Related Deductions. The Complainant says that all savings by then had been put towards mortgage repayments, and once more she had been told that this was a temporary banking problem, which would be resolved in the short to medium term.

The Complainant submits that it is important to note that there is a significant gap in the paperwork she received from the Bank in relation to the second half of 2010 in the lead up to the review in the New Year of 2011. The Complainant says that this is the very period that would have resulted in her seeking financial advice from the Bank. The Complainant says however she has internal bank evidence from the middle of 2011, which illustrates the tone of conversation and directives provided during these important earlier meetings. The Complainant refers to a note between staff which states "Client must reduce monthly outgoings significantly". The Complainant states that over the next 6 months, this was always repeated after the bank had gone through her outgoings with a fine tooth comb to see where cutbacks could be made from her Standard Financial Statements (SFS).

The Complainant refers to the message to "engage with your lender" which the Government officials put out and the "engage with your lender" which the Banks repeated. The Complainant submits that as seen "engaging with the lender" has proven to be to her detriment as not engaging would have retained her 'critical illness' policy so that it would cover her when she did contract a serious illness. The Complainant says that, her critical illness policy was far more significant to her in her maintaining the mortgage payments overall. The Complainant submits that she can only emphasise that she was given absolutely no option but follow the Bank's directives at the time.

The Complainant states that having gone through the most horrific of illness and treatments, the constant uncertainty which has shadowed her every turn with regards to her financial situation, has made these times traumatic, worrisome and deeply distressing. The Complainant states that this is more so, as a result of the directives provided by the Bank. The Complainant states she is not a financial advisor. The Complainant says the Banks, given their predominant social standing, are regarded as fiscally astute. The Complainant states that therefore she fails to see how she could have worked any differently *when snookered* by representatives of a system, whose directives have inherently failed her.

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

The dispute relates to interactions with the Bank regarding the Complainant's Serious Illness Policy at a meeting in 2011. The Complainant alleges that during this meeting, following the completion of a Standard Financial Statement, she was informed that her financial affairs would balance better if she cancelled a number of insurance policies which included both serious Illness cover and Life cover. Following this advice, the Complainant cancelled a life policy with serious illness cover in February 2011. The Complainant, regretfully, was diagnosed with a serious illness

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in 2013. It is the Complainants belief that if the Bank did not advise her to cancel the policy, she would have been in a position to claim from the insurance company for serious illness benefit.

The Bank's position is that it did not advise the Complaint to cancel her serious illness policy. The Bank states that while the Bank may recommend a customer to review their financial commitments including polices etc, the Bank would not advise any customer to cancel a policy.

This would be a decision for the customer alone to make.

The Bank states that in 2009, following Judicial Separation Proceedings, the Complainant was given a period of approximately four months to arrange funds for to buy out her husband's share of the home for the agreed sum. The Complainant approached the Bank for a home Loan. This mortgage was approved on the following conditions:

- Settlement payment was made to former husband for his interest in the property

- That the total borrowings with other accounts with the Bank and other entities be discharged from the proceeds of the advance.

The Complainant was issued with a Mortgage in the amount of €200k+ on the 22 May 2009.

In 2010, the Complainant approached the Bank requesting additional funding of €20,000 to get her residential investment property (RIP) finished and rented or sold. The Banks states that as the Complainant had considerable short term debt built up since the mortgage issued, the Bank was not agreeable to this and offered her a 6 month capital payment holiday (CPH) on her mortgage account. This the Bank says would have allowed the Complainant a 6 months interest only repayment on her mortgage account. The Bank states that it agreed to this to allow the Complainant to catch up on her short term debt and also finish her RIP mortgage. This interest only restructure was applied to the mortgage account on the 24th August 2010.

The Bank submits that on 31 January 2011, its Mortgage Manager, met with the Complainant and her friend. The Bank says that the Complainant advised that her financial situation had deteriorated since the last meeting 6 months previously. The Bank states that the Complainant requested €10,000 to complete her RIP property, which was declined. The Bank says that the Complainant requested a further 6 month capital payment holiday on her mortgage account. The Bank states that the Mortgage Manager at the meeting advised the Complainants of MABS (Money Advice and Budgeting Service). MABS is the State's money advice service which guides people through dealing with problem debt. The Bank says that in February 2011, the Bank agreed to capitalise the arrears and apply a capital payment holiday (CPH) for a number of months. This CPH started in March 2011.

The Complainants capital payment holiday arrangement expired on the 16th August 2011 and the Mortgage Manager met with the Complainant to discuss her mortgage and completed a standard financial statement (SFS). The Bank's position is that while completing the SFS, the Complainant

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was asked what steps she had already taken to reduce her monthly expenditure. The Bank says the Complainant advised that she had cut back on shopping/phone usage/fuel and no holidays. When asked what steps she proposed to take to reduce expenditure going forward, the Complainant is said by the Bank to have advised that she would continue as she has been.

The Bank states that the Complainant was approved for a moratorium for 6 months.

The Bank submit that the Complainant maintained in her correspondence dated 14th June 2016 that she attended her local bank branch in October 2011. The Bank says that the Complainant completed an SFS at this meeting and alleges that she was informed that her affairs would balance better if she cancelled a number of insurances policies, which included both serious illness cover and life cover.

The Bank's position is that it feels it acted fair and reasonable in relation to this matter, however on review of the file, it acknowledge there was late response to the Complainant's letter dated the 11 February 2014. Also there was a lack of clarity in the Bank's final response letter to the Complainant, and in light of the shortcomings, the Bank offered €750.00 to the Complainant.

Evidence

Further submissions from the parties

In the Complainants submission of 30 July 2017 she states, among other things:

> *"… the actions of requesting very detailed financial statements, and engaging with personnel who came out and met with me to discuss the minute (on more than one occasion) illustrates the depths of this process. And in particular in reference to the meetings I had at local branch level during late October of 2010 and again in November (To clarify and correct the 'Summery of Dispute' referred to in your letter). These activities resulted in a Capital Repayment Holiday being granted on foot of reductions enacted by the beginning of the New Year. Reductions advised upon by [the Bank] which included the cancelling of my Serious Illness Cover.*
>
> *The gravitas of the Banks position in relation to my mortgage indebtedness cannot be simply discounted. Indeed, their role as 'Agent Provocateur', saw to it that such pressures ensured my compliance with their advice leading up to the granting of the Capital Payment Holiday, given that such failures to comply would eventually see my financial affairs being taken out of my control (as they put it), and I have witness to this occasion. This was most certainly incredibly distressing realisation for someone who has never missed a payment in 32 years with [the Bank].*
>
> *For the Bank to conclude 'it may recommend a customer review their financial commitments' is by admission a Passive/Aggressive stance. It certainly bears no relation to the active advice*

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given, nor does it acknowledge that the whole process itself was indeed much more than just a solo activity.

I cannot emphasis strongly enough that taking the Banks advice as a customer of long standing, has significantly impacted on my financial outlook to the tune of 148,000 euro (the lump sum that would have been due) And, this loss has gravely compounded my indebtedness. It is on this basis that I seek full restitution and compensation".

<u>Time line for when the serious illness policy was cancelled</u>

18 January 2011 – Bank issued a letter to the Complainant regarding the capital repayment holiday arrangement as it was due for a review.

31 January 2011 – The Complainant met with a Bank official advising that her situation had gotten worse – budget cuts and lower wages. The Complainant requested a €10k top up on the residential investment property mortgage but this was declined. The Bank recommended a full capital payment holiday on the home loan for 6 months and to continue to pay "interest only" on the RIP Loan. The Provider states that there is no reference on its system to reviewing expenditure in recommendation, or notes referring to cancellation of policies.

> *"Mortgage Manager recommendations*
> *I met [the Complainant] & her friend .. at the .. Hotel at 5.00pm 31/1/11. She said her situation has gotten worse since the last MM meeting 6 months ago, due to the recent budget cuts etc & she said she is not on night duty now & as a result her wages are lower, by 600 p/month. However, she said that she may get back onto night duty again in the future & her income may increase again. The RIP in …is unrented as the property is uninhabitable still, as it needs a bathroom & Kitchen & toilet. … She has requested a further 6mths i/o on ML re …, as she said she is struggling with the full bill.*
>
> *We filled the I & E sheet & this is borne out by same, so I am recommending a full CPH on ML ref ... For 6 months. She will continue to pay the i/o on the RIP property & keep all s/t debt up to date. I advised of MABs".*

16th February 2011 - the Serious Illness Policy and benefits ceased.

18 February 2011 – The Bank informed the Complainant it was prepared to capitalise the arrears on the Home Loan. The Complainant was also approved "interest only" for a further 6 months – to expire in August 2011.

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18 February 2011 – Bank's Account Collection Comments

> *"[Saw] [the Complainant] today & confirmed that i/o is approved for a further 6mths & doc will be sent out in the next few days & the payment will be set up for the March payment once she returns them in time. I advised her that the Feb bill is due as of 16th Feb last & that she needs to lodge to pay the Feb bill. She said she will organise same as soon as she gets [p]aid in a few days time"*

18 February 2011 – The Bank to the Complainant:

> *"I am pleased to advise you that the Company is prepared to capitalise the outstanding arrears balance of ... over the remaining term of 220 months"*

18 February 2011 – Bank to the Complainant:

> *"Further to your recent contact, I am pleased to advise you that the Company is prepared to capitalise the outstanding arrears balance of …"*

21 February 2011 – Bank to the Complainant

> *"Our records indicate that your monthly repayment of ... has not been paid in full and therefore your account is in arrears of... from the due date shown".*

23 February 2011 – The Complainant signed agreement for Capitalisation and Capital Payment Holiday.

In regard to the above timeline the Complainant's position is that the review was imminent for January 2011. The Complainant states that it is important to note during this period one of her parents was dying of a serious illness, and again she had no intention of cancelling her critical illness policy given her experience and the ramifications. The Complainant explains that that month she met with representatives from the Bank, at branch level on the possibilities of extending the interest only arrangement. The Complainant says however, in order to acquire this facility, she would have to be seen to be willing to make cuts to her expenditure. The Complainant submits that she was advised to cut out all payments to insurance companies except those directly connected with her mortgage. The Complainant says that this included her critical illness policy. The Complainant states that the policy numbers not pertaining to her mortgages were written down on a piece of white Bank jotter pad. The Complainant states that she recollects this clearly as being in the named Branch, as she remembers the female staff member joking with her at the time saying; *"I looked healthy enough and I would be in a position to recommence possibly at a later date when things settle down with the Banks, although meantime the sum of 148 euro was a large sum that could be going towards the mortgage. To be seen to be paying it towards 'critical illness', by the bank, would not work in my favour if I was to hope for a reduced payment plan".*

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The Complainant states that this directive was further emphasised at a meeting on the 31st January. The Complainant says that her friend who accompanied her was a witness to this.

The critical illness policy was cancelled on the 16th February 2011.

Timeline of events in relation to the cancellation of life cover in 2012 – As set out in the Provider's submission to this office of **19 July 2017**

4th April 2012

The Complainant completed a Standard Financial Statement

"The Bank were unable to process same as we required payslips in order to assess the ARA".

12th April 2012

"Customer sent request to [Underwriter of life cover] asking to cancel polices".

"Completed Waiver to cancel Life Cover on RIP Loan".

16th April 2012

"E-mail to and from branch re. waiver – branch stated had spoken to customer – she was putting alternative cover in place will call with new policy. Bank declined to accede to cancelling policy when no new one was in place.

The Complainant then put an alternative policy in place which was assigned to the Home Loan. The 2 [life] policies were then cancelled".

Provider File Note of 23 April 2012

> *"The Client submitted a [life policy] Policy 4828… and DOA for this loan and the term and amount are ok but it was scanned with the clients other No. .. which is a RIP loan and she submitted a waiver for this loan – J.. has emailed the Branch Manager about the waiver and they are in discussions with the client but no action was taken on the home loan.*
>
> *I placed the above [life] Policy on the cancellation list to [the Underwriter] and the [2nd life policy] Policy on the NOA worksheet and wrote to the Client confirming this".*

23rd April 2012 – The Provider's Mortgage Department to the Complainant

"We have received details of your [new life assurance] policy and have updated our records accordingly.

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I have contacted [Underwriter of 1st life assurance policy] to advise them to cancel your existing policy immediately. However, please note that as your policy is billed in arrears you may still be charged with your next mortgage instalment. In relation to closing or retaining your … block policy you should contact [Underwriter] on …. for advice in relation to same" "Important: Please read the information relating to housing loans printed on the reverse side of this letter".

24th April 2012 – Communication from the Provider to new Underwriter regarding assignment of the Complainant's new policy.

25th April 2012 – The Provider receives acknowledgement from new Underwriter on the assignment.

The Complaint for Adjudication

The complaint is that the Bank incorrectly and unreasonably required / allowed the Complainant to cancel her serious illness 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. 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 **16 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.

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A Submission dated **2 April 2020** was received from the Complainant. This submission was exchanged with the Provider and an opportunity was made available for any additional observations arising from the additional submission. The Provider made a post Preliminary Decision submission dated **20 April 2020**. This was exchanged with the Complainant. There were no further submissions from the parties. I have considered the contents of these additional submissions, together with all the submissions and evidence in setting out my final determination below.

As regards whether the Provider assisted or advised the Complainant in relation to the cancellation of the serious illness policy in February 2011, the Provider's position is that it did not advise the Complainant to cancel the life assurance policy which she cancelled in February 2011. The Provider re-iterated this position in its post Preliminary Decision submission.

The Bank's position is that while the Bank may recommend a customer to review their financial commitments including policies etc., the Bank would not advise any customer to cancel a particular policy. The Bank states that this would be a decision for the customer alone to make.

The Bank was asked by this office whether the Bank would have known from the mortgage application of the details of the Complainant's previous medical history. The Bank's response was that during the Complainant's mortgage applications in 2008 and 2009 it would only be the Life Assurance Consultant who would have requested any medical information from the Complainant in regard to her application for the life policies. The Bank states that therefore the Bank would not have access to these proposal forms completed by the Complainant.

The Bank was also asked by this office whether the Bank has a policy in place as to what items of expenditure should be kept in place, in such situations, for example life or serious illness cover.

The Bank's response is that when the Bank is assessing a borrower's request for a restructure arrangement it has always allowed for borrowers to make insurance repayments. In letters offering any restructure arrangement the details will include any applicable insurance premium being paid along with the proposed restructure repayment. Also on restructures where the borrower had insurance billing with the Mortgage the Bank would have kept the insurance up to date even if the borrower was not paying the Mortgage.

The Complainant's response (29 August 2019) to the Provider's above submission is as follows:

> *"It's of no surprise that [the Bank] would hide behind its common default tactic of projecting that it is at the client's discretion to balance the financial outlook. It has to be remembered that in 'engaging' with the banks (as citizens, we were encouraged to do by Government) that their advisory capacity was fundamental in reshaping loan structures. Indeed, most if not all actions were to ensure the Bank's co-operation in providing a restructure. The pressure direct or indirect is most profound. Again as a [hospital worker] facing into such difficulty, the Banks were adamant my restructure met a criteria, which*

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likewise involved their own review of a Financial Statement and their subsequent verbal commentary. This review through to the timeline line of the approval of restructuring is clearly is self-evident. The two cannot be conveniently dismissed as being independent of each other.

They are also distancing themselves from the insurance aspect of their own contract and security - so how can this be so? As in not seeing the health history attached to their arrangement, as I was asked to supply.

They have also failed to answer the key question correctly as to what protocols they had in place when advising me what expenditure had to remain in situ for the restructure, both verbally and in writing. There was no such list as to those things you keep, or are permitted under the restructuring. Had there been, indeed, red flags on both sides would have been raised at the outset, given the extent of their rebuttal. Critical illness cover, given my health issues at the time, was very much a part of my financial outlook and contract going forward, and to avail of the restructure it was advised such a significant amount would not have me matching their criteria".

Analysis

I note that there is conflicting account by the Complainant in the submissions as to when she states she was advised by the Bank that her affairs would balance better by cancelling the serious illness policy. In a letter dated 14 June 2016 the Complainant refers to October 2011, but later corrected this to October 2010. I note that the serious illness policy was cancelled in February 2011. Therefore, it must be accepted that any advice that was allegedly given about the cancellation of the cover, would have pre-dated February 2011.

The Bank's position is that it did not advise the Complaint to cancel her serious illness policy. The Bank states that *"While the Bank may recommend a customer to review their financial commitments including polices etc, the Bank would not advise any customer to cancel [a policy]"*. The Bank states that this would be a decision for the customer alone to make.

The evidence submitted does not show if there was any consideration by the Bank as to what the Complainant was giving up by way of this particular insurance cover. I also have not been furnished with evidence of the Bank having in place a policy with regard to items that are considered essential to keep in place by way of insurance cover, other than the life cover required by statute. At a minimum I would have expected some guidance for the Complainant as to what should and would be accepted by the Bank as something that it would not expect the Complainant to give up, or that would require greater consideration from the Complainant before giving it up.

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Any discussion between the parties should have taken account of the Complainant's own health history, her age and family health circumstances. The length of time that the policy was in place was also an important consideration. Here the Complainant was in her 50s and she had health issues, as did a close family member. The Complainant had been paying for this policy for almost 10 years. Once the policy was cancelled the Complainant's health and age, most probably would have affected her ability to avail of similar cover again at the same cost and for the same cover.

In the Bank's post Preliminary Decision submission it disputes that it assisted or advised the Complainant in relation to her decision to obtain an alternative life cover policy in 2012. I am satisfied that from the evidence submitted, and outlined above, the Bank did have an input into the Complainant obtaining an alternative life policy in 2012.

It must be noted that while there is a statutory requirement for life cover to be in place in respect of a mortgage, there is not the same requirement in respect of serious illness cover.

The evidence shows that the Provider rightly ensured that the mortgage was secured by a life policy and it appears that a cheaper form of this cover was arranged. While there is a statutory requirement for such life cover, I consider that some input from the Provider was also required when discussing / recommending / suggesting cutting back on a policy such as the policy the Complainant had which provided serious illness cover.

The evidence from the Manager in question who is said to have suggested the cancellation of the policy is that:

> *"I have no recollection of my dealings with [the Complainant]. I would however like to put on record that I would never tell a customer that their affairs would balance better if they cancelled a number of insurances including serious illness cover".*

However, the Bank's own position is that it may recommend a customer to review their financial commitments including polices. It is also evident as pointed out above that the Bank had some involvement in arranging / putting in place alternative life cover for the Complainant.

While the Complainant was the main decision maker with regard what to do with the serious illness policy, as an item of expenditure that was most likely identified as something that could be cut back upon, I would have expected some guidance from the Bank to the Complainant to think carefully before cutting back or cancelling the serious illness policy.

The Bank, for example, could have explored with the Complainant her actual need for the serious illness cover based on her own health situation and that of her family, in relation to coverable events under the policy and have the Complainant consider whether spending the amount on the premium is better than the risk of not having a pay-out should an illness be contracted.

I accept that hindsight has unfortunately shown that keeping the policy in place may have been the best approach. However, a pay-out under the policy was always going to be subject to the

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underwriter's claim assessment and in particular whether the policy criterion for the illness in question was met.

In the Complainant's post Preliminary Decision submission dated **2 April 2020**, the Complainant took issue with the following sentence in my Preliminary Decision:

> *"There is no certainty as to whether a claim will be successfully paid out under a policy, and as it was not tested here, the outcome for the Complainant as regards a claim (if the policy had been kept in place), is unknown, and the coverable amount under the policy cannot be an influencing factor in the resolution of this complaint".*

In the above regard, the Complainant stated that:

> *"As for meeting any criteria for a claim, the insurance company confirmed my serious illness...did indeed qualify as a serious illness which the policy covered to the tune of 138,463 as of 12th August 2015 (see attached) So I fail to fully understand where it can be assumed that this is 'untested'".*

It must be noted that the attached letter referred to by the Complainant, was a letter from the Underwriter of the Serious Illness Policy dated 12 August 2015, merely setting out the extent of cover which had existed under the policy. I have copied the content of this letter below.

Please find enclosed the information as requested.

Policy Type	Protection Plan
Policy Commencement Date	18th December 2002
Total Premiums Paid	€11,252.28
Full Encashment Date	16th February 2011

I trust this is to your satisfaction, but should you have any further queries please do not hesitate to contact me at the above address or on FREEPHONE [redacted]

As can be seen from the content of this letter it made no reference as to whether a claim would have been paid. There was no claim assessment by the Insurance Company to establish whether the Complainant met the policy criteria for the illness in question.

A claim assessment involves much more than a mere confirmation of cover. An Insurance Company would first require that a claim form be completed. An insurance company would require details of the insured's medical condition, and would seek the names of doctors and medical specialists that the Insured attended, and full details of the insured's medical history. The medical condition has to meet the specific criteria set out in the policy document. Not all medical conditions meet the specific criteria set out in a policy document, and therefore not all claims qualify for benefit. As an insurance contract is based on the medical questions the insured person answered on the application form when applying for the insurance cover, an insurance company would also need details of

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the insured's medical history to confirm that all the information given on the application form was correct.

I am in no way questioning or disputing the Complainant's medical condition or accuracy of information supplied to the insurance company at any stage. I am merely pointing out that the claim assessment process was not gone through here, as the policy had been cancelled, and in that respect I had commented on the factual situation that exists, that the Complainant's claim was not tested.

I accept that the greater responsibility rested with the Complainant as to the appropriateness of cancelling the Serious Illness policy mindful of her own health and that of her family's health history. It is clear that the Complainant has made great efforts to meet her loan payment commitments at a time which had been difficult for many people because of the banking crisis and the Government's measures in dealing with that crisis. The Complainant has highlighted the measures that were put in place to deal with the financial crisis and the need to remedy the banking system's failures, as factors impacting on her re-payment capacity. The measures that particularly impacted upon the Complainant were reductions in her pay, longer working hours, new and increased taxes.

However, I believe the Bank could have taken more care in its dealings with the Complainant so that she fully understood the need to weigh up all considerations before cancelling the Critical Illness Policy. There can be no doubt that the cancellation of the policy has caused considerable stress and inconvenience to the Complainant. While ultimately it was the Complainant's decision as to whether to keep the policy or cancel it, given the overall circumstances, and considering what is fair and reasonable, I consider that a compensatory payment is merited here.

Having regard to all of the above, I am partially upholding the complaint and direct the compensatory payment of €15,000 (fifteen thousand euro) to mark the Bank's conduct in its dealing with the Complainant in relation to weighing up her needs for the serious illness policy when considering whether to cancel the policy to meet loan repayments to the Bank.

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)(g).***

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainant in the sum of €15,000, to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the Provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in

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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

8 May 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

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