Decision Ref:	2020-0190
Sector:	Insurance
Product / Service:	Term Insurance
Conduct(s) complained of:	Mis-selling (insurance) Delayed or inadequate communication Complaint handling (Consumer Protection Code) Dissatisfaction with customer service Misrepresentation (at point of sale or after)
Outcome:	Substantially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants entered into a life and specified illness insurance policy, arranged by the Provider (an insurance broker). The Complainants submit that when the First Complainant was diagnosed with Rheumatoid Arthritis and undergoing treatment in respect of this condition, she contacted the Insurance Company, the underwriter of the policy, as regards submitting a claim, but was informed that the condition was not covered by the Policy. The Complainants submit that they understood from the documents given to them by the Provider at the point of sale, that Rheumatoid Arthritis was a condition covered by the Policy which they entered into. The Complainants submit that the documentation furnished by the Provider was misleading and, consequently that the Policy was mis-sold to them.

The Complainants' Case

The Complainants were sold a "*Life Cover, Specified Illness Cover, and hospital cover*" by the Provider.

The First Complainant submits that at the point of sale, in **2011**, they were furnished with two documents by the Provider, "*showing all Specified Illness Cover for part and full*

payment" by the Insurance Company and that one of the illness listed under full payment was Rheumatoid Arthritis.

They submit that on the basis of the information provided to them, they understood that the condition of Rheumatoid Arthritis was one which was covered by the Policy they entered into.

The First Complainant submits that she was subsequently diagnosed with Rheumatoid Arthritis of her hip joints. She submits that when she contacted the Insurance Company in question, in **2016,** enquiring about a claim entitlement under the policy, she received the response that Rheumatoid Arthritis was not a condition which was covered and it referred her to the Terms and Conditions Booklet of the Plan, in this regard. She says that she then "*referred to the Booklet and surprisingly there is no mention about Rheumatoid Arthritis*".

The Complainants submit that the document which was furnished by the Provider led them to believe that the policy offered by the Insurance Company, which policy they incepted, provided cover in respect all of the conditions which were listed on the sheet.

The Complainants seek to have the Provider pay for the costs of the First Complainant's treatment to date and anticipated surgery which she will have to undergo. She submits that she has spent approximately €2,000 to date and is facing a hip replacement operation of her right hip, which will cost approximately €11,500.

The Complainants further submit that when they made a complaint to the Provider, it did not respond to them and that it "*completely ignored our complaint.*"

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

The Provider acknowledges that the Complainants were given a document at the point of sale with the Insurance Company's logo on the corner of the page which showed a list of insurance companies and the conditions covered by each of them. It submits that the document was a comparison sheet of illnesses that were covered by each insurance company, at that time.

The Provider says that "*this comparison was for illustration purposes and to allow our clients to make a full and informed decision as to which insurer best suited their needs for specified illness cover.*" The Provider submits that it deals with many insurance companies and that the Complainants had the option to select from any of the companies listed on the page.

The Provider submits that:

> "*on this particular sheet which was given at the client's initial meeting (while deciding which insurer to proceed with) you will notice that SOME illnesses have an abbreviation LIE; ADL noted beside them. What these abbreviations mean:*
> *LIE: Loss of Independent Existence*
> *ADL: Activities of Daily Living*

/Cont'd…

For anybody not familiar with these abbreviations, it is then stated near the foot of the page the 'some illnesses may be covered by LIE or PTD subject to measurement of Activities of Daily Living (ADL).'

The Provider further submits that it advised to *'check appropriate terms and conditions for details.'*

The Provider has submitted that although

> *"LIE; ADL is CLEARLY typed in capital letters alongside the words Rheumatoid Arthritis in the [Insurance Company] section. Yet the clients were still happy to proceed with at this point."*
>
> [original emphasis]

The Provider has submitted that "*Should the clients have been unhappy with this at the point of sale, there were other insurance companies available to them. Some of the other companies DO cover Rheumatoid Arthritis (again, the sheet in question clearly indicates which companies do cover this.) However the clients were happy to proceed with [Insurance Company] until such a point that a claim was not being paid."*

With regard to the Second Document provided at the point of sale, which the Complainants have submitted was misleading, a document titled "***Lista Powaznych Zachorowan***", the Provider submits that:

> *This sheet was given to the customers at their initial meeting too. It is titled "Lista Powaznych Zachorowan" which translates to "List of Serious Illnesses". This is not specific to [Insurance Company] and does not state that [Insurance Company] cover these illnesses, nor does it have the [Insurance Company] logo on it.*
>
> *Upon initial meeting with the clients, all insurance companies [the Provider] deals with were presented to the customers (hence the sheet with the [Insurance Company] logo was also given to the clients.) Some companies do cover Rheumatoid Arthritis, as can be seen on that sheet. And so coming back to this "list of serious illnesses" sheet, this is used to allow Polish clients to understand the English illness names in their own language. Again, to reiterate it is not specific to [Insurance Company] and this is why no [Insurance Company] logos are on this document.*
>
> *It is now being implied that this sheet was given to the clients specific to their [Insurance Company] policy, which is false. It was just a translation sheet, which the client herself states they were given at their initial meeting (therefore BEFORE THE CLIENTS APPLIED TO [Insurance Company]). And again reiterating that the objective of the initial meeting was to choose which insurance company best suited the clients best. They selected [Insurance Company] even with the option to pick another company.* [original emphasis]
>
> *We feel that if anything, this should have helped very much with the clients understanding of what illnesses were covered by each company.*

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The Provider submits that within the terms and conditions which the clients received with their policy, Rheumatoid Arthritis is not listed and that:

> *"to refer back to the sheet with the [Insurance Company] logo, it indicates that "some illnesses may be covered by LIE or PTD subject to measurement of Activities of Daily Living (ADL)". And it also states to "check appropriate terms and conditions for details."*
>
> *To simplify what this means, is that in the event that Rheumatoid Arthritis becomes severe to a point where it causes Loss of Independent Existence subject to ADL (as defined by [Insurance Company]), the client would be eligible to make a claim (under LIE). This is accurate. The client would be claiming under Loss of Independent Existence (LIE) and not under the condition that caused it.*
>
> *So the client would not be claiming for Rheumatoid Arthritis, but the claim would be due to the severity of the symptoms from this condition and the effect it has on the clients daily life. Hence the reason the sheet had given the letters LIE; ADL next to the words Rheumatoid Arthritis in the [Insurance Company] section, as it is only covered under these circumstances with [Insurance Company] (when compared to other insurers.)*
>
> *LIE; ADL is explained in further detail in the Terms and Conditions of the policy documents that the customers received. But unfortunately in this instance [the First Complainant] admits she did not fully read the terms and conditions when they were posted to her.*

The Provider submits that it is important to note that a claim could still potentially be considered by the Insurance Company for the First Complainant's condition should her symptoms worsen and meet the Provider's definitions under LIE (subject to ADL) and that

> *"therefore, we are satisfied that <u>correct</u> information was given to the client at the point of sale."* [original emphasis]

It refutes the Complainant's complaint that the Provider failed to respond to her complaint and submits that the First Complainant contacted it on **14 November 2016** stating that she would be contacting the Ombudsman. It issued its response letter to the First Complainant, three days later, on **17 November 2016**.

It concludes that it had not been at fault, as it gave the customers correct information at the point of sale.

<u>The Complaint for Adjudication</u>

The Complainants' complaint is that the Provider wrongfully furnished them with misleading documentation at the point of the sale indicating that Rheumatoid Arthritis was covered by the policy they incepted, when in fact it was not. The Complainants are also dissatisfied because they say that the Provider mishandled their complaint.

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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 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 **01 May 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 substantive submissions from the parties, within the period permitted, the final determination of this office is set out below.

The Complainants' complaint is that the Provider wrongfully furnished them with misleading documentation at the point of the sale indicating that Rheumatoid Arthritis was covered by the policy they incepted, when in fact it was not. The Provider contends that it provided suitable information at the point of sale.

I note following timeline of Events, as submitted by the Provider in respect of the subject matter of the Complainants' complaint:

> ***11/08/2011*** *[Agent's Name] advisor with [the Provider] met with clients to discuss insurance. At this point, various insurance companies were compared and the page with [Insurance Company] logo and the English to Polish - illnesses were used to aid clients understanding of each insurance company and what they covered.*
> *From the insurance companies available, [Insurance Company] was recommended.*
>
> ***11/08/2011*** *[Insurance Company] proposal form was completed with the customers Declarations and direct debit mandate were signed by the clients and advisor.*

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13/08/2011 *Application and supporting documents were received by [the Provider] office file set up by [Agent] (Provider administrator).*
Life and compliance checklist completed by [Agent].

15/08/2011 *Suitability letter posted to the clients*

22/08/2011 *Proposal submitted to [Insurance Company].*

22/08/2011 *Policy started.*

04/11/2016 *[The Provider] received a copy form [Insurance Company] a copy of which had been sent to the client) stating they had investigated the clients' complaint and detailing the outcome of same. [Insurance Company] state that [the Provider] are an independent intermediary and that the client can pursue their concerns with [the Provider] if they wish to do so.*

14/11/2016 *Email received from [First Complainant] making a complaint about the 2 documents she received at point of sale from [the Provider]. Also that she is sending her complaint to the Financial Services Ombudsman and Consumer Protection Commissioner.*

14/11/2016 *[The Provider] completes an internal investigation about [the First Complainant's] complaint.*

17/11/2016 *Letter sent to [the First Complainant] from [the Provider] to acknowledge receipt of complaint and with the outcome of the internal investigation findings. Also stating that if she is dissatisfied she can contact the Financial Services Ombudsman but noting that in this instance, she appears to have already done so (as per [the First Complainant]'s email on 14/11/16) and that [the Provider] are fully willing to comply with the Ombudsman.*

The Provider has furnished a written account from the advisor responsible for the sale of the policy to the Complainants, with his recollection of the sale of the policy, within an email dated **19 January 2018**:

To whom it may concern

I am sorry to hear that [the First Complainant] was diagnosed with Rheumatoid Arthritis.

Based on the information received I can confirm that [the Provider] office did everything possible to resolve this dispute.

I do remember the clients, but as many years have passed I will only state truthfully what exactly I can recall from selling the policy. I would like to add that all information passed to client at the start was to give the clients option of many insurance companies.

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When doing comparison of insurance companies, I used booklets from [Insurance Company]. On the specified illness cover list from [Insurance Company] (original document attached) Rheumatoid Arthritis is included but under LIE (Loss of Independent Existence) or PTD (Permanent and Total Disability), subject to measurement of Activities of Daily Living (ADL) or Activities of Daily Work (ADW). I explained as much as possible about the policy before the sale. I also gave the clients a list of basic translations of illness claims from English to Polish to allow clear translations before they pick chosen company.
The client has good English but I like to make sure my customers are always fully informed in their native language also. The clients wanted [Insurance Company] as they are a very good company and their hospital cover will work if hospitalised in Poland.

According to my knowledge [Insurance Company] decided that [the First Complainant's] condition is not severe enough to make valid claim under LIE at this time, but this does not exclude the possibility of paying compensation in the future. Unfortunately, we have no influence on the payment of compensation by insurance companies.

The Provider has made the following submissions regarding the two documents in question, which were furnished to the Complainants:

A document with [Insurance Company] logo on it (designed and worded by [Insurance Company], not [the Provider]. This documents displays and compares various insurance companies and gives some information about what each company DOES and NOT cover, Some of the companies DO cover Rheumatoid Arthritis, some do not. And some may pay out if the condition meets certain criteria (this is the case with [Insurance Company]). The sheet clearly displays the letters LIE; ADL directly beside rheumatoid arthritis in the [Insurance Company] section. The same sheet notes that "some illnesses may be covered by LIE or PTD subject to measurement of Activities of Daily Living (ADL) and follows this by stating to "check the appropriate terms and conditions for details".

The second document is not specific to [Insurance Company]. [The Provider] deal[s] with various insurance companies. This document is simply a list of illness names translated from Polish to English. It was given to the clients at their initial meeting (while exploring and comparing various insurance company options). It does not state that [Insurance Company] cover these illnesses, nor does it have [Insurance Company] logo on it. It was just to allow clients to understand the illness names in their own language. Note: Rheumatoid Arthritis is among the illnesses translated on this sheet because SOME insurance companies [the Provider] deals with DO cover Rheumatoid Arthritis. And the clients had the option to pick another insurance company if they wished to do so, but they were happy to proceed with [Insurance Company]."

I have had regard to the documentation in question and note the following:

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Document 1

The document with the Insurance Company logo on the right hand corner of the page, contains a list of insurance companies and the respective conditions covered by each one. The first thing I noticed and which I find very significant is that it is clearly stated, in the top left hand corner of the page as being "*For Financial Adviser use only*."

[emphasis added]

It also strikes me quite clearly that the purpose of this document is as a promotional document and that the contents and layout were designed to promote the Insurance Company in question's specified illness cover policy. The banner headline at the top states:

> *"Specified illness cover from [Insurance Company] – we tick all the boxes!"*

Underneath that, it states:

> *Choosing the best insurance provider for your client's specified illness cover used to be difficult; trying to decide who offers the most comprehensive cover at the right price was not always easy. However, with [Insurance Company]'s recent specified illness cover enhancements – we believe we've made the choice very simple for you.*

The document goes on present a table of over 50 conditions, listed in alphabetical order and 7 Providers listed across the top, creating the effect of columns. A tick mark features beside a condition which is covered by a provider, with an "x" appearing when a condition is not covered. The Insurance Company's policy appears as the first column, with green ticks down alongside each of the conditions listed. This is presumably what the tagline "*we tick all the boxes"* refers to. Tick marks in the other provider columns are in noted in black while the "x" marks appear in red font

Having regard to the relevant entry, "*Rheumatoid Arthritis*", for ease of reference I have set it out in the format in appears within the document:

Insurance Company	**Insurer B**	**Insurer C**	**Insurer D**	**Insurer E**	**Insurer F**	**Insurer G**	**Insurer H**

[Conditions in alphabetical order…]

Rheumatoid Arthritis	✓(LIE;ADL)	×	✓	✓	✓ (ADL)	✓	✓	✓

The Complainants submit that they understood from this, that the condition of Rheumatoid Arthritis was a condition in respect of which cover was provided by the Insurance Company.

The Provider has submitted however, that:

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"on this particular sheet which was given at the client's initial meeting (while deciding which insurer to proceed with) you will notice that SOME illnesses have an abbreviation LIE; ADL noted beside them. What these abbreviations mean:

LIE: Loss of Independent Existence
ADL: Activities of Daily Living

For anybody not familiar with these abbreviations, it is then stated near the foot of the page the 'some illnesses may be covered by LIE or PTD subject to measurement of Activities of Daily Living (ADL).' And to 'check appropriate terms and conditions for details.'

The Provider contends in support of its position that:

"LIE; ADL is CLEARLY typed in capital letters alongside the words Rheumatoid Arthritis in the [Insurance Company] section. Yet the clients were still happy to proceed with at this point."
[original emphasis]

The Provider says that, "*Should the clients have been unhappy with this at the point of sale, there were other insurance companies available to them. Some of the other companies DO cover Rheumatoid Arthritis (again, the sheet in question clearly indicates which companies do cover this.) However the clients were happy to proceed with [Insurance Company] until such a point that a claim was not being paid."*

The Provider refutes the Complainants' contention that there were "*hidden terms and abbreviations*" given at the point of sale and counters that

"*there were abbreviations beside Rheumatoid Arthritis on the sheet with [Insurance Company] logo on it , due to the conditions surrounding this condition. But they were not hidden. They were clear and in capital letters so we feel this is a very unfair statement. I also note that the <u>full wording</u> for these abbreviations is outlined on that same sheet*" [original emphasis]

I am of the view that there are a number of issues arising from the approach adopted by the Provider.

With regard to its assertion that:

LIE; ADL is CLEARLY typed [original emphasis] in capital letters alongside the words Rheumatoid Arthritis in the [Insurance Company] section. Yet the clients were still happy to proceed with at this point.

Significantly, the acronyms LIE and ADL are not explained anywhere within the document itself. The Provider has submitted that these mean:

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LIE: Loss of Independent Existence
ADL: Activities of Daily Living

and that:

> *"For anybody not familiar with these abbreviations, it is then stated near the foot of the page the 'some illnesses may be covered by LIE or PTD subject to measurement of Activities of Daily Living (ADL).' And to 'check appropriate terms and conditions for details.'"*

It is not explained anywhere what LIE or ADL stands for, or what one is being directed to checking the terms and conditions for. This is most likely due to the fact that the document is stated to be for Financial Adviser use only. It is by no means clear, how a consumer would have an understanding of what these terms stand for, what the full meaning of the terms are, or more importantly what they mean for the purpose of cover when they appear beside a condition.

The Provider has argued that the reader is directed (which I accept that it is, in small font) at the footer of the page, to "*Check appropriate terms and conditions for details*" in this regard. However, again and notably, this is a note directed at Financial Advisers rather than the customer, to check the appropriate terms and conditions, as it is not intended as a consumer document.

The Provider was asked by this Office to confirm the date upon which the Terms and Conditions booklet for the Life Term Cover plan was furnished to the Complainants. It responded that:

> *"We are confident that the [Insurance Company's] Terms and Conditions were provided to [the Complainants] on 11/08/2011. It is our company policy now, as it was in 2011, for our advisers to leave a copy of the Terms and Conditions (specific to the company and product being recommended to them) when they meet with the customer. We feel that this is good practice as it allows the clients an opportunity to read the Terms and Conditions in detail before the application is submitted.*
>
> *The clients were also provided with the Terms and Conditions a second time, upon policy issue. We have a letter on our file confirming that the original policy schedule (which was accompanied by [the Insurance Company's terms and conditions) were posted to the customers from our office on 26/08/2011.*

The Complainants responded that:

> *I wish to confirm that we were issued Terms & Conditions booklet with our welcome pack directly from [Insurance Company] and never from [the Provider] agent.*
> *After our initial meeting we were only left with [Insurance Company] Specified Illness cover list (comparison list that I have already attached to my historical emails) and Polish list of all diseases as also previously attached, but nothing else in addition to this.*

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Stating that [Provider] agent left full Terms & Conditions booklet on 11/8/11 as we certainly believe is to be false.

I note that within in its formal response to this Office, dated **08 February 2018**, the Provider observed:

> "*LIE; ADL is explained in further detail in the Terms and Conditions of the policy documents that the customers received. But unfortunately in this instance [the First Complainant] admits she did not fully read her terms and conditions <u>when they were posted to her</u>.*"
>
> [emphasis added]

On balance, I accept that the Complainants first received the terms and conditions by post and not at the point of sale. It is not clear therefore, how the Provider's assertion that they should have checked the terms and conditions as directed by the document in question, as '*some illnesses may be covered by LIE or PTD subject to measurement of Activities of Daily Living (ADL)'*, could have been achieved by the Complainants, before they incepted the policy. Neither am I satisfied that it would be understandable to a layperson as to what it was they were being directed to check for.

In the absence of a clear explanation as to what the terms meant, as regards the level of cover offered in respect of the condition, I am of the opinion it would be reasonable for a consumer to understand that the affirmative tick which appeared beside the condition meant that the condition was one in respect of which cover was provided under the Insurance Company's policy in respect of that condition.

With regard to this document and the comparative analyses of the conditions that each company did and did not cover, I am satisfied that the document presented to the Complainants in isolation, and without any advice as to what LIE and ADL meant and the effect of these terms, was misleading.

<u>*Document 2*</u>

With regard to the Second Document which was provided to the Complainants at the point of sale, which the Complainants have submitted was misleading - titled "*Lista Powaznych Zachorowan*", the Provider's position is that:

> *This sheet was given to the customers at their initial meeting too. It is titled "Lista Powaznych Zachorowan" which translates to "List of Serious Illnesses". This is not specific to [insurer] and does not state that [insurer's] cover these illnesses, nor does it have the [insurer] logo on it.*
>
> *… this is used to allow Polish clients to understand the English illness names in their own language. Again, to reiterate it is not specific to [insurer] and this is why no [insurer] logos are on this document.*

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> *It is now being implied that this sheet was given to the clients specific to their [insurer] policy, which is false. It was just a translation sheet, which the client herself states they were given at their initial meeting (therefore BEFORE THE CLIENTS APPLIED TO [Insurance Company]). And again reiterating that the objective of the initial meeting was to choose which insurance company best suited the clients best. They selected [insurer] even with the option to pick another company*.
>
> [Original Emphasis]

The Complainants meanwhile have submitted that they understood the list of illnesses was to show the list of conditions covered by the Insurance Company's policy, in their national language.

The copy furnished by the Provider to this Office as part of its formal response to the Complainant's complaint has a handwritten note on the face of it stating:

> *"English to Polish illness names which was given to the customer to allow understanding of names from English to Polish. It is not an [Insurance Company] document. No [Insurance Company] logo. Was used when comparing various insurers (before [Insurance Company] was even decided upon."*
>
> [Original Emphasis]

I have had regard to the document in question.

It is quite clear that the list of conditions is taken word for word from, and in the order in which they appear from Document 1 above, the Insurance Company's promotional comparison sheet. As the Insurance Company's policy was the only one which indicated that all the conditions listed were covered under its policy, and that the list of translated conditions mirrored those in Document 1, I can understand how this had the potential to lead to the Complainants' understanding that this Document 2 was a translation of the list in question, in Polish.

An element which I believe had the potential to compound a misunderstanding in this regard and which suggests that the document related to the level of cover provided, is that some way down the numbered list of conditions, there appears a heading of "*Partial Payment:" [untranslated]* and then a newly numbered list of conditions features underneath this heading.

Complaint Handling by the Provider

A further aspect of the Complainants' complaint was the manner in which their complaint was handled by the Provider when they contacted it. The Complainants have submitted that they never received a response to the email which they sent to the Provider on **14 November 2016**.
I have had regard to this email, which states as follows:

> *Dear [Provider]*

/Cont'd…

I am writing to you today with the complaint regarding my Life Term Cover Plan.

Myself and my husband we acquired Life Term Cover Plan with [Insurance Company] by your company in August 2011. During the sale of the mentioned plan we were handed a forms showing all Specified Illnesses Covered for full and part payment under our plan. One hand out is in English and have [Insurance Company] logos on the very top right hand corner and second one is in English with Polish translation of all illnesses. I am attaching a copy of mentioned lists below.
Some time ago I was diagnosed with Rheumatoid Arthritis and since I am undertaking treatments to deal with the Rheumatic Pain of my hips.
I send a query to [Insurance Company] asking if I am entitled to make a claim under this diseases.
[Insurance Company] position in this case is that the mentioned diseases is not covered under my Terms and Conditions which I received with Welcome Pack, even that you can see it on both lists mentioned above.
Surprisingly this diseases is not in the booklet at all.
[Insurance Company] informed me that they cannot be responsible for information which your company passed at the day of the purchase and you as a selling body are responsible for misleading information.
I am attaching a [Insurance Company] official reply regarding this query as well.

The Provider's response dated **17 November 2016** stated as follows:

Dear [First Complainant]

We are writing to you regarding your email dated 14/11/2016, and wish to acknowledge your complaint in relation to the above policy. We attach a copy of our complaints procedure which must be followed in compliance with the Regulations as set out by the Central Bank of Ireland.

Here is our response on the matter. We take this issue very seriously and have investigated it within our office. We have thoroughly assessed all paperwork on your file, including the items you completed with your advisor when taking out the policy. Furthermore, we have assessed the documentation you attached to your email.

We are satisfied that we provided adequate information relating to your policy at the time in which you took out this cover. Our advisor followed procedure with regards giving you Polish/English translations of the illness names that may appear in your terms and conditions. This is a measure we introduced to ensure our customers can translate these condition names into their own language <u>when they receive detailed documentation from the insurer.</u>

We always feel it is important to help our customers where their language barrier may affect their understanding of illness names. And furthermore we always advise our clients to check their terms and conditions, as this contains the most detailed version of what is actually covered on your policy.

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> *[Insurance Company] confirms that your Terms and Conditions booklet, which was posted to you, outlined all the illnesses that are covered on the plan. In this case, Rheumatoid Arthritis was not listed under your policy conditions. And unfortunately was not covered in the event of a claim.*
>
> *In relation to the list of illnesses that states Rheumatoid Arthritis on it (attached to your email), you will notice that it states regarding this condition, that "some illnesses may be covered by LIE or PTD" and in the same sentence it states to "check appropriate terms and conditions for details". Again, reiterating what we advise our clients to do, which is to read all terms and conditions to ensure they are happy with what the policy covers. Had you done so, you would see that Rheumatoid Arthritis is clearly not covered on your plan.*
>
> *We regret that you are unhappy that your policy does not cover this condition. However, as with all policies, some conditions are covered and some are not. The onus is on the client to fully read what is covered on their plan. Therefore we admit no liability and will not be pursuing your complaint further internally.*

The Complainants have submitted that they never received this letter. They submit that after they made their complaint to this Office, that the Provider then produced a copy letter dated **17 November 2016**. They have pointed to the fact that the copy letter as furnished to this Office is unsigned and that this suggests that the Provider has backdated this letter.

The Provider says that the letter was signed by its Managing Director before being posted to the Complainants on **17 November 2016**. It submits that the "*unsigned file copy*" was a photocopy of the original letter and that "*the photocopy was taken before it was signed and posted (which is why there is no signature on this particular version*".

When the Complainants submitted their complaint to this Office, I note that they were not in receipt of a final response letter from the Provider and that this letter was sent to the Provider on **31 January 2017,** seeking a copy of such a letter. On **03 February 2017**, the Provider then emailed the unsigned copy of the letter to this Office, dated **17 November 2016**.

The Complainants' response to this was that they had never received such a letter from the Provider at any time after submitting the complaint to it. They submit that they have not previously had an issue with not receiving post.

Having had regard to the evidence, on balance I do not find it possible to draw any firm conclusions as to why the Complainants never received the letter which the Provider submits it issued on **17 November 2016**. In the absence however of any evidence of wrongdoing by the Provider regarding its complaint handling, it is not appropriate to uphold this element of the complaint.

Overall, in relation to the Complainants' complaint that they were furnished with misleading information at the point of sale of the policy and consequently were mis-sold

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the policy, I have taken into account the Provider's assertion that the Complainants had the benefit of the comparison sheet and were free to pick whichever policy they chose. I am of the view however that this is to ignore the fact that the role and indeed professional duty of a broker, is to identify for the benefit of the customer who does not have expertise in such things, what the key features and limitations of each policy are, in order to establish the suitability of a product.

The Provider has submitted that:

> *"the clients were happy to proceed with [Insurance Company] until such a point that a claim was not being paid."*

My understanding of the situation is that the Complainants were happy to proceed with the policy of the insurance company on the basis that they understood that each of the conditions listed on this sheet and which featured a tick beside them, were covered for either full or partial payment by the policy in question.

The Provider has not attempted to submit that the terms "*LIE*" or "*ADL*" were explained to the Complainants. Rather, it has sought to rely on the fact that these acronyms featured beside the condition of Rheumatoid Arthritis, and effectively, that the Complainants ought to have educated themselves as to what these meant and the distinction that these terms represented, in terms of the cover available in respect of the condition which the terms appeared beside. It does so with reference to the direction on the face of the document to check the terms and conditions.

As noted above, I am satisfied that this direction was not however directed toward the customer, but rather to the Financial Adviser responsible for the sale of the product. I do not therefore consider this a reasonable position for the Provider to adopt and, in my opinion, it does not represent a satisfactory or sound approach to the sale of such a policy.

I consider that the fact that the sheet in question was quite clearly marked as being for financial adviser use only, made it unsuitable and inappropriate for the use to which the Provider put it. It does not appear from the evidence which has been made available, that the terms and conditions of the policy were made available to the Complainants at the point of sale by the Provider, and rather the Complainants were furnished only by the Provider, with the promotional document and the translation document, in order to inform their choice of policy.

With regard to the second document – the list of translations from English to Polish – I note the Provider's position that this document was not specific to the Insurance Company in question but it was rather a list of illness names translated from Polish to English. I accept that there is no Insurer Company logo on the document, but the list of illnesses is clearly lifted directly from Document 1, the promotional document, to the extent that it mirrors the inclusion of the heading of "*partial payment*", and a list of conditions underneath. This suggests that the conditions listed underneath were subject to partial cover. In my opinion, this seems to imply there is a policy underlying the information being provided. I can understand how this could potentially lead to confusion and whilst the

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Provider has submitted that it uses this to aid customers' understanding, I do not consider that it was prudent to present it in the format in which it appeared.

I accept that the Complainants had an opportunity, upon receipt of the Welcome Pack from the Insurance Company, which included a copy of the terms and conditions relating to the Policy, to review the Policy details and to avail of the cooling off period set out at page three of the booklet, if they were not satisfied that it met their requirements. The First Complainant has submitted in this regard that:

> *"I read all documentation included to make sure that what we chose is in this Plan (Life Cover, Specified Illness Cover, Hospital Cover) additionally I read very few first illnesses from Terms and Conditions Pack. But I never thought to check if the illnesses from the presentation list are fully included in Terms and Conditions and I never thought that there might be missing illnesses in this booklet, illnesses which were ticked on [the document]".*

Whilst this was not a particularly prudent approach by the Complainants, it is clear that they relied heavily on the information given to them by the Provider and it does not negate the responsibility of the Provider to provide sufficient and appropriate information at the point of sale. The manner in which the Provider has represented the events which occurred, to my mind, points to an abdication of its professional duties and responsibilities toward the Complainants. The Provider has essentially adopted the position that they ought to have informed themselves as to the relevant restrictions on cover and what the terms LIE and ADL meant, when they appeared beside a condition.

I am satisfied that the Provider had a duty to the Complainants with regard to the sale of the product and that it did not fulfil its duty in this regard. The Central Bank's Consumer Protection Code requires providers to explain clearly to clients the restrictions, conditions and exclusions that apply to a policy.

I note that among the General Principles enunciated by the Consumer Protection Code, 2006, are that a Provider must ensure that it:

1. *acts honestly, fairly and professionally in the best interests of its customers and the integrity of the market;*
2. *acts with due skill, care and diligence in the best interests of its customers;*
3. *does not recklessly, negligently or deliberately mislead a customer as to the real or perceived advantages or disadvantages of any product or service;*

Chapter 2, "Provision of Information to The Consumer" provides at section 12:

12 *A regulated entity must ensure that all information it provides to a consumer is clear and comprehensible, and that key items are brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information.*

Within Chapter 5, "*Insurance Products & Services*", it is provided that:

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7. *A regulated entity providing serious illness policies must, before completing a proposal form, explain clearly to the consumer the restrictions, conditions and exclusions that attach to the policies.*

I am not satisfied that the Provider in the present instance has complied with these obligations. The evidence available simply does not bear that out.

It is also of some concern to me, how the Provider has sought to defend its position in the manner in which it has and this suggests that it does not believe that it has acted in any way incorrectly. The Provider has submitted that, at the point of sale:

> *"there were other insurance companies available to them. Some of the other companies DO cover Rheumatoid Arthritis (again, the sheet in question clearly indicates which companies do cover this.)"*

It is not possible to speculate on whether the Complainants, if they had chosen to incept a different policy in 2011, would ultimately have been successful in any claim arising from the First Complainant's condition of Rheumatoid Arthritis. This, of course, would depend on the particular terms and conditions of such other policy and the severity of the Complainant's condition with regard to relevant medical evidence. However, the complaint in this instance is one of mis-selling by the Provider and on the basis of the evidence before me, I consider it appropriate to substantially uphold this complaint on the basis that the sales process employed by the Provider was significantly flawed, for the reasons which I have identified throughout the course of this Decision. In my opinion, the standard and nature of the information furnished to the Complainants by the Provider compromised the Complainants' opportunity to make a properly informed decision at the time of incepting the Policy and therefore the sale of the product by the Provider failed to reach the standards required by the above provisions of the Consumer Protection Code 2006.

It is important to bear in mind that the policy selected by the Complainants had considerable value, with regard to the range of illnesses and conditions covered by it. The issue arising however concerns the quality of the information which the Provider made available to them at the point of sale, in order to ensure that they could make a fully informed decision as to which policy would suit them best. I believe that a compensatory payment is appropriate to mark the Provider's failings in this regard.

<u>Conclusion</u>

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is substantially 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 Complainants in the sum of €4,000, to an account of the

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Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants 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 ***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.

MARYROSE MCGOVERN
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

27 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

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