An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0264
Sector:	Insurance
Product / Service:	Mortgage Protection
Conduct(s) complained of:	Mis-selling Dissatisfaction with customer service Misrepresentation (at point of sale or after)
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainants met with the Provider's agent in **May 2010** as they wanted to reduce the amount they were paying for their insurance policies. The Provider's agent recommended a mortgage protection policy and a life assurance policy. A number of years later, the Complainants advised the Provider that the policies they incepted were not in line with their instructions and did not meet their needs.

The Complainants' Case

The Complainants believe *"[w]e were mis-led on the policies that we were sold by [the Provider's agent]."* The Complainants explain that they had two insurance policies in **2010** with a financial services provider and a mortgage with another financial services provider. The Complainants conducted a review of their financial situation as they were paying €210.32 per month for their insurance policies. They contacted the Provider's agent who had been recommended to them by a friend. The Provider's agent met with the Complainants and *"… we explained that we wanted equally matched policies but it would be great if we got them a bit cheaper. Our requirements were that our mortgage would be protected and our family would have ample protection as well."*

The Complainants explain that, at the agent's request, *"… we got details of the policies that we had in force but finished up with policies that were totally unsuitable for us"* and two policies were then put in place costing €155 per month.

The Complainants submit that the Provider's agent *"… kept telling us that the new policies were similar to what we had and we trusted him to do what was best for us but we were totally misled."* The Complainants also advise that *"[w]e never really looked into our policies as we trusted that he had listened to our needs and solved them."*

The Complainants state that they *"… took a closer look at them in October when I [the Second Complainant] had to have a breast removed. It was only then that we realized what we had and we were shocked."* The Complainants explain that they contacted the Provider about what they discovered with neither the Provider nor the Provider's agent taking responsibility for misleading them.

In terms of the policies, the Complainants submit that the Provider's agent: *"… took our family cover which included serious illness and left us with just life cover. The serious illness he put into our mortgage cover on an accelerated, reducing policy. We were never told what accelerated meant."*

It is further stated by the Complainants:

> *"There is no way that we would have taken out those 2 policies if they had been explained to us. Why would anyone take out an accelerated life and serious illness policy when we had clearly told him that we wanted serious illness with our family protection? …"*

In resolution of this complaint, the Complainants state the following:

> *"If it was possible we would love to have separate policies as before.*
>
> *We have been refused a payout from [an insurer] but they will not issue [the Second Complainant] with a new serious illness policy that would cover breast cancer."*

The Correct Respondent Provider

On their Complaint Form, the Complainants identified the Provider and the Provider's agent as the financial services providers against which their complaint was being made. Solicitors acting on behalf of the Provider made a number of submissions in respect of which entity should be the appropriate respondent financial services provider for the purposes of this complaint. This Office issued a comprehensive preliminary opinion on **11 June 2019** setting out the basis as to which entity it believed to be the appropriate respondent.

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In concluding this opinion and finding that the Provider was the appropriate respondent, this Office observed:

> *"**Conclusion***
>
> *Having reviewed all of the aforementioned evidence, and for the reasons as stated above, it is the preliminary opinion of the FSPO that [the Provider's agent] was acting for and on behalf of the Provider in the course of the sale and inception of the Complainants' Insurance Policies in May 2010. This is evident as [the Provider's agent] furnished the Complainants with the Provider's Terms of Business and it was the Provider which was noted as the financial advisor on the policy application forms.*
>
> *On this basis, the FSPO is of the preliminary opinion that the correct respondent financial services provider to this complaint is the Provider, as it is the Provider which is referenced on all of the material documentation at the time of the advice, sale and inception of the Insurance Policies that [the Provider's agent] was acting de-facto agent of the Provider when the insurance policies were sold to the Complainants. …"*

I have reviewed this preliminary opinion and the documentation referred to, some of which is set out below, and I accept that the appropriate respondent for the purposes of this complaint is the Provider.

The Provider's Case

The Provider's solicitors delivered a response to this complaint on **2 August 2017**, in which it questioned whether the Provider was the correct respondent. However, without prejudice to its position in that regard, a response to the substantive complaint was also furnished.

The Provider states it appears the main request from the Complainants was to reduce costs while still retaining a strong level of cover. The Provider explains that in **May 2010**, its agent set up two insurance policies for the Complainants to replace two more expensive policies – one of which was potentially a very expensive reviewable plan. The Provider explains that the Complainants' overall level of cover was reduced in order to make cost savings as requested by them, with critical illness cover being placed alongside the life cover on the mortgage protection policy and a separate convertible term policy with just life cover.

Subsequently, the Second Complainant developed a lump on her breast and had undergone a number of surgeries to treat this. The Complainants' insurer twice refused a critical illness claim on the grounds that her illness did not meet their criteria for a payment.

In **October** and **November 2015**, the Complainants made a complaint to the Provider that the policies taken out in **2010** were not exactly what they wanted and that they were unhappy that critical illness cover had been reduced and was not attached to their mortgage protection policy and therefore assigned to their mortgage loan provider.

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The Provider explains that an investigation was carried out and it was concluded that the Provider had no case to answer. On review of the file, the Provider notes that a lot of documentation was issued to the Complainants clearly showing the structure of their cover with the insurer together with the two separate policies with the types and level of cover under each policy.

The Provider submits that its agent appeared to have acted, at all times and in his capacity as a consultant to the Complainants, in accordance with the applicable law and in accordance with his authorisation as a mortgage and multi-agency intermediary. The Provider explains that the Complainants contacted its agent in **April 2010**, with a view to saving costs on their insurance at the height of the economic recession. The Provider's agent advised the Complainants that in order to save costs they would have to revise their levels of insurance cover. The cover to be provided and the benefits of each recommendation were discussed with the Complainants in detail and in person.

It is submitted that over the course of five separate face-to-face meetings, the Provider's agent took full facts from the Complainants, clarified sick pay entitlements, discussed recommendations (using quotations and illustrations), completed application forms, discussed special acceptance terms and hand delivered original policy documents. On **4 August 2010** and **13 May 2010**, the Complainants received a letter from the Provider in respect of their policies advising them to read their policy documentation to make sure the information was correct. The Provider explains that as part of the hand delivery of the original policy documents, the Complainants received a policy issue letter from the Provider again advising them to read the attached policy schedule and policy documents.

On **19 July 2011** and **15 August 2011**, the Complainants were sent review letters by the Provider in respect of each policy clearly showing the type and level of cover that they had in place. On **14 September 2011**, the Provider's agent met with the Complainants for a review meeting and further review letters were sent by the Provider to the Complainants outlining their cover on **9 August 2012**, **7 September 2012**, **16 June 2015** and **24 July 2015**. It is submitted that, the conduct complained of was *"… in no way, shape or form unreasonable, unjust or oppressive or improperly discriminatory in its application to the Complainants, either by [the Provider' agent] or [the Provider]."* The Provider also submits that there was no mistake of law or fact in the conduct the subject matter of this complaint and the Provider and its agent, endeavoured, at all times, to fully explain the conduct complained of to the Complainants.

The Provider concludes its submission by stating that there is no basis upon which the Complainants can substantiate their complaint against the Provider. The Complainants were informed on numerous occasions, both verbally and in writing, of the level and type of cover put in place arising from their instructions to the Provider's agent.

I note that this Office was subsequently advised of a change in the Provider's solicitors by letter dated **18 January 2019**.

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The Provider's Agent

By letter dated **6 November 2019**, this Office was supplied with *"… a detailed written collection of events and chronology as well as … contemporary notes …"* in respect of the Provider's agent. The Provider's solicitors state that the Provider's agent:

> *"… wishes to state that he has 41 years' experience in the insurance industry and that this is the first time any complaint has been made against him. While he sympathises with the Complainants position, [the Provider's agent] went over and above the standards required of him in his services to the Complainants. [The Provider's agent] attended a number of meetings with the Complainants in which their options were assessed and discussed with them and the Complainants acknowledged and signed off on those options. [The Provider's agent] even went so far as to hand deliver the policy documents to the Complainants so that any queries arising could be addressed. …*
>
> *Accordingly, it is submitted that [the Provider's agent], and thereby the Provider, acted in accordance with the applicable law and in accordance with his authorisation as a mortgage and multi-agency intermediary. …"*

I have reviewed the documentation enclosed with this correspondence, some of which I will set out below.

Further Submissions

A number of submissions were made by the parties to this complaint. While I have considered these submissions, I do not propose to recite the contents of all of them here, however, I note the following exchange.

The Complainants' responded to the Provider's submissions by way of a letter received by this Office on **6 December 2019**. The main observations made by the Complainants in respect of the Provider's agent, his account of events and documentation are that they are inconsistent, varied and not consistent with the Complainants' instructions. The Complainants submit that:

> *"Because [the Provider's agent] passed on the responsibility of switching our mortgage, he asked to look at our life policies that we had in place at the time. He advised us that we were paying a lot for our policies and as we were trying to change our mortgage, it was agreed that he would quote us for cover on our mortgage as we were happy with the other policy."*

The Complainants further note that *"… as a broker with years of experience, [the Provider's agent] should know exactly what our original policies contained."* The Complainants also point out that they did not receive the *Fact Find* from **5 May 2010** and that *"[t]here are mistakes on it but due to not receiving a copy, we were never able to change."*

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It is also noted by the Complainants that the application form for mortgage protection was completed on **7 May 2010** but the *Reason Why* letter was not signed by them until **14 June 2010**. The Complainants also draw attention to and question why their policy was in effect from **5 August 2010** yet they did not sign the *rated letter* until **8**/**9 August 2010**.

In concluding this submission, the Complainants state:

> *"… If someone changes their policy, you would expect that you would receive like for like or a very similar policy. We understand that on [the Provider's agent's] advice, that a cost saving was required, but not at the expense of our family cover. To reduce our cover to where it is now, all he had needed to do was take the hospital & cash (accident) cover away. Instead he dismantled our policy's by giving us a life or serious illness policy with it decreasing every year. By the time we are close to the end of our mortgage, we will be still paying €126.69 with little or no cover left on the policy.*
>
> *…*
>
> *… As you can see, [the Provider's agent's] account of what happened leaves a lot to be desired, meetings, dates, figures do not match as he has two different letter's with conflicting information. …"*

The Provider's solicitors responded to these submissions on **7 January 2019** in quite some detail. However, I note the following comments:

> *"**Meetings and Dates***
>
> *… While there may be discrepancies as to certain dates originally provided and subsequently clarified, it does not alter the substance of what transpired at the meetings as well as the recommendations made and accepted by the Complainants. Those recommendations were set out in the documentation supplied to and signed by the Complainants. …*
>
> *While the Complainants queried some aspects of the chronology they failed to address the matter of the review meetings held in the second half of 2011. The fact that these review meetings took place completely undermines the arguments forming the basis of their complaint; that they were not aware of the cover provided on the policies set up in 2010. The policies in 2011 were the policies set up by the Provider in 2010. During the review meetings, this cover was discussed in detail as it would have to have been to undertake the review. The Complainants advised that they were still interested in reducing the cost of their cover and it was decided to submit an application for mortgage life and serious illness cover to [the insurer] to see if a cost reduction could be obtained. Following medical underwriting, it was decided not to proceed further with that application.*

/Cont'd…

FactFind/Application Form

…

We are not sure what points the Complainants are trying to make in respect of the issuance and signing of the various documents. It is not uncommon for policy commencement dates to be back-dated to a date prior to the date of signing the special acceptance terms. This is normally done to ensure that there is no break in cover where cancellation letters for previous policies may have been submitted to the insurer. It can also be done to ensure that there is no duplication of premium between the previous policies and the new policies. If anything, the Complainants' submission in this regard merely confirms that they reviewed and signed-off on the relevant documents.

Cover Provided

The Complainants confirmed in their submission that when re-mortgaging was not an option, they still needed to reduce costs and decided to review their existing life and serious illness cover to obtain this cost reduction. The recommendations were made on the basis of fully protecting their mortgage liability for both life cover and serious illness cover and then providing additional life cover for both. The recommendations for cover that [the Provider's agent] made to the Complainants were on this basis and were acceptable to them and they were very happy with the cost reduction. …

The Complainants now state that they wished to have cover on a like for like basis. [The Provider's agent] states that he found [the Complainants] to be intelligent, articulate and financially aware and it is respectfully submitted that no matter what product you are purchasing, you cannot obtain a like for like basis with a substantial reduction in cost; in this case a 40% cost reduction. …"

The Complaint for Adjudication

The complaint is that the Provider, through its agent, failed to recommend and/or arrange appropriate policies for the Complainants in line with their needs and/or instructions.

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.

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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 13 July 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, I set out below my final determination.

Timeline

The Provider has prepared a timeline of events at section 3 of the Schedule of Evidence and I note the following events:

Late April 2010	The First Complainant contacted the Provider's agent in relation to reducing the costs associated with their mortgage.
5 May 2010	The Complainants met with the Provider's agent where the Complainants advised that they needed to reduce their insurance costs.
7 May 2010	Applications forms completed for two insurance policies.
9 August 2010	Policy ending 701 hand-delivered to the Complainants.
23 August 2010	Policy ending 801 hand-delivered to the Complainants.
8 September 2011	The First Complainant telephoned the Provider's agent to request a meeting to carry out a review of the life assurance and mortgage protection policies.
14 September 2011	The review meeting took place and applications were completed for the Complainants' insurers in order to try reduce costs again.

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Fact Find

A Fact Find appears to have been prepared in or around **5 May 2010**. The *Notes* section in the Fact Find states as follows:

> *"Had a good discussion with [the Complainants]. They are interested in switching their mortgage to save money. I referred to [mortgage broker]. They are not satisfied with the cost of their existing life cover and requested me to provide alternative quotes. I agreed to research the market and come back with recommendations."*

In the submission received by this Office in **December 2019**, the Complainants remark that they did not receive a copy of the Fact Find and that it contains a number of mistakes. In this submission, the Complainant's have made a number of handwritten notes on the Provider's responding documentation. However, the Complainants do not appear to have taken issue with the above note.

Mortgage Protection Policy

Reason Why letter

The Complainants signed a *Reason Why* letter dated **6 May 2010** in respect of a mortgage protection policy on **14 June 2010**. This letter states:

> *"During our recent review meeting we discussed your current protection provisions and your requirements for the future. You are interested in switching the mortgage to save money. You wished to obtain a quote for a mortgage protection policy. You are satisfied with your other life policies at the moment and do not want to requote them. I said that I would research the market and get back to you with my recommendations.*
>
> *Having researched the market we are recommending the products below for the following reasons:*
>
> ***[Insurer] Mortgage Protection***
> *The policy offers €210,000 life cover and €210, serious illness cover on a joint life, on a payout decreasing benefits basis and this is the type of policy that you specifically wanted in order to satisfy the mortgage conditions of your bank/building society. …"*

Application form

At section 2 of the application form, critical illness cover has been selected in respect of both Complainants. The Complainants signed the *Declarations* section of the application form on **7 May 2010**.

/Cont'd…

The following are among the declarations acknowledged by Complainants

> *"…*
>
> - *I/We understand that terms and conditions, as provided to me/us, will apply.*
> - *I/We have read over the replies to all questions in this application form …"*

Provision of documentation

The Provider wrote to the Complainants on **13 May 2010** enclosing a number of documents regarding the Complainants' mortgage protection application.

This letter states:

> *"We have taken your instructions and applied to [Insurer] for the above policy. We enclose the following documents.*
>
> - *Copy of your [Insurer] proposal form.*
> - *Copy of your disclosure notice.*
> - *Reasons Why Statement.*
> - *Important Notice.*
> - *Terms of Business.*
> - *Section 30 receipt.*
>
> *We would recommend that you read through the attached documentation carefully making sure that all the information is correct. If any amendments are necessary please return the forms to us immediately with your instructions.*
>
> *Please note that cover is subject to the terms and conditions of your policy and will only be in place once your policy document is issued. …"*

Important Notice

The *Important Notice* referenced in the Provider's letter states:

> *"I refer to the reasons why/recommendation letter and quotations which are enclosed and were discussed with you in detail recently. After further discussion you elected to proceed with the following plan: [Insurer] Mortgage Protection.*
>
> *The cover on your policy is based on the information contained in the proposal form. I am enclosing a copy of the proposal form for your attention. Please take time to check this copy to ensure that the information contained therein is correct. Incorrect or incomplete information could in the event of the claim being declined or progressing of the claim application being delayed.*

/Cont'd…

Having checked your copy of the proposal form, should you need to make any alterations or amendments please contact us as a matter of urgency. …"

This notice was been signed by the First Complainant.

Hand delivery of documents

The Provider's agent hand-delivered an original copy of the Complainants' *Mortgage Protection* policy and schedule on **9 August 2010**.

This included a cover letter dated **9 August 2010** which states:

"We now have the pleasure in enclosing your original [Insurer] policy document and schedule of cover for your attention with a start date of the 1st of August 2010. …

Please read the attached schedule of cover in conjunction with your policy document making sure that all the information is correct and meets with your requirements, if any amendment is necessary please contact us as soon immediately with your instructions.

The policy is written on a joint life basis, the sum insured is €220,000 life cover and serious illness cover for a term of 30 years. …"

Policy Schedule

The Complainants' policy schedule dated **5 August 2010** states as follows:

"The schedule below sets out the details of the premium and benefits which apply to this policy. You should read this with your policy conditions. …

…

Insured events:	*Life Assured (1)*	*Life Assured (2)*
	Death or Critical Illness	*Death or Critical Illness*

…"

Correspondence from the Insurer

The Insurer wrote to the Complainants by letters dated **1 June 2010** and **5 August 2010** confirming acceptance of their application for cover and advised that their application would be subject to the special terms detailed in these letters.

/Cont'd…

I note that one of the special terms was that the *Level of Benefit* was on a decreasing basis. The letter of **1 June 2010** has been signed by both Complainants.

The Provider's agent wrote to the Second Complainant on **24 October 2012** in respect of a claim for critical illness benefit. While this letter concerns the Second Complainant's claim, I note that the Provider's agent enclosed a copy of the mortgage protection policy conditions with this letter.

Convertible Term Assurance

Reason Why letter

The Complainants signed a *Reason Why* letter dated **12 July 2010** in respect of a life assurance policy. This letter states:

> *"During our recent meetings where we discussed putting a mortgage protection policy in place it was also decided to quote for a convertible term assurance policy. I said that I would research the market and get back to you with my recommendations. …"*

Application Form

At section 2 of the application form, the applicants were invited to choose the type of cover required. The four options are *Life cover only*, *Critical Illness cover only*, *Life & Critical Illness (Accelerated cover)* or *Life & Critical Illness (Double cover)*. The option selected on the Complainants' application form is *Life cover only.* When asked how much cover was needed, figures have been inserted for each of the Complainants in respect of life cover however, there is a dash beside critical illness cover. The Complaints signed the *Declarations* section of the application form on **20 July 2010**. The following are among the declarations acknowledged by Complainants

> *"…*
>
> - *I/We understand that terms and conditions, as provided to me/us, will apply.*
> - *I/We have read over the replies to all questions in this application form …"*

Provision of documentation

The Provider wrote to the Complainants on **4 August 2010** enclosing a number of documents regarding their life assurance policy. This letter states:

> *"We have taken your instructions and applied to [Insurer] for the above policy. We enclose the following documents.*

/Cont'd…

- *Copy of your [Insurer] proposal form.*
- *Copy of your disclosure notice.*
- *Reasons Why Statement.*
- *Important Notice.*
- *Terms of Business.*
- *Section 30 receipt.*

We would recommend that you read through the attached documentation carefully making sure that all the information is correct. If any amendments are necessary please return the forms to us immediately with your instructions.

Please note that cover is subject to the terms and conditions of your policy and will only be in place once your policy document is issued. …"

Important Notice

The *Important Notice* referenced in the Provider's letter states:

"I refer to the reasons why/recommendation letter and quotations which are enclosed and were discussed with you in detail recently. After further discussion you elected to proceed with the following plan: [Insurer] Convertible Term Assurance.

The cover on your policy is based on the information contained in the proposal form. I am enclosing a copy of the proposal form for your attention. Please take time to check this copy to ensure that the information contained therein is correct. Incorrect or incomplete information could in the event of the claim being declined or progressing of the claim application being delayed. Having checked your copy of the proposal form, should you need to make any alterations or amendments please contact us as a matter of urgency. …"

This notice was signed by the Complainants.

Provider's Note

There is a handwritten note on what appears to be a product comparison document which appears to have been generated in **July 2010** and states:

"[The Provider's agent] rang me to say to take the Hospital Cash off this quote as the clients need to increase the cover on their Mortgage Protection. They will add on the Hospital Cash at a later date."

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Hand delivery of documents

The Provider's agent hand-delivered an original copy of the Complainants' *Convertible Term Assurance* policy and schedule on **23 August 2010**. This included a cover letter dated **23 August 2010** which states:

> *"We now have the pleasure in enclosing your original [Insurer] policy document and schedule of cover for your attention with a start date of the 1st September 2010.*
>
> *Please read the attached schedule of cover in conjunction with your policy document making sure that all the information is correct and meets with your requirements, if any amendment is necessary please contact us as soon immediately with your instructions.*
>
> *The policy is written on a dual life basis, the sum insured is €150,000 for a term of 20 years with a conversion option. …*
>
> *If you would like a quotation for Personal Accident/Permanent Health Insurance, Serious Illness cover, Pension or Health Insurance in the future please contact [the Provider's agent] on …"*

Policy Schedule

The Complainants policy schedule dated **12 August 2010** states as follows:

> *"The schedule below sets out the details of the premium and benefits which apply to this policy. You should read this with your policy conditions. …*
>
> ***Main Benefits***
>
> *You have selected the level benefit option. Your sum assured on your main benefits and premium will stay the same for the term of the policy.*
>
> *Please refer to your policy conditions for a full explanation of your benefit(s).*
>
> *…*
>
> ***Insured Events …***
>
> *Death …*
>
> ***Additional Benefits***
>
> *Children's life cover applies to this policy.*
>
> *This policy has a conversion option attaching. …*

/Cont'd…

…

Special Conditions

Life Assured (1) had been accepted on standard life. Life Assured (2) has been accepted on special terms.

You have previously signed non standard acceptance terms for this policy. These acceptance terms form part of your policy schedule. …"

Policy Conditions

The policy conditions state as follows:

*"**Introduction***

These conditions and your policy schedule set out the details of your contract with us. Please read them carefully. …"

Part 3 of the policy conditions sets out the main benefits under this policy as follows:

*"**Main Benefits***

This section describes the main benefits available under the Term Assurance & Convertible Term Assurance options. Your policy schedule will show which benefits apply to your policy. …

5. Main Benefits

The main benefits provided under the Term Assurance & Convertible Term Assurance contracts are Life Cover and Critical Illness Benefit … Your policy schedule will show:

- *which of these options apply to your policy;*
- *what the sum assured is in respect of each Life Assured; and*
- *when each benefit will be paid.*

…

6. Life Cover

This benefit will only apply if death is listed as an insured event on your policy schedule. …

/Cont'd…

7. Amount of critical illness benefit

This benefit will only apply if critical illness is listed as an insured event on your policy schedule. …"

Financial Review Addendum

The Provider prepared a *Financial Review Addendum* following the meeting that took place with the Complainants in **September 2011**. This document contains the following conclusion:

"I met [the Complainants] again to discuss the different quotations that I had run. Following discussion it was agreed to reduce serious illness cover on the mortgage protection policy from 100% to 75%. It was also agreed to put additional life cover on [the Second Complainant] only of €150,000.00. [The First Complainant] has death in service benefit of approx. €250,000.00 which they feel is adequate, this will reduce the overall monthly cost to approx. €98.00 as against €155.00 per month for the existing policies. …"

Reason Why 2011

The Provider's agent prepared a Reason Why letter dated **16 September 2011** which was signed by the Complainants. This letter states:

"During our recent meeting we discussed your current protection provisions and your requirements for the future. You currently hold a mortgage protection policy on a joint life basis with €215,000 life cover and €215,000 serious illness cover with 29 years remaining at a fixed monthly premium of €126.69. You also have a dual life level term policy with a sum assured of €150,000 each with a conversion option with 19 years remaining at a fixed monthly cost of €28.31. Both policies carry a premium loading for [the Second Complainant] on health grounds. It was agreed to re-quote both these policies to see if acceptance terms could be obtained without loading or with a lower loading. You also wished to substantially reduce the cost of your cover which means reducing the amount of cover or reducing the term. As [the First Complainant] has death in service it was agreed to quote for the additional cover on [the Second Complainant's] life only. …"

Statement from the Provider's Agent

The Provider's agent wrote to the Provider on **17 July 2017** in respect of this complaint.

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This letter states, in part:

> *"Prior to April 2010 I did not know [the Complainants]. As set out, [the First Complainant] contacted our office in [location], spoke to me and told me that they had a mortgage and told me that they were interested in re mortgaging as they needed to reduce costs. As is my standard procedure I arranged a meeting with [the Complainants] to discuss their requirements in detail. A meeting was arranged for the 4th May 2010 in their home.*
>
> *At the first meeting a fact find was completed to ascertain their family circumstances, current income and current financial commitments / liabilities. The total monthly financial payments for mortgage, other loan commitments and life & serious illness assurance came to €1,762.00 per month. [The Complainants] told me that this was not affordable and that they needed to their (sic) reduce costs.*
>
> *…*
>
> *During the recession most lenders were providing very limited mortgage facilities and none of the lenders were providing re-mortgage facilities. I advised [the Complainants] of this and we discussed other possible options for reducing costs. They were paying €210.00 per month for their existing Mortgage Life, Serious Illness Cover and Term Life Cover which they felt was quite high. It was agreed that I would check options for putting alternative cover in place with a view to reducing costs. As [the First Complainant's] was the only income I advised him to check what sick pay entitlements his occupation provided as this would help me to make recommendations to properly meet their requirements. At our next meeting [the First Complainant] advised me that he had sick pay entitlements of full salary for a certain period and that after this period the employer had long term income protection cover in place which would provide 75% of salary inclusive of social welfare entitlements right up to retirement at age 65. Once this had been clarified it was agreed that I would check options for putting Life and Serious Illness Cover in place at a substantially reduced cost.*
>
> *Having considered their requirements and having researched the market I prepared some quotations and I met [the Complainants] again in their home. We discussed the recommendations in detail and I have advised them it was not possible to put the same level of cover in place as they currently held and also achieve the substantial reduction in cost they required. At the time they held €110,000.00 Serious Illness Cover each on a level term basis and therefore should either make a successful serious illness claim they would receive a €110,000.00 each and my understanding was that any such claim payment would be used to reduce their outstanding mortgage balance. My recommendation was to put €220,000.00 joint life decreasing mortgage life cover in place with €220,000.00 joint life decreasing serious illness cover on a 30 year term to fully protect their outstanding mortgage balance. Should either die or make a successful serious illness claim the outstanding mortgage balance would be fully repaid.*

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This was discussed with [the Complainants] and they were advised of the type of cover and how it worked. Their existing additional life cover of €150,000.00 was on a unit linked basis and I advised them that with this type of policy their premium after a number of years would be subject to premium review and this would continue to happen on a five yearly basis. Based on the ages of their children I recommended putting €150,000.00 dual life level term cover in place on a 20 year term with conversion option. This would provide cover until their children would be adult. Cover and cost would be fixed and conversion option would allow them to put new cover in place at the end of the term without medical evidence.

The total monthly cost of revised mortgage life, serious illness and term cover came to €125.94 providing a cost reduction of 40% on the cost of their existing cover. The cover provided and the benefits of each recommendation had been discussed in detail and (sic) [the Complainants] and they decided to accept the recommendations as the cover provided met their requirements and provided the substantial cost saving they required. The necessary application documentation was completed.

Following medical underwriting acceptance terms were issued with an increased premium applied on [the Second Complainant] on medical grounds. This brought the combined monthly premium to €155.00. I again met [the Complainants] and gave them a copy of the special acceptance terms which clearly set out the details of the cover provided. I discussed the acceptance terms with [the Complainants] which were acceptable to them and they signed the acceptance letter. Policy documents were then issued with copy documents issued directly to [the Complainants] and the original policy documents received by our office. It is our practice to receive the original policy documents as it allows us to check for errors and where possible to personally deliver the policy documents. The original policy documents were personally delivered to [the Complainants].

…

My clear understanding and the brief I was given was that [the Complainants] needed to reduce costs substantially and that when re mortgage facilities were not available they were willing to amend their life and serious illness cover to obtain a cost reduction. I met [the Complainants] on five occasions:

- *first meeting - to complete fact find and obtain relevant information*
- *second meeting - to clarify [the First Complainant's] sick pay entitlements*
- *third meeting - to discuss my recommendations in detail and complete application forms once they had decided to proceed.*
- *fourth meeting - to discuss special acceptance terms letter and have acceptance terms signed.*
- *fifth meeting - to deliver original policy documents.*

/Cont'd…

Each of the first three meeting (sic) was of at least a one hour duration and meetings four and five were for thirty to forty minutes. At all stages I made it clear to [the Complainants] what cover was to be provided in each option and they were fully aware that their serious illness cover was to be included in their mortgage policy. They both signed a suitability statement outlining the cover details, special acceptance terms were subsequently issued again outlining the cover details which where (sic) explained to them and signed the acceptance terms. They then received copy policy documents and I personally delivered the original policy documents.

Because of changed circumstances [the Complainants] are now claiming that they did not understand what was being recommended to them and that they did not read the policy documents. I found [the Complainants] to be intelligent and financially aware. Five meetings totalling four to four and half hours were held over a number of weeks….

We review all clients cover on a regular basis to ensure that the cover they hold continues to meet their requirements and to discuss their ongoing financial needs. I again met [the Complainants] on the 14th September 2011 for a customer review meeting and to discuss ongoing requirements. My file notes from the meeting show that [the Complainants] were interested in further reducing the cost of their life cover. One of their suggestions was to have term life cover of €150,000/00 on [the Second Complainant] only as [the First Complainant] had approximately €250,000.00 death in service benefit from his employment. They also suggested that serious illness cover on their mortgage policy could be reduced from 100% to 75%. I researched these options and this level of cover was available for an overall monthly cost of €98.00 as against a monthly cost of €155.00 for the cover that we had put in place in 2010. [The Complainants] decided that this reduced level of cover and reduction in cost would meet their requirements and an application form and relevant documentation was completed and submitted to [the insurer]. … [D]ue to the policy exclusions and ongoing tests it was decided not to proceed with the [insurer] application.

My clear understanding and the brief I was given from my first meeting and at each subsequent meeting with [the Complainants] was that they needed to reduce their financial costs. Initially this was to be by re mortgaging and when this was not possible by reducing the cost of their life & serious illness cover. They were made aware and were aware at all times that to obtain a substantial cost saving it would mean amending their level of cover. They accepted this and proceeded to put cover in place being fully aware of the cover type recommended. That they were aware that there (sic) serious illness cover was included in their mortgage policy is proven by the fact that at the review meeting in September 2011 they were willing to reduce the serious illness cover on their mortgage policy from 100% to 75% and they were also willing to remove [the First Complainant's] life cover to obtain a further costs reduction. …"

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At the beginning of this letter, the Provider's agent also references a letter dated **19 November 2015** explaining his conduct in respect of the Complainants. I note that this earlier letter is in similar terms to those outlined above.

Analysis

The Complainants maintain the position that the Provider's agent and by extension the Provider, did not adhere to their instructions and/or needs when researching and recommending their mortgage protection or life assurance policies.

The Complainants explain that:

> *"… we wanted equally matched policies but it would be great if we got them a bit cheaper. Our requirements were that our mortgage would be protected and our family would have ample protection as well."*

The Provider's agent explains:

> *"My clear understanding and the brief I was given was that [the Complainants] needed to reduce costs substantially and that when re mortgage facilities were not available they were willing to amend their life and serious illness cover to obtain a cost reduction."*

The common theme between the parties' understanding of the agent's mandate was the need to save money or reduce costs. The contention which underpins this complaint is that the cover provided by the policies was not in line with what the Complainants wanted. The Provider's agent has prepared a detailed account of his interactions with the Complainants. In an email to this Office dated **6 February 2020**, the Complainants submit that their recollection of the meetings with the Provider's agent is not the same as that of the Provider's agent. However, the Complainants have not provided, in any great detail, an account of the discussions that took place between the parties at any of their meetings.

While the parties have opposing views as to what the Complainants' instructions/needs were, it is inevitable that such matters would have been discussed during the meetings that took place between the parties and if any misunderstanding existed, then this should have been clarified at those meetings or reflected in subsequent correspondence or documentation. In light of this and the documentation provided to and signed by the Complainants, I accept that it is likely that the terms upon which the Provider's agent was engaged are those as outlined in the passage from the statement of the Provider's agent cited above.

Notwithstanding this, I have set out a number of documents that were furnished to the Complainants by the Provider's agent in respect of their policies. Many of which have been signed by them, in particular the application forms.

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The documents provided to and signed by the Complainants clearly explain the type of cover being offered by each policy and direct the Complainants where to find further detail in respect of the type of cover being offered. These documents also advise the Complainants to review them and advise the Provider if there are any errors or inconsistencies. I am satisfied that, irrespective of the instructions given to the Provider's agent or the Complainants' needs, if they read and reviewed these documents, they would have been aware of the cover they were purchasing.

I note that the Complaints say that *"[w]e never really looked into our policies as we trusted that he had listened to our needs and solved them."* Applications for insurance and insurance policies are important matters and should have been treated as such by the Complainants. It is incumbent on the Complainants to ensure that they reviewed the application forms and all of their policy documents prior to incepting their policies.

This is so notwithstanding the level of trust they reposed in the Provider's agent who I note was someone the Complainants had never dealt with before but was recommended to them.

Having been afforded ample opportunity to review the relevant documentation, there is no evidence that either Complainant sought to amend them, clarify their instructions or raise any queries in respect the level of cover provided by either of the policies or that they were dissatisfied with the cover being offered. This is also evident from the review that took place in or around **September 2011**.

I also consider that there were other factors that ought to have alerted the Complainants to the fact that there may have been a difference in the type of cover provided by their new policies in comparison to their old policies. The Complainants' original insurance costs were €210.00 per month whereas the policies recommended by the Provider's agent cost €125.00 per month. This represents a 40% reduction in premium. Given such a substantial reduction in premium, I would consider it reasonable for the Complainants to assume that there was some compromise in cover and they were not getting *equally matched policies*.

The Complainants have raised certain points in their submissions received by this Office on **6 December 2019**. I consider most of the points raised to be somewhat extraneous and unsupportive of their position. In particular, the points relating to the signing and dating of documents and the date of inception of cover. Furthermore, had the Complainants read the various policy documents, they would have been aware of these issues and could have raised them at a significantly earlier point in time. The Complainants also highlight the fact that they did not receive the Fact Find. Even if this is the case, the Complainants were provided with a number of more relevant and illuminating documents regarding their policies.

Finally, the Complainants assert that *"[t]he serious illness [the Provider's agent] put into our mortgage cover on an accelerated, reducing policy. We were never told what accelerated meant."*

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I note that the *Reason Why* letter signed by Complainants and dated **6 May 2010** states:

> *"The policy offers €210,000 life cover and €210, serious illness cover on a joint life, on a payout decreasing benefits basis and this is the type of policy that you specifically wanted in order to satisfy the mortgage conditions of your bank/building society. …"*

I am satisfied that if the Complainants read this document with an appropriate level of attention and also read the mortgage protection documentation, they could have sought an explanation as to what this meant prior to or at the time the policy was incepted. I also note that this does not appear to have been raised at the review meeting that took place in **September 2011**. Furthermore, the Complainants have not identified any obligation on the part of the Provider or the Provider's agent to explain this particular aspect of their cover.

For the reasons outlined in this Decision, I do not uphold any aspect of 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.

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

6 August 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,

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(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.