An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0266
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Settlement amount (life)
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns the reduction in loan protection / life savings cover applicable to the account of the Complainant.

The Complainant's Case

"Loan Protection / Life Savings Insurance" is a benefit provided by the Provider attaching to members' accounts (including the account of the Complainant). In or around August 2018 the Complainant was *"shocked"* and very annoyed to learn that the Provider had reduced the maximum Life Savings Insurance cover of €12,700.00 to €5,000.00 on her account. The Complainant submits that the *"decision is extremely unfair to older members"* as she states that she has saved with and borrowed from [the Provider] over many years, with the knowledge that this cover was €12,700.00. The amount of insurance payable is proportionate to the number of shares a member has at a certain age.

The Complainant made a formal complaint to the Provider in a letter dated 13 August 2018. She argues that *"The drop in cover for older members and their families who are reliant on [this insurance]"* is unfair. The Complainant contends that as an older member *"at this later stage of life"* she would be unable to source an alternative or similar insurance cover at a reasonable cost to her.

The Complainant states that she should have been made aware of the Provider's proposed reduction in insurance cover, and been given the opportunity to discuss the matter with the Provider at the members AGM before the cover was reduced.

The complaint is that the Provider has unfairly reduced the Complainant's Life Savings Insurance maximum payment and taken this decision without her prior knowledge or any consultation with members.

The Provider's Case

The Provider states that the insurance at issue in this complaint is provided free of charge to members *"as an additional incentive for members to build up their shares and as a death benefit to their families".*

It contends that the Life Savings Insurance is a free benefit available to the Complainant and other members. However, it submits that *"the cost to [the Provider] is quite significant"*. The Provider states that it did an assessment of the average payments made to beneficiaries and goes on to say that the impact on members will be negligible. The Provider explains that the Complainant would receive other cost savings through various means, due to its decision.

The Provider notes the Complainant's disappointment but advises that it is not in a position to reinstate the previous benefit level of €12,700.00.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

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

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

/Cont'd…

A Preliminary Decision was issued to the parties on 8 June 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.

Following the issue of my Preliminary Decision, the parties made the following submissions:

1. Letter (received by e-mail on 17 June 2020), from the Complainant to this Office.

2. Letter (received by e-mail) from the Provider to this Office, dated 25 June 2020.

3. Letter (received by e-mail on 1 July 2020), from the Complainant to this Office.

Copies of the above submissions were exchanged between the parties.

Having considered these additional submissions and all of the submissions and evidence furnished to this Office by the parties, I set out below my final determination.

The Complainant has been a member of the Provider (or its predecessors) for 50 years, and is now in her mid 70s.

From 1970, the Provider has had an insurance scheme in place whereby (on satisfying certain criteria) a member benefitted from cover for their savings which would pay out on death on a euro per euro basis up to age 54, then decreasing every five years until aged 65 when the payout level would be €0.25 per euro saved.

The parties to the policy are the Provider and an insurer – customers are not policyholders, and do not pay premiums for this benefit. In 1970 the maximum payout under this cover was limited to around IR£10,000. Prior to the matters giving rise to this complaint the maximum payout was €12,700. It is the reduction of this potential payout to €5,000 that is the subject of the Complainant's complaint.

The Board of the Provider made the decision to reduce this maximum payout on 25 June 2018, the change was implemented on 1 July 2018 and notified to members by display of information leaflets in branch and on the Provider's website. The Provider's annual report also explained the change and summarised the financial review which led to the Board making its decision. The Provider states that at its 2018 AGM (for which the Provider states it made buses available for members) information about the change was read out.

/Cont'd…

Analysis

The Provider has raised a number of matters which I will deal with as preliminary issues. The Provider submits that as the Complainant did not pay for this benefit (and was not a party to the policy), and argues that therefore, the benefit does not fall within the meaning of *"provision of a financial service"* within the meaning of the Financial Services and Pensions Ombudsman Act, 2017 (the Act) – and that accordingly, this Office is therefore not entitled to investigate the conduct complained of in this complaint.

I do not accept this submission. There are myriad services which a provider can provide that a customer does not directly pay for. I am satisfied that the fact that the Complainant does not pay for this benefit does not preclude this Office from investigating the Provider's conduct in relation to its provision.

In relation to the Complainants' contention that the Board ought to have put the decision to reduce maximum payout amounts to the members at an AGM (or otherwise included members in the decision making process), Section 48 of the Credit Union Act, 1997 provides for conditions to be met in order for a credit union to provide certain additional services. However, Section 4 of Schedule 2 of Part 9 of the Credit Union Act 1997 (Regulatory Requirements) Regulations, 2016 (S.I. 1/2016), provides that insurance services such as the subject matter of this complaint constitute services exempt from additional services requirements. This means that the decision to reduce the benefit payable under this scheme was one that the Board was entitled to make without consulting its members.

There is no question that the Complainant has personally been affected by this change. She may be one of a number of customers in a similar position.

However, I cannot accept that, through being a loyal customer and paying interest, she has contributed to the scheme in a manner that would equate her to the position of a policyholder – one can only enjoy all of the rights of a policyholder by paying premiums and being a party to a policy.

The Complainant feels that the decision was discriminatory against her and other people of her age. She feels that as a long standing member in her senior years, she has been let down by the Provider and is now in a situation where the life savings / loan protection benefits payable to her have reduced and due to her age she is unable to pay for cover from another provider.

Nevertheless, the Provider has a commercial discretion to make such a decision. I cannot interfere with that commercial discretion unless it is unreasonable, unjust, oppressive or improperly discriminatory. Furthermore, the Provider is required to make decisions based on the interests of its membership as a whole, and not based on the requirements of any one of its individual members. I have been provided with no evidence to believe that the decision was made in a discriminatory, unfair, or oppressive manner.

/Cont'd…

The Provider has explained its decision as follows:

- The Board of Directions of [the Provider] were elected by the [Provider's] members to have overall responsibility for the general control, direction and management of [the Provider].

- The cost of providing the free Life Savings Insurance rose from €669,927 in 2016 to €865,140 in 2018. A rise of 24% over a small number of years.

- The financial review highlighted that out of 504 claims that arose during the reporting period [2015-2018] only 3 claims came in at the maximum payable rate of €12,700 and that the average claim was €2,402.

- The Board, using its commercial discretion, took the financially pragmatic decision that there was no logic in paying excessive premiums for insurance cover that was not being availed of by a majority of [members], and therefore reduced the maximum cover to €5,000.

The Provider went on to state "*it is deeply regretted that the Complainant, who is one of our longest serving members, has been affected by this however the Board, when making financial decisions, must make such decision for the good of the [credit union] as a whole, whether it be our newest member or our longest serving member, if would be wrong for the Board to make a decision that financially favoured the few at the cost of the many*".

The Complainant has made a post Preliminary Decision submission dated **17 June 2020** in which she states:

" the following submission in relation to the two facts you refer to in reaching your decision

1. *The cost of providing the Life Saving Insurance rose from 669.927 in 2016 to 865.140 in 2018. The cost quoted for 2016 did not include the four credit unions which was in fact 906.024. The cost for 2018 did include the four credit unions. So there was a fall in the premium from 2016 to 2018.*

2. *The Board using its commercial discretion, took the financially pragmatic decision that there was no logic in paying excessive premiums for Insurance Cover that was not being availed of by the majority of its members. I just wish to clarify that the credit union did not pay premiums for 12,700 cover for all 504 members who died. The premium was only paid for the 3 members who had 12,700 in their Savings. The additional cost of the premium for those three members would be in the region of 100 euros per year".*

/Cont'd…

The Provider, in a post Preliminary Decision submission dated 25 June 2020, responded to the above statements as follows:

> *1. "The insurance premium for the Life Saving Insurance rose from €669.927 in 2016 to €865.140 in 2018. The fall in the premium occurred due to the fact that the Board lowered the maximum payable claim".*

And that:

> *2. "[the Provider] paid premiums on the balances of each individual Member, up to (the then) €12,700 maximum payable limit. Savings is a transient feature, Some Members save with [the Provider] in on a long-term basis, some save on a daily, weekly, monthly, and quarterly basis. [The Provider] provide the indemnity on an all for all basis, up to the maximum payable limit".*

The Complainant, in a post Preliminary Decision submission dated **1 July 2020,** requests that I:

> *"consider writing to the Central Bank requesting them to write to credit unions regarding their confusing advertising in relation to Life Savings Insurance".*

The Complainant enclosed a scan of the leaflet in question and states that *"…the leaflets used by the credit union (standard credit union leaflet issued by the Irish League of Credit Unions) entitled THE "REAL COMFORT IN KNOWING "PROTECTION"* includes mis-leading statements.

The Complainant submits that:

> *"The statement 'Once earned, your insurance remains in force as long as you have your savings in your credit union' is totally misleading members to believe they have insurance in force for life provided they leave their savings in their credit union".*

The Complainant states that*:*

> *"There are many elderly members, who may no longer fully understand how the life savings insurance works, whose families may be dependent on the life savings insurance to pay for funeral arrangements. This matter needs to be brought to their attention as a matter of urgency".*

I have reviewed the leaflet in question. In my view, it does not appear to be misleading.

/Cont'd…

I note that the leaflet contains the phrase:

> "*This leaflet is issued by the Irish league of credit unions in respect of its affiliated credit unions and is for guidance only. Members should always check with their own credit union, who is the policy holder, for further details*".

It also contains the phrase:

> *"Loan protection insurance and life savings insurance are paid for by your credit union at no direct cost to qualifying members. Eligibility criteria, maximum benefit limits, terms and conditions apply, Contact your credit union directly for more information".*

It is my view that the leaflet makes it clear that terms and conditions will apply, and that further information can be sought by a member through their own credit union.

Overall, I find that the Provider's explanation for its decision and its conduct is not an unreasonable one. I have been provided with no evidence that its conduct is either disproportionate or arbitrary. It has made its decision based on the premiums that would be payable if it maintained the €12,700 payout. This is a matter for the commercial discretion of the Provider.

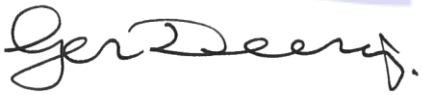
It has not simply decided to discriminate against older customers. I can find no evidence of wrongful conduct by the Provider in this complaint.

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

Conclusion

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

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

10 August 2020

/Cont'd…

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.