An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0303
Sector:	Insurance
Product / Service:	Mortgage Protection
Conduct(s) complained of:	Complaint handling (Consumer Protection Code) Failure to provide correct information Misrepresentation (at point of sale or after)
Outcome:	Substantially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainants incepted a mortgage protection policy with their Mortgage Loan Provider in **December 2009**. The policy is administered by the Provider, against which this complaint is made. The Second Complainant was involved in a workplace accident in **2015** and made a claim under the policy. The Second Complainant returned to work in summer **2018** but had to cease working in winter **2018** due to the injuries sustained in her accident. The Second Complainant attempted to make a further claim under the policy during **October 2018** and was advised by the Provider that monthly benefits under the policy would commence in 3 months. The Provider advised the Second Complainant in **February 2019** that her claim was declined as she had not been in continuous work for 180 days since her last claim.

The Complainants' Case

The Complainants explain that the Second Complainant was involved in a workplace accident in **2015** and underwent surgery in **September 2016**. The Complainants applied to the Provider under their mortgage protection policy *"… which they paid for for (sic) one years mortgage in February 2017. This would have been paid up to February 2018."*

The Second Complainant returned to work in **May 2018**. However, the Second Complainant *"… exasperated her condition by trying to get back to work and under medical advise had to cease work in October of 2018."* The Complainants state they re-applied to the Provider under the mortgage protection policy.

The Complainants submit that they were informed by the Provider that *"… we were covered and that we had to wait for a 3 month period before the policy would commence."* The Complainants approached their bank on foot of this and advised it that their mortgage protection policy would cover their mortgage loan repayments for a year but this would not commence for 3 months. In the intervening period, the Complainants applied for and were granted a 3 month moratorium on their mortgage loan on this basis.

The Complainants advise that *"[w]e were told that we would hear from [the Provider] when the policy would start. We never did."* With only three days before the expiry of their moratorium, the Second Complainant emailed the Provider on **29 January 2019** to request the forms *"… to start the process."* The Complainants did not get a response to this email and the Second Complainant contacted the Provider by telephone a few days later *"… when she was then and only then told that she was not eligible for cover due to not being back to work for the 6 month period …."*

Despite this, the Provider continued to collect monthly premium payments in respect of the policy. The Complainants were also left in the position of having to inform their bank that they would not be able to pay their mortgage loan. The Complainants explain they are now in arrears on their mortgage loan and on their third moratorium.

The Complainants submit that *"… had they told me when I applied that I was not eligible then I could have got a [financial services provider] loan to pay the mortgage of which would have been up to day."*

The Complainants explain that the Provider has *"… accepted they were wrong and apologised also for this. They are now responsible for this as they accept they were wrong. …"*

In resolution of this complaint, the Complainants:

> *"… wish for [the Provider] to compensate [them] for 1 years worth of mortgage payments … there inability to inform us and continue to take our money for mortgage protection for a policy that they knew they were not paying out on resulted in us negotiating with bank for further moratoriums, going into arrears on mortgage then we feel that they are responsible for one years payment of our mortgage at 920 Euro per month for 12 months. We are seeking 11,040 Euro as compensation as this would have been what they told us we were covered for and continued to take our 61 Euro per month for 3 months while continuing to portray that we would be covered. …"*

The Provider's Case

The Provider, referring to a telephone call on **19 October 2018**, explains that on listening to the call, the Second Complainant confirmed that she previously claimed for her condition but did not provide return to work dates and, based on the answers provided during the call, a claim form was issued. However, in order for the claim form to be fully assessed, the Second Complainant was advised that the claim form would need to be fully completed.

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The Provider states the Second Complainant was advised that she met the requalification period to make a claim but the Second Complainant did not give exact dates of when she returned to work *"… on the information provided, we would have (sic) she met the requalification period."*

Upon reviewing the claim form, the Provider states that the Second Complainant's GP advised the Second Complainant's returned to work was in **May 2018** and was certified unfit again to work in **October 2018**. As the Second Complainant had previously claimed for this condition, the Provider needed proof from her employer that she had returned to work for at least 180 days which was requested along with the exact certification date from her doctor.

A letter was sent to the Second Complainant requesting the date she was certified to work and a letter from her employer stating she was in continuous work for 6 months prior *"… to last date worked letter from emps stating she RTW after previous period of disability on [May] 2018 until [October] 2018 when she was certified unfit to work again …"* The Provider submits this was only 148 days and the Second Complainant must have returned to work for 180 days if her accident or sickness was the same. Therefore, the claim could not be accepted.

The Provider explains the terms and condition of the policy would have been issued by the Mortgage Loan Provider when the Complainants first purchased the policy. The Provider refers to section 3 of the policy terms outlining that a person claiming under the policy much be in continuous work for 10 days if the accident or sickness is the same, as for a previous claim.

The Complaints for Adjudication

The complaints are that the Provider:

1. Failed to inform and/or adequately inform the Second Complainant of the requirement to have been in continuous work for 180 days before she would be eligible to receive the benefits under the policy; and

2. Wrongfully informed the Second Complainant and/or unreasonably allowed the Second Complainant to believe she was covered under the policy in respect of her absence from work in **October 2018**.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence.

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

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

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

A Preliminary Decision was issued to the parties on 20 August 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.

The Policy

The relevant section of the policy in respect of this complaint is section 3. This states:

> *"**3. Accidental & Sickness cover***
>
> *…*
>
> *If **you** are **working** or on statutory maternity leave … and you suffer an **accident** or **sickness** during the **insured term** for at least 90 days in a row, you will be entitled to make a claim.*
>
> ***We** will not pay **you** for the first 60 days in a row of any **accident** or **sickness** as this period of any claim is excluded.*
>
> *Thereafter **we** will pay **you** a **monthly benefit** for each continuous period of 30 days that **you** remain out of **work** due to **accident** or **sickness** …*
>
> ***We** consider the first day of **accident** or **sickness** as the day a **doctor** certifies that **you** are unable to **work** due to **your accident** or **sickness**. …*

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Further accident & sickness claims

*If **you** have made an **accident** & **sickness** claim which ends for whatever reason, **you** will not be able to make another **accident** & **sickness** claim until **you** have been in continuous **work** (…) for:*

- *30 days if the **accident** or **sickness** is different; or*
- *180 days if the **accident** or **sickness** is the same."*

The Claim

The Second Complainant contacted the Provider by telephone on **19 October 2018** to enquire about making a claim under the policy. The Second Complainant confirmed she wished to make a sickness claim. The Provider's agent acknowledged that a previous claim had been made. The Provider's agent then asked when the Second Complainant last worked. This was followed by a number of questions about the Second Complainant's sickness/illness. When the parties were discussing the Second Complainant's medical certificates for her employer, the Second Complainant, in response to a question from the Provider's agent regarding how long she would be out of work, advised that she would be out of work indefinitely. Following this, the Provider's agent placed the Second Complainant on hold as *"I just need to get the terms of your policy checked."* The call resumed as follows:

Provider: *That's fine I've checked the details. Now for your policy you must be out of work for a period of 90 days before you submit the claim form back to us. Do you think you are going to be out of work for three months or more?*

Complainant: *I will be yes.*

Provider: *… I'm just going to get the claim details for you now. Now I can send the claim form out in the post to you or if you have access to the internet … you can also register your claim online. Which option do you think will be easier for you?*

Complainant: *I can print them here at home. That's no problem.*

Provider: *So do you want to register it online or will I just send it to you in the post?*

Complainant: *… just send them to me in the post, please.*

Provider: *I'll do that so. That's absolutely fine. So can I just ask you a couple of questions. So this condition that you're off with at the moment, its linked to the claim that we [agreed] to pay for you up to October 2017, is that right?*

Complainant: *That is correct.*

Provider: *Ok, I'll just have to check the qualification period on that as well.*

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Having been placed on hold again, the conversation continued:

Provider: *Ok, that's fine. It falls under the qualifications of the policy. So that's absolutely great. … So the claim form I'm sending to you, you'll have it in the next 7 days.*

The Provider's agent then outlined the claim form to the Second Complainant, advising that there were three sections to be completed. A section to be completed at the nineth day by her GP which would be **29 December 2018**, a section to be completed by the Second Complainant and a section to be completed by her employer.

Towards the end of the call, the Provider's agent explained:

> *"… the policy doesn't pay the first 60 days that you're out of work. It pays from the 61st day every 30 days then going forward and if you stay out of work long-term, it pays a maximum of 12 months … Now for the initial claim, when you're sending in the new claim form to us please keep a copy of everything you're sending us. When we receive your claim form then we'll respond to you in writing with the update on your claim within the period of 14 days. … And as I've said, you'll have the claim form within the next 7 days."*

The Second Complainant wrote to the Provider by email dated **29 January 2019**, advising that she had waited the 90 days as instructed and was now requesting that a claim form be sent to her:

> *"… I was in touch with yourselves in October regarding claiming on my mortgage protection due to an accident at work, I was told that I was covered but that I had to wait 90 days to make the claim.*
>
> *I would be grateful if you can now send me out the forms that I require to be filled out by my job and GP. …"*

The Provider wrote to the Second Complainant by email dated **5 February 2019** advising that it had sent her a claim form by post. The Second Complainant forwarded a claim form to the Provider by email dated **6 February 2019**. The Provider acknowledged receipt of the claim form on **13 February 2019** and requested certain additional information:

> *"We have received your claim form for your Sickness claim.*
>
> *We note on your claim form, your doctor advises you returned to work in May 2018 and you were certified unfit to work in October 2018.*
>
> *The terms and conditions state that if you have made an accident or sickness claim which ends for whatever reason, you will not be able to make another accident & sickness claim until you have been in continuous work for 30 days if the accident or sickness is different or 180 days if the accident or sickness is the same.*

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We will need the following information / documentation from you to complete our assessment:

- *Confirmation from doctor of the date you were certified unfit for work in October 2018.*

- *Letter [from] employer showing the date you returned to work after your accident, and that you have been in continuous work for the 6 months prior to 29 September 2018."*

The First Complainant emailed the requested correspondence from the Second Complainant's GP and employer to the Provider on **19 February 2019**. The Second Complainant's employer stated that she returned to work on **9 May 2018** and had been absent from work since **2 October 2018**. The Second Complainant's GP confirmed she was certified as unfit for work on **2 October 2018**.

The Second Complainant emailed the Provider on **25 February 2019** enquiring as to the status of her claim. The Provider wrote to the Second Complainant on **26 February 2019** declining her claim on the basis that:

*"The following **condition/s** of the insurance policy **has/have** not been met:*

This means:

You did not return to work for a period of 180 days or more after your last claim for this condition.

If you check your policy documents you will find the Sickness requirements detailed in the terms & conditions section. …"

The Final Response Letter

The Complainants made a formal complaint to the Provider on **27 February 2019**. The Provider issued a Final Response letter on **29 March 2019** stating as follows:

"I understand that you contacted us by phone on 19 October 2018 to request a Disability Claim Form.

On listening to the call I understand that you were not asked had you resumed working after your previous claim. I note that you confirmed that your illness was connected to your previous claim but it was not confirmed if you had returned to work. I apologise that this was not asked.

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The terms and conditions of your policy state: 'If you have made an accident & sickness claim which ends for whatever reason, you will not be able to make another accident & sickness claim until you have been in continuous work (…) for:

- *30 days if the accident or sickness is different; or*
- *180 days fi the accident or sickness is the same.'*

In your email you advised that you felt [the Provider] has been dishonest in dealing with you and that you felt [the Provider] had profited from a claim that was not going to be paid.

I would like to take this opportunity to apologise that our service has not met your expectations and you have felt it necessary to complain. …"

The Complainants' policy was cancelled with effect from **22 March 2019** and a refund of premiums paid since **October 2018** totalling €369.00 was issued to the Complainants on **26 March 2019**.

A telephone conversation took place on **19 October 2018** between the Second Complainant and one of the Provider's agents. During this call, the Provider's agent correctly advised the Second Complaint of the 90 day waiting period before a claim could be made. The Provider's agent was also expressly made aware that the Second Complainant's claim was a further claim/linked to her previous claim. In response to this, the Provider's agent stated that she would *"… just have to check the qualification period on that as well."* Having done so, the Provider's agent advised the Second Complainant *"… that's fine. It falls under the qualifications of the policy."*

Section 3 of the policy sets out the conditions attaching to an *accident & sickness claim* and a *further accident & sickness claim*. From a review of this section of the policy, it appears the only *qualification period* (suggesting time) applicable to a further claim relating the same accident or sickness is that the Second Complainant was required to have been in continuous work for 180 days from when her last claim ended. As noted above, having checked the *qualification period*, the Provider's agent confirmed that everything was essentially fine.

The impression given by the Provider's agent during this call was that she placed the Second Complainant on hold in order to check the *qualification period* and, in doing so, reverted to the policy terms. However, based on the information imparted by the Second Complainant and the questions asked by the Provider's agent, it is unclear how the Provider's agent was able to confirm or verify that the Second Complainant met the *qualification period* under the policy if the date the Second Complainant resumed work was not first established. This information was a prerequisite to giving such clarification.

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Furthermore, if the Provider's agent gave an appropriate level of consideration to the policy terms, it would have been reasonably apparent that she was unable to confirm whether the *qualification period* was met unless she knew when the Second Complainant returned to work after her initial claim.

The Provider has submitted an email/draft email from **31 July 2019** written by one of its managers. This email states:

> *"From listening to the call I don't think the customer was asked when they returned to work after the first claim and subsequently went out sick again therefore the requalification period was not addressed.*
>
> *It was stated and I agree incorrectly that they fall under the qualification of the policy but I don't know what the associate was actually addressing in this statement. …"*

In the context of the telephone conversation, I am satisfied that the *qualification period* being referred to by the Provider's agent was the 180 day continuous work requirement. Therefore, I accept that the Provider's agent incorrectly informed the Second Complainant that she met this *qualification period*.

Furthermore, as the Provider's agent indicated that she would check *qualification period*, I would consider it reasonable, particularly in light of the other policy information imparted during the telephone conversation, to have highlighted or stated the specific qualification period surrounding a further claim in respect of the same accident/sickness or at the very least, advised the Second Complainant that qualification periods applied to further claims. Therefore, I accept that the Provider's agent also failed to inform and/or adequately inform the Second Complainant of the requirement to have been in continuous work for 180 days before she would be eligible to receive the benefits under the policy.

While the Second Complainant was given the false impression that she met the relevant qualification period under section 3, I am not satisfied this constitutes any assurance or guarantee that her claim would be accepted nor I am satisfied the Provider's agent advised the Second Complainant that her claim would be accepted. There are other criteria mandated by section 3 which must be satisfied before a claim could be accepted and which, at the time this telephone conversation took place, the Provider's agent did not comment on or purport to comment on. These include for example, the need to have been suffering from the *accident* or *sickness* for a 90 period, the need to satisfy the policy definition of *accident* and/or *sickness*, and verification of when the Second Complainant was medically certified as unfit to work. Further to this, on the basis of the evidence, I am satisfied the Provider was entitled to decline the Second Complainant's claim as she had not been in continuous work for 180 days.

The second Complainant took the prudent step of contacting the Provider to establish whether she was eligible for payment under the policy. I accept that the Complainants made certain decisions as a result of the information given and not given on that call.

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Had the second Complainant been given the information that her claim was not eligible in **October 2018** the Complainants could have taken a different course of action, or at least they would have been in a better position to explore the options available and deal with the reality of the situation.

With regard to the provision of information to a consumer, the Consumer Protection Codes state that a regulated entity must ensure that all information it provides to a consumer is clear and accurate, and that key items are brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information.

Provision 4.1 of the Consumer Protection Code 2012 states that:

> *4.1 A regulated entity must ensure that all information it provides to a consumer is clear, accurate, up to date, and written in plain English. Key information must be brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information.*

Having made the call to establish her entitlement under the policy, I believe that a key item was not brought to her attention, as it should have been, by the Provider during the call on **19 October 2018**. This had serious consequences for the Complainants.

Had the correct information been conveyed to the Second Complainant during the telephone conversation, she would have been aware at that point, that her claim would not succeed as she had not been in continuous work for 180 days prior to her claim. It was not until **26 February 2019** that the Second Complainant was made aware her claim was being declined on this basis. The Complainants maintain that had they known of the eligibility criteria earlier, they could have applied for a loan to cover their mortgage loan repayments.

I accept that the Provider's mistake caused a delay in terms of when the Second Complainant knew she was not eligible to make a claim. However, this must not be viewed in isolation. When the Second Complainant incepted the policy, she was provided with a copy of the policy terms. Additionally, it is reasonable to expect the Second Complainant to have consulted the terms of her policy around the time of contacting the Provider and/or making a claim. While this does not excuse the Provider's conduct, it must nonetheless be taken into consideration when assessing the impact and consequences of this conduct on the Complainants.

The Complainants maintain that *"… had they told me when I applied that I was not eligible then I could have got a [financial services provider] loan to pay the mortgage …."* A period of approximately four months passed from when the telephone conversation took place and the Provider's decision to decline the claim was issued. Once the Complainants became aware of the Provider's decision, they could have, and it is reasonable to have expected them to have, sought alternative means of meeting their mortgage loan repayments.

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Based on the evidence and my comments in the previous paragraph, I am not satisfied that any difficulty encountered by the Complainants in meeting their mortgage loan repayments after the Provider's decision to decline the Second Complainant's claim was necessarily caused and/or contributed to by the Provider.

For the reasons outlined in this Decision, I substantially uphold this complaint and direct the Provider to pay a sum of €4,000 to the Complainants.

Conclusion

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) (b), (e) and (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 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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

11 September 2020

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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.