An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0356
Sector:	Insurance
Product / Service:	Hospital Cash Plan
Conduct(s) complained of:	Failure to process instructions Dissatisfaction with customer service
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The complaint concerns a health insurance policy.

The Complainant's Case

The Complainant submits that he purchased a Hospital Income Plan in **1989** from the Provider's predecessor in title. He further submits that one of the reasons he took out this plan was because his premiums could be automatically billed to his credit card.

The Complainant submits that the Provider wrote to him on **5 August 2016** to advise that there had been an administrative issue with its billing system and it had not collected premiums since **February 2016**. The Provider further advised that it had waived any premiums due and that "*We have taken all necessary steps to prevent this kind of error occurring in the future…".*

The Complainant submits on **15 February 2019**, the Provider advised him that due to an ongoing administrative issue with the credit card collection company, it was no longer in a position to accept credit cards as a viable method of payment on his policy. The Complainant further submits that the Provider required him to transfer his payment method to Direct Debit and furnished him with a Direct Debit Mandate that was to be emailed or posted back to the Provider before **16 April 2019**. The Complainant states that the Provider told him that his policy would automatically be cancelled if he did not contact the Provider by **16 April 2019**.

The Complainant submits that he wishes to continue having his premiums deducted from his credit card "*as agreed in the policy".*

The Provider's Case

The Provider wrote to the Complainant on the **15 February 2019** informing him that it would no longer be able to accept Credit Card as a form of payment. The letter went on to explain that the Provider would now require the Complainant to pay by direct debit. The letter further stated that the Complainant would need to complete a direct debit mandate and the Provider would need to have received this by the **16 April 2019**. The letter concluded by stating that

> *"… if we do not hear from you by the 16th April 2019 then your policy will automatically cancel."*

The Provider wrote to the Complainant on the **21 February 2019** referring to a call on the **20 February 2019** acknowledging his complaint and advising that it had logged a formal complaint on his behalf. The Provider issued its Final Response Letter on the **13 March 2019**, stating that it had taken

> *"the decision to remove credit card as a method of payment. This decision wasn't taken lightly … but I am unable to change this decision."*

The Provider wrote to the Complainant on **16 April 2019** advising that his policy had been automatically cancelled as it had not heard from him regarding changing his premium payment method to direct debit.

The Complaint for Adjudication

The complaint is that the Provider has wrongfully ceased permitting the Complainant to make his premium payment using his credit card.

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 **23 September 2020**, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

Chronology of Events

- **1989:** The Complainant incepted a Hospital Insurance Plan with the Provider's predecessor in title.

- **8 June 2016:** The Provider wrote to the Complainant and informed him that due to an issue with the Provider's billing system, it had not been able to collect premiums since February 2016. The Provider went on to say that it had decided to waive any premium between March and July 2016, that the Complainant's policy remained unchanged and that the Complainant remained fully covered throughout that period.

- **21 November 2017:** The Provider wrote to the Complainant informing him that it wanted him to telephone to "*confirm your correct Credit Card details and Expiry Date"* or to "*….complete and return the attached Credit Card Authorisation slip".*

- **1 December 2017:** The Provider received the completed "*Card Authorisation slip"* from the Complainant.

- **21 November 2018:** The Provider wrote to the Complainant informing him that it would now send him an annual letter reminding him of his policy.

- **15 February 2019:** The Provider wrote to the Complainant informing him that it would no longer be able to accept Credit Card as a form of payment. The letter went on to explain that the Provider would now require the Complainant to pay by direct debit. The letter further stated that the Complainant would need to complete a direct debit mandate and the Provider would need to have received this by the **16 April 2019**. The letter concluded by stating that "*if we do not hear from you by the 16th April 2019 then your policy will automatically cancel".*

- **20 February 2019:** The Complainant telephoned the Provider and enquired about the letter he received from the Provider dated 15 February 2019. The Provider's Agent informed the Complainant that it was no longer accepting payment by credit card and would now be accepting payment by direct debit only.

/Cont'd…

The Complainant informed the Provider's Agent that he would be referring the matter to the Financial Services and Pensions Ombudsman and was offered guidance that before he did this he would have to log a complaint with the Provider. The Provider's Agent logged the complaint.

- **21 February 2019:** The Provider wrote to the Complaint regarding the telephone call that took place on the 20 February 2019, and informed him that it would "*aim to have your complaint finalised no later than 17 April 2019".*

- **13 March 2019:** The Provider issued its Final Response Letter to the Complainant.

- **22 March 2019:** The Complainant wrote to the Provider stating that he had referred the matter to the Financial Services and Pensions Ombudsman.

- **1 May 2019:** The Complainant wrote to the Provider stating that he had not received a response from the Provider. He informed the Provider that he had forwarded the Complaint to this office and that he objected to the decision of the Provider to cancel the policy as the Financial Services and Pensions Ombudsman had not yet reached a decision on the complaint.

- **9 May 2019:** The Provider's Agent telephoned the Complainant in relation to a letter the Complainant sent the Provider on 1 May 2019.The Provider's Agent confirmed that it received the letter of 1 May 2019, but it had not received the letter of 22 March 2019. The Provider's Agent informed the Complainant that there was nothing that could have be done at that stage as the policy was cancelled, as the direct debit has not been set up. The Provider's Agent confirmed that it would formally reply to the letter the Complainant sent on the 1 May 2019.

- **10 May 2019:** The Provider wrote to the Complainant following on from the telephone conversation on 9 May 2019 outlining its position that it

  "*remains the same, in that as you are unable to pay for your policy by credit card any longer, a direct debit needs to be set up. As this wasn't done, the policy was cancelled …. If you do wish to set up a Direct Debit, we will be happy to reinstate the policy."*

Policy Terms and Conditions

The terms and conditions relevant to this complaint are as follows:

"***PART 5 – PREMIUM***

1. Consideration

The Policy is issued in consideration of the statements contained in the Enrolment Form and the agreement of the Policyholder to pay the premium charged. Payment of Premium will maintain this Policy in force until the next Premium due date".

/Cont'd…

> ***"3. Premium Due Dates***
> *3.2 Premium will be charged in a manner similar to that specified in Item 6 of the Policy Schedule".*
>
> ***"PART 6 – ADDITIONS***
> *…. The relevant premium for such Eligible Person will be debited to the Policyholder's Credit Card Account or Bank Account as authorised in the Enrolment Form and/or Direct Debit Mandate".*
>
> ***"PART 7 – TERMINATION OF INSURANCE***
> *2. Termination by the Company*
> *Subject to the provisions of this Policy, the Company may give notice of termination hereof by registered letter to the Policyholder at his or her own last known address. Such termination shall become effective seven days following the date of such notice".*

Analysis

The Complainant first purchased his Hospital Income Plan in 1989. I noted from the evidence made available to this Office that the terms and conditions of the policy do not create an obligation on the Provider to accept payment by Credit Card.

I note in the terms and conditions the following:

> "***PART 5 – PREMIUM***
> ***1. Consideration***
> *The Policy is issued in consideration of the statements contained in the Enrolment Form and the agreement of the Policyholder to pay the premium charged.* ***Payment of Premium will maintain this Policy in force until the next Premium due date****".*

In its submissions to this Office the Provider has stated that:

> "*Therefore, strictly speaking the only obligation on* [the Provider] *is to maintain the policy in force with the same terms until the next Premium due date. Each Premium due date then is effectively as opportunity to reset the terms of the Policy Schedule".*

I also note from the Complainant's submissions to this Office that he received a letter from the Provider in **October 1989**, which stated the following:

> "*For your convenience premiums are automatically billed to your card account, either monthly, quarterly or yearly, whichever you choose. This means that you never have to worry about missing a payment".*

/Cont'd…

Furthermore I note that in the Policy Schedule dated the **14 July 1992**, the Policy states:

> "*Premium: 12 monthly instalments of IR£ 19.60 billed to the Insured Cardholder's* [Bank Name] Access Irish Pound Card Account when due".

The Provider responded to the Complainant's submission that the Complainant agreed with the Provider that his premiums would be deducted by credit card and was also "*as agreed in the policy".*

The Provider has stated that:

> "*…we cannot see it reasonable to rely on promotional literature from over thirty years ago to put an obligation on* [the Provider] *to maintain the same method of payment now".*

Therefore under **"PART 5 – PREMIUM"**, I am satisfied that payment of the premium by Credit Card only guarantees that the policy's terms and conditions will not be changed until the next "*Premium due date".* It is then at the discretion of the Provider to change the terms and conditions at the next due date, and at the discretion of the Complainant to renew the policy at the amended terms and conditions, if desired.

Furthermore under ***"PART 7 – TERMINATION OF INSURANCE"***, it gives the Provider the discretion to terminate the policy by giving the Complainant seven days' notice. The terms and conditions state that:

> *"Subject to the provisions of this Policy, the Company may give notice of termination hereof by registered letter to the Policyholder at his or her own last known address. Such termination shall become effective seven days following the date of such notice".*

As a result the terms and conditions of the policy create an obligation on the Provider to allow the Complainant to purchase the policy by the same payment method, but this obligation continues only up until the next renewal date. However the terms and conditions of the policy allow for the Provider to terminate the policy with the Complainant, by giving him seven days' notice.

In applying the relevant Provisions of the Consumer Protection Code, 2012, I note that *Provision 2.2* of the Code states that a Regulated Entity is required to:

> "*act[s] with due skill, care and diligence in the best interests of its customers;"*

Having considered the evidence made available to this Office, I am satisfied the Provider met its obligations under this Provision. In its submissions to this Office, the Provider has said that:

/Cont'd…

> *"…Given the impossibility of continuing the policy as it was (with premiums paid by credit card) we considered that it would be unreasonable to cancel the policy outright, even though we would have been within our rights to do this. Instead, we carefully considered the most appropriate way forward which would be in the best interests of our customers. That is, to give all affected customers sixty days' notice to consider if they wanted to keep the policy in force with a Direct Debit agreement."*

The Provider wrote to the Complainant on the **15 February 2019**, informing him that it would no longer be receiving payments by Credit Card and that he had until the **16 April 2019**, to complete a direct debit mandate and send it to the Provider. The Provider further stated that if it did not hear form the Complainant by 16 April 2019, the policy would be automatically cancelled.

The Provider in its submissions to this Office has explained that:

> "*while* [the Provider] *was of course dedicated to maintaining relationships with outsourcers carrying out essential maintenance, this proved impossible despite our best efforts".*

The Provider, therefore ceased its relationship with the bank in question at the end of 2018.

On the basis of the evidence made available by the parties, I am satisfied that the Provider's conduct was a reasonable one based upon the evidence available, details of which are outlined above. I am satisfied that the Provider acted in accordance with the terms and conditions of the policy and met its obligations under the Consumer Protection Code, 2012. Such obligations however did not require the provider to continue its commercial relationship with the bank in question, with which the Complainant held a credit card

I am not satisfied that the Complainant's practice of making his premium payments using his credit card which continued from 1989 until 2019, created an obligation on the part of the Provider to make that facility available to the Complainant indefinitely. It is inevitable that as improvements are achieved in payment methods and platforms, that practices will likewise be altered in the context of such evolution. I am satisfied that, in this instance, the Provider made a reasonable opportunity available to the Complainant to continue his cover, by moving to a direct debit payment method. This was not attractive to the Complainant who elected not to continue the relationship on that basis, but I am satisfied, taking account of the terms and conditions which I have referred to above, that there was no obligation on the Provider's part, to facilitate the Complainant's request to continue making his premium payments using his credit card, after the Provider's relationship with the credit card issuer, had ceased.

Accordingly, I do not believe that there is any reasonable basis upon which it would be appropriate to uphold this complaint.

/Cont'd…

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.

MARYROSE MCGOVERN
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

15 October 2020

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that—

(a) ensures that—
(i) a complainant shall not be identified by name, address or otherwise,
(ii) a provider shall not be identified by name or address,
and
(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.