An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0363
Sector:	Insurance
Product / Service:	Life
Conduct(s) complained of:	Delayed or inadequate communication
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns the Provider's conduct as financial advisor / broker regarding life policies which the Complainant and her late husband held with a third party insurer, which they incepted in 2004, to provide cover over their mortgage loan.

The Complainant's Case

The Complainant and her late husband:

> *"engaged the services of* [the Provider] *as insurance brokers and financial advisors to purchase two dual life insurance policies with* [an Insurer*] in or about January 2004",* one of which was to act *"for the purpose of assignment to* [the mortgage loan provider] *in consideration of a mortgage loan advanced to* [the Complainant and her late husband]*".*

As a result, on **1 February 2004** the Complainant and her late husband took out dual life cover which would pay out up to €165,000 in the event of death of one of the insured, such pay-out being intended towards the mortgage account held with the third party lender.

The policies lapsed in **December 2011** due to the non-payment of premiums.

The Complainant's husband passed away in **December 2013**. The Complainant states that it was only when a claim was submitted to recover under these policies, that she learnt that they had lapsed.

In this regard, the Complainant's representatives set out her complaint as follows:

> *"The premiums for both policies were set up to be paid by direct debit from a* [bank] *account in the sole name of* [the Complainant's late husband]… *On or about the* ***1st of November 2011*** *the direct debit for the premium for policy number xxxxx501 were returned unpaid by* [the bank].
>
> *By a single letter dated the* ***7th of November 2011*** [the Insurer] *wrote to both* [the Complainant and her late husband] *to advise them of the fact that* the premium was outstanding. That letter was copied by [the Insurer] to [the Provider], *as their financial advisor.*
>
> *By single letter dated the* ***21st of November 2011*** [the Insurer] *again wrote to both* [the Complainant and her late husband] *to request that they pay the outstanding premium for November 2011. This letter was also copied by* [the Insurer] *to* [the Provider].
>
> *By single letter dated the* ***19th of December 2011*** [the Insurer] *wrote… to both [the Complainant and her deceased husband] to advise them that the policy had lapsed but that they could apply to reinstate the policy. This letter was also copied by* [the Insurer] *to* [the Provider].
>
> [The Complainant*]… never had sight of any of these letters and therefore was unaware that the policy had lapsed until December 2013 when her husband died and she sought to claim the benefit of the policy to repay the mortgage….* [the Complainant] *has two young children and had expected that the mortgage protection policy set up by herself and her deceased husband would come into effect on her husband's death.* [The Provider] *never contacted* [the Complainant] *directly to inform her that premium payments were not being made or that the policy had lapsed".*

The Complainant notes that the insurer wrote to the Provider twice regarding the unpaid premium, and once regarding the subsequent lapse of the cover but she *"was completely unaware of this and was not contacted by* [the Provider] *in relation to this correspondence…"*

In addition, the Complainant's solicitors also advise as follows:

> *"*[The Complainant] *was completely unaware of the lapse of the mortgage protection policy in this case which obviously is an extremely important matter / protection for* [her] *given that the life policy in question protected the mortgage on her principal private residence in which she resided (and still continues to reside) with her young family.*
>
> *It is* [the Complainant's] *contention that there was a duty of care on the part of the Provider in this case to inform her firstly of the warning of the potential lapse of the policy and also the consequences of same".*

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Furthermore, the Complainant notes that in a telephone conversation between an agent of the Provider (M) and an agent of the lender (D) on **12 December 2013**, (M) advised (D) that she was aware that the Complainant's deceased husband had been:

> *"in and out of hospital and that there were difficulties…* [illness] *and it became more and more pressing… if I had only known they were under this level of pressure it would have been a phone call I would have made way back… hindsight is a great thing"*.

The Complainant submits that the Provider should have contacted her directly, as one of the named policyholders, to advise her of the correspondence it had received from the Insurer in relation to the unpaid premium and subsequent lapse of cover. In this regard, in its correspondence to the Provider dated **7 August 2015**, the Complainant's solicitors advised that the Provider's *"failure to contact* [the Complainant] *to advise her of the unpaid premia constitutes negligence, breach of contract and breach of duty on* [the Provider's] *part and* [the Complainant*] is now at a substantial loss as a result of the lapse of this policy".*

The Complainant seeks for the Provider to:

> *"pay the sum of 165,000.00 Euro being the amount payable on foot of policy number xxxxx501 together with 115,000 Euro being the amount payable on foot of policy number xxxxx557".*

The Provider's Case

In 2016, the Provider acknowledged that the circumstances of the Complainant's husband's death were very sad, but he believed the complaint against him, as broker, to be without basis.

The Provider submitted that, while it is said that the Complainant was not aware of the correspondence in relation to the missed premiums, he as broker, could not be held responsible for non payment of the premiums.

The formal investigation of this complaint was commenced by this office in **September 2019**. On **11 October 2019**, notification was received by this office from the Provider's representative that the Provider had died on [date redacted].

The submissions made available in reply to the formal investigation of the complaint, were advised to be "*based on a draft prepared by him before his death*". In that regard, the Provider furnished a number of letters relevant to the allegations made by the Complainant.

The first letter was jointly addressed to the Complainant and her late husband by the Provider dated **25 November 2011** and advised as follows:

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> *"I refer to the above policy numbers for your Protection Plans with* [the Insurer]. *We have recently received correspondence from* [the Insurer] *stating that the mandate has been returned unpaid and your policies will lapse if payment is not received.*
>
> [The Insurer] *requires the payment of the outstanding premiums urgently to maintain policy benefits. Please contact* [the Insurer] *directly on* [telephone number] *in order to complete payment.*
>
> *Alternatively, should you wish to review or discuss your protection requirements based on your current circumstances, please do not hesitate to contact us at the above number and we will be delighted to discuss the matter with you."*

On **23 December 2011** the Provider again wrote a letter jointly addressed to the Complainant and her husband advising as follows:

> *"I refer to the above policy numbers for your protection plans with* [the Insurer*]. We have recently received correspondence from* [the Insurer] *stating that they have not received the outstanding premiums and as a result, your policy has lapsed.*
>
> *If you wish to apply for re instatement of the plan please forward the outstanding premium to* [the Insurer] *directly. Alternatively, should you wish to review or discuss your protection requirements based on your current circumstances, please do not hesitate to contact us at the above number and we will be delighted to discuss the matter with you."*

The Provider pointed out that the mortgage protection and personal protection contracts were initially set up as single contracts with both the Complainant and her late husband as the lives assured. Therefore, as a matter of procedure, all correspondence was addressed to both insured parties, in line with the initial application format.

The Provider says that standard industry practice led the insurer to send 3 letters in total to the clients, addressed to both, as they were set up on a single contract. The 3 letters in question were dated 7 November 2011, 21 November 2011 and 19 December 2011.

The Provider pointed out that as a matter of internal best practice, he also issued 2 further letters (in addition to the 3 letters sent by the insurer) simply explaining the missed premium situation and the consequences of same.

The Provider took the view that he had acted above and beyond his duty of care in issuing supplementary correspondence as outlined above, in making it clear to the named policyholders that the premiums were unpaid.

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The Provider pointed out that in normal industry standard, correspondence would be issued only from the life company directly to the policyholders. It was ultimately the customers' responsibility to ensure that at all times, there were sufficient funds available in the account, to meet the required premium payment. Nevertheless, in the spirit of "*our House View of customer centred approach*" the Provider issued additional correspondence to the Complainant and her late husband.

The Provider pointed out that he did not accept that he had a duty to contact each of the named policyholders separately. He pointed out that between the insurer and his office, 5 separate letters had issued to the Complainant and her late husband, advising of the ongoing situation.

The Provider also pointed out that as part of his service agreement with all customers, he issued in writing a clear and simple service agreement to the Complainant and her late husband known as "*Terms of Business*". This explained his service role in the process to provide advice, making the customer aware of the various contract options available at a given time and based on their personal circumstances. Once the legal contract was effected between the customer and the insurer, a service level agreement was created between those 2 parties, supported by the policy terms and conditions. The Provider pointed out that he always oversaw correspondence issued by the insurer and where he believed it to be in the spirit of his "*House View of customer-centred approach"*, he also corresponded with the clients, as evidenced by his letters of 25 November and 23 December 2011.

The Provider took the view that the telephone conversation between its agent (M) and the lender (D) referred to by the Complainant was taken out of context, as it was a call being made by (M) seeking to secure a moratorium on the mortgage repayments, after the Complainant's husband had passed away. The Provider submitted that the comment sought to be relied upon by the Complainant was in fact regarding (M's) regret that a moratorium had not been sought sooner, and not that the Complainant had not been telephoned in relation to missed premium payments.

The evidence made available includes a letter from the Provider to the Complainants' representatives in September 2015 which concluded by noting that the Complainant and her late husband had experienced ongoing financial difficulty due to the Complainant's late husband's ill health and inability to work and both parties attempted to resolve some of the difficulties during the Summer of 2011. The Provider pointed out that he had supported and facilitated them in an effort to improve their position with the mortgage. The policies had 2 named parties i.e. the Complainant's late husband and the Complainant herself, as joint owners and therefore both parties had joint responsibility to ensure that the policies continued to be paid.

The Provider noted that he could only sympathise with the Complainant, but could not accept any charges of negligence or breach of contract or breach of duty.

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The Complaint for Adjudication

The Complainant's complaint is that the Provider, as her financial advisor, failed in November 2011 to inform her of information that it had received, regarding the policies held jointly by the Complainant and her husband, insofar as it failed to inform her directly at that time, that the premium in respect of those policies had not been paid and the policies were at risk.

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.

A Preliminary Decision was issued to the parties 17 August 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.

On a number of occasions the Complainant's representatives requested an Oral Hearing for the purpose of the investigation of this complaint and following a reminder from the Complainant's solicitors in that regard, in February 2020 this office wrote to the representatives on 13 March 2020 asking for clarification as to why the Complainant took the view that an Oral Hearing would be of benefit, bearing in mind that the Provider had died in October 2019. Thereafter, the Complainant's representatives confirmed that in light of the Provider's unfortunate death, it was in agreement that the benefit of an Oral Hearing was minimised and the Complainant's representatives accordingly confirmed that the adjudication could proceed on the basis of the evidence already before this office.

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It is important to bear in mind that this decision concerns only the complaint regarding the conduct of the Respondent Provider as broker, in relation to these events. This decision makes no comment regarding the actions of the insurer which was the subject of an adjudication by the Financial Services Ombudsman in 2014. Likewise, this decision makes no comment regarding the actions or conduct of the lender in relation to these matters.

The evidence received includes audio evidence of the conversations between the Provider's representative and the lender, during 2013. This conversation took place after the untimely death of the Complainant's late husband, and the contents have been noted in that context.

Analysis

On the basis of the evidence furnished to this Office as part of this complaint, it is clear that letters issued to the Complainant and her husband in 2011, in relation to the missed premium payments. It seems in that regard that the insurer wrote to the Complainant and her late husband on 3 occasions, and indeed the broker, being the respondent Provider to this complaint, also wrote to the Complainant and her late husband twice during the same period.

It is notable in that regard that at least 5 letters issued to the Complainant and her late husband warning as to the non-payment of premium and the risk of the policies lapsing, or having lapsed. The question which arises for consideration in this matter is whether there was an obligation on the respondent Provider to write to both the Complainant and her late husband separately, in order to notify each of them, when he became aware that the premium payments had not been made in November 2011.

The essence of this complaint is that the Provider was on notice of circumstances which placed an onus him to ensure that the Complainant was written to separately from her late husband. The basis of this contention is the fact that the Provider was made aware during 2011, that the Complainant's husband had been diagnosed with, and was undergoing treatment for, [illness].

It is clear however, that the Complainant herself was in a better position than the Provider to understand the ramifications of her husband's illness and any consequences. There is no evidence however, that the Complainant notified the Provider that she should become the primary channel for communication because of her husband's illness, or indeed that the Provider should ensure that steps were taken to issue communications to her separately from any communications being sent to her husband or being jointly addressed.

I do not accept that it was a matter for the Provider to take it upon itself to ensure that all communications would issue to the joint policyholders separately from each other, in the absence of notification from the Complainant or her husband as to any reasons for such a step to be taken for example, if the Complainant and her husband had separated, or indeed were living at 2 separate addresses for any other reason.

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I accept that in the circumstances outlined, the Provider issued correspondence to the Complainant and her late husband when it received notifications from the insurer, although the Provider had no contractual obligation to do so. I also accept that this represented the Provider's efforts to provide the best possible service to the Complainant and her husband. I accept the Provider's position in that regard that this action went "above and beyond" what was contractually required.

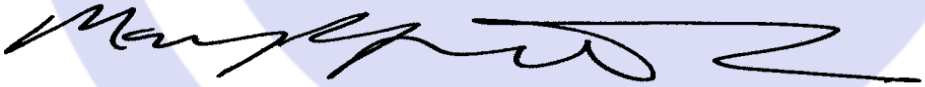
One must have every sympathy for the Complainant as she has found herself in very difficult circumstances arising from these tragic events. Whilst the Complainant and her late husband were under financial pressure during 2011, it is not clear as to how it arose that the premium payments were not met, as a result of which, following warnings from the insurer, ultimately the policies lapsed owing to non-payment of premium.

This was a difficult time for the Complainant and her late husband and one can well imagine that the financial pressure upon them was immense. The jurisdiction of this office however, permits the FSPO to uphold a complaint against a financial service provider only where there is evidence of wrongful conduct, within the meaning of ***Section 60(2)*** of the ***Financial Services and Pensions Ombudsman Act 2017***. In this instance, I can find no evidence of such wrongdoing on the part of the Provider and accordingly, I take the view that it would not be reasonable to 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.



MARYROSE MCGOVERN
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

9 September 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.

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