An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0452
Sector:	Insurance
Product / Service:	Term Insurance
Conduct(s) complained of:	Failure to process instructions in a timely manner
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns a life assurance policy the Complainant arranged with the Provider in November 2018.

The Complainant's Case

The Complainant submits that she applied for a life assurance plan with the Provider on **15 November 2018**. The Complainant says that the initial application was completed during a phone call with the Provider. She says that she received a letter with the draft application on the same day and was required to review the form to ensure all details were correct. The processing of this application was delayed because she noticed the wrong name had been added to the application form which required the form to be re-drafted. The Complainant says that once this was rectified she signed and returned the agreement along with a signed direct debit mandate on **18 November 2018.** It was agreed that the policy and premium payments were to begin on **January 2019.**

The Complainant says that in **April 2019**, she noticed the premiums were not debiting from her account, and it became apparent that her policy had not been incepted. The Complainant says that *"this has made me extremely stressed and worried that my Life assurance cover has not come into effect".* The Complainant contends that this experience has heightened other personal stresses in her life.

The Complainant also submits that at the time of the application, the Provider *"failed to set out clearly any discount or loadings in generating this quotation".*

The Provider's Case

The Provider issued an apology to the Complainant for "*not putting your policy into force".* The Provider says that any breakdown in customer service is taken seriously and it has acknowledged that it did not provide adequate customer service to the Complainant on this occasion.

In April 2019, the Provider wrote to the Complainant to apologise and to advise that her policy was now in place and it backdated cover to **24 January 2019,** with free premiums applied to the first 5 months of the Policy, as a result of which the first premium payment would fall due for payment by the Complainant in June 2019.

The Complaint for Adjudication

The Complaint is that the Provider was guilty of maladministration and poor customer service in that it failed to ensure all instructions from the Complainant were processed fairly and promptly. The Complainant also says that at the time of the application, the Provider failed to set out clearly any discount or loadings applied in generating the quotation.

The Complainant says that these issues have caused her and her family undue stress and she wants the Provider to provide redress. She says that the Provider "*should review their processes and implement controls to prevent this happening to anyone again in the future".*

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.

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A Preliminary Decision was issued to the parties on **20 November 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

- **12 November 2018:** The Provider's Insurance and Investments Manager (referred to as the Provider's agent) telephoned the Complainant and discussed her insurance protection needs and in that context, carried out a financial review with her.
  Having listened to the Complainant's needs, the Provider's agent advised the Complainant that he recommended taking out [Life Assurance Policy A] as security for her mortgage loan. The Provider's agent also recommended the Complainant take out [Life Assurance Policy B] that would suit the Complainant's financial needs in respect of other items such as funeral expenses. The Complainant told the Provider's agent that she wanted to consider the policies and the Provider's agent told her that he would call her back.

- **12 November 2018:** The Provider's agent emailed the Complainant [Life Assurance Policy A] and [Life Assurance Policy B] brochures to review.

- **15 November 2018:** The Provider's agent telephoned the Complainant. The [Life Assurance Policy A] and the [Life Assurance Policy B] application forms were completed during the telephone call.

- **16 November 2018:** The Provider's agent emailed the Complainant all the relevant information that was discussed during the telephone call on the 15 November 2018, to allow the Complainant to review what was discussed the previous day.

- **18/19 November 2018:** The Complainant sent on the signed application forms to the Provider's agent.

- **24 December 2018:** The [Life Assurance Policy A] was commenced.

- **28 December 2018:** The [Life Assurance Policy A] terms and conditions were issued to the complainant.

- **1 April 2019:** The Complainant sent the Provider a complaint in relation to her life assurance policy.

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- **17 April 2019:** The Provider put the [Life Assurance Policy B] into force and backdated the policy to the 24 January 2019, which was when the policy had been due to commence. The Provider confirmed that the Complainant would not be charged premiums for the period in question and the first premium would fall due for payment on 24 June 2019.

- **17 April 2019:** The Provider issued the Complainant with the [Life Assurance Policy B] terms and conditions.

- **18 April 2019:** The Provider issued its Final Response Letter to the complainant.

- **7 June 2019:** The Complainant wrote to the Provider and advised that she wished to cancel Policy B with the Provider. Some confusion thereafter ensued as to which policy this instruction referred to.

- **24 June 2019:** The first premium was collected from the Complainant.

- **9 July 2019:** The premium collected from the Complainant on the 24 June 2019 was refunded to the Complainant.

Analysis

This complaint concerns a Life Assurance Policy [Policy B] that the Complainant incepted with the Provider. I note that the Complainant's Life Assurance Policy should have come into force on the **24 January 2019**.

In the Complainant's complaint letter to the Provider on **1 April 2019**, I note that she advised:

> *"…I am very concerned about my Life Assurance Policy. From my understanding this had been formally agreed and was due to be implemented from January 2019 as per your letter dated 15 November 2018. I am very disappointed that appropriate steps have not been taken by [the Provider] to follow through with my policy and appropriate action taken to implement the above. It was with great shock upon my discovery that I noticed that Direct Debits have not been debited from my account although a signed Direct Debit Mandate was completed on 18 November 2018 and sufficient funds in my nominated bank account each month thereafter".*

In response to the Complainant's complaint letter on 1 April 2019, the Provider issued its Final Response Letter on **18 April 2019** and says:

> *"I have now finished my investigation into your complaint and I can give you a final response. I understand your complaint is in relation to the delay in putting this policy in force.*

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> *I have reviewed your policy file and the application completed confirms that the preferred policy start date was to be advised. I contacted* [name] *Insurance & Investments Manager and he has advised that he believed that he had instructed our New Business Department that your policy be put into force.*
> *…….*
> *Your policy has now been put in force with a start date of 24 January 2019, you will receive your policy documents over the next couple of days. Please read these carefully as they contain important information about your policy.*
>
> *As a token of apology for the breakdown in service I have arranged for five months premiums to be applied to your policy. The next premium payable on this policy will be the 24 June 2019".*

I note that the Provider backdated the policy to the 24 January 2019 and arranged for 5 months of premiums to be applied to the Complainant's policy. Thereafter the Complainant decided to cancel the policy.

In considering the evidence, I accept that the Provider failed to incept the Complainant's Life Assurance Policy B. It has acknowledged this error and it maintains that in the circumstances, whether or not the policy was incepted, the Complainant would have been covered in the event of a valid claim:

> *"We can assure [the Complainant] that in the event that a valid claim had arisen between January 2019 and April 2019 the Company would have honoured the claim received as the application had been processed and the only outstanding matter was the start date. If a claim had been made, we believe it would have been apparent the policy had not commenced due to an error on the Company's part. When [the Complainant] brought the matter to the Company's attention the Company rectified the position quickly".*

The Complainant is also unhappy because she says that the Provider failed to set out clearly any discounts or loadings applied in generating the quotation. I note however, the Provider's response that the policy quotation was issued on the basis of ordinary rates and I am satisfied therefore that there were no loadings or discounts to explain to the Complainant and I am satisfied that the Provider does not have a case to answer to her in that regard.

The Complainant says:

> *"My main concern is if I had of became ill or God forbid passed away and I had not followed up on my policy where would my 2 boys stand in regards to life assurance cover?"*

She says the Provider:

> *"should review their processes and implement controls to prevent this happening to anyone again in the future".*

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I note in the Provider's submissions to this Office that it addressed the Complainant's concern and noted that in the event of a claim having arisen, it would have honoured the claim as the proposal for cover had been accepted and processed. Whilst I accept the Complainant's submission that this situation has caused her stress, the Provider has stated that in the event of a claim arising, the Complainant would have been covered under the policy. It says:-

> *"Any breakdown in the Company's customer service is taken seriously and the type of error that occurred is not common. It is as a result of a human error that the second policy was not put into force at the time We apologise once again to [the Complainant] for what occurred. In acknowledging the error made, the Company backdated the start date of the policy to 24 January 2019 and agreed to cover the first 5 premium payments for [the Complainant]. Regretfully, when the 5 months came to an end, [the Complainant] decided to cancel the policy".*

Whilst I accept that there was an administration error by the Provider concerning the manner in which Policy B failed to be incepted for the Complainant, I note that within 16 days of the Complainant raising the issue with the Provider, it had rectified the error. Indeed, in recognition of the mistake which had been made, it confirmed to the Complainant that the Provider itself would meet the cost of the premium payments in question for the first 5 months, as a result of which the Complainant was covered for that period at no cost to her.

I note that although as a result, the Complainant's first premium payment then fell due in June 2019, she elected instead to cancel the policy. This of course was entirely a matter for herself.

Accordingly, on the basis of the evidence before me, I am satisfied that the Provider's error in the inception of Policy B was quickly remedied as soon as it was identified and that the compensatory measure which it made to the Complainant at that time, was appropriate to take account of the mistake which had been made.

I note the Complainant's submission that the Provider caused her undue stress but I am also conscious that within 16 days of the Complainant raising the matter with the Provider, it had fully addressed the error and the Complainant had received confirmation that she was covered.

Accordingly, on the basis of the evidence made available to this office, I do not believe there is any reasonable basis upon which this complaint should be upheld.

Conclusion

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

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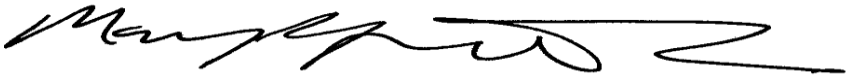
The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.



MARYROSE MCGOVERN
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

11 December 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.