An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0150
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Lapse/cancellation of policy (life) Fees & charges applied Failure to provide accurate investment information Failure to consider vulnerability of customer Fees & charges applied (life)
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant is the Estate of the late Mr P., who died in the Summer of **2019**.

Mr P. had incepted a life assurance policy with the Provider on **1 December 1985**, which lapsed on 24 January 2019, when he was aged 70, due to non-payment of premiums. At that time, the policy was providing life cover in the amount of €324,834 for a monthly premium of €592.12.

The Complainant's Case

The Complainant notes that the late Mr P.'s life assurance policy lapsed on 24 January 2019 due to non-payment, as direct debits presented to his bank account by the Provider for the November 2018, December 2018 and January 2019 monthly payments were returned unpaid by the bank due to insufficient funds.

The Complainant notes that the late Mr P. telephoned the Provider on 4 February 2019 and the Agent told him that as his policy had now lapsed, he would have to complete and return a Reinstatement Declaration of Health Form in order to have his life assurance policy considered for reinstatement.

The late Mr P. completed and returned this Reinstatement Declaration of Health Form to the Provider on 12 February 2019.

The Complainant notes that the late Mr P. next telephoned the Provider on 27 February 2019 to obtain its address so that he could post it money to pay the arrears and bring his policy up to date, but the Agent declined this offer of payment, as the policy was out of force.

The Complainant notes that the late Mr P. then met with his Broker in early March 2019 and following this meeting, the Broker wrote to the Provider on **11 March 2019** requesting for the reinstatement of Mr P.'s life assurance policy without the need for underwriting, as follows:

> *"*[Mr P.] *set up this plan with his late mother back in December 1985. To date he has paid €51,170 … premiums have always been paid effortlessly until 2016 when there was a hiccup in his account. Outstanding premiums were paid and the plan recommenced. Another hiccup occurred in mid-2018 and it appears that the premiums were paid by visa. A further series of hiccups happened later in 2018. During this period,* [Mr P.] *contacted* [the Provider] *and explained that he wanted to continue with the cover and did not want the policy to lapse. He discussed the payments with one of your team and was told it would take* [the Provider] *6 days to access his funds. He informed you that funds were in the account but unfortunately, by the time you had gone in for 2 premiums plus arrears, another direct debit had been presented and made a mess of this collection.* [Mr P.] *asked that you take payment immediately but you declined to do so. Could you not have accepted a payment over the phone? If you had done so, the policy would have been reinstated.*
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> *I have discussed the situation at length with* [Mr P.]*. He does not understand fully the workings of the direct debit system and unfortunately it has played havoc with his cash flow. He has the funds to pay the premium but the management of the payment system has not worked for him. This policy has been in place for over 33 years and we ask that you reinstate once* [Mr P.] *has made payment of the arrears. He should not be subject to any underwriting process as he has made numerous efforts to keep this going and make payments.*
>
> *We have noted on our files that* [Mr P.] *is a "**vulnerable consumer**". Under* [the Central Bank of Ireland's] *Consumer Protection Code* [2012]*, "vulnerable consumer" means a natural person who:*
>
> *a) has the capacity to make his or her own decisions but who, because of individual circumstances, may require assistance to do so (for example, hearing impaired or visually impaired persons); and/or*
>
> *b) has limited capacity to make his or her own decisions and who requires assistance to do so (for example, persons with intellectual disabilities or mental health difficulties).*

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> *In our opinion,* [Mr P.] *has not been able to manage this situation as best he could. I believe that "**he has limited capacity to make his or her own decisions and who requires assistance to do so**". He has now sought our help … He has explained that he has tried to pay the premiums but through no fault of his own, cannot see his way to managing his account to enable this to happen. His brother is now monitoring the account and will ensure that this episode is not repeated.*
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> *In hindsight (which is a wonderful thing), had* [Mr P.] *contacted this office when encountering difficulty the matter would have been resolved, policy kept in force and premiums paid. He didn't because he found the system cumbersome and he was not comfortable with it. He did contact you but you did not make it easy for him. Why did you not ask him for a cheque or visa payment?*
>
> *Having been a paying client for 33 years and without giving you any indication of ceasing his policy, I ask that you accept payment for arrears and reinstate the policy. A reduction in the sum assured to something like €250,000 would be acceptable to him as an option you could consider. If you go back over your recent contact history, you will see that* [Mr P.] *has been trying to pay the outstanding* [premiums] *but circumstances contrived against him.*
>
> *He is a "**vulnerable consumer**" and we believe that he should be afforded the protection of* [the Central Bank of Ireland's Consumer Protection Code 2012] *that is designed to look after those who cannot manage the complexities of the system in which they find themselves"*.

The Provider wrote to the Broker on 28 March 2019 to advise that it was not in a position to reinstate Mr P.'s life assurance policy without his request being reviewed by its underwriters.

Mr P. subsequently died some months later.

The Complainant sets out its complaint in the Complaint Form, as follows:

> *"*[Mr P.] *had become a vulnerable consumer and it appears that* [the Provider] *used this to avoid a claim which would arise in the near term. A combination of conflicting advice from* [the Provider's] *customer help line (*regarding his attempts to pay* [the Provider] *by phone),* [Provider] *administrative procedures and delays plus issuing direct debits for double the monthly premium (when there* [was] *funds in place for the expected monthly amount) conspired to frustrate repeated attempts to pay amounts due. A phone call to the Broker would have resolved the issue forthwith and this contact should have been made by* [the Provider]*"*.

In its letter to this Office dated 14 December 2019, the Complainant stated:

> *"… the situation regarding the policy became quite confused in late 2018 at a time with* [Mr P.] *started to become quite confused unbeknownst to his family.*

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Despite several attempts to clarify the position to himself he appears to have become totally confused regarding the payments and [the Provider] *kept sending him letters which he did not comprehend. This situation was compounded by* [the Provider's] *own administrative procedures which kept issuing direct debit requests for double the normal amount and which were unpaid by the bank although there were funds available for one monthly premium. To try and sort the situation out* [Mr P.] *requested by telephone that* [the Provider] *take payments immediately but this was declined. He was told that the 'system' was to receive payment by direct debit only …*

- *The essential element of this complaint is that* [Mr P.] *was trying to pay the insurance premium and believed that he was in compliance with the instructions received from the* [Provider's] *customer service agents.*

- *Despite being informed by the broker and* [the Complainant] *that* [Mr P.] *was a vulnerable customer,* [the Provider] *has not addressed this or taken account of this fact.*

- [Mr P.] *was becoming frail and confused and did not fully comprehend the written notifications he was receiving, hence his telephone calls to the* [Provider's] *Customer Help line.*

- [Mr P.] *was advised by the helpline on 10 December* [2018] *to ignore a letter he had received from* [the Provider] *regarding late payment. This served to complicate matters further.*

- *On 7 December* [2018] [Mr P.] *made a payment of two months' premium by telephone. He had previously been informed repeatedly that this was not possible as payments could only be accepted via direct debit.*

- *Sending letters to an elderly, confused person did not help to resolve the situation.*

- *It is questionable if the needs of a vulnerable consumer were in the forefront of the attention of* [the Provider].

- *Requesting a medical questionnaire* [Declaration of Health Form] *to be completed and then requiring a full medical report from a 70-year old prior to considering reinstatement of the policy is sinister when one considers that 31 years of premiums (totalling €51,170) had already been paid. It suggests that* [Mr P.'s] *confusion was being seized upon in order to get the policy out of force.*

- *Repeatedly referring to letters which* [Mr P.] *did not understand does not explain or justify the subsequent actions of* [the Provider].

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- *… a simple phone call to* [Mr P.'s Broker] *would have alerted all concerned to the gravity of the situation and resolved the problem. It is odd that such a communication did not take place.*

- *Both* [the Complainant] *and* [Mr P.'s] *broker have explained that once the situation came to light it was immediately clear that* [Mr P.] *was a vulnerable consumer. Listening to the recordings of* [Mr P.'s] *telephone contacts with* [the Provider] *confirm this. Yet* [the Provider] *failed to react and are thus responsible for the misunderstanding which arose"*.

In addition, in its letter to this Office dated **15 November 2020**, the Complainant stated:

> *"The Provider states without foundation that* [Mr P.] *was not considered by the company to be a vulnerable consumer. It should be noted that the insurance broker instantly identified his vulnerability upon first meeting* [Mr P.] *in March 2019.*
>
> *Given the nature of the product (life insurance), the age of* [Mr P.] *and that the plan has been in existence since 1985, it is entirely natural that there would be changes in health and capacity over such an extended period.*
>
> *After 34 years of compliance, the sudden inability of* [Mr P.] *to manage his account was not broached by* [the Provider]*. All effort, in spite of his severe health decline, was initiated by* [Mr P.] *and no effort was made to investigate this sudden change despite laboured phone calls that illuminate how unwell he was.*
>
> *Indeed, it appears sinister that the Provider chose just this moment to require* [Mr P.] *to submit a medical report. A change in health circumstances is to be expected after 34 years and the need to submit his health profile to the underwriters suggests an attempt to refuse or reduce cover or raise the premium.*
>
> *From 1985 to 2019* [Mr P.] *was a reliable and compliant customer of* [the Provider]*. Unfortunately, during the latter months of this period his health deteriorated and he struggled to manage his affairs. As evidenced in the recorded phone calls, it was* [Mr P.] *that contacted* [the Provider]*/Broker and requested help and guidance, not once but on multiple occasions. His vulnerability is auditorily evidence in these calls and this was immediately identified by the Broker upon first meeting* [Mr P.] *in March 2019 …*
>
> *It is evident that there is an imbalance in the process in that the various actors, who are ultimately paid by* [the Provider's policyholders]*, do not appear to be obliged to take into account the interest of* [Mr P.]*. On the contrary, a moral hazard exists whereby the Provider has an incentive to place a plan out of force thus avoiding any pay-out. In this situation the customer can be considered a nuisance and be treated with disdain.*

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> *In submitting the complaint, I recall that throughout the period of the complaint* [Mr P.] *repeatedly offered payments to the Provider which were declined. I consider that the Provider seized upon* [Mr P.'s] *vulnerability to place his plan "out of force" at the earliest opportunity in the knowledge that he was enfeebled and thus unable to pursue the matter.*
> *Consequently, I maintain my complaint that* [the Central Bank of Ireland's] *Consumer Protection Code* [2012] *has not been respected and that the behaviour of the Provider was unreasonable, unjust, oppressive and improperly discriminatory in its application to* [Mr P.]*".*

In order to resolve this complaint, the Complainant seeks from the Provider the following:

> *"Reinstatement of cover - Payment of premiums due by* [the Complainant] - *Payment* [to the Complainant] *of amount insured as at the date of* [the late Mr P.'s] *death".*

The Complainant's complaint is that the Provider wrongly or unfairly cancelled the late policyholder's life assurance policy insofar as the Provider furnished the policyholder with poor customer service and conflicting information that resulted in the lapsing of his policy for non-payment of premiums.

The Provider's Case

The Provider says that the late Mr P. incepted a life assurance policy with the Provider on 1 December 1985. This life assurance policy went out of force on 24 January 2019, due to non-payment. At that time, the policy was paid up to 1 November 2018 and there were three months' payment outstanding (November 2018, December 2018 and January 2019), totalling €1,776.45 (€592.15 per month).

The Provider sets out the following chronology of events in relation to the late Mr. P's policy:

10 September 2018: Direct debit presented to Mr P.'s bank in the amount of €592.15, for the September payment due.

13 September 2018: Direct debit returned unpaid by the bank due to *"Insufficient Funds"*.

14 September 2018: Billing letters sent to both Mr P. and his Broker advising of the returned direct debit and that the Provider will resubmit for the outstanding payment on 20 September 2018.

20 September 2018: Direct debit represented to Mr P.'s bank in the amount of €592.15, for the September payment due.

24 September 2018: Direct debit returned unpaid by the bank due to *"Insufficient Funds"*.

25 September 2018: Billing letters sent to both Mr P. and his Broker advising of the returned direct debit and that the Provider will apply to collect this

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payment again on 10 October 2018, this being the direct debit date for the scheduled October payment.

8 October 2018: 2018 Annual Benefit Statement sent to both Mr P. and his Broker, confirming life cover of €324,834 and a fund value of €0.00.

10 October 2018: Direct debit presented to Mr P.'s bank in the amount of €1,184.30, for the September and October payments due.

15 October 2018: Direct debit returned unpaid by the bank due to *"Insufficient Funds"*.

16 October 2018: Billing letters sent to both Mr P. and his Broker advising of the returned direct debit. This letter also alerted Mr P. to the fact that if no payment was received, his policy would go out of force on 22 November 2018 and he would then need to complete an Evidence of Health form to reactivate the policy, come 1 December 2018, and noted he could send the Provider a cheque for the outstanding amount if he preferred.

22 October 2018: Direct debit represented to Mr P.'s bank in the amount of €1,184.30, for the September and October payments due.

25 October 2018: Direct debit returned unpaid by the bank due to *"Insufficient Funds"*.

26 October 2018: Billing letters sent to both Mr P. and his Broker advising of the returned direct debit. This letter again alerted Mr P. to the fact that if no payment was received, his policy would go out of force on 22 November 2018 and he would then need to complete an Evidence of Health form to reactivate the policy, come 1 December 2018, and that he could send the Provider a cheque for the outstanding amount if he preferred.

7 November 2018: Mr P. telephoned and asked that the Provider debit his bank account that day for the money due. The Agent advised Mr P. that as his billing direct debit date was the 10th of each month, the Provider had already applied for this payment and it would be collected on the following Monday, the 12th November (as the 10th November fell on a weekend). The Agent also advised Mr P. not to panic if the money does not go through that day; rather, he would get another letter from the Provider and he was to telephone and it would see what could be done.

12 November 2018: Direct debit presented to Mr P.'s bank in the amount of €1,776.45, for the September, October and November payments due.

15 November 2018: Direct debit returned unpaid by the bank due to *"Insufficient Funds"*.

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16 November 2018: Billing letters sent to both Mr P. and his Broker advising of the returned direct debit. This letter again alerted Mr P. to the fact that if no payment was received, his policy would go out of force on 22 November 2018 and he would then need to complete an Evidence of Health form to reactivate the policy, come 1 December 2018, and that he could send the Provider a cheque for the outstanding amount if he preferred.

22 November 2018: Direct debit represented to Mr P.'s bank in the amount of €1,776.45, for the September, October and November payments due.

26 November 2018: Direct debit returned unpaid by the bank due to *"Insufficient Funds"*. Mr P.'s policy went out of force due to non-payment.

27 November 2018: Billing letters sent to both Mr P. and his Broker advising of the returned direct debit. This letter again alerted Mr P. to the fact that if no payment was received, his policy would go out of force on 22 November 2018 and he would then need to complete an Evidence of Health form to reactivate the policy, come 1 December 2018, and that he could send the Provider a cheque for the outstanding amount if he preferred. Separately, lapse letters also sent to both Mr P. and the Broker advised that the policy had gone out of force due to non-payment, as follows:

> *"We previously wrote to you to tell you that your* [policy] *is paid to 1 September 2018 and that we have not received payment since that date.*
>
> *As this has not changed your plan has now gone out of force and your benefits have been cancelled. To restore your plan benefits, please send us the amount due of €1,776.45 in the prepaid envelope provided, together with the payment slip from the bottom of this letter.*
>
> *You should be aware if we do not receive your payment before 1 December 2018 we will also need you to complete an Evidence of Health form which may be referred to our underwriters to review your plan terms. You may also need to complete a full proposal form before we can consider re-instating your risk benefits"*.

30 November 2018: Mr P. telephoned, noting his policy had gone out of force due to non-payment. He said when he telephoned previously (on 7 November 2018), he wanted the payment taken there and then, but was told a direct debit was already in place for the following Monday (12th November); however another payment came out of his bank account

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in the interim and this left his account short for the payment that the Provider applied for on 12th November. The Agent explained that it is not possible for the Provider to apply to a bank account right away and that when it creates a manual direct debit, it takes 3-5 working days to debit the account. Mr P. was told that the Provider could put the policy back in force and apply for the arrears in 3-5 working days. While he was unhappy that it would take this long, Mr P. accepted this solution. He then advised that though he was aware that three payments were due, he could not pay the total amount; rather, he could only make two of the payments due at that time (€1,184.30). It was agreed that the Provider would debit his account in the next 3-5 working days, for €1,184.30 of the €1,776.45 due. Mr P. was aware a further €592.15 was due for the upcoming month of December 2018 also and said he would not have that, and he asked if the Provider could wait until the following Friday after that was due, to seek that payment. The Agent advised Mr P. to contact the Provider the following Monday (3rd December) and it would see if it could set up a direct debit for the balance at that stage. Mr P. seemed happy with this proposed resolution and noted his embarrassment at the situation but the Agent told him not to be, that it is easily done and happens all the time. It was suggested that if other direct debits were affecting his policy payments, that Mr P. could send the payments into the Provider directly, however he noted that this would not work for him. The policy was reinstated and a direct debit was created for €1,184.30, for the September and October payments due.

5 December 2018: Mr P. telephoned as he had received the Provider's letters dated 27 November 2018 and it had caused confusion for him, following his telephone call of 30 November 2018 (when he had agreed to make two payments by way of direct debit in the coming 3-5 working days). The Agent explained that as agreed on 30th November, the Provider was due to credit his account for two months' payment (September and October) on 7 December 2018. He was also advised that the Provider was then due to apply for the next payment as usual on 10 December 2018 (for December and the November arrears). It was explained that if this was not paid, an attempt to collect it again would be made 5 days after that. However, if that was still not paid, he was told that the Provider will take the arrears with the next month's payment (on 10 January 2019). Mr P. was thus advised that he could ignore the letter dated 27 November 2018 as it was an automated letter and did not consider the payment that the Provider was in the process of applying for, which had been agreed on 30th November, *after* the letter issued.

7 December 2018: Direct debit presented to Mr P.'s bank in the amount of €1,184.30 (as agreed on 30th November), for the September and October payments. This payment was successful (the only successful direct

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debit between September 2018 and when the policy went out of force in January 2019).

10 December 2018: Direct debit presented to Mr P.'s bank in the amount of €1,184.30 (as agreed on 30th November), for the November and December payments.

13 December 2018: Direct debit returned unpaid by the bank due to *"Insufficient Funds"*.

14 December 2018: Billing letters sent to both Mr P. and his Broker advising of the returned direct debit. This letter alerted Mr P. to the fact that if no payment was received, his policy would go out of force on 22 January 2019 and he would then need to complete an Evidence of Health form to reactivate the policy, come 1 February 2019, and that he could send the Provider a cheque for the outstanding amount if he preferred.

20 December 2018: Direct debit represented to Mr P.'s bank in the amount of €1,184.30, for the November and December payments.

2 January 2019: Direct debit returned unpaid by the bank due to *"Insufficient Funds"*.

3 January 2019: Billing letters sent to both Mr P. and his Broker advising of the returned direct debit. This letter again alerted Mr P. to the fact that if no payment was received, his policy would go out of force on 22 January 2019 and he would then need to complete an Evidence of Health form to reactivate the policy, come 1 February 2019, and that he could send the Provider a cheque for the outstanding amount if he preferred.

10 January 2019: Direct debit presented to Mr P.'s bank in the amount of €1,776.45, for the November, December 2018 and January 2019 payments due.

14 January 2019: Direct debit returned unpaid by the bank due to *"Insufficient Funds"*.

15 January 2019: Billing letters sent to both Mr P. and his Broker advising of the returned direct debit. This letter again alerted Mr P. to the fact that if no payment was received, his policy would go out of force on 22 January 2019 and he would then need to complete an Evidence of Health form to reactivate the policy, come 1 February 2019, and that he could send the Provider a cheque for the outstanding amount if he preferred.

21 January 2019: Direct debit represented to Mr P.'s bank in the amount of €1,776.45, for the November, December 2018 and January 2019 payments due.

24 January 2019: Direct debit returned unpaid by the bank due to *"Insufficient Funds"*. Mr P.'s policy went out of force due to non-payment.

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25 January 2019: Billing letters sent to both Mr P. and his Broker advising of the returned direct debit. This letter again alerted Mr P. to the fact that if no payment was received, his policy would go out of force on 22 January 2019 and he would then need to complete an Evidence of Health form to reactivate the policy, come 1 February 2019, and that he could send the Provider a cheque for the outstanding amount if he preferred. Separately, lapse letters sent to both Mr P. and the Broker advised that the policy had gone out of force due to non-payment, as follows:

> *"We previously wrote to you to tell you that your* [policy] *is paid to 1 November 2018 and that we have not received payment since that date.*
>
> *As this has not changed your plan has now gone out of force and your benefits have been cancelled. To restore your plan benefits, please send us the amount due of €1,776.45 in the prepaid envelope provided, together with the payment slip from the bottom of this letter.*
>
> *You should be aware if we do not receive your payment before 1 February 2019 we will also need you to complete an Evidence of Health form which may be referred to our underwriters to review your plan terms. You may also need to complete a full proposal form before we can consider re-instating your risk benefits"*.

4 February 2019: Mr P. telephoned and said he had seen a payment coming out of his bank account and then credited back to it. As he did not clarify when this happened, the Provider was not sure to what he referred. That said, as the Provider had no record of a direct debit being collected from Mr P.'s account and then being rejected and credited back to his account, it was therefore reasonable to assume that whatever activity Mr P. saw on his account was the result of an action taken by his bank, and not by the Provider. Mr P. asked the Agent to take the payment due on his policy, however the Agent advised that as the policy had not been paid for more than 90 days at that stage, he needed to complete a Reinstatement Declaration of Health Form before the Provider could consider the policy's reactivation. It was also explained that the Form had to be completed, before the Provider could accept any payment. It was agreed that the Form would be sent to Mr P. and while he was not happy, he accepted this as the process. He then asked if he were to die while the policy was out of force, would it pay out, and he was told it would not, which shocked him. The Agent

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asked Mr P. to provide his mobile number in case the Provider needed to speak with him once the completed Form was received, and he provided this.

5 February 2019: Letter sent to Mr P. from the Provider's Life Servicing Alterations section, retrospectively seeking documentation relating to the death of his mother, as she was originally a joint trustee on his life assurance policy. This was not in connection with recent contacts or the policy status, rather it was obtaining anti-money laundering documentation for the file.

7 February 2019: Reinstatement Declaration of Health Form sent to Mr P. for completion.

15 February 2019: Completed Reinstatement Declaration of Health Form received from Mr P., signed 12 February 2019, wherein he stated that:

> *"I have had bloods taken roughly at six monthly intervals"*.

This Form was sent to Underwriting to be reviewed.

19 February 2019: Letter sent to Mr P. seeking further medical information in relation to the disclosure on his Reinstatement Declaration of Health Form, as follows:

> *"On your completed declaration of health, you advised that you have blood tests every 6 months.*
>
> - *Please advise the reason for these tests?*
> - *Do you have a medical condition that is monitored by regular blood tests?*
> - *If so, please tell us the name of the medical condition you have"*.

Mr P. never provided this information.

26 February 2019: Mr P.'s Broker telephoned seeking confirmation of what was required in order to facilitate the reactivation of Mr P's policy, and this was duly advised.

27 February 2019: Email received from the Account Manager asking if there was anything that could be done for Mr P. at this stage, as the policy had gone out of force. Separately, Mr P. telephoned seeking the Provider's address to send money. The Agent asked if he had received the letter of 19th February, as it was not possible to apply any money until the

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Provider received the requested clarification and it was underwritten. Mr P. said he had not received this letter and the Agent agreed to resend it. Mr P. was advised to contact his Broker, as it had been in contact with the Provider regarding the reactivation of his policy also.

4 March 2019: Mr P. telephoned to advise that two different sections of the Provider were now seeking information from him (from the file, one relates to documentation sought regarding the death of a policy trustee, the other to the reactivation of his policy). Mr P. indicated he was seeking copies of the documentation he noted he sent to the Provider previously, as he has lost most of it at this stage. The Agent assumed that Mr P. was looking for the requirements recently sought to reactivate the policy to be resent and the Provider's letter of 19th February was re-sent, as promised. Separately, an email response was sent to the Account Manager advising that the Provider had sent a letter to Mr P. seeking additional medical information and once this was received, underwriting would consider if his existing policy could be reactivated.

8 March 2019: The Broker telephoned seeking confirmation of the date Mr P.'s policy had lapsed and requesting a copy of the letter that had been sent to him on 19th February, which was duly sent by return email.

12 March 2019: Letter of 11 March 2019 received from the Broker asking the Provider to consider the reactivation of the policy without underwriting, and advising that it had registered Mr P. as a vulnerable customer. The Provider raised a complaint for investigation.

14 March 2019: The Provider wrote to the Broker acknowledging the complaint.

28 March 2019: The Provider sent its Complaint Response letter to the Broker, wherein it advised, *inter alia*, as follows:

> *"Our records show* [Mr P.] *has made several telephone calls to our Customer Service Department and noted he received letters to state his payment had not been collected from his bank account.* [Mr P.] *stated he would transfer funds into his bank account for the payment due and requested that we represent for the outstanding payment. Our Customer Service Representatives explained to* [Mr P.] *that it can take three to five working days for a direct debit to be represented to a bank account. Following* [Mr P.'s] *request a direct debit was presented to his bank account to collect the payments due. It was also advised to* [Mr P.] *that we would accept a cheque or postal order for the payments due.*

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Unfortunately, these represented debits were returned unpaid from [Mr P.'s] *bank with the reason 'insufficient funds'.*

As the paid to date on [Mr P.'s] *plan is 1 November 2018 and there was no further payments received,* [Mr P.'s] *plan has lapsed …*

I note that you have requested if [Mr P.'s] *plan can be reinstated, with payment of arrears due and not be subject to the Underwriting process. Unfortunately, we are not in a position to reinstate* [Mr P.'s] *plan without his request being reviewed by Underwriting.*

I appreciate you have advised [Mr P.] *is a vulnerable customer. However I am satisfied we made* [Mr P.] *aware of the payments that were outstanding and how he could make the payments due on his plan.*

When we receive the additional information requested we will review the reinstatement of the plan. If we are in a position to reinstate [Mr P.'s] *plan and we receive the outstanding payments due, it is important to note* [Mr P.'s policy] *is a flexible plan. This means that* [Mr P.] *can request a quotation for any level of cover, less than his current amount, and we can provide* [Mr P.] *with quotations for what this level of cover would cost him on a monthly basis until the next review date".*

26 August 2019: The Broker emailed the Account Manager to advise that Mr P. had died.

23 September 2019: Email received from the Broker with a letter from the Complainant's Solicitor attached, dated 20 September 2019, confirmed that it was acting on behalf of the Estate of the late Mr P. and seeking a copy of the telephone call recordings on file between Mr P. and the Provider, between 1 September 2018 and the date of death.

15 October 2019: A disk containing the requested telephone call recordings was sent to Solicitor.

21 November 2019: Telephone call from Broker seeking a copy of the policy document, which was duly posted to the Broker the following day.

25 November 2019: Email from Broker seeking a copy of the applicable policy 'Provisions, Privileges and Conditions' document, which was duly emailed to the Broker the following day.

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11 December 2019: The complaint was reopened following receipt of a letter from the late Mr P.'s brother, dated 9 December 2019.

13 December 2019: Complaint Response letter sent to the late Mr P.'s brother advising as follows:

> *"… It is important to note that we wrote o* [Mr P.] *to advise of the payments due on his plan and a copy of these letters was available to his chosen broker,* [named].
>
> *… on 19 February 2019, we wrote to* [Mr P.] *and requested additional details about information he disclosed on the Reinstatement Declaration of Health form. We were not in a position to reinstate* [Mr P.'s] *plan without his request being reviewed by Underwriting.*
>
> *I note that when we received the additional information requested we would review the reinstatement of* [Mr P.'s] *plan. Unfortunately, no further information was received from* [Mr P.].
>
> *The additional information was needed…in order to be able to review the reinstatement of* [Mr P.'s] *plan …*
>
> *I am satisfied we made* [Mr P.] *aware of the payments that were outstanding on his plan and how he could make the payments due on his plan. We also made* [Mr P.] *aware of what was needed in order to assess his reinstatement request.*
>
> *Our position remains as outlined in the response letter of 28 March 2019"*.

The Provider says that the late Mr P.'s life assurance policy went out of force on 24 January 2019, due to non-payment. At that time, the policy was paid up to 1 November 2018 and there were three months' payment outstanding (November 2018, December 2018 and January 2019), totalling €1,776.45 (€592.15 per month). The Provider says that its standard procedure is that when 90 days pass since a payment is last received, that a customer must then complete a Reinstatement Declaration of Health Form and declare if there has been any change in their health in the past 12 months. In the interest of treating all customers equally and fairly, the Provider says that this process applies to all customers.

The Provider says that with this in mind, when Mr P. telephoned the Provider on 4 February 2019, a Reinstatement Declaration of Health Form had been required, from 1 February 2019 (as confirmed it would be, in the Provider's correspondence to both Mr P. and his Broker on 14 December 2018 and 3 January, 15 January and 25 January 2019).

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Mr P. stated in the Reinstatement Declaration of Health Form he signed on 12 February 2019, and which the Provider received on 15 February 2019, that:

> *"I have had bloods taken roughly at six monthly intervals"*.

The Provider says that as a result of this disclosure, it wrote to Mr P. on 19 February 2019 seeking further clarification, which was never received. Had such clarification been received, the Provider says it may have permitted the reactivation of Mr P.'s policy on its original terms and subject to the arrears being paid; however, as clarification was never received, the Provider cannot say with any certainty, whether or not this would have been the case. Provider records show that the late Mr P. made the payments on his policy by way of direct debit since its inception in December 1985. It says that although its preferred payment method is direct debit, it also accepts payment in the form of cheque, postal order or bank draft, either by post or at its Head Office, or electronically using its online facility. The Provider says that it no longer accepts payment by telephone (in calls to its Customer Service Department), as it does not wish to have customers' financial information (debit/credit card details) on recorded telephone calls.

The Provider notes that Mr P. had not signed up for its online services and therefore, paying online was not an option for him at the time. The correspondence sent to Mr P. and his Broker regarding his missed payments advised that he could send the payment owing, directly to the Provider, though Mr P. advised by telephone on 30 November 2018 that this option did not suit him. Thus, the only payment option which was suitable to Mr P. in late 2018/early 2019, was direct debit, despite the fact that there would be an inevitable delay between a direct debit being created and the Provider presenting same to his bank account, which could, and did, result in the funds that Mr P. had lodged to his account to pay the Provider, being deducted by another debiting party in the interim. This was, however, outside of the control of the Provider.

In relation to the Complainant's comments that:

> *"On 7 December* [2018] [Mr P.] *made a payment of two months' premium by telephone. He had previously been informed repeatedly that this was not possible as payments could only be accepted via direct debit"*,

the Provider notes that there was no telephone call received from Mr P. on 7 December 2018. Rather, the call in question took place on 30 November 2018. The two months' payments referenced during this telephone call were not taken over the telephone, as claimed by the Complainant. The Provider says that instead, it was agreed during this call that while there were three months' payments outstanding at that point totalling €1,776.45, the Provider would only submit for two of those, by way of creating a manual direct debit in the amount of €1,184.30. This was done as agreed and the Provider applied to Mr P.'s bank account for a direct debit in the amount of €1,184.30 on 7 December 2018. Mr P. was clearly advised that a manual direct debit could take up to 5 working days to be presented.

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In relation to the Complainant's comments that: *"*[Mr P.] *was advised by the helpline on 10 December* [2018] *to ignore a letter he had received from* [the Provider] *regarding late payment. This served to complicate matters further"*,

the Provider notes that there was no telephone call received from Mr P. on 10 December 2018; rather, the call in question took place on 5 December 2018, when Mr P. telephoned regarding correspondence dated 27 November 2018, which noted that €1,776.45 in missed payments was outstanding. However, Mr P. had already previously telephoned the Provider on 30 November 2018, at which stage the Provider, on Mr P.'s request, manually created a direct debit for two of the three missed payments due, actions that took place with Mr P.'s agreement *after* the letter of 27th November had issued.

Therefore, when Mr P. telephoned the Provider on 5 December 2018, there were no longer three payments outstanding; rather, there was only one payment outstanding at that time, as the Provider was due to debit his bank account on 7th December for two of these three payments, as agreed with Mr P. by telephone on 30 November 2018. This was explained to Mr P. and it is for this reason he was advised he could disregard the letter of 27th November. In short, the Provider says that as it was in the process of applying to Mr P.'s bank account for two of the three payments, the information contained in the letter of 27th November was no longer correct or relevant.

Having reviewed the recordings of the telephone calls on file, between the Provider and Mr P., the Provider is satisfied that its various Agents who dealt with Mr P. throughout, furnished him with clear and correct information (as set out in the above timeline), and that Mr P. understood what was being explained and was always aware of what payments were due, in order to pay his policy up to date.

In relation to the Complainant's comments that the late Mr P. was a vulnerable consumer, the Provider notes that the Central Bank of Ireland's Consumer Protection Code 2012 (as amended) defines a vulnerable customer at pg. 78, as:

> *""**vulnerable consumer"** means a natural person who:*
>
> *a) has the capacity to make his or her own decisions but who, because of individual circumstances, may require assistance to do so (for example, hearing impaired or visually impaired persons); and/or*
>
> *b) has limited capacity to make his or her own decisions and who requires assistance to do so (for example, persons with intellectual disabilities or mental health difficulties).*

The Provider also notes that Chapter 3, 'General Requirements', of this Code states at pg. 9:

> *"Where a regulated entity has identified that a person consumer is a vulnerable consumer, the regulated entity must ensure that the vulnerable consumer is provided with such reasonable arrangements and/or assistance that may be necessary to facilitate him or her in his or her dealings with the regulated entity".*

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The Provider says that while there was no indication in the telephone calls that Mr P. did not have the capacity to deal with his own finances or that he required assistance in making his own decisions, Mr P.'s advanced years indicated a possible vulnerability, which the Provider is satisfied was acknowledged by the different Agents who he dealt with. In this regard, the Provider says it is clear from reviewing the telephone call recordings between its Agents and Mr P., over the period in question, that in recognising his advanced years, the different Agents took the time to be clear in their explanations to Mr P. and ensured that all expectations (with regards to payments and timelines), were also clearly explained.

When the Broker contacted the Provider in March 2019, the Provider notes that by that time, there were five months' payment due (November, December 2018 and January, February, March 2019). At that time, the Broker asked that the Provider waive the need to underwrite the policy reactivation, on the grounds that the Broker deemed Mr P. as being vulnerable. The Provider reviewed all the telephone recordings at that time, and it was satisfied that during his calls with the Provider, Mr P. did not give any indication of having intellectual or mental health difficulties. Rather, the Provider says it was clear that Mr P. was aware of the situation, the amounts due and (following an explanation from the Agent), that it would take 3-5 working days to debit his bank account when he asked the Provider to do so.

In addition, the Provider says that Mr P. noted receipt of the correspondence that was sent to him explaining the situation with his policy, when it would go out of force if payment was not received, and at what stage the Provider would require a Reinstatement Declaration of Health Form from him, should his policy go out of force. The Provider notes that a copy of each letter sent to Mr P. regarding the non-payment of his policy was also sent to his Broker. As a result, the Provider says that there were no grounds to make an exception in this case and allow the reactivation of Mr P.'s policy, without the requirements that would be sought from all other similarly-placed customers.

In relation to the Complainant's comments that:

> *"A phone call to the Broker would have resolved the issue forthwith and this contact should have been made by* [the Provider]*"*,

and similarly, that:

> *"… a simple phone call to* [Mr P.'s Broker] *would have alerted all concerned to the gravity of the situation and resolved the problem. It is odd that such a communication did not take place"*;

The Provider says it can have hundreds of direct debits returned unpaid on any given day. As a result, it is not feasible for the Provider to monitor each returned direct debit or indeed, telephone affected customers and/or their financial advisers. It is for this reason that the Provider's systems generate automated letters to its customers and their financial advisers, advising them of what has happened. It also automatically resubmits for direct debits approximately 5 working days after the initial direct debit is returned. Therefore, though a

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telephone call was not made to Mr P.'s Broker, the Provider says that the broker was made aware of each returned direct debit and the policy cancellation, through the correspondence that the Provider sent to the broker at the same time it wrote to Mr P.

The Provider appreciates this is a very difficult situation for the family of the late Mr P., who it understands passed away during the Summer of 2019 and it would like to offer its condolences to them. While it is unfortunate that there was no life cover in place at the time, the Provider is satisfied that Mr P.'s policy was administered correctly from August 2018 to date. It is also satisfied that sufficient steps were taken to ensure that Mr P. was made aware of the payments not paid and (when the policy lapsed) what was required from him in order to reactivate the policy.

In addition, the Provider says it is clear from the file that the need for clarification on the information he disclosed in his completed Reinstatement Declaration of Health Form, was made clear to both Mr P. and his Broker. Had the clarification sought been provided, a review of this information may well have resulted in the reactivation of Mr P.'s policy, subject to payment of the missed premiums. However, as the requirements sought from him were not received, the Provider cannot say with any certainty, whether or not Mr P.'s policy could have been reactivated (after it lapsed in January 2019). While it is unfortunate that a decision was made not to supply the Provider with the information that it had sought in its correspondence of 19 February 2019, this was out of the control of the Provider.

Accordingly, the Provider is satisfied that it correctly administered and lapsed the late Mr P.'s life assurance policy, due to non-payment of premiums. In addition, the Provider is satisfied that it gave the late Mr P., both in writing and verbally by telephone (with all written correspondence copied to his Broker) clear and correct information, insofar as Mr P. was made aware of the payments not being paid and how he could then pay them, and (when the policy lapsed) what was required from him in order to reactivate the policy, and the Provider is satisfied that Mr P. understood this.

The Complaint for Adjudication

The complaint is that the Provider wrongly or unfairly cancelled the late policyholder's life assurance policy insofar as the Provider furnished the policyholder with poor customer service and conflicting information that resulted in the lapsing of his policy for non-payment of premiums.

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.

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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 **7 April 2021**, 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.

Following the consideration of additional submissions from the parties, the final determination of this office is set out below.

The late Mr P. incepted a life assurance policy with the Provider on 1 December 1985. This policy went out of force on 24 January 2019, due to non-payment of premiums. At that time, the policy was paid up to 1 November 2018 and there were three months' payment outstanding (November, December 2018 and January 2019), totalling €1,776.45 (€592.15 per month).

The Complainant says that the Provider, when dealing with Mr P. throughout the period between September 2018 and February 2019 regarding his missed payments and the subsequent lapsing of his policy, failed to identify that Mr P. was a vulnerable consumer.

In this regard, the Complainant sums up its complaint in the Complaint Form, as follows:

> *"*[Mr P.] *had become a vulnerable consumer and it appears that* [the Provider] *used this to avoid a claim which would arise in the near term. A combination of conflicting advice from* [the Provider's] *customer help line (*regarding his attempts to pay* [the Provider] *by phone),* [Provider] *administrative procedures and delays plus issuing direct debits for double the monthly premium (when there* [was] *funds in place for the expected monthly amount) conspired to frustrate repeated attempts to pay amounts due. A phone call to the Broker would have resolved the issue forthwith and this contact should have been made by* [the Provider]*"*

In addition, in its letter to this Office dated 14 December 2019, the Complainant stated, *inter alia*, that:

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> *"Despite several attempts to clarify the position to himself* [Mr P.] *appears to have become totally confused regarding the payments and* [the Provider] *kept sending him letters which he did not comprehend. This situation was compounded by* [the Provider's] *own administrative procedures which kept issuing direct debit requests for double the normal amount and which were unpaid by the bank although there were funds available for one monthly premium. To try and sort the situation out* [Mr P.] *requested by telephone that* [the Provider] *take payments immediately but this was declined. He was told that the 'system' was to receive payment by direct debit only …*
>
> *The essential element of this compliant is that* [Mr P.] *was trying to pay the insurance premium and believed that he was in compliance with the instructions received from the* [Provider's] *customer service agents".*

I note the Provider's detailed chronology of events in relation to Mr. P's policy, and I am satisfied that these events are supported by the documentation and audio evidence made available. I note that the direct debits that the Provider presented to Mr P.'s bank account for payment of his life assurance policy on 10 September, 20 September, 10 October, 22 October, 12 November, 22 November, 10 December and 20 December 2018 and 10 January and 21 January 2019, were all returned by the bank as unpaid due to *"Insufficient funds"*.

The Complainant says that Mr P. had become confused as to the payments outstanding and forthcoming, and that this confusion was compounded by the numerous letters the Provider sent Mr P. during the period between September 2018 and February 2019 regarding his payments and his policy, as well as the conflicting and confusing advice Mr P. received each time he telephoned the Provider's Customer Service number and spoke with an Agent.

Similarly, in its letter to the Provider dated 11 March 2019, the late Mr P.'s Broker states:

> *"*[Mr P.] *does not understand fully the workings of the direct debit system and unfortunately it has played havoc with his cash flow"*.

I note that the Provider advises that the monthly payments in respect of Mr P.'s policy were paid by way of direct debit, since the policy inception in December 1985.

The late Mr P.'s life assurance policy was a contract of insurance, wherein the Provider agreed to provide the benefit, the life cover, in return for the payment of the monthly premium. In this regard, the Provider had cause to write to Mr P. (with copies sent to his Broker) on 14 September, 25 September, 16 October, 26 October, 16 November, 27 November, 14 December 2018 and 3 January, 15 January and 25 January 2019 regarding 10 direct debits that had been returned by his bank as unpaid due to *"Insufficient funds".*

I note that these letters were automated, and I therefore accept that the number of letters during any given period were dependent on the number of direct debits that are returned unpaid during that time.

I am satisfied that each of these letters provided Mr P. with clear and concise information necessary for the maintenance of his policy, including the total amount of each missed

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payment. I also note that each of these letters concluded by directing Mr P. to telephone the Provider's Customer Service number if he had any further questions.

Audio recordings of the telephone calls that Mr P. made to the Provider's Customer Service number on 7 November, 30 November and 5 December 2018 and 4 February, 27 February and 4 March 2019, have been supplied in evidence. On the basis of this evidence, I am of the opinion that Mr P. was aware when he telephoned the Provider of what payments were due and when, and that he suitably demonstrated this, in particular, during the telephone call on 30 November 2018 when he sought to spilt the arrears, by paying the September and October arrears over the then next 3-5 working days by way of a manual direct debit, and carry over the November arrears, so that it would then be collected along with the approaching December payment.

In this regard, I note from the recording of the telephone call between Mr P. and the Provider that took place on 30 November 2018, the following exchange:

Agent: *You see, when you call us, we can't do it* (i.e. take the payment) *on that date, we have to set up a direct debit, and it takes 3-5 working days to go into your account*

Mr P.: *Oh sugar -*

Agent: *You see, that's the thing. But I can put it back in force now if you want and apply to go into the account in 3-5 working days?*

Mr P.: *5 working days? Bugger it anyway. Right, it'll have to be that. Now, unfortunately love, since I was talking to ye the last time, there's another payment after coming up, due on top of it*

Agent: *Yeah*

Mr P.: *So you have one thousand one hundred or something, and then you have another five hundred come on on top of that, am I right?*

Agent: *That's right, yeah*

Mr P.: *Yeah, well I can't pay the whole lot. I'll tell ya, I'll put in some money into the bank and, work on it straight away will ya please?*

Agent: *Ok -*

Mr P.: *So that you'll get the eleven hundred and some odd few pounds, whatever it is …*

Agent: *… I can go in for 1184.3 if you want? That's -*

Mr P.: *Sorry love, say that again to me*

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Agent: *So, I can go in for two months' payments, of 1184.3, if you wanted me to do that?*

Mr P.: *Alright, but unfortunately I haven't transferred the money just yet until I was speaking with ya -*

Agent: *Oh yeah, no, but it won't be until, it'll take 3-5 working days to go into your account*

Mr P.: *Ok, fair enough, fair enough, that'll be grand, will you go in and take that much money?*

Agent: *Yeah, yeah that's no problem, I'll get that done and –*

Mr P.: *Now, alright so, now, hold on, there is another five hundred euros or thereabouts due for this present, sorry, for the month coming up, December, isn't it?*

Agent: *That's right, yes*

Mr P.: *Yeah, well, I won't have that but could you try and work from next Friday to take that five hundred euros out?*

Agent: *Well, I would say if you wanted to give us a ring on Monday or Tuesday, we'll be able to set up the direct debit for the balance if you want -*

Mr P.: *Ok, alright – as long as you're happy with that …*

Agent: *… I would just give us a ring maybe Monday and we can set up a direct debit then to go, or on Tuesday, to go in on Friday. Is that alright?*

Mr P.: *That'd be lovely, I'd be delighted …*

Agent: *… I'll go in for two months', and then if you give us a ring next week we'll be able to go in for the balance, and then it's up to date*

Mr P.: *Super.*

In addition, in what I consider to be a further example that Mr P. was aware when he telephoned the Provider of what payments were due and when, I note from the recording of the call that Mr P. made to the Provider on 5 December 2018, the following exchange:

Mr P.: *… I was expecting that money to be taken out yesterday or today -*

Agent: *Well it's actually, that money is due to come in on the 7th of December, so that's another 2 days away. So we're due to go into your account*

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on the 7th December to collect the 1184 and 30 cent, as per the call you were given, and that will put your plan, that will keep your plan up to date until, like you said, until we receive the next couple of payments.

Mr P.: *Yeah, the next payment will be due on the 10th*

Agent: *Yes, so now what will happen is, we will try and go in on the 10th, just because it is an automatic service, and if that one bounces back again, it'll just go in in 5 working days from there again, and if there's no payment that time, we'll go in for a double payment the next time round, so in January …*

Well like I said, we're due to go into your account now on the 7th to collect [indecipherable] *arrears and once they clear, then everything will be updated on the plan, there'll still be one month owed, but like you said, we can collect that then in the next month's premium as well*

Mr P: *Lovely.*

Having had access to the audio evidence in full, which comprises the recordings of the six telephone calls that Mr P. made to the Provider in relation to this matter, I am not convinced that the contents of this audio evidence indicated to the Provider that Mr P. was, at the time of the calls in question, a "vulnerable consumer", as that term is so defined by the Central Bank of Ireland's Consumer Protection Code 2012, as amended, or indeed, that he should have been regarded as a vulnerable customer in general.

That said, I am satisfied that the different Agents, by the manner in which they dealt with Mr P. during these telephone calls, implicitly acknowledged his advanced years (he was age 70 at the time), and I am satisfied that each took the time to ensure that Mr P. understood what information was being explained to him and also, what was being agreed, before concluding each call.

In a recent submission, the Complainant has suggested that Mr P had encountered a "*sudden inability … to manage his affairs*", but there is nothing in the evidence made available to this office which suggests to me that the Provider was put on notice of any such difficulty or that it ought to have been aware of this.

If indeed Mr P had sadly suffered from a "diminished capacity" as is now suggested, I take the view that it was a matter for the appropriate persons who were aware of this development, to share such information with the Provider, so that suitable measures and steps might have been taken. Based on the evidence available for this investigation I do not accept that the Provider could have recognised any such issue, and I agree with the Complainant that an issue of that nature is a matter of judgment, which requires assessment by a health professional, who is familiar with the person's health. Indeed, I am conscious that there are many customers of Mr P's age, and indeed older, who would be very

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considerably offended, were a suggestion of that nature to be made to them by their financial service provider.

It is clear that Mr P. did, on a number of occasions, contact the Provider in an effort to pay his arrears and bring his policy up to date. In this regard, I take the view that the different Agents he dealt with, supplied Mr P. with clear and correct information and accommodated, as best they could within the payment methods used by the Provider, his efforts to pay. For example, the Agent agreed with Mr P. by telephone on 30 November 2018 to create a manual direct debit for less than the total sum of arrears due. The onus was then on Mr P., as the policyholder, to ensure that the funds were in his bank account to honour the direct debits that he requested and agreed to, when they were presented.

I note the Provider wrote to Mr P., and his Broker, on 25 January 2019 to advise that his life assurance policy had gone out of force due to non-payment, as follows:

> *"We previously wrote to you to tell you that your* [policy] *is paid to 1 November 2018 and that we have not received payment since that date.*
>
> *As this has not changed your plan has now gone out of force and your benefits have been cancelled. To restore your plan benefits, please send us the amount due of €1,776.45 in the prepaid envelope provided, together with the payment slip from the bottom of this letter.*
>
> *You should be aware if we do not receive your payment before 1 February 2019 we will also need you to complete an Evidence of Health form which may be referred to our underwriters to review your plan terms. You may also need to complete a full proposal form before we can consider re-instating your risk benefits"*.

I note that when Mr P. telephoned the Provider on 4 February 2019 and asked that it take payment of the arrears, the Agent informed him that this could not be done because at that point his life assurance policy had lapsed due to non-payment, and he now needed to complete and return a Reinstatement Declaration of Health Form before the Provider could consider the reactivation of his policy.

I note from the correspondence the Provider sent to Mr P., and his Broker, on 14 December 2018 and on 3 January, 15 January and 25 January 2019 that each stated:

> *"You should also be aware that if we do not receive your payment before 1 February 2019 we will need you to complete an Evidence of Health form which may be referred to our underwriters to review your plan terms".*

I am therefore satisfied that the Provider furnished Mr P., and his Broker, with appropriate notice as to the consequence of his failure to make a payment prior to 1 February 2019. In this regard, I accept the Provider's position that all customers whose life assurance policies

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lapse, will be required to complete and return a Reinstatement Declaration of Health Form before it can consider the reactivation of the policy.

I note Mr P. completed and signed a Reinstatement Declaration of Health Form on 12 February 2019, in which he stated:

> *"I have had bloods taken roughly at six monthly intervals"*.

As a result of this disclosure, I see the Provider then wrote to Mr P. on 19 February 2019, as follows:

> *"On your completed declaration of health, you advised that you have blood tests every 6 months.*
>
> - *Please advise the reason for these tests?*
> - *Do you have a medical condition that is monitored by regular blood tests?*
> - *If so, please tell us the name of the medical condition you have"*.

The Provider subsequently emailed a copy of this letter to Mr P.'s Broker on 8 March 2019, at the Broker's request.

There is no evidence before me indicating that Mr P., or his Broker, responded to the Provider with the information that it had sought in its correspondence of 19 February 2019. In the absence of this, I take the view that the Provider was not in a position to proceed with Mr P.'s request, or indeed his Broker's later request as set out in its letter to the Provider of 11 March 2019, to consider the reactivation of his policy. In this regard, I am satisfied that the onus was on Mr P., as the policyholder, to ensure that the Provider was supplied with the particular medical information it sought, if he wanted it to consider the reactivation of his life assurance policy.

Having listened to the recording of the telephone call of 4 February 2019, I note that Mr P. expressed shock when told that as his policy was out of force, and that it would not pay out in the event of his death. I take the view that this ought to have sufficiently alerted Mr P. to the importance of sending the Provider the particular medical information that it then requested. As the medical information was not however forthcoming, I accept the Provider's position, that it cannot now say with any certainty, whether or not it would have permitted, at that time, the reactivation of Mr P.'s policy on its original terms, subject to the arrears being paid.

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Having considered this matter in detail, I am satisfied that the Provider correctly administered the late Mr P.'s life assurance policy and that it was entitled to lapse the policy in early 2019, due to the non-payment of premiums.

I take the view that each of the letters the Provider sent to the late Mr P., and to his Broker, regarding the missed payments, provided him with clear and concise information necessary for the maintenance of his policy, including the total amount of each missed payment. I also take the view that each of the Agents who dealt with the late Mr P. when he telephoned the Provider in relation to this matter, gave him clear and correct information, and having had access to the recordings of these telephone calls, I am satisfied that the late Mr P. indicated that he understood what had been explained and agreed to progress matters.

Accordingly, I am of the opinion that, given the evidence made available by the parties, that there is no evidence of wrongdoing on the part of the Provider, such that it would be reasonable or appropriate 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

17 May 2021

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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