An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref: 2021-0168

Sector: Insurance

Product / Service: Critical & Serious Illness

Conduct(s) complained of: Mis-selling

Outcome: Substantially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants incepted a life assurance policy with the Provider in and around **February 2013**, which also provided them with specified illness cover. This policy was sold to the Complainants by a third party entity, the Provider's tied agent, which acted for and on behalf of the Provider. Consequently, this complaint is maintained solely against the Provider.

The policy provided a lump sum death benefit of €262,000, together with standalone specified illness benefit of €157,000.

In **January 2016**, the Second Complainant was diagnosed with multiple sclerosis ("**MS**") arising from which the Complainants submitted a claim to the Provider for a serious illness benefit under the policy but on **14 February 2016**, the Provider declined the Complainants' specified illness claim in respect of the Second Complainant's diagnosis. In so doing the Provider relied upon a special terms letter dated **29 January 2013**, which was signed by the Complainants on **5 February 2013**, which stated that special terms had been applied to the policy, excluding MS cover in respect of the second Complainant.

The complaint is that the Provider mis-sold the policy to the Complainants in 2013, because the Provider did not advise the Complainants that MS cover was excluded for the second Complainant nor did it advise as to the consequences of the Complainants signing a Special Terms letter.

The Complainants' Case

October 2012 Meeting: the Complainants and the Provider's Tied Agent

The Complainants first met with a representative of the Provider's tied agent, Ms A., on **12 October 2012,** at a branch of the Complainants' bank (the **"Bank**") to discuss life assurance and serious illness cover. The Bank, the Provider's tied agent and the Provider are all members of the same group of companies.

The Complainants state that they completed a life assurance policy application form at this meeting, but that there was no reference to any exclusions applying to their policy. The Complainants describe this meeting as follows:

> "*…Online application completed. Life assurance advisor was present.*
>
> *Statement of suitability signed. A copy was not provided to* [the Complainants]. *There was no mention of exclusions to the policy or further processes to be engaged in. Life assurance advisor was present.*
>
> *Declaration signed. No copy provided to* [the Complainants]. *The premium for the policy was set…."*

Interval between the October 2012 Meeting and the February 2013 Meeting

The Complainants completed a tele-interview regarding their medical history on **15 October 2012,** as part of the policy application process.

The Complainants contend that their policy then commenced on **19 October 2012,** which they submit is the date on which their policy application was accepted.

February 2013 Meeting: the Complainants and a Representative of the Complainants' Bank

On **5 February 2013**, the Complainants attended a meeting with their Bank's business and financial advisor, Mr J. to discuss a loan application and matters relating to their farm account.

The Complainants submit that Mr J. did not discuss or offer them any advice or information in relation to their policy during the course of this meeting.

The Complainants accept that they signed the second page of a special terms letter dated 29 January 2013, at the meeting with Mr J. on **5 February 2013**, which states on page one:

> "*No Specified Illness Benefit will be payable in respect of* [the Second Complainant] *in the event of a claim for* [MS] *or any illness or disability arising directly or indirectly therefrom including complications from any of its treatments*"

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However, the Complainants submit that they were only supplied with the signature page of this letter, and that they were not supplied with the first page of the special terms letter dated 29 January 2013, detailing the above MS exclusion in respect of the Second Complainant's policy.

The Complainants state in this regard that:

> "*We attended …to finalise a loan*. We *were provided with a sheet to sign which had no page numbers. It transpired that this was signing to agree policy exclusions and when we pursed a claim in 2016 we saw the first pages for the first time (letter dated 29 January 2013). No life assurance advisor was present, it was the bank manager* [Mr J.], *and no discussion took place with regards to life assurance. Both* [of us] *were present. Only then was the policy commenced, despite* [signing] *the declaration and premium in October 2012. No policy was sent to us that outlined exclusions and each annual statement in relation to the policy had no exclusions specified. We were never sent a policy statement and conditions…*
>
> *the application process had commenced in October of 2012…it was some four months after signing paperwork and discussing options and premiums that we were provided with a page to sign that we had no idea related to our life assurance policy; the page was not numbered and did not identify there were preceding pages and we still continue to receive annual statements on the policy that do not specify exclusions".*

The Complainants believe that the Provider covertly secured their signatures on the special terms letter in February 2013, in order to finalise documentation which should have been completed in October 2012. The Complainants state in this regard that

> "…. [the Provider] *had not followed their own process from the application some four months previous*. [The Provider] *has already confirmed this procedural irregularity. This only confirms the motive to obtain signatures but it remains that only one page was provided and no explanation to* [the Complainants]."

The Complainants also submit that the Provider failed to assess the suitability of the policy for them following the application of the special terms, and that that they did not receive an adequate cooling off period, during which they could cancel the policy. The Complainants state in this regard that the 30 day cooling off period which applied from the date the Complainants signed the relevant declarations on 12 October 2012, had expired before the special terms were applied to the policy excluding MS in respect of the Second Complainant, in January 2013.

The Complainants contend that the sale of the life assurance policy to them was in breach of Provisions 4.1, 4.2, 4.22, 4.32, 4.36, 4.37, 5.19, 5.21 and 6.13 of the Consumer Protection Code 2012 (the "**CPC 2012**").

The Complainants are seeking for the Provider "*to either make good on the claim (€157,000) or refund the paid premiums (€11,372 to date) at they were not taken in good faith as the policy was mis-sold*".

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<u>The Provider's Case</u>

The Provider denies that the Complainants' policy was mis-sold.

It says that the Complainants were informed of the exclusion of MS from cover for the second Complainant, and that "*it is firmly of the view that* [the Complainants] *did know of the exclusion*..."

The Provider's position is that the information in the special terms letter regarding the exclusion of MS was clear and readily understandable.

<u>October 2012 Meeting</u><u>: the Complainants and the Provider's Tied Agent</u>

The Provider states that at the first meeting with the Complainants on **12 October 2012**, the Provider's tied agent's representative, Ms A., who is an insurance and investments manager, conducted a personal review with the Complainants. Based on this information, the Complainants were furnished with a financial plan. Ms A. discussed the options available to the Complainants in respect of life cover and recommended the 'Life Choice –Your Family policy'. The Provider states that during the meeting Ms A. also

> "*Explained the features* [of the policy] *and provided a brochure (which included information on restrictions and exclusions) to* [the Complainants] *and provided them with a Statement of Suitability confirming why she felt the policy was suitable for them.....During the meeting* [the Complainants] *were also provided with a two part quotation…including details of the 30 days cooling off period*….[the Complainants]..*signed the Disclosure Declaration which confirmed that they had been provided with parts 1 and 2 of the quotations*. [The Complainants] *completed a Life Choice – You and Family application during the meeting"*

<u>Interval between the October 2012 Meeting and the February 2013 Meeting</u>

The Provider states that during the application process, the Complainants opted to complete a tele-interview regarding their medical history, which occurred on **15 October 2012**. The Provider submits that based on the information supplied during that tele-interview, the Provider was only in a position to supply cover in circumstances where special terms were applied to the policy.

The Provider states that an initial special terms letter was sent by internal post to Ms A. on **19 October 2012,** at the Bank branch where she first met with the Complainants. However, Ms A. had left earlier than expected on sickness/maternity leave on **15 October 2012**, and was replaced by Mr. D.

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The Provider submits that there was an interaction, whether face to face or otherwise, between Mr. D. and the Complainants on or before **25 January 2013,** during which the special terms were communicated to the Complainants, although the Provider is not in a position to confirm on what precise date this occurred. The Provider submits that

> "*the telephone call of 25 January 2013 reflects that* [the Complainants] *knew of the special terms when they met with* [Mr. D.], *who had replaced* [Ms A.]

The telephone call, which the Provider refers to, is a call between Mr D. and a Provider representative made on **25 January 2013.** The Provider states that Mr D. called to request the First Complainant's date of birth and smoking status, so that he could provide the Complainants with a revised quotation for the First Complainant only, as the Complainants were considering proceeding with the application on a single life basis, due to the special terms applied to the Second Complainant's policy. The Provider notes that in the call recording Mr D. sates "*she has been rated and they are thinking now of just doing it in his name only*". The Provider states that:

> "[w]*hile it is clear from the call that all knew special terms were applied, records suggest* [the Complainants] *could not recall if they had actually received the special terms letter*"

The Provider submits that the Complainants ultimately proceeded with the policy on a dual life basis, and a further special terms letter was sent to Mr D. on **29 January 2013**, as the previous special terms letter dated 19 October 2012, was no longer valid, such special terms letters only being valid for 30 days.

February 2013 Meeting: the Complainants and a Representative of the Complainants' Bank

The Provider submits that a copy of the special terms letter dated **29 January 2013**, detailing the exclusion of MS cover in respect of the Second Complainant, was supplied to the Complainants at a second meeting on **5 February 2013**.

Initially the Provider stated in a letter to this office dated 30 May 2019, that Mr D., an insurance and investments manager, met with the Complainants on 5 February 2013, and supplied them with the special terms letter.

However, the Provider in later submissions to this office, confirmed that it was, Mr J., a business and financial advisor employed by the Bank, who met with the Complainants, and supplied them with a copy of the special terms letter.

The Provider explains that Mr D. was not present at the Bank branch on 5 February 2013, but that he left a copy of the letter in the Bank branch so that it could be signed by the Complainants in his absence.

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The Provider submits that the information in the special terms letter regarding the exclusion of MS is clear and readily understandable and consequently, it was not necessary for Complainants' insurance advisor, Mr D., to be present when the special terms letter was signed by the Complainants on 5 February 2013. The Provider states that by signing the special terms letter, the Complainants confirmed their acceptance of the special terms.

The Provider does not accept the Complainants' contention that the Complainants were not furnished with the first page of the special terms letter, which outlined the revised terms being offered. The Provider contacted Mr J. who confirmed that he specifically recalls the meeting on 5 February 2013. Mr J. stated that he supplied the Complainants with the cover letter and both pages of the special terms letter, and that he:

> *"explained very clearly that the special terms in relation to* [the Second Complainant] *related to family medical history"*

The Provider further submits that Mr D. supplied the Complainants with a copy of the special terms letter for their records and that this is supported by a handwritten, undated note on the special terms letter which states

> "*Copy sent D Given*"

The Provider states that policy documentation was issued to the Complainants on **13 February 2013**, which highlighted that the Complainants had a 30 day cooling-off period to cancel the policy and included a policy schedule which reminded the Complainants that special terms applied to the policy.

<u>The Complaint for Adjudication</u>

The complaint is that the Provider mis-sold the life assurance policy to the Complainants in the period from October 2012 to February 2013.

<u>Decision</u>

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

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint. Having reviewed and considered the submissions made by the parties to this complaint, I formed the view that the submissions and evidence furnished disclosed certain conflicts of fact, such that an Oral Hearing was required to seek to resolve those conflicts.

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Accordingly, an Oral Hearing took place on **19 August 2020,** at which the parties gave their sworn evidence. It was determined at that Oral Hearing that further written particulars were also required by this Office, and on **19 October 2020**, these details were requested from the parties. Thereafter, a further exchange of submissions and evidence took place.

This office is satisfied that the evidence made available by the parties, including all documentary evidence, observations and submissions supplied, together with the evidence given at the Oral Hearing, are together sufficient to enable a Decision to be made in this complaint.

A Preliminary Decision was issued to the parties on **13 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.

A crucial question to be considered in this complaint is whether or not the Provider advised the Complainants that MS cover would be excluded for the Second Complainant's serious illness cover, and also the advice given by it as to the consequences of signing a Special Terms letter. In examining this issue, I think it is useful, in that regard, to firstly examine the information and documentation supplied to the Complainants, regarding the MS exclusion, at each stage of the application process.

October 2012 Meeting: the Complainants and the Provider's Tied Agent

The Complainants first met with the Provider's agent's representative, Ms A. on **12 October 2012**, to discuss life assurance and serious illness cover. I note from the documentary evidence before me that the Complainants completed and signed the life assurance policy application with Ms A., indicating that they wished to incept the policy which included a standalone specified illness cover of €157,000 for monthly premiums of between €155.16 and €158.05, depending on the start date of the policy.

The documentation submitted to this office related to this meeting includes the following:

- an application form;
- a policy brochure and key feature document;
- a case report generated following a financial review;
- part 2 of a Quotation number **42;
- a financial plan;
- a plan of action report; and
- a statement of suitability/reasons why letter.

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The policy brochure set out that a serious illness benefit was payable in the event of a diagnosis of MS with persisting symptoms. However, none of the above documentation contains any reference to the special term excluding MS cover from the Second Complainant's policy, because at that point in time (12 October 2012) the Complainants had not yet completed a further part of the policy application process, namely their medical tele-interview. Consequently, the Provider had not yet applied the special term excluding MS to the Second Complainants policy.

The Complainants, as indicated in their application form, opted to complete a medical tele-interview. I am satisfied that these tele-interviews were clearly another part of the application process, and that the Complainants were informed that the cover offered would be based in part on the information supplied during these tele-interviews.

Page 5 of the application form signed by the Complainants on **12 October 2012**, headed "*Important Information*" states in this regard:

> *"If you proceed with this application, the resulting policy will be based on the information you tell us*
>
> > *-in this application form…*
> > *-in any teleinterview you complete.*
>
> *If you complete a teleinterview, it will be recorded and you will be sent a transcript of the teleinterview for you to check and keep for your records"*

<u>Interval between the October 2012 Meeting and the February 2013 Meeting</u>

Each of the Complainants completed their tele-interview with a nurse on **15 October 2012,** three days after the first meeting. A copy of the Second Complainant's responses to the questions posed during the tele-interview, which was issued to the Second Complainant by the Provider after the tele-interview, confirms that the Second Complainant disclosed that her mother had suffered from MS.

At the Oral Hearing, the Provider introduced new evidence regarding the content of the discussion between the Second Complainant and nurse during the tele-interview. The Provider referred to a letter dated **13 May 2016** from the Complainants' solicitor to the Complainant which states:

> *"…our instructions are that during the medical examination of* [the Second Complainant] *the issue of multiple sclerosis was raised and it was explained an increase in premium might arise due to the history of MS in* [the Second Complainant's] *family"*

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The above extract does not in my view constitute evidence that the Second Complainant was aware that MS would be excluded from her serious illness cover. Rather, this letter simply suggests that the second Complainant was informed that her family history might result in a higher premium being applied to her policy cover.

The Complainants contend that their policy then commenced on **19 October 2012**, following the tele-interviews and that the Provider

> *"sought to have the special terms covertly signed in February 2013, in an attempt to finalise documentation that should have been signed in October 2012."*

However, I am satisfied that it was brought to the Complainants' attention during the course of their first meeting with Ms. A., that the policy would not come into force until (i) the Provider had accepted the Complainants for cover, (ii) it had issued the policy documents and (iii) the first premium payment was paid.

This is because page 7 of the application form contains a declaration signed by the Complainants on 12 October 2012, which states

> "***I understand that***
>
> 1. *The proposed contract will not come into force until* [the Provider] *has accepted me for cover and issued a policy document and I have made the first premium payment.*
> 2. *….*
> 3. *If I do not pay the first premium, the contract will not be valid even if you send me a policy document*"

Part 2 of the quotation number **42 supplied to the Complainants during the course of the meeting on 12 October 2012, also states in this regard, on page 2

> *"*[a]*s with Part 1 of your quotation, the information supplied in this booklet is also based on the assumption that your application to* [the Provider] *is accepted.* ***A policy does not start until the first premium has been paid and the policy documents have been issued***"

[my Emphasis]

The policy documents were issued to the Complainants on **13 February 2013**, and according to the First Complainant's evidence at the Oral Hearing, the Complainants began paying premiums in February/March of that year. Consequently, I do not accept the Complainants' contention that the policy cover commenced in October 2012. It is clear that policy did not commence until **February 2013**, when the Provider accepted the Complainants for cover, the policy documents were issued and the first premium was paid.

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In this regard the Provider states that it sent a copy of a special terms letter dated **19 October 2012**, to Ms A. at the Complainants' Bank branch, rather than to the Complainants directly (albeit that the letter on its face, was addressed to the Complainants at their home address). It is unclear to me why such an important letter, was not also directed to the Complainants for their attention, at their home address, rather than being solely transmitted to the representative of the Provider's tied agent for her attention, at the address of the Complainants' Bank branch.

The special terms letter dated **19 October 2012** stated:

> *"For **occupational reasons** an extra premium of **€6.27** per **month** will be payable for the **Accident Payment** in respect of* [the First Complainant] *for the full term of the proposed benefit*
>
> *For **occupational reasons** an extra premium of **€6.01** per **month** will be payable for the **Broken Bones Payment** in respect of* [the First Complainant] *for the full term of the proposed benefit*
>
> *No **Specified Illness Benefit** will be payable in respect of* [the Second Complainant] *in the event of a claim for* [MS] *or any illness or disability arising directly or indirectly therefrom including complications from any of its treatments*
>
> ***As a result of the above exclusion a discount of 4% has been applied to the Specified Illness Benefit cost element of the premium and this is reflected in the initial monthly premium quoted below.***
>
> *The initial premium will be **€166.39** per **month** and not as originally proposed…."*

The Provider states that the contents of this special terms letter were communicated to the Complainants on or before **25 January 2013**. While the Provider cannot confirm the precise date on which those details were communicated to the Complainants, the Provider makes this contention, based on the contents of a telephone call between Mr D. (Ms A.'s successor) and the Provider, which the Provider believes

> "*demonstrates that* [the Complainants] *were aware special terms applied and in particular to the cover for* [the Second Complainant]."

However, this contention conflicts with the Complainants' account of events. They categorically state that they did not receive any information from the Provider relating to the Special Terms on or before **25 January 2013**.

I note the following exchange in this regard, at the Oral Hearing:

[Ombudsman]	*Whatever about the contradictions in the paperwork, what I want you to comment on there now, before the cross-examination begins is whether you ever had a discussion with Mr.* [D.] –

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[First Complainant]	*No.*
[Ombudsman]	*Just let me finish the sentence. Whether you ever had a discussion with Mr.* [D.] *about taking out insurance in your own name only because of the issue that was being raised with your wife's health and special terms?*
[First Complainant]	*No, never. I never met with him or he never phoned me.*

At the outset, it should be noted that Ms. A. confirmed that she left work on sick leave/maternity leave on **15 October 2012,** as a result of which she did not receive the special terms letter dated **19 October 2012,** which was sent to her a few days later. This means that Ms. A. did not send or communicate the contents of the special terms letter to the Complainants, as she was not in a position to do so.

In considering whether or not the Provider's call on **25 January 2013,** evidences the Complainants' awareness of the contents of the special terms letter, it is useful to transcribe a portion of this call:

"……

Mr. D.	*Can I just check this. It's ****639*
Provider	*Yeah, fire away.*
Mr. D.	*What was the premium on that?*
Provider	*It was €166.39*
Mr. D.	*€166.39, was that including with special care, is that what the special care figure was*
Provider	*I'll look here now*
Mr. D.	***She has been rated and they are thinking of just doing it in his name only now****. Now he is not in my system to get a quote for him only for. So what would I need to get there, just name date of birth and that and just I can do a new quote for him and that, a letter of quote would do, to get it going wouldn't it?*
Provider	*Yeah, yeah, that would be fine yeah. Go with a quote, yeah.*
Mr. D.	*That's all right*
Provider	*Emm. One second there now. Yeah that's the rated one*
Mr. D.	*So that's the rated one €166. Ok, right, what's his date of birth*
Provider	*His date of birth*
Mr. D.	*Yeah*
Provider	[date of birth redacted]
Mr. D.	*,,, and he's a non-smoker*
Provider	*hold on I'll check, non-smoker yeah*
Mr. D.	*And what's the address just on it……"*

[my Emphasis]

A few observations can be made in relation to the above call recording. The call in question, was a call between Mr D. and the Provider, to which the Complainants were not party. Therefore, the call does not offer any conclusive evidence that the Complainants were aware of, or had been advised of, the special terms applying to the policy.

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The reference which Mr D. makes to the Second Complainant being "*rated*", and that "*they are thinking of just doing it in his name only now*", may suggest that there was some communications between the Complainant/s and Mr D. regarding the policy, and the special terms applying, particularly as Mr D. refers to monthly premiums of €166.39, which was the revised premium outlined in the special terms letter **19 October 2012**. However, the call offers no indication as to the extent of the information supplied to the Complainants if any, in relation to the special terms. Furthermore, it is unclear as to why Mr D. refers to the Second Complainant only as being "*rated*", when in fact it was the First Complainant's rates which were higher than normal and the issue for the Second Complainant was a cover exclusion, rather than a rating.

I also note that in an email from Mr D. to the Provider, dated the same day, **25 January 2013**, Mr D. states:

> "*[C]an I get special terms again for this as cannot find Clients cannot remember getting it*"

In circumstances where Mr D. was unable to locate the special terms letter on 25 January 2013, it seems unlikely to me that he was in a position to convey the precise contents of the special terms letter to the Complainants. Furthermore, this email suggests that the Complainants had not received a copy of the special terms letter at this point in time. Consequently, while this email raises an issue as to whether there was some discussion between the Complainants and the Provider, regarding the existence of the special terms letter, that issue remains entirely unresolved, given that Mr. D. was not available to offer his evidence at the Oral Hearing.

In those circumstances I believe there to be inadequate evidence available upon which it would be reasonable to make a finding that the Provider communicated the contents of the special terms letter to the Complainants on or before **25 January 2013**, as suggested by the Provider.

Following on from Mr D.'s email of 25 January 2013, the Provider sent a new special terms letter dated **29 January 2013,** to Mr D at the Complainants' Bank branch (although again, it was addressed on its face, to the Complainants at their home address). It seems in that regard that the first special terms letter dated 19 October 2012 had expired, as it had been valid only for a period of 30 days.

February 2013 Meeting: the Complainants and a Representative of the Complainants' Bank

There are directly conflicting accounts from both parties, as to precisely what was discussed during the course of the subsequent meeting on **5 February 2013,** between the Complainants and Mr J., who is not an employee of the Provider, nor of the Provider's tied agent. Mr J. was in fact an employee of the Complainants' Bank.

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The Complainants' evidence at the Oral Hearing was that they met with Mr J. in order to complete a loan application and carry out other matters relating to their farm account. The Complainants are adamant that their life insurance policy was not mentioned during the meeting and that Mr D. did not draw their attention to or explain the special terms letter, during the course of this meeting.

The Complainants submit that they were supplied by Mr J., with only the second page of the special terms letter dated **29 January 2013,** which did not contain details of the special terms applicable to their policy, but which they were nevertheless asked to sign. However, the Provider submits that the Complainants were supplied with both pages of the special terms letter (and a cover letter), and that the Complainants understood the contents of the special terms letter.

I think it is useful at this point to set out the contents of both pages of the special terms letter dated **29 January 2013**.

Page one of the second special terms letter stated

> *"….For **occupational reasons** an extra premium of **€6.29** per **month** will be payable for the **Accident Payment** in respect of* [the First Complainant] *for the full term of the proposed benefit*
>
> *For **occupational reasons** an extra premium of **€5.41** per **month** will be payable for the **Broken Bones Payment** in respect of* [the First Complainant] *for the full term of the proposed benefit*
>
> *No **Specified Illness Benefit** will be payable in respect of* [the Second Complainant] *in the event of a claim for* [MS] *or any illness or disability arising directly or indirectly therefrom including complications from any of its treatments*
>
> ***As a result of the above exclusion a discount of 4% has been applied to the Specified Illness Benefit cost element of the premium and this is reflected in the initial monthly premium quoted below.***
>
> *The initial premium will be **€165.59** per **month** and not as originally proposed…."*

Page two of the second special terms letter dated **29 January 2013** stated above the Complainants' signatures:

> "***Schedule of revised terms***
> ***Application no. *****639***
> ***Person(s) to be covered: [the Complainants]***
> *29 January 2013*
>
> ***Declaration of Acceptance***
>
> *We accept that the application be issued subject to the revised terms above.*

/Cont'd…

We confirm that there have been no changes in the state of health of the person(s) to be covered since the application form was completed and that all other information in connection with the application is still correct. (A copy of your completed application form is available on request)"

Both Complainants separately gave evidence at the Oral Hearing about how they came to sign the special terms letter, during the meeting on **5 February 2013**.

The following evidence was given in this regard by the First Complainant:

[Provider's Representative]	*In relation to the special terms letter and on that I would just refer you to it in the tab which is tab 16. This is the special terms letter which you signed on the 5th February 2013. First of all, can you just confirm on page 2 of that, which is the declaration of acceptance, that that is your signature on the 5th February?*
[First Complainant]	*Yes, yes.*
[Provider's Representative]	*And you did sign it during that meeting with Mr. J.?*
[First Complainant]	*Yes.*
[Provider's Representative]	*Before you signed it did you take the opportunity to review it?*
[First Complainant]	*The papers was all given, as I said we were there that day in the bank with* [Mr J.] *to organise the five different things that I pointed out to you. The information in the papers was given us to sign as part of all of this, different parts to be done out, five different items and everything was said, it was just pointed out to us, it was all in terms of the business. Insurance never ever was mentioned on that day.*
[Provider's Representative]	*Okay and you wouldn't have thought it would be prudent to read through a document which you are placing your signature on?*
[First Complainant]	*As I said everything was put to us and it was said that it was all in order and that is what it was.*
[Provider's Representative]	*Is it your evidence that during that meeting* [Mr J.] *never discussed the special terms with you?*
[First Complainant]	*As I said, insurance never was mentioned.*

The Second Complainant's evidence was as follows:

[Provider's Representative]	*….. Just on that, you accept that is your signature on the* [special terms letter]?
[Second Complainant]	*It is, yes.*
[Provider's Representative]	*Did you take the time before signing it to review the document?*
[Second Complainant]	*We signed other documents and this review, the application that is on these two pages –*

/Cont'd…

[Provider's Representative]	*Correct, the contents of the special terms letter and the schedule of revised terms?*
[Second Complainant]	*It wasn't there, we weren't shown it.*
[Provider's Representative]	*Okay.*
[Second Complainant]	*As I have stated already, this was already dealt with. We had no reason to be going through anything regarding our life insurance. Why would we have a reason to go through it when it was already done.*
[Provider's Representative]	*When you said it was already done, what do you mean by that?*
[Second Complainant]	*We had completed everything with* [Ms A.] *about four months before we sorted out the farm loan.*

Both Complainants suggest that they signed the special terms letter while completing other banking documentation relating to a loan application and their farm account. Neither Complainant confirmed what precisely they understood the special terms letter to relate to, nor did they indicate at what point during the meeting, the special terms letter was signed. In particular, I note that neither Complainant confirmed that they read the signature page of the special terms letter, despite being directly questioned on this point.

In circumstances where the Complainants' own evidence suggests that they did not read the documentation presented to them for signing, I consider it unlikely that they were in a position to know, whether or not they were also presented with the first page of the special terms letter, containing the detail of the special terms applicable to their policy.

Furthermore, I do not accept that it was reasonable for the Complainants to believe that their policy application had been completed "*with* [Ms A.] *about four months before we sorted out the farm loan*", because they had signed declarations at the meeting with Ms A. confirming their understanding that the policy would not commence until the policy documents issued and the first premium was paid. Given that the Complainants subsequently completed medical tele-interviews on 15 October 2012, and no premiums were paid in 2012, I do not consider it reasonable that the Complainants could have believed that the policy cover was already in place.

I also note that while the second page of the special terms letter did not contain the special terms, it did refer to "*revised terms above"* and the letter asked the Complainants to confirm that there was "*no changes in the state of health of the person(s) to be covered since the application form was completed*". It would have been prudent of the Complainants in these circumstances, to have questioned what these "*revised terms above*" were, before signing the page.

The Complainants in this regard must bear some responsibility for the events which have arisen, insofar as they failed to read the page which they signed, or to raise any questions as to what it was that they were signing. The Complainants had an obligation to carefully read any document which they signed and to raise questions if they did not understand it.

/Cont'd…

Upon being questioned at the oral hearing, Mr J. gave the following account of supplying the Complainants with the special terms letter at the meeting on 5 February 2013.

[Mr J.] *The special terms letter was provided to me by* [Mr D.]. *So the letter was provided in an envelope and I, our meeting, the initial part of our meeting, both* [the Complainants] *were present. We discussed business lending. When we had completed the business lending discussion I left the office to go to the I&I office to collect an envelope with the special terms and then returned to my office and provided the special terms to the customers where they signed them.*

[Provider's Representative] *Are you saying that there were two separate parts to the meeting?*

[Mr J.] *Yes. I distinctly remember leaving the office and coming back with the envelope in my hand, and then having a discussion around the special terms and providing the envelope to the customers where they read the special terms and signed them.*

…………….

[Ombudsman] *Maybe you could describe that in physical terms, where did you have to go?*

[Mr J.] *I walked across, the I&I office, I am sorry, it has changed a few times in the building. At that stage it was at the far end of the office so I walked across the main floor. I left my office, went out, walked across the main floor and entered the I&I office.*

[Ombudsman] *Okay and the I&I office is for the I&I manager; isn't that right?*

[Mr J.] *Yes.*

Mr J.'s account of how he came to hand the special terms letter to the Complainants was, in some respects, more detailed and specific than the Complainants' recollection of that meeting. Mr J. referred to particular details, such as retrieving the special terms letter from the Insurance and Investment office during the meeting, and that the special terms letter was in an envelope. Furthermore, as explained above, I do not accept the Complainants' contention that Mr J., or the Provider, "*sought to have the special terms covertly signed in February 2013 in an attempt to finalise documentation that should have been signed in October 2012*". The policy cover was not put in place until February 2013, and I have not identified any motive for the Provider, Mr D. or Mr J. to hide or obscure the existence of the special terms letter.

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Consequently, I accept Mr J.'s evidence that he supplied the Complainants with an envelope provided to him by Mr D., and on the balance of probabilities I accept that the envelope contained both pages, and the cover letter of the special terms letter, which the Complainants signed.

As to the extent of the discussion, which Mr J. had with the Complainants in respect of the special terms, and the extent of the Complainants' understanding of the special terms, I note the following exchange

[Provider's Representative]	*I might take you back, one step back. Could you explain for the Ombudsman what occurred during that discussion?*
[Mr J.]	*The special terms discussion?*
[Provider's Representative]	*Correct?*
[Mr J.]	*I provided the special terms to the customers, they read the documentation and we had a conversation around the special terms. So at that point the customers were, I was attempting to ensure they understood that so we had a basic conversation around that. They understood that there was an exclusion on the policy and it became evident during our conversation that the exclusion related to medical family history on* [the Second Complainant's] *side.*
[Provider's Representative]	*How did that become evident?*
[Mr J.]	[The Second Complainant] *advised me that I believe it was her mother had a medical condition that related to the special terms.*

I also note the following exchange, which I had with Mr J. at the Oral Hearing

[Ombudsman]	*Okay, thank you. The evidence you gave, Mr* [J.], *was that there were sort of two parts to this meeting. One was to do with the banking piece and then the other piece was when you, at Mr.* [D.]'s *request and even though you didn't actually work for this financial service provider, your task, as it were, was to have the special terms letter signed. I understand what you have said, that you formed the opinion that they understood the contents of the letter. Maybe you could explain to me, you have mentioned in your direct evidence that they read the letter so maybe you could clarify for me did they read it out loud to you, or in your presence?*
[Mr J.]	***No, they didn't read it aloud.***
[Ombudsman]	*So how do you know that they read it in its entirety?*

/Cont'd…

[Mr J.]	***I know that they read the part regarding the exclusion because we had a specific conversation around the exclusion because I think*** **[the Second Complainant]** ***volunteered information that there was a family medical condition and it was her mother that had a similar condition.***
[Ombudsman]	*Did you not know that before they opened the letter?*
[Mr J.]	*No.*
[Ombudsman]	***You hadn't opened the envelope?***
[Mr J.]	***No.***
[Ombudsman]	*So they opened the envelope, they read the letter and then* [the Second Complainant] *from your recollection said something to indicate her family history?*
[Mr J.]	*That's correct. I don't think it mentions family history in the letter.*
[Ombudsman]	*When you say you had a discussion around it, what was the nature of that discussion?*
[Mr J.]	*The discussion was we discussed that there was an exclusion for multiple sclerosis. When we discussed multiple sclerosis [*the Second Complainant] *advised that there was a family history, that her mother had multiple sclerosis. I think I recall that she said at that stage that she did not suffer from that or had no conditions at that point.* …………
[Ombudsman]	*Can I just clarify with you, you are giving me the impression of somebody who has a very clear recollection of this meeting; is that correct?*
[Mr J.]	*The meeting did occur seven years ago. I remember like completing special terms was a fairly unique event for me so I have a clear recollection to that. I did realise at the time and* ***something stuck in my head that it was important, that the customers understood what was in the letter, understood what they were signing****. So that is something I would always do.* ……..
[Mr J.]	*Yes, they understood it. Now, whether as the doctor states, that the regulation part et cetera, I cannot comment on any of that,* ***but I am one hundred percent clear that they signed it and they understood it and that we had a discussion around the exclusion on multiple sclerosis and that they understood that*** [the Second Complainant] ***would not be covered.***

/Cont'd…

[Ombudsman] *Okay and the discussion that you have had, as I understand your evidence, the discussion that you had was the discussion that you volunteered yourself to have with* [the Complainants]. *It was not something that Mr.* [D.] *asked you to do?*

[Mr J.] ***That's correct and it was a basic discussion***. ***It was enough of a discussion for me to understand that they understood the documentation***, *understood what they were signing when they signed it.*

[Ombudsman] *Did Mr.* [D.] *give you any instructions in terms of how you were to go about achieving the acceptance or the signature of the special terms letter?*

[Mr J.] *The only instructions that I received that I recall receiving from Mr.* [D.] *was that the customer needed to sign the special terms and, you know, read the special terms before they signed it. I was under the impression that he had already discussed this with them* ***but again I did not provide any advice. My sole role in relation to that was for them to sign special terms*** *and understand --*

[my Emphasis]

As I have already noted there is a direct contradiction between the evidence of the Complainants who state that there was no discussion in relation to the life assurance policy, or the MS exclusion, and Mr J.'s evidence, which was that there was a discussion in relation to the MS exclusion, and that the Complainants understood this exclusion.

However, in my view there are very considerable inconsistencies in Mr J.'s evidence regarding how he came to form the view that the Complainants understood the special terms applying to their policy. Even if I accept Mr J.'s evidence that there was some discussion around the MS exclusion, I am satisfied that this discussion was limited, that Mr J. did not explain the special terms to the Complainants, and that he could not have known whether the Complainants fully understood the specials terms being offered to them for the policy they had proposed for.

According to Mr J.'s evidence, the conversation between Mr J. and the Complainants in relation to the special terms was a "*basic*" once, and Mr J. *"did not provide any advice"* in relation to the special terms or the policy. However, Mr J. maintains that the Complainants read and clearly understood the special terms.

It is challenging to understand Mr J.'s evidence that on the one hand he did not offer any advice to the Complainants, and yet on the other hand, that he made sure that the Complainants understood the special terms being applied to the policy cover.

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In addition, it would appear from Mr J.'s evidence that he did not receive any information from Mr D. regarding the special terms letter, other than that the Complainants should read and sign the letter. Mr J. gave evidence that he had not read the special terms letter before handing it to the Complainants, as it was contained in an envelope that Mr J. did not open. Similarly, Mr J. acknowledges that the Complainants did not read the special terms out loud. In these circumstances, it is my view that Mr J. could not have known whether the Complainants either fully read or fully understood the special terms.

It is also notable that Mr J. stated that he was under the impression that Mr D. had discussed the special terms letter with the Complainants, and that his only instruction was that the Complainants needed to read and sign it. This would also appear to be inconsistent with Mr J.'s understanding of the necessity of ensuring that the Complainants understood the contents.
As referenced above, I accept, on balance, that Mr J. supplied the Complainants with the special terms letter to be signed. In such circumstances, given the specific rating of premium and the exclusion applied by the Provider, one would expect that a meeting of this nature would have included a discussion regarding each special term, the consequences, and any potential options to proceed in an alternative manner. It is clear to me however that such a discussion with the Provider was not possible at that time, as somewhat bizarrely, the meeting took place in the absence of any representative of the Provider.

It is more than a little disappointing that the Provider permitted the conclusion of this policy inception process, in this way. In my opinion, a comprehensive discussion ought to have ensued at this meeting, regarding the special terms being offered by the Provider, to put cover in place. Apart from the fact that the evidence suggests that Mr J. was not familiar with the content of the particular special terms, it is also clear that Mr J. was a business and financial advisor employed by the bank. He was not an employee of the Provider, there is no evidence available that he held an authorisation to act on behalf of the Provider, and he was not in a position to answer the Complainants' queries as to any alternative policy options, if the special terms being offered, as set out in the letter, were not attractive or acceptable to the Complainants.

Mr J. did not have any relevant experience advising customers on proposals for life assurance or serious illness polices. This was acknowledged by Mr J. during the course of the Oral Hearing when responding to the following question posed by the Complainants' representative:

[Complainants' Representative] *Okay so you have no experience of taking the life insurance process application from end to end?*

[Mr J.] *That's correct.*

Quite apart from any confidentiality or data protection concerns, I am satisfied that it was not appropriate for the Provider to have Mr J. conclude the sales process of the policy, on its behalf. It remains unclear as to why Mr J. was held out by the Provider to be an appropriate person to make the special terms letter available to the Complainants and to request them to sign that letter.

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The Provider's position is that the special terms were not complex and that it was not necessary for Mr D. to advise the Complainants on this aspect of the policy cover. The Provider states that Mr J. *"was neither advising nor closing out the sale of the policy"*. In essence the Provider submits that it was sufficient for the Complainants to themselves read the special terms letter and sign it. I do not accept this. Neither do I accept the Provider's contention that Mr J. was not *"closing out the sale of the policy"*, when he secured the Complainants' signature indicating their acceptance of the special terms, as it is clear that the policy could not have come into being, without securing the Complainants' acceptance of the special terms offered.

Furthermore, I do not agree that it was not necessary to explain the special terms being offered by the Provider, to the Complainants. Provision 4.37 of the CPC 2012 provides that

> *"Prior to a consumer completing a proposal form for a serious illness policy, a regulated entity* ***must explain clearly to the consumer the restrictions, conditions and general exclusions that attach to that policy****."*
>
> [my Emphasis]

In my view it is telling that, just as it had progressed the matter in October 2012 when it sent the special terms letter to Ms A., the Provider again sent the special terms letter dated 29 January 2013 to Mr D. and not to the Complainants directly at their home address. This suggests that the Provider expected Mr D. to be present when the Complainants signed the special terms letter, presumably so Mr D. would discuss and explain the special terms to the Complainants. If the Provider did not consider it necessary for Mr D. to be present when the Complainants signed the special terms letter, then it is unclear why the Provider did not issue the special terms letter directly to the Complainants, at their home address.

It should also be borne in mind that there was a considerable delay between the initial sales meeting on 12 October 2012 and the date on which the special terms letter was signed on 5 February 2013. The Provider has offered little by way of explanation for this delay, although it appears to have arisen as a result of Ms A. leaving earlier than expected on sick leave. Given the four month period which elapsed, it is unlikely that the information supplied to the Complainants by Ms. A. about the policy was fresh in the Complainants' minds. Therefore, it is particularly disappointing to note that the Complainants were not afforded the opportunity by the Provider, to meet again and discuss the situation which had arisen from the medical information which had been noted during the tele-interviews. I am satisfied that the Complainants ought to have been given access to an appropriate advisor who was in a position to advise them in respect of the special terms being offered for the policy cover sought, and indeed any potential alternatives which might be available.

Initially the Provider in a submission to this office dated **30 May 2019**, had maintained that a copy of the special terms letter was supplied to the Complainants for their records during the course of the 5 February 2013 meeting. The Provider referred to an undated handwritten note on a copy of the special terms letter stating "*Copy sent* [D.]", in support of this position.

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However, it is clear that it was Mr J. and not Mr D. who attended the meeting with the Complainants in February 2013. Mr J. then gave the original signed special terms letter to Mr D., who sent a copy of it to the Provider by fax. Accordingly, the handwritten note "*Copy sent* [D.]", seems more likely to refer to the fact that a copy of the special terms letter was sent by Mr D. to the Provider (rather than sent to the Complainants).

Mr J.'s evidence at the Oral Hearing was that he could not recall whether he supplied the Complainants with a copy of the special terms letter at the meeting on 5 February 2013, for their records:

> "*I do not specifically remember. The event occurred seven years ago so there is certain parts of the meeting that I remember clearly but I cannot recall if I provided a copy of the letter. But it was always my policy to follow procedures so I would have acted exactly as advised by* [D.]"

Given that Mr J. does not recollect whether he supplied the Complainants with a copy of the special terms letter for their records, at the meeting on 5 February 2013, I consider it appropriate to accept the Complainants' evidence in this respect, which was that during this meeting, they were not supplied with a copy of the special terms letter, to take home.

Subsequently, the Provider issued policy documents to the Complainants on **13 February 2013**, a copy of which have been submitted to this office. While the policy schedule stated that "*special terms apply to this policy*", the policy documents did not contain a copy of the special terms letter, nor did the policy documents set out the special terms which had been applied to the Complainants' policy, such that the exclusion of cover for MS, was made clear in that communication.

In these circumstances, I am satisfied that the Complainants were not supplied, for their records, with a copy of the special terms applying to their policy, whether during the course of the meeting on 5 February 2013 or otherwise. This is very disappointing and I have no doubt that this contributed to the Complainants' confusion as to the level of cover which was ultimately put in place.

These special terms formed an important part of the policy terms and conditions, and I am mindful in this regard of provision 4.2 of the CPC 2012 which states

> "*A regulated entity must supply information to a consumer on a timely basis. In doing so, the regulated entity must have regard to the following:*
>
> > *a) the urgency of the situation; and*
> > *b) the* ***time necessary for the consumer to absorb and react to the information provided****."*

[my Emphasis]

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In my view, the Complainants were not afforded sufficient time or opportunity to absorb the special terms offered, in circumstances where the evidence suggests that the only chance they had to read the special terms, was during the course of their meeting on 5 February 2013, with Mr. J. of the bank, who had very questionable authority to hold himself out as representing the Provider. The evidence indicates that they were not supplied with a copy of the special terms letter for their records.

In particular, I fail to understand why the special terms were not included in the policy documentation issued to the Complainants on **13 February 2013**. The special terms formed an important part of the contact of insurance, with potentially serious implications for the Complainants.

Notwithstanding all of the errors made by the Provider prior to this point, if the Complainants had received confirmation of the special terms, with their policy documentation on 13 February 2013, it would have given them a valuable opportunity to consider whether the policy was suitable for their needs, bearing in mind that the policy documentation contained a 'cooling –off notice' that would have enabled the Complainants to cancel the policy within 30 days if they took the view that the cover was not suitable to their circumstances.

I am mindful in this regard of Provision 4.1 of the CPC 2012 which states:

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

I do not consider that the statement on the policy schedule that "*special terms apply to this policy*", was sufficient to bring key information regarding the existence of the exclusion for MS in the Second Complainant's cover, to the attention of the Complainants, in the absence of any information as to what the special terms were.

It should be borne in mind that the policy conditions issued to the Complainants on 13 February 2013, listed MS with persisting symptoms, as a specified illness covered by the policy. I am satisfied that the policy documents presented to the Complainants in isolation, and without any information as to the particulars of the special terms applied to the policy, was misleading. I consider it strange and unacceptable that the Provider omitted to include details of the special terms in place, when supplying the Complainants with a copy of their policy documents.

I also consider that the failure of the Provider to supply the Complainants with a copy of the special terms letter for their records, given that it formed part of the policy's terms and conditions, contravened provision 4.22 of the CPC 2012 which sets out:

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> *"A regulated entity must provide each consumer with the terms and conditions attaching to a product or service, on paper or on another durable medium, before the consumer enters into a contract for that product or service…"*

I am satisfied that the Provider had a duty to the Complainants with regard to the sale of the product and that it did not fulfil its duty in this regard. The CPC 2012 requires providers to explain clearly to clients the restrictions, conditions and exclusions that apply to a policy, and that providers must supply clients with the terms and conditions attaching to a product or service, on paper or on another durable medium. However, in my view the Provider did not comply with these obligations.

I also note that annual benefit statements which issued to the Complainants following the policy inception, did not contain any reference to the special terms, and stated that the Complainants should "*read your policy documents for details of the terms and conditions of your policy*". However, as pointed out above, the policy documents did not contain details of the special terms.

It is also disappointing to note that the First Complainant was furnished with incorrect information when he phoned the Provider on **7 May 2014**, insofar as he was advised that the policy benefits were identical for both Complainants:

> *"..OK, you've got loads of benefits here. So what you've got, I'll go through each of your benefits, so for yourself and* [the Second Complainant], *so on your life you have €262,000 life cover, you have stand alone serious illness of €157,000, you've got hospitalisation payment of €210……..*[the Second Complainant] *has the exact same benefits except her lump, actually no, its all the exact same for* [the Second Complainant], *she has the exact same benefits as you…"*

This was clearly not correct in circumstance where special terms in the form of an exclusion from cover for MS, had been applied by the Provider to the Second Complainant, and yet the Provider's own records at that time, appear to have suggested otherwise.

Documents supplied to the Complainants

I do not however accept the Complainants' submission that the Provider failed to issue them with any policy documentation. The Complainants state in this regard that they did not receive any of the policy documents dated 13 February 2013, including the policy schedule. However, the Complainants acknowledge receiving annual statements relating to the policy at the same address to which the policy documents were issued.

The Provider states that its practice is to issue policy documents directly to customers, and that it did in fact issue policy documents directly to the Complainants in line with this practice.

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I have reviewed a copy of the policy documents dated 13 February 2013, which are addressed to the Complainants. I have also reviewed a screenshot of an entry in the Provider's IT systems (relating to the Complainants' policy) dated 13 February 2013, which the Provider submits, reflects that it issued policy documents on 13 February 2013 to the Complainants.

This screenshot states in the comments section:

> "*Issued. Sox added. Task set up to modify DD i.e., every 7th of the Month as per client's note on special terms.*"

I am mindful however, that prior to February 2013, the Provider had sent special terms letters addressed on their face to the Complainants, to the Provider's tied agent at the bank branch, and did not issue those communications directly to the Complainants. For that reason, I have had regard to the Provider's screenshot of an entry in its IT system dated 19 October 2012, which states in the comments section that

> "[s]*pecial terms posted to* [the Provider's tied agent] *via envelope & e-mailed to* [the Provider's tied agent] *as well.*"

However, unlike the screenshot of the IT system entry dated 19 October 2012, there is no indication on the screenshot of the entry dated 13 February 2013, that documents "[i]*ssued*" were posted to the Provider's tied agent, rather then the Complainants.

Consequently, and taking into account the Provider's stated practice to issue policy documents directly to its customers, the fact that the policy documents were addressed to the Complainants and the absence of evidence to suggest that the policy documents were sent to the Provider's tied agent (as was the case with the special term letters), I accept on balance that the Provider issued these policy documents to the Complainants and find no evidence of wrongdoing by the Provider in this respect. It may be that the Complainants did not receive the policy documents.

However, I do not find it possible to draw any firm conclusions as to why this was the case, or whether this was due to a postal issue. Apart from the question of the policy documentation issued on 13 February 2013, which I have dealt with above, the Complainants have submitted that they were not supplied with copies of documents arising from their first meeting with Ms. A. The Complainants' representative states in this regard:

> "….*Statement of suitability signed. A copy was not provided to* [the Complainants]. *There was no mention of exclusions to the policy or further processes to be engaged in. Life assurance advisor was present.*
> *Declaration signed. No copy provided to* [the Complainants]. *The premium for the policy was set....*"

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As outlined in the Reasons Why letter dated **12 October 2012**, (which outlined the reasons why Ms A. recommended the policy), the Complainants' statement of suitability consisted of:

- the reasons why letter;
- the financial plan;
- plan of action formed; and
- the quotation.

Copies of these documents have been submitted to this Office by the Provider. In this regard, I note that the Plan of Action, which was signed by the Complainants on 12 October 2012, contains the following declaration signed by Ms A.

> "*I confirm that I have provided the customer(s) with a copy of their Financial Plan and Plan of Action*"

I also note that the reasons why letter was signed by the Complainants on 12 October 2012, and that the Complainants have acknowledged that

> "[t]*here is no dispute that* [Ms. A.] *conducted her part of the application process with due process and consideration*"

Consequently, I am satisfied on balance, that the Complainants were in fact supplied with the Reasons Why letter, the Financial Plan, and Plan of Action. However, I note that while a quotation number **42 dated 12 October 2012, was supplied to the Complainants (and the Complainants signed a declaration in the application form acknowledging this), that quotation subsequently expired and was superseded by quotation number **03, generated on 29 January 2013.

This new quotation reflected the revised premiums applicable to the policy following the application of special terms. The Provider has acknowledged that this quotation was not supplied to the Complainants:

> *"Quotation number* [**]*03 (which was just an updated version of the original quotation) was generated after the sales meeting and therefore not provided to* [the Complainants]. *The Quotation (number* [**]*03) was generated by the Company so the relevant premium could be inserted on the special terms letter dated 29 January 2013".*

It is disappointing to note that the Provider failed to supply a copy of the up to date quotation to the Complainants, after it was generated on 29 January 2013. One can only surmise that if the Provider had arranged an appropriate follow up meeting with the Complainants in February 2013, to bring matters up to date and to discuss the need for special terms following the medical information disclosed during the tele-interviews, this new quotation may have been supplied to the Complainants at such a time.

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The quotation, contains important information about the policy, including the up to date policy premiums. It is not clear why this quotation was not supplied to the Complainants on 5 February 2013, when the Complainants signed the special terms letter but it seems to me to be likely that this was because the conclusion of the sale of the policy was in fact very flawed, as the Provider's representative Mr. D. did not arrange to meet the Complainants, and instead the sale was allowed by the Provider to conclude through the efforts of Mr. J. who was not an employee and who was not authorised to sell insurance on behalf of the Provider.

The quotation No. **03 formed part of the Complainants' statement of suitability, and in this regard, I do not consider that it was reasonable for the Provider to omit to supply the updated quotation dated 29 January 2013, to the Complainants, in circumstances where the initial quotation which was furnished to the Complainants had expired and contained incorrect policy premiums.

General Observations

Following the Preliminary Decision issued by this Office on **13 April 2021**, the Complainants made a number of submissions outlining their disagreement with the intended level of compensation to be directed, as referred to in the Preliminary Decision. They have pointed out that the claim made on the policy was for a serious illness benefit of €157,000 and they had paid premiums of approximately €16,556.76 in respect of the policy cover up to April 2021. The Complainants pointed out that the Provider's conduct had impacted significantly on them and also pointed out that it may not be financially viable in some instances to make a complaint to this Office when legal costs incurred by a complainant could exceed the compensation directed.

Although the Complainants were not legally represented in this matter, nevertheless, it should be noted that it is entirely a matter for any complainant or any provider, as to whether or not to engage legal representation for the purpose of engaging with this Office. The procedures of this Office do not require a provider or a complainant to do so, but if legal representation is desired by a party, the costs of such representation are a matter for that party themselves, and are not recoverable through the FSPO.

It is also important to bear in mind that the Complainants' policy over the years during which they made premium payments, had considerable value for them, with regard to the range of illnesses and conditions in respect of which it offered cover. Although a special term excluding cover for MS was in fact applied by the Provider to the Second Complainant, nevertheless, given the medical information and family history which had come to light, regrettably it is unsurprising that the Provider was unwilling to offer serious illness cover to the Second Complainant, without an exclusion for MS. Whilst the evidence shows many errors by the Provider in the sale of this policy, I accept that with a medical history of that nature, the Second Complainant was highly unlikely to have been able to secure cover for MS, with the Provider or indeed with any other insurer.

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Whatever criticisms can be made of the Provider, I accept that with the Complainant's medical history, the Provider was unwilling to make cover for MS available to her, and that the policy which came into being in February 2013, offered the second Complainant no cover for MS, as a result of which it is not now, nor was it ever open to her to seek to claim benefits, arising from her diagnosis of MS. Consequently, the insured amount of €157,000 for specified illness benefit offered by this policy, is of limited relevance, in these particular circumstances. I accept that the Provider was entitled to apply the special term excluding MS to the Second Complainant's serious illness cover, and that the term continues to apply to the Complainants' policy.

The complaint in this instance is one of mis-selling by the Provider. This investigation therefore concerns the quality of the information which the Provider made available to the Complainants at the point of sale, in order to ensure that they could make a fully informed decision as to whether the cover on offer was suitable and acceptable to them. For the reasons outlined above, I consider on the evidence before me that that there were very substantial failings on the part of the Provider, with respect to how the sale of the policy was conducted.

At this remove, I do not consider it appropriate to speculate on whether the Complainants would have sought an alternative policy, or indeed an alternative insurer, if they had been more clearly advised of the MS exclusion applicable to the Second Complainant's policy cover. It is unclear as to what alternative policy options may have been available to them at that time, taking account of their medical and family history details. Whatever those options may have been however, I am of the view that the Provider's failure to explain the special terms that had been applied to the policy cover, compromised the Complainants' opportunity to make a properly informed decision as to whether the policy was suitable for their needs.

In my opinion, this failure was compounded by the fact that the Provider failed to supply the Complainants with a copy of the special terms letter that had been applied to their life and serious illness cover, thereby depriving them of the opportunity to consider and absorb the contents of the special terms applicable. Nor do I consider it reasonable that the Provider failed to supply a copy of the revised and up-to-date quotation number **03 to the Complainants, after it was generated on 29 January 2013, by way of confirmation that the policy cover being offered to them was entirely different from what had been discussed in October 2012.

In particular, I am satisfied that the manner in which the sale of the policy was concluded, when the special terms letter was signed by the Complainants on 5 February 2013, was entirely unacceptable. It was not appropriate for the Provider to permit the sale of the policy to be concluded by Mr. J. who not authorised to sell insurance on behalf of the Provider, who was entirely unfamiliar with the contents of the specials terms, having not read them, and who had no experience selling or advising customers in respect of life assurance and serious illness polices or options.

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Consequently, and for the reasons noted throughout this Decision, I am satisfied that the sale of the product by the Provider contravened provisions 4.1; 4.2; 4.22; and 4.37 of the CPC 2012.

While such failings, in the usual course, would give rise to a referral by this Office to the Central Bank of Ireland, I am conscious that 8 years have elapsed since the sale of this policy took place, and there are likely to have been many changes to the Provider's sale processes and procedures in the intervening years, to take account of the evolving regulatory environment during that time.

On the basis of the evidence before me, I consider that it is appropriate to substantially uphold this complaint. I take the view that the sales process employed by the Provider was seriously flawed, for the reasons which I have identified throughout this Decision. Although I don't accept a number of the Complainants' contentions regarding certain policy documents and the statement of suitability which the Complainants state that they did not receive, nevertheless, taking account of the Provider's failures, in the manner in which this policy was sold, including the denial of an opportunity to the Complainants in 2013, to consider potential alternatives for cover, or to consider whether indeed they wished to proceed with cover at all, on the basis of the special terms offered, I believe that a significant compensatory payment to the Complainants is warranted. Accordingly, I remain of the view outlined in the Preliminary Decision, that it is appropriate to direct the Provider to make a compensatory payment to the Complainants, in the sum of **€15,000**.

In terms of the compensation directed, I note that the Complainants have indicated that the premiums paid to April 2021, in respect of the policy amounted to some €16,556.76. It is important nevertheless to bear in mind, as referred to above, that the policy selected by the Complainants had considerable value to them, with regard to the range of illnesses and conditions covered by it, and I do not consider it appropriate to overlook the fact that the Complainants have had the benefit of this cover over the relevant years, to date.

While this complaint has been substantially upheld, it is of course the case that this policy currently remains in place. Now that this complaint investigation has been concluded, it will be entirely a matter for the Complainants themselves, as to whether they will wish to continue to maintain the policy, in light of the substantial period during which it has remained in being, and the potential for recovery of policy benefits, into the future, weighed against any alternative insurance options which may now be available to them.

It will be important for the Complainants to give careful consideration to whether this policy remains suitable for their needs, whilst also bearing in mind that in the event that the Complainants complete a new proposal for alternative life assurance and serious illness cover, up to date developments in the Complainants' health will of course be taken into account by the insurer.

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Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is substantially upheld on the grounds prescribed in ***Section 60(2)(g).***

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainants in the sum of **€15,000**, to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants to the provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

- The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

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

MARYROSE MCGOVERN
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

27 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.