An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0269
Sector:	Insurance
Product / Service:	Term Insurance
Conduct(s) complained of:	Maladministration (life)
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint refers to a Term Life Insurance Policy, incepted by the Complainant in 1998/99. The complaint relates to conduct that took place in **November 2018** to **April 2019**. The Life insured is the Complainant.

The Complaint is that the Provider failed to:

1. Respond adequately to the Complainant's requests for clarity on her Term Life Insurance policy during 2018/2019;

2. Communicate effectively with the Complainant and within the time frames as set down in Chapter 10 Complaints Resolution, Provisions 10.9 of the Consumer Protection Code 2012 (as amended);

3. Adhere to the Consumer Protection Code 2012 (as amended), and in particular with reference to General Principles 2.4 (*has and employs effectively the resources, policies and procedures, systems and control checks, including compliance checks, and staff training that are necessary for compliance with this Code*), and 2.8. (*corrects errors and handles **complaints** speedily, efficiently and fairly*).

The other sections of the Consumer Protection Codes that will be considered here are General Requirement 3.1 ("*Where a regulated entity has identified that a personal 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"). And -

"Records and Compliance" 11.5 (*A **regulated entity** must maintain up-to-date **records** containing at least the following:*
*f) all documents or applications completed or signed by the **consumer**;*
*g) copies of all original documents submitted by the **consumer** in support of an application for the provision of a service or product;")*

The Complainant's Case

The Complainant explains that she had sought to amend the Term Life Insurance Policy application form, within months of the initial inception date. She says that that she contacted the Provider directly in February 1999 to add some *"specific medical details"* to her medical information, given by her the previous October (1998) through a Broker. The Provider initial response was that it considered that there was a non-disclosure of this additional information in 1998 and a new application form had to be completed. The plan was *"reinstated"* in August 1999 with the additional specific medical information to be included.

When the Complainant incepted the Term Life Insurance policy in October 1998. She opted to pay a *"10% extra charge over the 20 year lifetime of the plan for a Guaranteed Cover again option".* The Complainant says she received correspondence regarding the proposed new/converted policy on **26th October 2018.** This 'welcome Pack' referred to medical information given at the previous policy onset, warning that the Provider may *"end"* the cover or *"refuse to pay a claim"* if the correct information had not previously been given at the assessment of the original application. The Provider's letter went on to state "*A Summary of the Medical information you have given us in enclosed. Our decision to accept you for cover is based on this information"*. The Complainant states that a summary of medical information was not enclosed with the Provider's letter. As the Complainant was intending to continue with a new Term Life Insurance policy for a possible further 20 years, she was anxious to check that all the medical information, given in 1999, was correctly recorded.

The Complainant says she raised several issues with the Provider over a 5 month period in 2018/2019, and the Provider has not provided her with the clarity needed regarding what medical information was on its records. The Complainant states that the Provider has failed to confirm to the Complainant, that should the Complainant's next of kin, lodge a claim on the current Term Life Insurance policy, the Provider's assessment of that claim would include the correct medical history details as amended and accepted by the Provider in August 1999.

The Complainant cites customer service failings by the Provider while trying to progress her complaint. The Complainant says that there were delays in responding to her emails, "*not affording me the courtesy of a reply to some of my queries",* she found it was

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necessary to repeatedly contact the Provider regarding her concerns and queries around the Life Insurance policy documentation. This the Complainant says has caused her "*unnecessary and ongoing stress*", along with the time and effort in trying to resolve her complaint with the Provider. The Complainant also states that she was at an added disadvantage, in that she "*couldn't ring them because of [her] impaired speech – a fact they were well aware of*".

The Complainant maintains that the Provider gave her **"***inaccurate and false information*" by assuring her that they hold the correct medical information on its records. Despite the Complainant's requests, she maintains the Provider "*couldn't furnish me with a single medical fact".* The Complainant states that she is still uncertain what medical history details are attached to her policy, and in the unfortunate event of the policy being called on, which medical information the Provider will base any assessments on.

The Complainant wants the Provider to give a written assurance to her that in the absence of the medical information she submitted back in 1999, a claim will be paid out, without question should she die while the policy is in force.

The Provider's Case

The Provider states that its records show that it received an Application from the Complainant for plan number ***338, in 1998. While it later transpired (in 1999), that the Complainant had noted "*no*" to questions that should have been answered as "*yes*", she did note on the Application that she previously had a "loading" applied loaded by a third party life cover provider.

The Provider says that unfortunately, the Complainant's disclosure of a previously loading being in place was not noted / recorded by the Provider at the time. The Provider submits that this, coupled with the answers given by the Complainant (to the medical questions), resulted in her being accepted at Standard Rates (in 1998).

In **December 1998** the Provider received a request from the Complainant, to change the plan to a convertible term assurance plan (from a mortgage cover plan). This change was carried out as requested.

The Provider states that on **05 February 1999**, the Complainant attended the Provider's Head Office, to furnish additional medical information that had not been disclosed by her previously, and seeking confirmation if the new information would result in an increase in her existing payment.

The Provider states that following a review of this information, it was determined that there had been a serious level of non-disclosure on the part of the Complainant and as such, the original acceptance (at Standard Rates) could no longer apply. Therefore, the plan was cancelled and a refund of payments made to the Complainant.

The Provider says a complaint was subsequently raised by the Complainant and a new Application sent to her, for completion.

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It is the Provider's position that following the Provider's review of the new medical information and Complainant's file, it was discovered that in addition to the Complainant failing to disclose an accurate medical history on her Application (as she did not want her Broker to know the medical details in question), the Provider had not sought additional information from her in 1998, despite being made aware on the original 1998 Application, that she had been loaded by another life company.

The Provider says as a result, a decision was made by the Provider, to honour the original terms offered to the Complainant (Standard Rates), regardless of the new information provided by her. This decision was made by the Provider, in the knowledge that it would also be providing cover (at Standard Rates) on any subsequent plan, if the plan was converted in the future by the Complainant.

The Provider therefore states, the original plan was reactivated in 1999 and continued until its expiry in 2018.

The Provider submits that it does not have a copy of the Application completed in 1999 and the only medical information on file, is that which was provided by the Complainant, when she attended the Provider's Head Office on 5 February 1999.

The Provider says it is important to note that this plan was cancelled in February 1999, after the Complainant attended the Provider's Head Office and made it aware of medical information she had not disclosed on her application.

The Provider states that had the Complainant not provided the correct medical information in 1999, the plan would not have been reviewed and the Provider would not have made a business decision, to allow its reactivation. The Provider therefore says, it is clear that the reactivation of the plan was only permitted, after the Provider was in possession of the Complainant's full medical history.

The Provider says it made the decision at the time (to provide cover at Standard Rates), in the knowledge that on or before 2018, the Complainant could convert her existing plan to a new plan, of which they would also provide the cover at Standard Rates, regardless of the Complainant's health.

The Provider's position is that at no stage between 1999 and 2018, did the Provider give any indication to the Complainant, that the cover was not valid or that a claim would not be accepted. Likewise, the Provider says that at no stage since the Complainant converted her original plan and took out a new plan in 2018, has she been led to believe that the cover on the plan, or any possible claim made in the future, was in doubt. The Provider states rather the Complainant has been assured of the opposite, on many occasions between November 2018 and April 2019, by both e-mail and letter.

The Provider states that it does accept that the Complainant had to follow-up on emails, when responses were not sent to her in a timely manner and that the documentation on

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the file (which was forwarded to her to her on **12 April 2019**), should have been reviewed and sent with the initial response letter on **12 December 2019**.

The Provider says it also accepts it should have a copy of the missing documentation scanned to the Complainant's file. The Provider states while in 1998 / 1999, files were still retained in paper format, it appears that the underwriting documentation from that time was not scanned to the Complainant's file as it should have been in later years, when the Provider updated its storage process and switched to electronic storage.

For each of these failures, the Provider has apologised.

The Provider states that in recognition of these failures, the Provider would like to offer a goodwill gesture to the Complainant, of €2,500, which it hoped she would accept with its apologies.

The Provider states that the terms under which it has and will, provide the Complainant with the agreed life cover, was and is based on the correct medical information provided in 1999. Therefore, the cover is valid and a claim will be accepted by the Complainant's estate (or next of kin), should she pass away during the term of the plan, provided all payments are kept up to date.

The Complaints for Adjudication

The Complaint is that the Provider failed to:

1. Respond adequately to the Complainant's requests for clarity on her Term Life Insurance policy during 2018/2019;

2. Communicate effectively with the Complainant and within the time frames as set down in Chapter 10 Complaints Resolution, Provisions 10.9 of the Consumer Protection Code 2012 (as amended);

3. Adhere to the Consumer Protection Code 2012 (as amended), and in particular with reference to General Principles 2.4 (*has and employs effectively the resources, policies and procedures, systems and control checks, including compliance checks, and staff training that are necessary for compliance with this Code*), and 2.8. (*corrects errors and handles **complaints** speedily, efficiently and fairly*).

The other sections of the Consumer Protection Codes that will be considered here are General Requirement 3.1 (*Where a regulated entity has identified that a personal 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*). And -

"Records and Compliance" 11.5 (*A **regulated entity** must maintain up-to-date **records** containing at least the following:*

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*f) all documents or applications completed or signed by the **consumer**;*
*g) copies of all original documents submitted by the **consumer** in support of an application for the provision of a service or product; ..).*

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on **18 June 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.

Submissions dated **30 June 2021** and **17 July 2021** from the Complainant and submission dated **15 July 2021** from the Provider, were received by this office after the issue of a Preliminary Decision to the parties. These submissions were exchanged between the parties and an opportunity was made available to both parties for any additional observations arising from the said additional submissions.

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

The Provider in its response to the complaint of **28 August 2020** made an offer of €2,500. this offer was communicated to the Complainant by this office by way of letter of **28 August 2020**. In the Complainant's e-mail of **02 September 2020**, the Complainant advised that she wanted the complaint to continue through the FSPO process.

The Provider position is that the document (customer action note) completed by a

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member of staff when the Complainant attended the Provider's Office on 0**5 February 1999**, is in the Provider's records. The Provider says that a copy of this document was sent to the Complainant by email, on **12 April 2019**. This customer action note, records the Complainant having visited the Provider with further medical information, what was actually submitted by the Complainant on this day, is not on the Provider's files.

The Complainant's observation on the above is that:

> *"The Provider made no effort to search for this document right up to 06/04/19 which was the date I sent an email looking for a referral letter for FSPO. This in spite of the fact that I made the Complaints Department aware of my visit to the Provider's Dublin office in February 1999 in my email of 13/12/19 and again referenced it in my email of 19/03/19. I consider this negligence and complete disregard of the Complainant. What chance would my next of kin had if a claim had gone in anytime during the first 20 years of my plan up to the end of October 2018 as I had no reason to believe that my 1999 application form was missing or any reason to tell my next of kin that I had gone to the Dublin office of the Provider in February 1999 to disclose further medical information - after all I had given even more specific medical details in the August 1999 application form. They would have no knowledge of the [failings] that the Provider has now admitted only because of my persistence since November 2018 to the present. There was nothing on file only a partially completed form from 2018. My next of kin would just have had to accept the fact I had not given relevant facts - after all what proof had they and they also would be grieving. I have no doubt whatsoever that a claim wouldn't have been paid out".*

The Provider states that it does not accept the Complainant's claim that the Provider has refused to furnish her with assurances of the validity of the cover on both the plan that ran from 1998 to 2018 and her current plan.

The Complainant's observation on the above is that:

> *"The Provider offers the same emails / letters as I referenced in my submission of 06/01/2020 but noticeably omitted one very important sentence from the email of 17/01/2019: 'I have confirmed to you in writing that we are fully aware of all your medical details'**.** I would like also to reference another sentence from this same email which the Provider did include in the submission: 'I have been unable to locate a copy of the application form you have referred to. ..... Even though we cannot provide the form to you we are confirming that the information is on record.....'*

The Complainant states that *'details'* mean specifics or particulars, and to have *'on record'* is to have it set down in writing or in some other permanent form for later reference.

The Complainant submits that it appears to her that the Provider is deliberately trying to obfuscate to fit their own narrative and is not taking the Complainant's very real concerns seriously - but need to couch its responses in what may appear as comforting phrases to cover itself, but are really quite patronising and meaningless when you know if the Provider

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had anything on record it should have no difficulty giving it.

The Complainant states that the Provider did not give any assurances to her that a claim would be met as it did not provide a single concrete medical detail until the **12 April 2020** e-mail. The Complainant notes the Provider's now admittance, which means in effect that it is at last conceding that it had no medical information on file up to her email of **06 April 2020**.

The Complainant says that there is no meaningful clarification from the Provider that would relieve her stress that a claim would be paid out to her next of kin and that stress has continued to the present. The Complainant states that not once in the Complaints process was the word 'claim' mentioned by the Provider. Even in the short extracts in the submission the word 'cover' was used 5 times. The Complainant states that everyone who pays their premiums has cover, but not everyone who has cover will have a claim paid out when it goes through the assessment process mainly because a relevant fact is missing on their application form - usually medical. The Complainant submits that in the body of the Provider's submission the term 'acceptance of a claim' is mentioned 3 times but argues that it would have to be stronger than that. The Complainant says all claims are accepted initially but after the assessment process not all will be paid out.

As regards a resolution, the Provider states that the terms under which it has and will, provide the Complainant with the agreed life cover, was and is based on the correct medical information provided in 1999.

The Complainant's observation on the above is that:

> *"I am baffled - if the specific medical details submitted in August 1999 are recorded and maintained on my policy why has the Provider admitted [its failings] in relation to medical details and why are we in an investigation process if the Provider could provide me with a summary of those correct additional details from August 1999?"*

The Provider's states that in accordance with the governing terms of the Conversion Option, the acceptance on the current plan is at the same Rate as the acceptance on the original plan (subject to increased age) and not based on the same Medical Information. The Provider therefore states the acceptance on the new plan is at the same Rate as the acceptance on the original plan and not based on the same Medical Information.

The Complainant's observation on the above is that:

> *"I am having real difficulty knowing what this means - it reads to me as though the medical information you provided in 1999 is now irrelevant!! So what Medical information is it based on? The one in 2018 where you hadn't to fill in the medical section? Surely if this was the case the Provider would have had no bother providing me with a letter that there would be no assessment and a claim would be paid out straightaway. I have difficulty believing that any insurance company dealing with a Conversion plan would not base it on the original application form and the medical details it contained. Then in complete contradiction to this the Provider goes on to*

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> *say straight after the statement* [in its response of 28 August 2020]: *'Therefore, the Provider can confirm that the terms under which it has and will, provide the complainant with the agreed life cover, was and is based on the correct medical information provided in 1999.'"*

The Complainant states that before ever the complaints process began, she was informed by the Provider on **05 November 2018**:

*'The underwriting terms of the cover are based on the medical information provided under plan no ***338 in 1998 and on which you received standard rates'.*

The Complainant submits that on informing the Provider that it had sent out the wrong application form the Provider then wrote on **16 November 2018**:

*'The underwriting terms of the cover are based on the medical information provided under plan no ***338 on 19/08/99 and on which you received standard rates'.*

The Complainant states there is too much obfuscation going on with the Provider and no clarity. The Complainant says nothing will give her assurance at this stage but a letter from the Provider as she had asked for in her e-mail of **19 March 2019** and to which she never received a reply. The Complainant submits that the Provider can choose the wording but it has to contain confirmation that should a claim be made it will be paid out straightaway without a medical assessment (because of what the Provider are admitting as to its failures).

The Provider states that while it accepts that on several occasions, the Complainant had to send a follow-up email as she had not received a response to her initial email, it would like it noted that all queries raised by the Complainant were responded to.

The Complainant's observation on the above is that twice during the complaints process she asked the Provider how a potential claim on her policy would be handled in the absence of her correct application form and in the absence of her medical details being on record. The Complainant states that neither time was this very important and relevant question answered.

The Provider was questioned by this office as to its awareness and response to the Complainant's difficulty in contacting it by telephone due to her "impaired speech" and that she was reliant on communicating though e-mails and written correspondence.

The Provider's submits that it is important to note that the Complainant is not the only customer to request that they not be contacted by telephone and that all interactions be in writing (either e-mail or postal). The Provider says rather, this is noted as a personal preference of many customers during their dealings with the Provider, for many different reasons. The Provider states that this has no bearing on the service they receive from the Provider; rather, the Provider states, all customers are treated fairly, regardless of their means of contact or personal circumstances.

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The Complainant's observation on the above is that there is a big difference between a 'personal preference' and having a speech impairment. That one is an option you choose though other options would be open to you and the other denies you certain options and needs to be noted not as a personal preference, but as a barrier to certain types of communication or 'vulnerable'.

The Complainant states that what the Provider does not point out is that when she sent the e-mail on Monday **03 December 2018** to point out her speech difficulties she received no reply by e-mail until 9 days later Wednesday **12 December 2018** and no reference whatsoever to indicate that the Provider had noted her speech difficulties on its file. The Complainant states that in the actual response letter which she received **13 December 2018** she was in fairness given a direct e-mail address which she appreciated, but again no reference to the Provider having noted her speech difficulties and it appears to have been treated as a personal preference.

The Provider states it: '*refutes any claim that it purposely attempted to hide information from the Complainant, based on its knowledge that she could not contact them by telephone.'*

The Complainant's response to the above is that:

"I have no idea where this came from!! I mentioned in my submission of 12/05/2020 in the context of the delays in responding to my emails that 'I was at the added disadvantage in that I couldn't ring them because of my impaired speech - a fact they were well aware of'. This is merely stating the truth for me - whereas a customer who had a 'personal preference' for communication through email could ring and put pressure on to speed things up the reality is I couldn't. There was no reference on the Complainant's part to any 'hiding of information' and any of her submissions will prove that".

The Provider's position is that it can confirm it does have appropriate measures in place, to assist potentially vulnerable customers, which were implemented in this case, as outlined in its response.

However, the Complainant's observation is that:

> *"Try as I might I could find no policy document for the Provider on the internet in relation to accessibility or vulnerable customers. All I could find for [the Provider] is how they had made their website accessible - admirable in itself but doesn't provide practical help for anyone needing assistance in the complaint process.*
>
> *The complaint acknowledgement letter I received on 30/11/2018 only gave different contact telephone numbers if I needed to contact them and also stated that NT would telephone me to discuss my complaint with me. There were no options given other than telephone numbers for contact not even an email which is most unusual nowadays. There were no questions as to whether you required special assistance or if you had any practical needs they could help you with. As there was no e-mail I*

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had to look up the [the Provider's] website only to find there was no link to the Complaint department in the general website even though they had links for a lot of different departments. I had to run a separate search to find complaints and when I found the general email for the department I sent an email on Monday 03/12/18 for the attention of NT and hoped it would get to him. In it I explained about my impaired speech. I received no reply until Wednesday 12/12/18 so had no means of knowing whether NT had received my email or not.

Interestingly I also received dated 03/12/18 what the Provider describes as a 'Welcome Call Letter' which is obviously a general letter that goes out to all customers who have taken out a new plan. Once again no email is given and you are asked to ring a number if you want to contact them. They mention they had tried to contact me but I only answer the phone to immediate family and text everyone else and no messages were left on my phone and even if there were they would have left a phone number to ring!

I recently looked up the Provider's complaint form on the internet - again it only asked for your personal preference for contact which, while far superior to the acknowledgement letter I received, falls far short of checking whether you needed special assistance.

By comparison the FSPO complaint form had a section for accessibility and practical needs. FSPO also has an accessibility and different needs section on the internet and have an access officer who can be reached by telephone or email. Many organisations have an accessibility policy and the Provider would do well to draw up a policy on accessibility and live by it - I didn't notice any policy document in their documentation - they just referred to elements of the Consumer Protection Code.

I would draw particular attention to 'Where a regulated entity has identified that a personal consumer is a vulnerable consumer ....' The Provider had no means in either their complaint form, the acknowledgement letter I received or the Welcome Call Letter of 'identifying' a vulnerable consumer. The vulnerable customer has to do all the running and in my case it was just seen as a personal preference'. Would that it were!"

As regards compliance with Chapter 10 'Complaints Resolution', Provision 10.9 of the Consumer Protection Code 2012 (as amended). The Provider's position is that a response letter was sent to the Complainant on **12 December 2018** and that the complaint was then closed. The Provider states that while the Complainant continued to e-mail the Provider throughout January, February, March and April of 2019, it is important to note that her original complaint was not reopened by the Provider. The Provider submits that as the complaint was not reopened, the follow up queries were not subject to the timelines set out in Chapter 10. Provision 10.9.

The Complainant's observations on the above are that:

1. *"A complaint surely cannot be closed without informing the Complainant - at no*

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point from November 2018 to 6 April 2019 was I told the complaint was closed.

2. *The Provider has stated that my case was closed after 13 working days. What happened to the provision of updates at intervals of no greater than 20 days or if the complaint is not resolved by the 40th working day that the Complainant must be informed of when it is expected to have a resolution ...*
3. *I was working on the premise of the guidelines given on the FSPO's website:*

- Before making a complaint to the FSPO you must give your provider a chance to sort out the problem.

- Be patient and persistent. The provider may take up to 40 days to deal with your complaint. (I wasn't even afforded that courtesy going by the Provider's document)

- The provider should fully investigate your complaint.

- If they don't resolve it they will issue a final response letter to you. (It looks like their first response letter after 13 days was also their final response letter according to the Provider's document although it didn't state it was the final response letter).

- If nothing happens call on the provider to check on the progress of your complaint. (I couldn't ring so I resent emails).

4. It is somewhat disingenuous of the Provider to now tell me in September 2020 that they had closed the complaint on 12 December 2018! However they are still trying to create their own narrative to cover that they certainly didn't comply with Chapter 10 'Complaints Resolution'(as amended) in their dealings with me. It has reached a new low when a Complainant can be treated with such disdain and toyed with from 12 December 2018 to 12 April 2019 if the Provider closed the complaint on 12 December 2018 without informing the Complaint and only after 13 working days.

5. I would like to offer the following as proof that my complaint was not closed as stated on 12/12/18 or if it was I was not informed. In that first response letter the Provider stated '.....should you have any further questions please do not hesitate to email me directly at ..... - that doesn't sound like the complaint was closed. In the last email on 12/04/19 the Provider states '..... this letter serves as our Final Response letter to the issues you have raised .....' This was when the complaint was really closed".

In its response of **28 August 2020,** to this Office, the Provider states that unfortunately, the Complainant's disclosure of a previously loading being in place was not noted / recorded by the Provider at the time. The Provider says this, coupled with the answers given by the Complainant (to the medical questions), resulted in her being accepted at Standard Rates (in 1998). The Provider accepted it had not sought additional information from the Complainant in 1998, despite being made aware on the original 1998 Application, that she had been loaded by another life company.

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The Complainant's observation was that this is the first time she was clearly informed that the note, she insisted the Broker put on the October 1998 application form, of a loading by another company was not noted / recorded by the Provider at the time. The Complainant states that the fault clearly lies with the Provider. The Complainant submits that as a customer she just thought that different companies had different criteria when setting their rates.

The Complainant states that this communication of **28 august 2020**, was the first time she really understood why her policy was voided. The Complainant submits that it was not actually for a serious level of non-disclosure as after all she had insisted on the note regarding the loading by another insurance company being included clearly on the form - it was because the Provider had not noted / recorded this information. The Complainant states that therefore it was the Provider's fault.

The Complainant states she now realises that being on standard rates poses more danger for her next of kin if a medical assessment takes place on foot of a claim as the Complainant has not ever been told in writing the real reason she was left on standard rates.

The Complainant states that in light of all that has come out in this investigation - she would request that I use my statutory discretion to extend the time to take into account the asserted serious maladministration of her insurance policy right from the start as she believes is evident from the Provider's admissions.

In the Complainant's post Preliminary Decision submission of **30 June 2021**, the Complainant stated that she identified a further policy from May 2010 that she had filled out to apply for additional Death Benefit under her Salary Protection Scheme which in turn was underwritten by the Provider. The Complainant states that there was this additional life cover that could have resulted in adverse consequences for her next of kin due to the failure of the Provider to meet its obligations on Records and Compliance. The Complainant was also of the view that the Provider would have known of this when she raised her concerns and that it may have influenced its decision not to give her a "letter of comfort" as to the payment of any claim that were to arise.

In the Provider's submission of **15 July 2021,** it advised that while it is all one company (Corporate and Retail), there are many different divisions, each of which has different systems, product types and most importantly, are all separated by *Chinese Walls* preventing the sharing of information from one Division to another.

The Provider states that the Complainant's life cover plan on which the complaint was raised, is held by the Provider's Retail Division of the Company.

As regards the Complainant's Income Protection cover, the Provider states this would be held by the Corporate Business Division of the Company and as such, cannot be viewed by the Retail Division.

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The Provider states it would like to assure the Complainant that, when arranging the conversion of her plan in 2018 or dealing with her complaint in 2019 / 2020, it (the Retail Division of the Company), was not aware that she was a member of a scheme with its Corporate Business Division or that a claim was being made in relation that scheme. The Provider says even if this had been disclosed by the Complainant at the time, it would not have been possible to check any details on it.

In the Complainant's submission of **17 July 2021**, the Complainant quotes from the Provider's documentation where it is stated that there can be a sharing of information, between the different areas of the company. The Complainant also states that:

> *"The Provider may have different divisions but the fact remains that the serious incompetence in the Retail division has ramifications for my next of kin for a death benefit I took out with another division of the Provider and I note the Provider has made no assurance or comfort on that score or does [the Provider] now expect the complainant to spend another two and a half years proving a failing - 'that as the Provider did not retain the entirety of the medical evidence disclosed to it by the Complainant in 1999 ……. therefore a claim would have to be reasonably met by the Provider' - a failing that has already been proven without doubt in this investigation process. In my case, the same application form which the Retail Division has admitted it doesn't have a copy of, is important to verify both claims.*
>
> *Thanks to the skilled services of the Ombudsman it looks like the potential life insurance sum is safe in the event that a claim falls due for which I am very appreciative. However, the fact still remains that the failure of the Provider to meet its obligations on Records and Compliance could potentially endanger the death benefit of €319,638 unless it too is included in the comfort letter".*

<u>Analysis</u>

While the Complainant has sought an examination of issues going back to 1998 and 1999, I do not consider it necessary to do so, to adjudicate on this complaint.

The main complaint here concerns the Provider's response to a request from the Complainant to furnish her with the medical information that she disclosed to the Provider in 1999, and its failure to adequately address the consequences of its inability to furnish that information.

The following failings have been accepted by the Provider in its letter of **28 August 2020**, in response to the questions posed and evidence sought by this office as part of the investigation of this complaint.

- *"… the Complainant's disclosure of a previously loading being in place was not noted / recorded by the Provider at the time."*

- *"... the Provider had not sought additional information from her in 1998, despite being made aware on the original 1998 Application, that she had been loaded*

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by another life company."

- *"… the Provider does not have a copy of the Application completed in 1999 and the only medical information on file, is that which was provided by the Complainant, when she attended the Provider's Head Office on 5 February 1999."*

- *"... the Provider only has part of the original Application from 1998 and no Application or accompanying medical information from 1999".*

- *"The Provider also accepts it should have a copy of the missing documentation scanned to her file".*

- *"...the Provider accepts that on several occasions, the Complainant had to send a follow-up email as she had not received a response to her initial email…".*

- *"...that the documentation on the file (which was forwarded to her to her on 12 April 2019), should have been reviewed and sent with the initial response letter on 12 December 2019".*

- *"It appears that this document* ["Customer Action Note] *was not originally located by the Complaint Investigator previously, as it was not scanned as an "Underwriting" or "New Business" document".*

I accept that the Provider did not adequately resolve the issues the Complainant raised during the five months of communications from **November 2018** to **April 2019**. During this time the Complainant argued that should anything happen to her, which could result in her next of kin making a claim on the policy, then the Provider could decline to pay out as the Provider had based the current policy (Guaranteed Again Policy put in place 2018) on incorrect medical history details. I accept that during this five month period, the Complainant reasonably sought (on numerous occasions) confirmation from the Provider that any such claim would be honoured, however the Provider failed to furnish a satisfactory response to the Complainant.

The general position is that at claim stage for a death benefit policy, an Insurer would seek medical records from a GP or other treating medical professionals, to establish that full disclosure was made from the outset on the application form. If it was found that a full disclosure of medical information was not made from the outset, the Insurer could void the policy, and not pay out on the claim.

I accept that as the Provider did not retain the entirety of the medical evidence disclosed to it by the Complainant in 1999, it could not possibly say for sure that something was not disclosed to it, therefore a claim would have to be reasonably met by the Provider.

On that basis I accept that the Provider could reasonably have given the Complainant the assurances she sought when specifically asked for, but did not do so.

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I accept that it was reasonable of the Complainant to expect that the Provider would continue to promptly engage with her after it issued its letter of **12 December 2020**. I accept that this letter could have been clearer as to the finality of the Provider's response, if that is what was intended. As the Provider did not further engage with the Complainant, it resulted in her having to re-send correspondence to the Provider's Office.

A regards a customer's vulnerability, the Consumer Protection Codes - General Requirement 3.1 states that:

> "*Where a regulated entity has identified that a personal 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"*

I accept that when the Complainant brought her vulnerability to the Provider's attention, the Provider should have specifically acknowledged her vulnerability and advised what it could do to accommodate her. I accept that when the Provider did not answer the Complainant's e-mails promptly, due to her vulnerability she would have reasonably felt at a disadvantage, as she could not contact the Provider by telephone.

I accept that the Provider gave, what the Complainant describes as: "*inaccurate and false information*" by assuring her that the Provider held her correct medical information on its records, when it did not in fact have on its records, the application form she completed in 1999, nor a complete application form for 1998.

I accept the Complainant's position that she expended months of her own time in 2018 and 2019, by having to repeatedly contact the Provider regarding her policy with queries and concerns, which caused inconvenience and "*unnecessary and ongoing stress*".

I accept that the Provider could have provided information to the Complainant earlier than it did. In 2018, the Provider could not furnish the Complainant with a documentary record of her visit to its Offices in February 1999. However, after the Complainant requested a referral letter to accompany the Complaint Form she had completed for this Office, the Provider was able to furnish the Complainant with the details of her visit (along with some other documents).

As regards the Provider's obligations on "Records and Compliance" – Section 11.5 of the Consumer Protection Code 2012, the Code sets out what was required from the Provider, as follows:

> *"A **regulated entity** must maintain up-to-date **records** containing at least the following:*
>
> *a) a copy of all documents required for **consumer** identification and profile;*
> *b) the **consumer**'s contact details;*
> *c) all information and documents prepared in compliance with this Code;*
> *d) details of products and services provided to the **consumer**;*

/Cont'd…

*e) all correspondence with the **consumer** and details of any other information provided to the **consumer** in relation to the product or service;*
*f) all documents or applications completed or signed by the **consumer**;*
*g) copies of all original documents submitted by the **consumer** in support of an application for the provision of a service or product; and*
*h) all other relevant information and documentation concerning the **consumer**".*

I accept that it is clear from the evidence submitted and the Provider's own acknowledgement of its failings, that the Provider did not comply with (f) and (g) above, when it failed to maintain on its records all documents or applications completed or signed by the Complainant, nor all copies of all original documents submitted by the Complainant in support of an application for the provision of a service or product. It is not evident when this failure initially occurred, all the Provider could advise is that it may have happened when it was updating its storage process and switched to electronic storage. Nevertheless, I accept that this was a failure that has significant consequences.

Ultimately, I accept that the Provider could have reasonably given greater comfort to the Complainant as to the payment of the policy benefit, regardless of what medical information comes to light in the future. I accept it is reasonable for the Complainant to expect such certainty, due to the Provider's failure to maintain the information she supplied to the Provider in 1999.

It is my Decision that the complaint is upheld, and I direct that (i) the Provider pay the Complainant the compensatory payment of €5,000 (five thousand euro) and (ii) furnish the Complainant with a letter of comfort stating that, in the event that the policy benefit falls due for payment (or any other policy of insurance that is already in place with the Provider, that the disclosures have relevance to), the Provider will make payment without any enquiry as to the Complainant's medical history.

Conclusion

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

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider (i) pay the Complainant the compensatory payment of €5,000 and (ii) furnish the Complainant with a letter of comfort stating that, in the event that the policy benefit falls due for payment, (or any other policy of insurance that is already in place with the Provider, that the disclosures have relevance to), the Provider will make payment without any enquiry as to the Complainant's medical history.

- The Provider is to make the compensatory payment to the Complainant in the sum of €5,000 to an account of the Complainant's choosing, within a period of 35 days

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of the nomination of account details by the Complainant 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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

6 August 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.