An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0297
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Loading on policy for medical conditions/family history Fees & charges applied Fees & charges applied (life)
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The complaint concerns an amendment to the Complainants' mortgage protection policy in respect of the First Complainant's status as a smoker.

The Complainants' Case

The Complainants have set out their complaint in a submission accompanying their Complaint Form.

Overview of Complaint

The Complainants say that the First Complainant was advised by the Provider at the time of taking out a mortgage protection policy in **August 2017** that he could apply for a 'non-smoker' rate after 12 months of not smoking. The Complainants say that the First Complainant stopped smoking in **August 2017** when they moved into their new home. In **March 2019** (after 18 months), the Complainants say the First Complainant applied for and requested that the Provider apply 'non-smoker' rates to the policy.

The Complainants say the Provider offered non-smoker rates on **13 March 2019**. The Complainants say they accepted the offer and signed and returned a 'Policy Change Request Form' on **20 March 2019**.

The Complainants say that the Provider subsequently refused to implement their offer of **13 March 2019** on medical grounds relating to the First Complainant's 'PSA Blood Count' ("PSA").

The Complainants say the First Complainant's high PSA was disclosed in the original policy application/declaration in **August 2017** and also the fact that the First Complainant was taking medication for a prostrate condition which 'sometimes' can contribute to a high PSA. The Complainants say the Provider requested extra medical tests on the subject of high PSA in **August 2017** to satisfy its concerns. The Complainants say the First Complainant complied with all requests at the time and the Provider, being satisfied, issued a final policy.

The Complainants say that the Provider will not specify the further information it now requires from the First Complainant or his GP in order to satisfy its concerns beyond a vague reference to 'pending further investigations'. The Complainants say the First Complainant and his GP continue to monitor his health condition and PSA, and that the First Complainant is in general good health. The Complainants say the First Complainant's GP has advised that he does not know what further specific actions or investigations the Provider is expecting. The Complainants says there are many medical tests and procedures that could be undertaken but there is no guarantee that the Provider will accept any of these results as conclusive.

Given that the Provider is refusing to clarify what will satisfy their concerns, the Complainants say the situation is in stalemate, in favour of the Provider who is still receiving the higher policy rate payments.

The Complainants say the First Complainant feels the focus has shifted from "proving that he did in fact stop smoking" (which the First Complainant accepts is a reasonable request) to the Provider opening a new vague and open-ended concern in relation to the First Complainant's PSA.

The Complainants say the First Complainant feels that the Provider should not use the initial request to implement a "non-smoker rate" as a mechanism for a completely new medical health review or to re-open a query (PSA) that it has already investigated, accepted and closed. Should the Provider persist in this approach, the Complainants say it may negate any positive initiative to encourage policyholders to stop smoking and may in fact discourage policyholders from pro-actively sharing any change in their lifestyle or medical condition with the Provider for specific purposes on the basis that the Provider may use this information to generally seek to re-open their policy review.

The Complaint

The Complainants say the Provider has unfairly raised a query in relation to the First Complainant's PAS (which it had already raised in **August 2017** and resolved to its satisfaction).

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The Complainants say that the Provider should not be allowed to use a non-smoking review as an entirely new application or opportunity to re-open old queries that were previously closed.

The Complainants say the Provider has communicated in an extremely confusing manner and sometimes directly contradicted itself in the same document, to the point where the First Complainant did not feel the Provider has been fully open and honest in its dealings with this matter. In this respect, the Complainants refer to a letter from the Provider dated **28 August 2019**.

The Complainants request that the Provider be asked to implement the Quote ending 5059 dated **13 March 2019** on the basis that the First Complainant has proven that he has met the requirement (stopped smoking) and that the Provider refund the difference, being €1,600.00.

The Complainants say that any further objection or delay by the Provider is unreasonable and unfair.

In the event that this Office finds that the Provider was allowed to conduct a full policy review, the Complainants say that the First Complainant has no objection to any reasonable requests for further medical tests. However, the Complainants say the Provider needs to be specific in terms of the actions or tests it would like the First Complainant to undertake and close its concerns in relation to PSA as otherwise the tests and the costs of these tests could drag on indefinitely without any conclusion.

The Complainants say that the First Complainant suggests that if the Provider's medical team would communicate directly with the First Complainant's GP or Consultant Urologist and that a 10 to 15 minute constructive conversation might be more helpful and expedient than sending more questionnaires, that may or may not get lost or delayed in the post.

The Complainants say the First Complainant and his medical team are genuinely trying to be open and helpful *"if the* [Provider's] *Medical Team would just get off their high horse and engage in a reasonable manner."*

Timeline of Key Events

The Complainants set out the following timeline of events:

- Early **March 2019**, the First Complainant requested a quotation based on his new "non-smoker" status
- **12 March 2019**, the First Complainant was sent a quotation/new offer based on "non-smoker" rate
- **20 March 2019**, the Complainants signed, accepted and retuned the offer document
- **20 March 2019**, the Complainants also completed and returned a detailed 'Policy change request form'

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- **9 April 2019**, the Provider requested a 'Private Medical Attendants Report' from the First Complainant/his GP
- **7 August 2019**, the Provider advised the First Complainant's GP that a final decision would be postponed until the PSA issue was fully investigated and also noted "no previous investigations". The Complainants say this is confusing because at all times both the First Complainant and his GP were aware of and, monitoring, the First Complainant's PSA. The Complainants say it is unclear exactly what "further investigations" the Provider was asking for.
- **28 August 2019**, new policy offer from the Provider

In respect of the cover letter enclosing the new policy, the Complainants identify the following contradictory information:

The First and Second Complainants are both "non smoker premium rate apply"

and

The First Complainant is "smoker premium rates apply"

In respect of the 'Offer Document', the Complainants refer to the following:

Page 1: The First Complainant's smoker status is noted as "Smoker"

Page 3: The First Complainant is noted as "amended to non smoker rate"

Rates and Costs

The Complainants set out the following rates:

1. **July 2017** (start of policy) €262.28 per month
2. **March 2019** (first non-smoker offer) €125.49 per month
3. **August 2019** (revised 'final' offer) €216.60 per month

The Complainants say that the Provider's failure to implement the €125.49 rate for the period of **March 2019** to **February 2020** has cost €1,641.00 (€125*12).

The Complainants say that the Provider's failure to implement the €125.49 rate for the period of **March 2020** to **February 2032** will cost €19,697.00 (€1641.00*12).

Other Factors

The Complainants say that during **March** to **September 2019**, there were many phone calls and emails between the First Complainant and the Provider's representatives to try to clarify the specific action/information that was required in order to close the matter, which led to great frustration.

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The Complainants say that many of the Provider's letters arrived late, weeks later than the letter head date and some did not arrive at all. The Complainants say that sometimes the Provider would share and communicate by telephone or email and sometimes the Provider would insist on postal communications. The Complainants say that the Provider refused repeated requests from the First Complainant to copy him on correspondence sent to his GP so that the First Complainant could keep things moving.

The Complainants believe that the Provider had an unreasonable and unrealistic expectation in relation to how quickly his GP could respond to queries and that the Provider was often very vague in its requests. The Complainants say the First Complainant's GP has several hundred patients and grew frustrated with the Provider's process and queries. The Complainants say that it did not help that the Provider did not inform the First Complainant when it had requested information from his GP and that it was often only after several weeks that the Provider would inform the First Complainant (when the First Complainant queried the delay). This made it extremely difficult for the First Complainant to engage with his GP in order to get a response to the Provider. On several occasions, the Complainants say that the First Complainant's GP had not received the correspondence. The Complainants say this had a negative effect on the First Complainant's relationship with his GP (which was otherwise excellent) and was a major reason why, in **September 2019**, the First Complainant decided to pause and consider his options.

The Complainants instigated a "poor service request" with the Provider in relation to long delays and extremely poor communication, which the Provider accepted, and offered and paid compensation in the amount of €1,000.00. The Complainants advise that the compensation was strictly in relation to the poor customer service request and the original query/request for non-smoker rates was still open.

The First Complainant provided a further submission under cover of email dated **27 August 2020**. In this submission, the First Complainant says the Provider always breaks out of the *"smoking related premium €amount"* on its policies and quotes. The First Complainant submits that the Provider is showing it is insuring two clear and separate risks, independently, as follows:

A. The cost of normal insurance having accessed the policyholder's status

B. Additional cost consequence (premium) specifically tied to being a smoker

The First Complainant says A can be claimed in the event of the death of either policyholder and B can be removed if the policyholder proved they stopped smoking. The First Complainant submits that there is nothing, therefore, to prevent the Provider from reducing the policy by the B amount and there is no basis for the Provider to attempt to link A and B because the Provider has, itself, quoted them separately. The First Complainant contends that the Provider cannot have it both ways.

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The First Complainant contends that the Provider accepted and quoted for the 'Normal Risk' under A above, when the policy was taken out. The First Complainant says this cannot change or avoid the Provider's obligations. The First Complainant says this is a fundamental principle of such policies and some policyholders will be a bad risk and some will be a good risk, that is the industry. The First Complainant says that his stopping smoking was the only change and to remove the smoking premium was the only request. The First Complainant says that Provider and Government policy encourage people to stop smoking and an incentive is to offer to remove the 'smoking premium' (without conditions).

The First Complainant states that the Provider's insistence that his application to remove the separately quoted smoking premium should trigger a full underwriting review effectively means the Provider is saying that all bets are off and that the Provider can take this opportunity to re-quote a completely new policy based on new data (for a now older customer) and neatly escape their liabilities for any pre-existing condition (known or unknown) at the time the policy was first taken out.

The First Complainant sets out the following scenario:

> *"**Scenario:** Congratulations we will remove the €100 Smoking Premium but the good news is this new full underwriting review gave us the opportunity to discover you have terminal cancer that was not evident 3 years ago when you first took out the policy and we are going to increase your base policy rates based on that new knowledge (or refuse to insure you as you will likely die next week …) **Fair ??**"*

The First Complainant says that as the consumer will always be older then, statistically (older in the population generally meaning poorer health) a review such as this will always result in a negative financial outcome for the consumer and a positive outcome for the Institution.

The First Complainant submits that this is a fundamentally an unfair and unreasonable position for any financial institution to take with a consumer. The First Complainant says that:

> *"the Institution may point to their t's&c's as a defense, I have read the t's&c's and even I did not understand that their t's & c's meant "full underwriting review" would be required."*

The First Complainant says:

> *"I think ask 10 lawyers & you won't get 100% consistency in their interpretation – How then is the average consumer supposed to make an informed decision on this point. It is reasonable to say –*
>
> ***If I stop smoking I should be entitled to stop paying the premium amount that hat*** (sic) ***specifically relates to my status as a smoker.***

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> *T's & c's should not be written for the purpose of obfuscation or to escape/avoid/restructure the basic liabilities of the institution - they should clarify t's & c's in clear language for the consumer."*

On the second page of this submission, the First Complainant addressed the *ex gratia* payment of €1,000.00 that was accepted from the Provider. The First Complainant says that the *ex gratia* payment was only accepted in respect of the poor customer service experienced up to that point and was not in full and final settlement of the complaint. The First Complainant cited the following passage from Provider's letter of **3 September 2019**:

> *"I would like to offer you an ex gratia payment of €1000 euros in recognition of the delay, lack of clear communication and inconvenience you have experienced."*

The Provider's Case

The Provider says that the Complainants met an Insurance and Investments Manager on **5 May 2017**. The Provider says the Complainants were in the process of applying for a mortgage and wished to consider options for life cover benefit. The Provider says the Insurance and Investments Manager completed a personal review with the Complainants during the meeting. Based on the information provided, it was recommended that the Complainants consider a particular policy. The Provider says the Insurance and Investments Manager provided a letter stating why she felt such a policy would be most suitable for them. The Provider says the letter stated that it, together with the financial plan, important information and plan of action formed their statement of suitability. The Provider says the Complainants signed the letter to confirm that they agreed with the recommendation made and that they wished to take out the recommended policy.

The Provider says the Insurance and Investments Manager completed a policy application form with the Complainants during the meeting and it was confirmed on the application form that the Complainants wished to take out the policy with life cover of €460,000.00 on a joint life basis, with cover to decrease over a term of 15 years. At the time the application form was completed, the Provider says the First Complainant was a smoker. The Provider says the policy went into force on **26 July 2017** following receipt of confirmation from the assignee that the mortgage cheque had issued on that date. The Provider says the original policy documentation was issued to the assignee on **28 July 2017** and that a policy pack was also issued to the Complainants on **28 July 2017**, which consisted of a policy schedule, policy conditions and an important information document.

On **13 March 2019**, the Provider says the First Complainant telephoned it to inform the Provider that he was now a non-smoker. The Provider says it issued a quotation (ending 8059) indicating what premiums could be, based on non-smoker rates if certain assumptions were met and that it also issued a 'Policy Change Request form' to the Complainants on **13 March 2019**.

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The Provider says a Policy Change Request form is required to be completed if a policyholder wishes to change status on an existing policy to non-smoker and an application to do so involves collecting up-to-date medical details and underwriting.

The Provider says the quotation outlined the monthly premium that was being paid under the policy at the time of €264.90 per month (including 1% Government Levy). The Provider says section 2 of the quotation set out the effect of amending the First Complainant to non-smoker rates if his application was accepted. If the application was accepted and not subject to loading based on medical evidence at the time, the Provider says the revised premium was quoted as being €126.74 per month (including 1% Government Levy) if the change were to take effect from **26 March 2019**. The Provider says the quotation also set out a number of 'Assumptions and Information' which included the following:

> *"This quotation has been prepared and issued on the basis of the information provided to us. The details and assumptions contained in the quotation will be impacted if there is any change to the information or if the information provided was incorrect or incomplete."*

The Provider says section 3 of the quotation highlighted the important note to the Complainants which included the following statement:

> *"Policy changes are subject to the Policy Conditions and Policy Schedule. The benefits which your Policy provides and the circumstances in which they are payable are set out in the Policy Conditions, the Policy Schedule and any subsequent amendments or endorsements that may apply …"*

The Provider says the Complainants were invited to complete the Policy Change Request form if they wished to apply to change their policy. As referred to earlier, the Provider says the Policy Change Request form is a form that existing policyholders are required to complete when they are making certain changes to their policy.

Section 6 of the Policy Change Request form, the Provider says, explains that:

> *"sections 8 – 10 inclusive must be completed if the policy change request includes any of the following:*
>
> - *addition of a new benefit*
> - *addition of a new life assured*
> - *increase in the amount of cover on an existing benefit (where the Life Events Option does not apply)*
> - *extension to the policy term (where the Medical Free Conversion Option or Life Events Option do not apply)*
> - *amending smoker status to non-smoker"*

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The Provider says sections 8 – 10 inclusive seek up-to-date medical information from policyholders as the changes above involve underwriting.

Section 7 of the Policy Change Request form, the Provider says, highlights the following:

> *"If you proceed with the alteration, the policy will be based on the information provided:*
>
> - *as set out on this form containing your application details*
> - *as set out in any other form related to your application*
> - *as set out in any communication from you notifying us of any changes required in advance of the alteration coming into effect*
> - *as set out in any questionnaire completed by you or by a medical examiner and signed by you, and*
> - *by you in any tele-interview you compete"*

The Provider then states, as follows: *"Which of the above applies depends on the method up to date medical details are provided."*

In this case, the Provider says the Complainants completed the Policy Change Request form on **20 March 2019** which was returned to the Provider on **22 March 2019**. By completing this form and signing the declarations (section 11), the Provider says the Complainants confirmed and acknowledged the following declarations:

> *"I declare that: …*
>
> - *I have read and understand the replies to all questions in this policy change request form and confirm that all statements herein and any statements written at my request or in any questionnaire completed by me or by a medical examiner in connection with this application signed by me are true and complete and shall form the basis of the proposed contract.*
>
> *I authorise you to seek:*
>
> - *any information from any doctor now or in the event of a claim who has at any time attended me and I authorise them to give* [the Provider] *such information. I agree this authority will remain after my death …*
>
> *I understand that …*
>
> - [The Provider] *reserves the right to test declared non-smokers for nicotine."*

The Provider says the Policy Change Request was passed to its medical underwriters for assessment.

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The Provider says that alterations are subject to underwriting as set out in section 2.3 of the policy conditions, which state:

> *"… Any amendments outside of Conditions 2.1 and 2.2 above will be subject to underwriting and acceptance by the Company.*
>
> *Where a request for such an amendment is accepted by the Company, this will result in your Premium being re-calculated to take account of the changes being made and will be confirmed by an endorsement to the Policy."*

Following assessment of the Policy Change Request form, the Provider says a Private Medical Attendant's Report ("PMAR") was requested from the First Complainant's GP and also that the First Complainant have a mini screening and cotinine test carried out. The Provider says a completed PMAR was received on **16 April 2019**. The Provider says the First Complainant completed the mini screening and cotinine test on **29 April 2019**, the results of which were received on **30 April 2019**.

Based on the medical information provided in the PMAR, the Provider says it wrote to the Complainant's GP on **31 May 2019**. The Provider says it asked the First Complainant's GP to arrange for a urine microscopy and an up-to-date PSA test to be carried out on the First Complainant. The Provider says it wrote to the First Complainant on **31 May 2019** and asked that he make contact with his GP to arrange an appointment to have the tests carried out.

Following receipt of test results on **19 July 2019**, the Provider says it was identified that since the policy was taken out, the First Complainant's PSA had materially increased. In light of this information, the Provider says it initially determined to postpone the decision on altering the policy as requested until further investigations were carried out and that it wrote to the Complainants on **25 July 2019** to inform them of this.

On **7 August 2019**, the Provider says the First Complainant telephoned following receipt of the above letter and was unhappy with its contents and wanted to understand why his request to amend to smoker status was taking so long.

On **28 August 2019**, having assessed the information received to date, the Provider says it wrote to offer special terms to the Complainants in light of the medical information received. The Provider says it offered non-smoking rates with a loading of +50% to be applied to the First Complainant. The Provider says its letter advised that the revised monthly premium would be €218.77 per month (including 1% Government Levy) if accepted. The Provider says it wrote to the First Complainant's GP on **4 September 2019** outlining the reason for applying the additional loading.

In respect of the loading applied to the above non-smoking rate, the Provider says it was applied for medical reasons as the First Complainant's medical details had changed from the time the policy was initially taken out.

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The Provider says it does not believe the terms offered to be unfair, and that it is quite usual and industry practice for underwriting to apply as part of a request to take into account that a policyholder is no longer a smoker.

As part of the Provider's investigation into a complaint made by the First Complainant on **7 August 2019**, the Provider says a Final Response letter issued on **3 September 2019**. In accepting there was some delay on its part, the Provider says it offered €1,000.00 which was later accepted by the Complainants in full and final settlement of their complaint. The Provider says the Complainants were asked to sign an acceptance form, which was emailed to them on **3 September 2019**. The Provider says the Complainants signed the acceptance form on **2 September 2019** and emailed it to the Provider on **4 September 2019**. The Provider says the €1,000.00 was paid into the account nominated by the Complainants on **5 September 2019**.

The Provider says the indicative quotation provided to the Complainants on **13 March 2019** reflected a revised premium if €126.74 per month (including 1% Government Levy), based on the First Complainant being amended to a non-smoker. The Provider says the quotation provided was for illustrative purposes only and was not guaranteed.

The Provider says it was clear that the application to change was subject to underwriting and acceptance by the Provider. The Provider says the Complainants completed and signed the Plan Change Request form and in doing so, acknowledged that the Provider may seek medical information as part of the alteration process.

The Provider says that, at the date of its Complaint Response, the Complainants have not signed and returned the special terms letter issued on **28 August 2019**. As a result, the First Complainant remains noted as a smoker under the policy and the monthly premium remains as €264.90 (including Government Levy). The Provider says the revised premium was valid for 30 days and had the Complainants accepted and signed the revised terms offered on **28 August 2019**, it would have implemented the revised monthly premium of €218.77.

The Provider says it remains open to the Complainants to apply at any time during the term of the policy to amend the smoker status. As always is the case, the Provider says, an amendment of this nature is subject to underwriting and acceptance by the Provider. The Provider says that if the Complainants would like to proceed with amending the First Complainant's smoker status, it would be happy to arrange for a new indicative quotation and Plan Change Request form to be issued. The Provider says that as the previous Plan Change Request form was completed on **20 March 2019**, a new form would need to be completed and the application would be subject to underwriting and acceptance by the Provider.

When a policy is applied for, the Provider says it assesses the risk as a whole based on medical information available at the time and activities, such as smoking, that can adversely impact the health of a life assured.

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The Provider says smoker status is not dissimilar to taking into account other medical conditions that may apply at the time of application. If, for example, an applicant had been diagnosed with a lung condition at the time of application, this the Provider says, depending on the nature and severity of the condition, would likely involve loading.

If at a later date the applicant recovered from the lung condition, it is open to the applicant to apply for cover at a later date in the hope cover would be cheaper. In assessing an application in these circumstances, the Provider says it would re-assess the risk as a whole to see if the overall risk had reduced. If this was the case, the Provider says it is reasonable to expect the premium to be lower taking into account the reduced risk, although age may have since increased and this is also a factor that is taken into account. The Provider says this would be similar to the insured applying to take out a new policy with a new insurer who would be underwriting the risk based on medical data provided at the time. Once a policy is taken out however, the Provider says the terms agreed at that time and the premium agreed will not change unless the applicant applies for a change (such as ceasing to be a smoker) to be taken into account.

The Provider says it is also important to mention that in some cases policyholders are advised to cease smoking as a result of a diagnosis of another condition. In such cases, ceasing to smoke does not always mean a reduction of the risk for insurers and indeed, the Provider says, may involve a greater risk. Ceasing to smoke after lengthy periods of smoking can also give rise to medical conditions. The Provider says these are just some of the reasons why an insurer must re-assess its risk as a whole.

The Provider says that while it affords the opportunity to existing policyholders to apply for smoker rates to be dis-applied when an insured ceases to smoke, as set out in the policy conditions, it involves full underwriting at the time so that the Provider can re-assess the risk at that time. The Provider says it was never suggested to the First Complainant that he could apply to remove his smoker status without underwriting being involved.

The Provider says it is also open to the First Complainant to apply to another insurer for life cover which takes account of the fact that he is now a non-smoker. The Provider says it believes that such an application would involve the First Complainant submitting up-to-date medical details and would involve full underwriting.

The Provider says it hopes that the Complainants understand that it must re-assess its risk if a fundamental change to the policy is requested and that his particular policy is flexible insofar as it permits changes on an existing policy, but it does involve a re-assessment of risk at the time as set out in the policy.

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The Complaints for Adjudication

In the submission accompanying their Complaint Form, the Complainants have expressed dissatisfaction in respect of the level of customer service received from the Provider following a request to amend their policy in **March 2019**. It appears that a formal complaint was received by the Provider around **7 August 2019** in respect of the policy amendment, which included a complaint in respect of the level of customer service received.

In the Final Response letter dated **3 September 2019**, the Provider offered:

> *"an ex gratia payment of €1000 in recognition of the delays, lack of clear communication and inconvenience you have experienced."*

Arising from this offer, the Complainants signed an 'Acceptance Form' dated **2 September 2019**, in the following terms:

> *"* ***Agreement***
>
> *I wish to accept the ex gratia offer of €1,000 for the breakdown in service I received during my recent dealings with the Company."*

In light of the Complainants' acceptance of the *ex gratia* payment in respect of the breakdown in service received from the Provider, I consider that any complaint concerning this aspect of the Provider's conduct to be resolved and, therefore, will not be examined as part of this complaint.

Accordingly, the complaints are that the Provider:

> Misinformed the Complainants in **August 2017** and **March 2019** that they could apply for reduced non-smoker rates on their policy in respect of the First Complainant following 12 months of not smoking; and
>
> Used a non-smoking review as a means of re-opening old queries that were previously closed.

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 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.

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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 4 August 2021, outlining my preliminary determination in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

In the absence of additional submissions from the parties, within the period permitted, I set out below my final determination.

The Provider's Complaint Response

By letter dated **23 November 2020**, this Office furnished the Provider with a Summary of Complaint which comprised a Schedule of Questions and a Schedule of Evidence Required. This letter requested that the Provider provide as response to the complaint within 20 working days. The letter also drew the Provider's attention to ***section 59*** of the ***Financial Services and Pensions Ombudsman Act 2017*** in respect of its obligation to respond to the complaint.

By email dated **21 December 2020**, the Provider advised that it was in the process of preparing its response to the complaint and requested a further 10-15 working days in which to provide its response. This Office responded to the Provider on **23 December 2020** and, noting that the Complainants wanted to progress matters, requested the Provider's response on or before **8 January 2021**.

Not having received the Provider's Complaint Response or any further communication from the Provider for that matter, this Office emailed the Provider on **26 January 2021** requesting an update. By email dated **29 January 2021**, the Provider apologised for the delay in responding, advising that it was *"experiencing some ongoing system issues which resulted in the undue delays."*

Following a brief email exchange, on **5 February 2021**, the Provider requested a further five working days within which to deliver its Complaint Response, which was granted by this Office on **9 February 2021**. However, the Provider's Complaint Response was not received within the requested time period and, disappointingly, the Provider did not contact this Office to request a further extension of time or seek to offer an explanation or apology for the delay. On **23 February** and **2 March 2021**, this Office emailed the Provider requesting an update. Disappointingly, the Provider did not respond to either of these emails.

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This is most unacceptable conduct by the Provider and a matter which I will take up separately with the Provider.

By letter dated **8 March 2021**, this office wrote to the Provider expressing disappointment at the absence of a formal response to the complaint from the Provider. On an exceptional basis, the Provider was granted an extension of time to **16 March 2021** to deliver its formal response to the complaint.

By email dated **9 March 2021**, the Provider delivered its Complaint Response. Following this, this Office emailed the Provider on **12 March 2021** noting that one of the Provider's email attachments was missing. The Provider's complete submission was not received until **16 March 2021**.

The First Complainant delivered a response to the Provider's Complaint Response on **2 April 2021**. This Office forwarded the First Complainant's submission to the Provider on **6 April 2021**, requesting that it make any additional observations within 10 working days.

As a response was not received to this email, this Office emailed the Provider on **23 April 2021** advising that the matter would progress to adjudication. By email of the same date, the Provider requested an extension of time to respond to the First Complainant's submission. This Office granted a five day extension on **26 April 2021**. However, the Provider did not deliver its response within this timeframe. This Office emailed the Provider on **6 May 2021** requesting an update. By letter dated **17 May 2021**, this Office wrote to the Provider expressing disappointment with the level of engagement of the Provider with the complaint and granted a final five day extension within which to respond to the First Complainant's submission. The Provider responded to the First Complainant's submission on **21 May 2021** and apologised for the delay in responding.

Evidence

The Complainants signed a Statement of Suitability dated **10 May 2017** in respect of a particular policy. At the top of the second page of this document, it states, as follows:

> *"Subject to certain conditions, you can vary the level and type of cover from time to time to suit your changing circumstances."*

By letter dated **28 July 2017**, the Provider wrote to the Complainants enclosing their 'Policy Schedule', 'Policy Documents' and an 'Important Information Notice'. In this letter, the Complainants were invited to study these documents carefully to ensure the policy met their needs and was to their satisfaction.

In respect of the 'Policy Conditions', policy amendments are dealt with at Section 2 of Section B. Section 2 comprises three subsections. Section 2.1 relates to a 'Medical-Free Conversations Option' which, according to the Complainants' policy schedule, is not operative on their policy.

/Cont'd…

Section 2.2 relates to a 'Life Events Option' which provides a policyholder with the option of increasing the 'Lump Sum on Death Benefit'. Of relevance to the present complaint is section 2.3, which states, as follows:

> *"**2.3. Other Policy Options***
>
> *Outside the terms set out in Conditions 2.1 and 2.2 above, at any stage throughout the Term of Cover you may request to amend the Term of Cover or the amount of Protection Benefits. Any amendments outside of Conditions 2.1 and 2.2 above will be subject to underwriting and acceptance by the Company.*
>
> *Where a request for such an amendment is accepted by the Company, this will result in your Premium being re-calculated to take account of the changes being made and will be confirmed by an endorsement on the Policy."*

In the 'Important Information' document, it states, on page 4, in respect of policy amendments, as follows:

> *"*[I]*t is open to you at any time to seek to amend the terms of your policy or the amount of benefits provided under your policy. You can amend the term of the policy. Varying the terms in this manner will be subject to medical and financial underwriting by* [the Provider] *and a variation of the terms will result in your premium being re-calculated."*

The Provider returned a call to the First Complainant on **13 March 2019**. During the course of the conversation, the First Complainant advised that the Complainants were *"going through a little bit of a tightening in the budget"*. Following this, the First Complainant indicated that the policy the subject of this complaint was somewhat expensive and queried if the Provider could *"have a look at it"*. In this respect, the First Complainant advised that he was a smoker when the policy was incepted and that he had been a non-smoker for approximately two years. The Provider's agent advised that keeping everything the same on the policy and taking the First Complainant's smoking status into consideration, the policy premium would reduce to €126.74. The Provider's agent indicated to the First Complainant that smoking status would be something that would cause premiums to be higher. The First Complainant queried what he would need to do in order to have the smoking status on his policy updated. In response to this, the Provider's agent explained that he would issue a quote which the Complainants would have to sign and that the Complainants would also have to complete a Plan Change Request Form. The Provider's agent then explained that *"removing the smoking status is something that just has to be reviewed by the underwriting team"* but if the First Complainant had not had any nicotine products or been smoking in the previous year or two, the First Complainant should be fine. The Provider's agent advised that when the Complainants returned the relevant documentation, it would be reviewed.

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By letter dated **13 March 2019**, the Provider wrote to the Complainants, as follows:

> *"Thank you for your enquiry about the above policy. I am pleased to enclose the information that you requested.*
>
> *Please sign and return the enclosed Policy Change Request form within 30 days, if you wish to change your policy in line with the enclosed quotation (*[number ending 5059]*). After we receive your signed request we will review and contact you if any further information is needed. As the policy is jointly owned, the request must be signed by both policyholders. A letter of authority from your assignee* [Assignee] *may also be needed. Once we have all required information we will make the change to your policy.* […]*."*

The quotation enclosed with this letter states, beginning on page 2, as follows:

> ***"2. [Policy] QUOTATION***
>
> *Please see below the likely effect the proposed changes will have on the policy.*
>
> ***REVISED REGULAR PREMIUM DETAILS***
> ***Effective Date*** ***Alteration***
>
> *26/03/2019* *Based on the changes below, your revised premium will be €125.49 per month* […]
>
> ***REVISED SMOKER STATUS***
>
> *Effective Date: 26/03/2019*
> [The First Complainant] *has been amended to non smoker rates*
>
> ***Assumptions & Information***
>
> ***1.*** *This quotation has been prepared and issued on the basis of the information provided to us. The details and assumptions contained in the quotation will be impacted if there is any change to the information or if the information provided was incorrect of incomplete.*
>
> […]
>
> ***3. IMPORTANT NOTES***
>
> […]
>
> *Please note that* [this quotation] *is produced for illustration purposes only and while every care is taken to ensure that the information is accurate and clear, no responsibility is taken for errors or omissions.*

/Cont'd…

This quotation does not confer any rights. Policy changes are subject to the Policy Conditions and Policy Schedule. The benefits which your Policy provides and the circumstances in which they are payable are set out in the Policy Conditions, the Policy Schedule and any subsequent amendments or endorsements that may apply. […].*"*

On page five, it states, as follows:

*"**POLICY CHANGE REQUEST***

Quotation number: […]

Policy number: […]

Please amend my/our policy in line with the revised benefits and/or premiums as set out in the quotation number above. […].*"*

The Complainants signed the quotation form which is dated **20 March 2019**. The Complainants also completed and signed a 'Policy Change Request Form' dated **20 March 2019**. Section 6 of this Policy Change Request Form is titled 'Underwriting method' and states that an applicant is required to complete sections 8 to 10 of the form if, for instance, an application is being made to amend smoker status to non-smoker. Section 7 of the form contains a 'Material facts notice and other important information'. At the fourth paragraph of this section, it states, as follows:

"If you proceed with the alteration, the policy will be based on the information provided:

- *as set out in this form containing your application details*
- *as set out in any other form related to your application*
- *as set out in any communication from you notifying us of any changes required in advance of the alteration coming into effect*
- *as set out in any questionnaire completed by you or by a medical examiner and signed by you, and*
- *by you in any teleinterview you complete.*

[…]

We may not necessarily contact your doctor(s). […] *We may ask you to have a medical examination with a nurse or doctor.* […].*"*

A number of declarations relating to the application to amend the policy are set out in section 11 of the form.

/Cont'd…

In particular, I note the following declarations:

> *"**I authorise you to seek:***
>
> - *any information from any doctor now* […] *and I authorise them to give* [the Provider] *such information.* […]
>
> ***I understand that:***
>
> - *the proposed policy changes will not come into force until* [the Provider] *has accepted me* […]*."*

The Provider wrote to the Complainants on **9 April 2019** to inform them that it had written to the First Complainant's GP and requested that he complete a PMAR.

During a telephone conversation on **26 April 2019**, the Provider's agent explained to the First Complainant that the requested changes to the policy had not gone into effect yet as they were still being underwritten.

The Provider's agent apologised for the delay in assessing the application and also advised that any premium adjustment would be backdated.

It appears that between **April** and **July 2019**, certain correspondence was issued to the First Complainant's GP and that the First Complainant also underwent certain medical assessments.

The First Complainant telephoned the Provider on **15 July 2019** seeking an update in respect of the status of policy change request.

Following this, in an undated letter [which appears to have issued around **25 July 2019**], the Provider wrote to the Complainants, stating:

> *"Thank you for your recent request to amend your* […] *Life Care Plan seeking to amend the smoker status on this policy.*
>
> ***Following careful consideration by our Chief Medical Officer, we regret that we are unable to offer* [the First Complainant] *non-smoker rates pending outstanding medical investigations.*** […]*."*

The Provider wrote to the First Complainant's GP on **7 August 2019** to advise that it was postponing a final decision on the First Complainant's application for cover due his *"benign hypertrophy with recent PSA increasing from 1.63 in 2017 to 3.64 in June 2019 noting no previous investigations were done."*

The Provider retuned a call to the First Complainant on **12 August 2019**. During this conversation the First Complainant raised the point of the Provider investigating matters which were not related to his smoking status, such as his PSA.

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By letter dated **28 August 2019**, the Provider offered to amend the Complainants' policy in the terms set out in the enclosed 'Special Terms Letter.' In respect of the First Complainant, these terms were, as follows:

> *"•* ***€419,060.00 Lump Sum on Death with expiry date 26th July 2032***
>
> - *Please note an extra premium loading of +50% applies for medical reasons.*
> - *Non-smoker premium rates apply.*
> - *Please note the Life Events Option will not apply."*

In response to a formal complaint raised by the Complainants in early **August 2019**, the Provider issued a Final Response letter dated **3 September 2019**, responding to each aspect of the complaint, in relevant part, as follows:

> *"1. The amendment was subject to full medical underwriting*
>
> *I confirm that any request to amend a smoker status on a policy will be subject to our underwriting process. You might note that the Plan Change Request sets out in Section 6 Underwriting Method that you were required to complete sections 8-10 if your proposed amendment was changing smoker status. The information in these sections informs our medical underwriting and risk assessment of your proposed amendment.*
>
> *I would also direct you to section 7 Material facts notice and other important information, of your Plan Change Request Form which I enclose for your records. This states the following:*
>
> […]
>
> *Full underwriting is also provided for in section 2.3 of your policy conditions which states:*
>
> […]
>
> *I further confirm that when any person requests to have their status amended from smoker to non-smoker then that request is subject to full medical underwriting, and not just conditions in relation to smoker status, in line with the terms and conditions of your application and policy conditions which I have enclosed for your records. Please accept the Company's apologies for any lack of clarity in our review of the smoker status on your policy. The review of your smoker status cannot be done independently of your full medical records.*
>
> *2. Communications between our underwriting department and* [the First Complainant's] *medical practitioner*
>
> […]

/Cont'd…

3. Time taken to underwrite the amendment

[…]

4. The Company's underwriting decision to offer rated non-smoker terms to [the First Complainant]

Our underwriters have advised that on examination of the medical evidence which we retain on file and have received as part of your plan change request, that while we will offer [the First Complainant] *non-smoker premiums these will be rated at 50% due to medical conditions as per the correspondence issued to you on 28 August 2019. I have asked our underwriting department to write to your medical practitioner in the coming days to explain the reasons for the rated smoker terms.*

I further note your dis-satisfaction that the special terms states:

Please note the Life Events Option will not apply.

I can confirm that this option has not applied to your policy at any time since inception […]*."*

Analysis

The Complainants signed a policy application form dated **10 May 2017**. In the context of the present complaint, I note that on page 4, the First Complainant answered 'Yes' to the following question:

"Have you smoked cigarettes, cigars or pipe tobacco in the last 12 months?"

As part of the Provider's review/assessment of the Complainants' circumstances, the Provider's Insurance and Investments Manager appears to have prepared a 'Case Report' dated **5 May 2017** and a 'Financial Plan' dated **5 May 2017**. I also note that the Complainants signed a 'Plan of Action Report' dated **10 May 2017**. In this report, the Complainants acknowledged, amongst other matters, that the information contained in the Financial Plan was accurate. Having considered these documents, I note that there is no mention of, or reference to, the Complainants being eligible for, or that they could apply for, non-smoker rates if the First Complainant was a non-smoker for 12 months.

I also note that the documents which issued to the Complainant around this time clearly communicated an entitlement to vary or amend the policy at any time. In the Statement of Suitability dated **10 May 2017**, I note it is stated that *"you can vary the level and type of cover from time to time to suit your changing circumstances."* At section 2.3 of the Policy Conditions issued to the Complainant on **28 July 2017**, it states that *"at any stage throughout the Term of Cover you may request to amend the Term of Cover or the amount of Protection Benefits."*

/Cont'd…

In the Important Information document, which was also issued to the Complainants on **28 July 2017**, it states that *"it is open to you at any time to seek to amend the terms of your policy …."*

When the First Complainant spoke with the Provider's agent on **13 March 2019**, he queried, in essence, whether the Provider could offer a better premium in respect of the Complainants' policy. In this respect, the First Complainant advised that *"one significant thing that has changed"* was his smoker status.

Following a brief discussion of the reduction in rates applicable to non-smoker status, the First Complainant enquired as to how these rates could be applied to the Complainants' policy. In response to this, the Provider's agent outlined the relevant process.

Having considered this telephone conversation, I note that the purpose of the call was to seek to reduce the amount the Complainants were paying in respect of their policy for budgeting purposes and because the policy premium was considered to be too expensive.

I also note that the First Complainant was not seeking to reduce the premium based on any previous assurances nor did he reference any such assurances, in particular from **August 2017**, that the Complainants could apply for reduced non-smoker rates in respect of the First Complainant following 12 months of not smoking.

As can be seen from the Complainants' application form, the question asked in respect of smoker status was whether either Complainant smoked in the previous 12 months. In the Policy Change Request Form, the Complainants were asked at question 2 in section 10 on page 8, which of the listed options best described their smoking habits. In response to this, the First Complainant chose: *"I used to smoke but stopped over a year ago"*, stating that he stopped smoking in **August 2017**.

In a submission dated **2 April 2021**, the First Complainant refers to a:

> *"discussion that took place with* [Insurance and Investments Manager] *regarding the opportunity for me to <u>return to standard non smoking rates, after 12 months, providing I could prove I had not smoked, via medical exam, after 12 months,</u>"*.

I note that the First Complainant's reference to such a discussion would appear consistent with the above-cited passages regarding policy amendments/variations and the criteria surrounding eligibility for non-smoker rates as indicated by the above questions in the application form and Policy Change Request Form (being a non-smoker for 12 months).

While eligibility for non-smoker rates appears to be aligned with an applicant/policyholder being a non-smoker for a period of approximately 12 months, I cannot see any evidence to suggest that the Complainants were in any way prevented from applying for reduced non-smoker rates or that the Complainants were mis-informed in either **August 2017** or **March 2019** as to whether they could apply for non-smoker rates.

/Cont'd…

The Complainants contend that in assessing the policy change request in respect of the First Complainant's smoker status, the Provider should not be permitted to engage in a full review of the First Complainant's health or re-visit matters previously reviewed during Complainants' initial policy application. The Complainants also contend that the Provider's assessment of the policy change request should be confined to matters relating to the First Complainant's smoker status and should not involve a broader assessment. In response, the Provider has set out the basis for conducting a full underwriting review when a policy change request is made.

In particular, the Provider says that for policy amendments it is necessary to re-assess risk as a whole to determine whether overall risk has changed.

In terms of policy amendments, I note in the Statement of Suitability it is stated that an application to vary the policy would be *"Subject to certain conditions"*. At section 2.3 of the Policy Conditions, I note it is stated in plain and clear language that amendments outside of sections 2.1 and 2.2 *"will be subject to underwriting and acceptance by the Company."* The Important Information document states that *"*[v]*arying the terms in this manner will be subject to medical and financial underwriting …."*

During the telephone conversation on **13 March 2019**, the Provider's agent informed the First Complainant that the amendment to his smoker status would be reviewed by the Provider's underwriting team and that when the Complainants' returned the relevant documentation, these documents would be reviewed.

Under cover of letter dated **13 March 2019**, the Provider issued a quotation in respect of an amendment to the First Complainant's smoker status. At section 2, the quotation outlined *"the likely effect"* that the *"proposed changes"* would have on the Complainants' policy. At section 3, the Complainants were advised that the quotation was for illustrative purposes and that it did not confer any rights. This section of the quotation further advised that policy changes were subject to the Policy Conditions and Schedule.

In terms of the quotation issued to the Complainants on **13 March 2019**, I accept that it was reasonably clear from this quotation that it was not intended to constitute a legally binding offer to amend the policy and something which was capable of being accepted by the Complainants. It is my opinion that by signing the 'Policy Change Request' section on page five of the quotation, the Complainants were submitting a request to the Provider to amend their policy in line with the revised benefits contained in the quotation. Further to this, the quotation must be viewed in the context of the passages cited above as contained in the documentation issued to the Complainants in **May** and **July 2017** regarding policy amendments and the fact that the quotation was also accompanied by a Policy Change Request Form.

In respect of the Policy Change Request Form, I note this form set out the information on which the amendment would be based (at section 7); requested detailed information in respect of the Complainants' health (at section 10); and stated that the proposed policy changes would not come into force until accepted by the Provider (at section 11).

/Cont'd…

It is also indicated in section 7 and section 11 that the Provider may seek to contact the Complainants' medical practitioners or have the Complainants attend medical assessments.

While the Provider's agent indicated during the telephone conversation on **13 March 2019** that as the First Complainant had not smoked or used any nicotine products in the previous two years that his application should be fine, the First Complainant was nonetheless advised that the application would have to be reviewed by the Provider's underwriting team.

In circumstances where I am satisfied that it was open to the Complainants to apply for an amendment to their policy based on a change in smoker status, I do not consider that this necessarily means the Complainants are automatically or immediately entitled to such an amendment to their policy on an unqualified basis. Accordingly, having regard, in particular to section 2.3 of the Policy Conditions, but also the documentation issued to the Complainants in **May** and **July 2017** and in **March 2019**, and the First Complainant's conversation with the Provider's agent on **13 March 2019**, it is my view that an amendment of the First Complainant's smoker status was subject to underwriting and acceptance by the Provider.

On considering the documentation issued to the Complainants, I note that the Provider did not agree or indicate that an assessment of a policy change request would be confined exclusively to an assessment of matters related only to the specific amendment requested, in this instance, by reference solely to the First Complainant's smoker status, health conditions associated with smoking or those parts of the First Complainant's anatomy potentially or likely affected by smoking. I also note that the Provider did not agree or indicate that an assessment of a policy change request would not entail a full or comprehensive assessment of the First Complainant's medical health.

Having reviewed the language of the documentation outlined above, I do not accept that the basis on which a policy change request would be assessed is necessarily restricted or confined in such a manner - as contended by the Complainants. It is my opinion that an assessment which takes place on foot of a policy change request allows for a broad assessment and allows the Provider to engage in a full or comprehensive assessment of the First Complainant's medical health, regardless of whether this means reviewing matters previously considered as part of the Complainants' original application.

As the purpose of the Provider's assessment was to ascertain the risk associated with providing cover to the Complainants in light of the First Complainant's non-smoker status, I accept that it was reasonable for the Provider to carry out an assessment of the First Complainant's overall medical health and not only by reference to matters necessarily connected with smoking. Further to this, I do not consider that the Provider used this as an opportunity to unreasonably or unfairly re-assess or re-visit matters previously assessed at the time of the Complainants' original application or to assess or review matters relating to the First Complainant's health generally.

/Cont'd…

On the contrary, I would consider it unfair and unreasonable to expect the Provider to assess the First Complainant's medical health by reference only to his smoker status and to require the Provider to ignore or exclude any matters that would have a bearing or potential bearing on risk that were not directly or likely related to the First Complainant's smoker status.

Following the Provider's assessment, it offered reduced non-smoker rates in respect of the First Complainant subject to a +50% loading. In the First Complainant's submission dated **2 April 2021**, he states, as follows:

> *"There is no rationale or justification offered for the +50%. It was a sham to give with one hand and take back with the other."*

In a submission dated **21 May 2021**, the Provider says it accepts that the assessment on whether to apply a loading was solely determined by it following the assessment of medical details received at the time of the policy change request. The Provider further says the justification and rational for the +50% loading was because the First Complainant's PSA levels increased since the policy was taken out. The Provider also refers to the following extract of a letter sent to the First Complainant's GP on **3 September 2019**:

> *"We initially postponed a final decision on* [the First Complainant] *because of his recent PSA result which had increased materially since the previous test. Having re-considered and taken into account that no referral is planned we are now prepared to offer life cover at an increased premium in respect of the raised PSA …"*

In a submission dated **24 May 2021**, the First Complainant stated, as follows:

> *"It is also not reasonable for* [the Provider] *to use a PSA score (or any other medical data) as a reason for premium loading, without at least offering me some reasonable way of addressing their concerns. They did not do this at any point and they ignored my Doctor when he said it did not require any further referral* [at] *that point.*
>
> *FYI I am one of those people that have a volatile PSA score, my Doctor knows this but has no idea why.*
>
> *Apparently a PSA score is a very unreliable indicator – should never be used as a stand alone indicator – and my PSA score is currently quite low (4)."*

In a submission dated **4 June 2021**, the Provider responded to these points, as follows:

> *"In general, raised PSA levels are a factor that insurers take into account when assessing the risk it is being asked to take on and it's often the case that an insurer will not be willing to provide cover if PSA levels are raised beyond a certain point.*

/Cont'd…

> *While an insurer may seek additional information from an applicant, an insurer's decision is reached based on medical records/examinations and the opinions of medical experts.* […]
>
> [The First Complainant] *mentioned his PSA levels can vary. While we cannot offer any assurances that the Company's decision will differ,* [the First Complainant] *is entitled to submit a plan change request at any time during the term of his policy. The Company is more than happy to assess a further plan change request in the future if his PSA score improves."*

In circumstances where I accept that the Provider was entitled to engage in a full assessment of the First Complainant's medical health, arising from the Provider's assessment of the policy change request, I accept that the Provider was entitled to apply a loading to the revised premium.

In this respect, I note that the loading was applicable to the revised premium only and it appears the Provider did not seek to apply this loading to the Complainants' current premium or the premium the Complainants would continue to pay in the event the revised premium was not accepted.

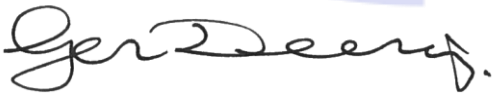
The First Complainant states that he was not given the opportunity to address the Provider's concerns regarding his PSA and that the Provider ignored his doctor's comments regarding the need for a referral. The First Complainant also makes certain submissions regarding his PSA and the reliability of PSA scores. However, I note the Provider's submission that it is willing to assess a further plan change request if his PSA score improves.

For the reasons outlined in this Decision, I do not uphold this complaint.

Conclusion

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

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



GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

3 September 2021

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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.