An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0321
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Lapse/cancellation of policy (life)
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The complaint relates to the Complainants' life insurance 'Life Protector Plan'.

The Complainants' Case

The Provider advised the Complainants of its intention to change the means of collecting monthly premiums, from a deduction through *"payroll"* to a Provider preferred direct debit method by way of letter dated **18 February 2019**. The letter also informed the Complainants that from **April 2019**, the Provider would no longer request payments through an employer payroll system.

The Complainants state they do not have a bank account, and the current system of paying through a payroll deduction (since policy inception in **April 1995**), is their preferred method of paying premiums into their Life Protector Plan. The Complainants assert that the Provider is in *"breach of contract"* and they now request that all *"monies"* be returned.

The Complainants were informed in a letter dated **5 April 2019**, that as no alternative instructions were received by the Provider, it has *"applied to the plan"* for the monthly premium deduction of €37.55.

It appears that the Complainants have not arranged to make further premium payments, up to the date of their complaint to this Office.

Ultimately the Complainants want the Provider to revert to its system of making premium deduction through the relevant Complainant's payroll. Alternatively, the Complainants request a return of all premiums paid as they allege *"breach of contract"* by the Provider.

The Provider's Case

The Provider stated to the Complainants in its Final Response Letter of **25 April 2019** that continued payments are needed to maintain the Life Protector Plan policy. The Provider states that both Complainants are covered for life cover of €6,944 and accelerated specified illness cover of €3,472. However, the Provider states that the value of the plan, at that date was €196.66 and the Plan was at a *"paid up status"* and continuing to decrease in value as deductions are made to cover the policy monthly premiums.

The Provider explains in the Final Response Letter that the 'payroll' deduction facility was withdrawn to new customers in **2002**, and due to a reduced number of existing customers still using 'payroll' deductions it sees direct debit payments as more efficient and timely for all its customers, going forward. The Provider did offer alternative payment schedules and methods to the Complainants, including bank draft, postal order or calling into its Head Office in Dublin to make a payment directly.

As part of this Final Response Letter, the Provider also notes that the Second Named Complainant is no longer covered on this plan as her accelerate permanent total disability benefit expired on her 65th birthday as per the terms and conditions of the plan. This was communicated to the Complainants by letter dated **7 November 2018**.

The Provider made further submissions to this Office dated **31 August 2020**. In these submissions, the Provider again stresses that the numbers availing of the payroll deduction facility had significantly decreased in recent years and therefore *"it was decided that it was no longer feasible for the Provider to offer this facility and to cease this method of payment going forward"*. The Provider states that as a result of this decision it wrote to the Complainants informing them of this change on **18 February 2019** and sent a reminder letter on **5 April 2019**. The Provider states that the Complainants chose not to make any further payments direct to the Provider and their plan was made paid-up. While in paid-up status, the benefits remained in place and the costs of the plan were deducted from the value of the plan, in accordance with the governing terms. The Provider states that on **13 November 2019**, the plan value reached zero and the plan went out of force, in accordance with the governing terms.

The Provider accepts that without a bank account, it is not possible for the Complainants to make payments by direct debit, cheque or banker's draft, however, it states that they still have the option to make payments by postal order or by cash at the Provider's head office in Dublin.

The Provider rejects the claim that removing the facility to pay for the plan through the First Complainant's employer's pay roll has breached the contract between the parties.

/Cont'd…

Under the contract in question, the Provider states that it agreed to provide the requested level of benefits, in accordance with the plan terms and conditions, in return for the agreed payment from the Complainants. It states that the terms and conditions of the plan do not reference the method of how the payment would be made, only that it is made as agreed. The Provider asserts that when the Complainants chose not to make payments, they chose to withdraw from the contract that was in place. The Provider asserts that if changing an existing method of payment was regarded as a "breach" of contract, then the Provider would not be able to allow any customer to change how they make payments for their life cover plan. The Provider states that it is *"not unusual for customers to opt to make payment using the Provider's on-line services, rather than by the Direct Debit method they signed up for or they asked that we suspend the Direct Debit in place and instead opt to send Postal Orders to the Provider each month."* The Provider again stresses that these examples demonstrate a change to a process rather than a *"breach"* in the original contract.

The Provider states in its further submission that *"it is not possible for the payroll deduction facility to be reinstated. Nor is it possible to refund the payments made over the years"*.

The Provider notes that while the facility in question is no longer in place, the payments paid over the years covered the cost of the benefits being provided to the Complainants since **1995**, benefits which could have been paid to the Complainants in the event of a claimable event arising during that time.

The Provider states that it has complied with Section 3.10 of the General Requirements of the ***Consumer Protection Code 2012 (as amended)*** which states that: *"Where a regulated entity intends to amend or alter the range of services it provides, it must give notice to affected consumers at least one month in advance of the amendment being introduced"*.

The Complaint for Adjudication

The complaint for adjudication in this instance is that the Provider has withdrawn its method of collecting monthly premiums from a 'payroll deduction' method through the First Complainant's employer, and that its alternative means of payment are not agreeable to the Complainants. The Complainants contend that the Provider is in *"breach of contract"*.

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.

/Cont'd…

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

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

Having reviewed and considered the submissions made by the parties to this complaint, I 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 24 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.

I note that the Complainants incepted a life protection policy with the Provider in **1995**. A copy of the Terms and Conditions of this policy have been furnished to this Office by the Provider. I note that there is no term contained with this policy that indicates the method/methods of payment that apply in respect of the policy.

I note that since inception, the Complainants had been making payments in respect of the policy through deductions from the First Complainant's payroll. In this respect, I accept the evidence submitted by the Provider which states that over the last number of years the numbers of customers utilising payroll deductions as their preferred payment method has significantly reduced. I note that by letter dated **18 February 2019**, the Provider informed the Complainants that from **April 2019** it would no longer be accepting payment through payroll deduction and recommended direct debit payments as an alternative. This was followed up by a letter dated **5 April 2019** noting that payroll deductions were no longer possible and recommending direct debit as a replacement method of payment. I note that a complaint was made by the Complainants by way of letter in respect of this change. This was acknowledged by the Provider by way of letter dated **23 April 2019** and I note that a phone call between the parties took place on **24 April 2019** before the Provider issued its Final Response Letter on **25 April 2019**.

/Cont'd…

In respect of the Provider's Final Response Letter, I note that it acknowledges that the Complainants do not have a bank account but then goes on to state that they have the option of making payments by cheque, bank draft, postal order or cash payments. It is regrettable that the Provider gave the options of cheque and bank draft to the Complainants, given that these options are only available to an individual who has a bank account and the Provider was aware that the Complainants did not have a bank account at the time it provided this information. It was therefore unhelpful for the Provider to refer the Complainants to payment methods via cheque and bank draft when it knew these were payment methods that the Complainants could not avail of.

Regarding the Complainants' allegation that the Provider *"breached"* the contract, I note that there is no term in the policy terms and conditions which stipulates payment method. It is understandable that in the twenty-five years or so that elapsed since the policy was incepted, as technology and consumer habits change, payment methods for long-term financial products would also change correspondingly.

Therefore, I do not find that the Provider breached the contract or any terms and conditions of the policy document by informing the Complainants in **February 2019** of the change in payment methods that was due to apply to their account. I note that the Complainants are in the unusual position of not having a bank account. However, this does not preclude them from maintaining the policy as they could still pay their premium by postal order or cash.

In the interests of completeness, I do not believe it would be appropriate to direct the Provider to refund the Complainants for the payments made in respect of the policy from inception to date as the policy was active and provided cover for the Complainants from its inception in **1995** up until **13 November 2019** and therefore the Complainants had the benefit of the policy during this time period albeit they did not make a claim pursuant to same.

Accordingly, while I understand the frustration the Complainants feel as a result of the change in the payment methods applicable to their policy, I must accept that the policy entered into between the Complainants does not stipulate any specific forms of payment methods and it was not unreasonable for the Provider to amend the payment methods it will accept over the lifetime of the policy. Accordingly, the Provider has not breached the contract/policy agreement entered into between it and the Complainants and is further not obliged to refund the Complainants for the payments made in respect of the policy from inception to date.

For the reasons set out 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.

/Cont'd…

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

16 September 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.