An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0322
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

In 2019, the Complainant made a complaint to this Office about her life assurance policy. As the complaint was not resolved by way of mediation, a formal investigation of the complaint was progressed, and a preliminary decision was issued to the parties on 14 September 2020.

On 28 Sept 2020, the FSPO was notified that the Complainant was deceased, having died on 28 April 2020. The deceased is referred to in this Decision as the Complainant, and has been represented in this matter since 24 June 2021, by her court appointed executrix.

The Complainant's Case

The Complainant made this complaint, contending that she originally took out the policy twenty seven (27) years earlier:

> *"solely to insure that all my bills and funeral would be paid at time of passing so as not to burden others."*

She stated that she had *"maintained this policy impeccably all these years without fail"*.

The Complainant submitted that she posted a cheque to the Provider in **2017** to cover her yearly premium, and that she is *"sure that I did mail it…from U.S.A."* She further submitted that as she was in the United States when she posted the cheque, the cheque was *"in $ instead of Euros"*.

The Complainant stated that she was unaware that the cheque had not been received by the Provider until she forwarded her premium payment for **2018** and was then informed by the Provider that her policy had lapsed.

The Complainant asserted that she paid her premium for **2018** *"with $"*, which resulted in the Provider requiring proof that she was resident in Ireland. She stated that nevertheless, she was still left with *"no policy"* after furnishing the Provider with *"all the required paperwork"*.

The Complainant contended that the Provider *"at one stage"* stated that it had received a *"U.S.A. cheque"* which *"might well be the cheque that is missing"*. The Complainant further said that she did not *"feel I should have to go in front of a doctor after 27 years to keep my life insurance"*.

The Complainant sought to have the Provider re-instate her policy *"to the way it stood"* prior to its cancellation.

The Provider's Case

In its letter to the Complainant dated **23 August 2018**, the Provider stated:

> *"As we received a cheque in dollars, and the address provided on the instruction was a USA address, our premiums area followed procedure when indication of possible USA residency is received.* [The Provider] *has a duty to act on indicia that a client may be living abroad. We appreciate the clarification you have provided regarding your residence and apologise for the confusion our procedure may have caused*."

The Provider goes on to state:

> *"It is important to note that as this policy has not been paid since the **1st of July 2017**, we do require the Health Section of a Proposal Form to be completed and revival will be subject to Underwriting. We can confirm we have postponed the refund of premiums to await receipt of the above in order to proceed with revival."*

In its Final Response Letter dated **15 January 2019**, the Provider stated that the cover on the Complainant's policy *"lapsed with effect of the **1st of July 2017** due to non-payment of the annual premium which was due on the **1st of July 2017**"*. The Provider further stated that no annual payment was received in **2017** for the policy cover.

The Provider submits that it allows *"3 month for revival of a policy without medical requirements, after this time period, a policy is subject to underwriting conditions"*. It further submits that the underwriting conditions state that the Complainant's policy does not *"have the option to be revived after a period of 3 months"*.

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The Provider, as a *"gesture of goodwill"* offered the Complainant *"the option to revive this policy"* once she completed the underwriting requirements:

> *"Based on the information provided to date, we have determined an Independent Medical is required in order to proceed with revival. On receipt this will be reviewed by our Underwriters. We will not be in a position to revive the policy without the above requirement."*

The Provider made further submissions to this Office dated **17 February 2020**. In these further submissions, the Provider attached the original policy documents which contain the terms and conditions regarding payment of premium. The Provider states that in accordance with the terms and conditions of the policy, *"the payment of premiums is due within 30 days of grace of the commencement date and the renewal date on going"*. The Provider states that if premiums are not paid, *"the policy will become paid up and the life insured sum will reduce to €0.00"*.

The Provider states that these terms and conditions were issued at policy inception. It also states that it wrote to the Complainant on a number of occasions to advise her that the premium had not yet been paid and subsequently, to inform her of the policy lapse. The Provider states that these letters also advised the Complainant that the revival of the policy was subject to acceptance by the Provider.

The Provider states that it sent correspondence on the following dates to the Complainant:

- **19 June 2017**: Cash Renewal Letter
- **03 July 2017**: Cash Renewal Letter
- **17 July 2017**: Overdue Letter
- **18 August 2017**: Lapse Letter.

The Provider states that as per clause 4 of its terms and conditions, it provides a 3-month grace period, within which the policy can be revived without any evidence of the continued good health of the policyholder. The Provider states that after this period of time, the policy cannot be revived.

In its further submissions to this Office, the Provider repeated the goodwill gesture made in its Final Response Letter that it would provide the Complainant with the option of reviving the policy once the underwriting requirements were fully satisfied. The Provider stated that in order to complete a review, the Complainant completed the Health Section of a proposal form and that based on the information contained therein it was determined that a private medical attendant's report would be required. The Provider states that it requested this report from the Complainant's noted GP but received confirmation from same that the Complainant was not a patient of this GP. The Provider states that the Complainant then advised the Provider that she did not have a GP and therefore the Provider assisted with arranging an independent medical in place of a private medical attendant's report, in order to continue the revival of the policy.

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In its further submissions, the Provider also further explains the issues surrounding the receipt of the cheque in U.S. dollars. It states that it received a cheque in U.S. dollars in **2018**. It states that the envelope which the cheque was received in, shows a postage date of the **13 July 2018** and it was received by the Provider on **18 July 2018**.

The Provider states that the cheque itself was dated **7 February 2017** which is where the confusion over the date of the cheque occurred. The Provider also states that the correspondence accompanying the cheque disclosed a new address in the U.S.A. for the Complainant. The Provider states that if a client is identified to be a possible U.S.A. resident, it is required to inform the client that due to the regulatory framework in the U.S.A., this limits how it may service and administer its policies.

The Provider states that at the time the cheque was received, the policy was paid up and still had an encashment value and therefore the cashier team issued a letter to inform the client of the Provider's obligations, and the request was passed to underwriting to see if revival was possible. Under Foreign Account Tax Compliance Act legislation (FACTA) the Provider states that it is also required to identify U.S residents or citizens that may be reportable for Foreign Tax purposes to Revenue, and therefore as the Complainant's policy holds an encashment value it is a reportable policy for U.S. residents.

The Provider states that the life cover element of the policy had lapsed or ceased at the time of the **2018** statement, however, as this is a policy that has a savings element also and an encashment value remained on the policy, it was still an active/live policy, and therefore was stated to be '***In Force, Paid Up'***. The Provider states that this contrasts with the previous year when life cover was applicable and premiums were being paid and the status was '***In Force, Premium Paying'***. The Provider states that before **2018**, the policy showed the relevant amounts for the Life Cover, whereas in **2018** no life cover element was shown, as this benefit had lapsed.

The Complaint for Adjudication

The complaint is that the Provider wrongfully classified the Complainant's life assurance policy as *"lapsed"*, due to non-receipt of the premium for **2017**. The Complainant maintains that she sent the payment, and that the Provider's non-receipt of this payment is not due to any fault on the part of the Complainant.

Decision

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

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

A Preliminary Decision was issued to the parties on **14 September 2020**, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

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

I note that the policy held by the Complainant with the Provider is currently active but that the life insurance benefits have lapsed with effect from **1 July 2017**. After careful consideration of the policy documents furnished to this Office, the following terms of the policy are noted to be relevant to this complaint:

> *"Sixth Schedule*
> *1. Payment of Premiums*
> *The initial premium due on the Date of Commencement of this policy must be paid by the Policy Owner on the Commencement Date otherwise this policy will be deemed to be void ab initio. Thirty days' grace is allowed for the payment of each subsequent renewal premium. Should the Life or Lives Insured die during the said period of grace, any premium then due and unpaid shall be deducted from the amount otherwise payable on settlement of the claim. No receipt for any premium shall be valid unless on the Company's printed form.*
>
> *2. If, after this policy has acquired an encashment value, the total premium is not paid within the days of grace, the policy shall be made paid-up under the provisions of paragraph 15 of the Schedule.*
> *…*
> *4. Notwithstanding anything contained in paragraphs 2 or 3 above, this policy may be reinstated to the full Sum(s) Insured within three months of the due date of the first unpaid renewal premium by written request to the Company, from the Policy Owner or his executors, administrators or assigns and payment of the unpaid premiums due. The Company shall have the right to debit the Policy account with a late payment charge determined by the Actuary. No evidence of the continued good health or insurability of the Life or Lives Insured shall be required in connection with such reinstatement and the entitlement to have this policy so reinstated shall apply even if the Life or Lives Insured shall have died during the intervening period.*
> *…*

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15. Paid Up Policy
After this policy has acquired an encashment value it may, at the request of the Policy Owner be converted to a paid-up policy with the First Life Sum Insured and Second Life Sum Insured equal to zero and with a reduced Minimum Guaranteed Encashment Value. No further premiums shall be credited to the CAPP Account. However, the other conditions of the Second Schedule shall continue to apply to the CAPP Account and to the Unit Account. In the event that the Paid Up Value is less than a minimum value (determined from time to time by the Company's Actuary) the policy shall be encashed for its encashment value.

I note that the Complainant has been unable to furnish any documentary evidence that she paid the **July 2017** insurance premium. While I accept that there was a cheque which was received by the Provider dated **2 July 2017**, I note that this cheque was only received by the Provider a year later, on **18 July 2018**.

Furthermore, I accept that the Provider wrote to the Complainant on four separate occasions in relation to the life assurance policy at the contact address made available by her. These letters were dated respectively **19 June 2017**, **03 July 2017**, **17 July 2017** and **16 August 2017** (the Provider incorrectly state that it issued correspondence on **18 August 2017**).

I note that the correspondence on **19 June 2017** reminded the Complainant of the date when the renewal premium was due. The subsequent correspondence on **3 July 2017** and **17 July 2017** informed the Complainant that the Provider had not received the renewal premium which was due on **1 July 2017** and reminded her that she must forward the premium payment in order to maintain her policy. Thereafter, further correspondence was sent to the Complainant again, on **18 August 2017** informing her that the premium payment had not been received and that, as a result, her policy had lapsed; it further stated that any revival application would be subject to acceptance by the Provider.

Given the absence of any documentary evidence supplied by the Complainant, I cannot accept that the Complainant paid the premium on the policy in **July 2017**. I also acknowledge that the Provider made reasonable efforts to communicate to the Complainant that she had missed her premium and also made reasonable efforts to communicate to the Complainant that her policy had lapsed, subsequent to the said missed premium.

Furthermore, I accept the Provider's submissions that per clause 4 of its terms and conditions, a 3-month grace period within which the policy can be revived without any evidence of the continued good health of the policyholder is provided for, but that after this period of time, the policy cannot be revived.

I note that the Provider then made a goodwill gesture to the Complainant and stated that even at that stage, it would provide the Complainant with the option of reviving the policy, once the underwriting requirements were fully satisfied.

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Notwithstanding the Complainant's objections to being assessed by a doctor after maintaining life insurance for 27 years, I accept that it was within the rights of the Provider to insist upon this, if the Complainant wanted to reinstate this life assurance cover at that stage.

At the time of the Preliminary decision of this office in September 2020, I indicated my opinion that it would be a matter for the Complainant to now consider that option, and if she wished to do so, she should communicate with the Provider as soon as possible, as the Provider could not be expected to hold that offer open indefinitely. Sadly, it seems that by that time, the Complainant was deceased, and she had chosen not to accept that option of reinstating life cover, prior to her death.

On the basis of the evidence, I cannot hold the Provider responsible for the non-payment of the Complainant's **2017** premium payment. Accordingly, I do not consider it appropriate to direct the Provider to restore the Complainant's policy to the position in which it stood, prior to it lapsing for non-payment of premium.

For the reasons outlined above, I do not consider there to be any reasonable basis upon which it would be appropriate to uphold this complaint.

Conclusion

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

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

MARYROSE MCGOVERN
Deputy Financial Services and Pensions Ombudsman

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.