An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0333
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Mis-selling (insurance) Failure to advise on key product/service features
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint arises out of a health insurance policy and relates to the asserted mis-selling of the policy by the Provider against which this complaint is made. It arose when the insurer refused to indemnify the Complainant for a claim that he made under the policy which had been sold by the Provider.

A separate complaint against the insurer for the failure to make payment on foot of the Complainants' claim has been dealt with separately.

The First Complainant held a domestic health insurance policy with the Provider, against which this complaint is made, for a number of years. The Second Complainant was insured under this policy. In **November 2014**, the First Complainant telephoned the Provider to enquire about continuing cover with the Provider as the Complainants had recently moved from Ireland to [another jurisdiction]. During the call, the First Complainant incepted an international health insurance policy. The Complainants believe that the international policy was mis-sold by the Provider.

The Complainants' Case

The First Complainant explains the complaint relates to a dispute which arose between himself, as policyholder, and a third party provider in respect of a decision of the third party provider to decline a claim made on behalf of the Second Complainant under the policy.

The Complainants were living in Ireland and in **2004** took out a relatively expensive health insurance policy with the Provider. This policy included lengthy waiting periods in respect of pre-existing conditions – 10 years for the First Complainant and 3 years for the Second Complainant.

In **April 2014**, the Complainants relocated outside the State and in **November 2014**, the Complainants spoke to the Provider ahead of the renewal date of their policy and discussed how they could best ensure continuity of the policy despite the fact the Complainants were no longer resident in Ireland. During the telephone conversation, the Provider's agent suggested that she would transfer the First Complainant to its *International Department*. The First Complainant was then transferred to one of the Provider's international sales personnel.

The First Complainant submits that he was lulled into a false sense of security and was under the mistaken impression that *"… I was remaining within the [Provider] (where I had been a customer for 10 years) and the Terms and Conditions, of my existing Policy, would NOT be varied dramatically and the EXTRA Premiums I was being asked to pay would provide ADDITIONAL benefits."* Contrary to this, the First Complainant states that he was mis-sold an inferior product at an enhanced price, that in no way matched the cover previously in place with the Provider.

Specifically, the Complainant asserts that the *huge implications* of *Chronic Conditions* were not properly explained to the First Complainant: *"[t]he innocent sounding example given, suggesting my 'blood pressure medication, might not be covered', completely glossed over the real implications of a Clause that can be used to invalidate any major Claim that arises."* The Complainants say the implications of *Chronic Conditions* should have been highlighted and not glossed over in such a superficial and misleading manner. The First Complainant states that a policy which excludes chronic conditions is a useless product and he never would have purchased such a product as it defeats the very purpose of health insurance.

The Complainant states that compounding this situation is the revelation that while the Provider paid for two small procedures for the Second Complainant in **2016**, it flagged the policy as a potential chronic situation emerging. This was done without informing the policyholder and the Provider continued to collect substantial premiums, secure in the knowledge that any future claim would be denied.

Since the Complainants transferred to the new policy, premiums have been increased to €6,620 in **2014/2015** to €8,633 in **2015/2016** and **2016/2017**. In comparison, the Complainants were paying €5,263 in respect of the original domestic policy for superior cover.

The Complainants believe they have paid thousands to the Provider for healthcare that simply did not exist. The First Complainant states that they found themselves in a situation where he was expected to meet hospital and other costs totalling over €30,000 in respect of the Second Complainant as a direct result of the Provider's mis-selling.

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In emails dated **27 July 2017** and **24 January 2020**, the First Complainant points to the *opaque and confusing* structure of the Provider group of companies as an important aspect to this complaint, in that this is a contributing factor to the delays in settling the Complainants' complaints and that the Provider did not explain the *division of responsibility* between the various entities when this complaint was first raised with the Provider.

In a submission dated **20 April 2020**, the First Complainant expressed his dissatisfaction with the Insurer's handing of his complaint made in **February 2017**. In particular, he states that the Insurer never notified the Complainants or this Office that the mis-selling aspect of their complaint should have been directed to the Provider. The Complainants state they had to wait until **June/July 2019** to be made aware of this division of responsibility. The First Complainant also highlighted that when the Provider cancelled the policy in **February 2017**, it failed to take into consideration that the policy was suspended pending resolution of the Complainants' declined claim, and the fact the Complainants were customers of the Provider since **2004** and never missed a premium payment.

The Provider's Case

The Provider explains that on **17 November 2014**, the First Complainant contacted it to advise that he was currently residing outside Ireland and wished to discuss the options available to both him and his wife. The First Complainant advised that he would be residing abroad for more than 180 days per year. The Provider states that its agent correctly advised the First Complainant that his current domestic policy was invalid as a customer must be an Irish resident to be covered on that policy. The Provider's agent recommended considering an international policy with cover specifically designed for Irish residents who are working or studying abroad for longer than 180 days with the intention of returning to Ireland in the future. The Provider refers to clause 6 of the domestic policy terms which contains the 180 day residency requirement.

The Provider states that the First Complainant was transferred to the Provider's International Membership Team which is a department within the Provider. Referring to the First Complainant's understanding that he was speaking to an entity outside of the Provider, the Provider states that the First Complainant was advised during the transfer of the Provider's tied agency status. Prior to the transfer, the First Complainant was advised that he would hear a short compliance statement. The Provider explains the transfer of calls are not recorded. However, the Provider cites a sample of the relevant regulatory statement which states: *"[The Provider] is tied to [the Insurer] for [the Provider's International Health Insurance] which is underwritten by [the Insurer]."* The tied agent status of the Provider was also outlined in the documentation sent to the First Complainant on **18 November 2014**.

Upon transfer to the International Team, the First Complainant advised that he was looking for something to keep continuity of cover. The Provider explains that its international policies enable customers to transfer from their domestic policies and recognises waiting periods already served against the waiting periods of its international policies.

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On return to Ireland, customers are not required to serve new waiting periods if they return to their previous domestic policy once their travels are complete.

The Provider says it was also highlighted that there were two levels of cover, Level 1 and Level 2. Therefore, prior to recommending a policy to the First Complainant, the Provider's agent sought relevant information from him by posing a number of questions in the form of a *fact find*. By gathering and recording appropriate information, the agent was in a position to recommend a level of cover that would reflect the Complainants' personal circumstances and needs.

The Provider states it was established that the First Complainant was taking light medication for high blood pressure and that neither Complainant had any planned treatment or appointments. The Provider remarks that it was not disclosed during the telephone conversation that the Second Complainant was suffering from an ongoing medical condition. It was noted that the Second Complainant had surgeries in the past but nothing ongoing. The Provider states that the benefit specifically in respect of chronic conditions on both Level 1 and Level 2 were brought to the First Complainant's attention and the agent alerted the First Complainant to the fact that an ongoing blood pressure condition could be deemed a chronic condition and that he should choose the level of cover which would best suit the Complainants' medical needs. It was also highlighted that a chronic medical condition was long term and ongoing, however, not necessarily serious in nature.

After further discussion, the First Complainant advised that he felt Level 2 cover was not necessary as monitoring and medication for blood pressure was covered under the national health system where he was now residing. The Provider states that its agent recommended Level 1 cover. The Provider says it is also satisfied that it was explained to the First Complainant that the international policy was different to his domestic policy: it was risk rated where the premium is based on age. A quotation of €6,620 was provided. The Provider states the key benefits of the policy, which have been outlined in the Provider's Formal Response, were also discussed.

The Provider says the First Complainant agreed to transfer cover from domestic cover to international Level 1 with immediate effect (**15 November 2014**) and it was confirmed that the domestic policy would be cancelled the same day. The Provider states that its agent again queried if the First Complainant was happy that Level 1 only provided emergency cover in respect of chronic medical conditions should there be anything that was deemed to be chronic *'ongoing in nature and requiring long term medication where the cost of the medication or consultant/GP visits would not be covered, however emergency cover up to €10,000 applied.'* The Provider states that the First Complainant confirmed he was happy with this level of cover. The Provider states that the First Complainant was also advised to read through the policy documentation, terms and conditions and to revert to the Provider if he had any questions. No further contact was made by the First Complainant.

A notification was issued to the First Complainant's postal address on **18 November 2014** which included the Provider's Rules - Terms and Conditions Member's Handbook.

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The Provider also refers to the policy definition of *Chronic Medical Condition*. The Provider submits that it was only ever its intention to provide the First Complainant with the most appropriate cover and relevant advice regarding Level 1 and Level 2. The Provider relies on the information disclosed during the fact find to assist in making a policy recommendation which in turn enables customers to make an informed decision on the level of cover that best suits their needs. It also stated that subsequent renewal notifications issued annually to the First Complainant in advance of renewal which invited him to contact the Provider to review his international policy. However, no contact was ever made.

The Provider advises that the First Complainant's international policy was cancelled due to non-payment of premiums effective from **15 January 2017**. Payment reminders were issued to the First Complainant on **17 February** and **24 February 2017**, followed by a cancellation notice on **23 May 2017**.

The Provider advises that matters relating to underwriting, claims or benefits are handled by the third party Insurer and matters in relation to the sale of a product or service are handled by the Provider.

The Provider states that on **15 March 2017**, following a request from the Insurer, a copy of the call from **17 November 2014** was provided. The Provider says its records indicate that prior to issuing the call, it was reviewed in full and the review was provided to the Insurer. The Provider advises that it was satisfied with all aspects of the call and had no concerns in relation to the selling of the international policy. The Provider states that it was made aware of the Complainants' case in **March 2017** which related to matters other than the selling of the policy. The Provider also refers to the complaints section of the international policy (2017-2019) and the Operations Manual which sets out the types of complaint the Provider and the Insurer are responsible for.

The Complaints for Adjudication

The complaints are that the Provider:

> Mis-sold a health insurance policy to the First Complainant in **November 2014**;
>
> Failed to properly inform the First Complainant about the nature and extent of cover provided by the international policy;
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> Wrongfully cancelled the policy; and
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> Delayed in its handling of the Complainants' formal complaint.

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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.

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 June 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.

Following the issue of my Preliminary Decision, further submissions were received by this Office, copies of which were exchanged between the parties.

Having considered those additional submissions and all submissions and evidence furnished by both parties to this Office, I set out below my final determination.

Policy Inception

The policy the subject of this complaint was sold by the Provider as a tied agent of a separate entity, the Insurer and the policy was underwritten by yet another third entity. The Provider, against which this complaint is made, was only responsible for selling the insurance.

The First Complainant incepted an international health insurance policy with Level 1 cover during a telephone conversation with the Provider on **17 November 2014**. He spoke to three agents of the Provider in incepting the policy. The conversations with the second and third agents that he spoke to are of most relevance.

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Given the importance of this call I have transcribed some of the relevant parts of the conversation.

It would appear that the first agent simply did the security checks and confirmed what service the Complainant was seeking.

Agent 2	Good Morning [Provider] Healthcare, my name is [redacted] can I take your policy number please?
First Complainant	Em yeah its [redacted]
Agent 2	**…** and who am I speaking to there?
First Complainant	My name is [First Complainant]
Agent 2	Brilliant [First Complainant], I believe you have done your checks with my colleague there, haven't you?
First Complainant	That's right
Agent 2	And what can I do for you this morning?
First Complainant	Right, well when I was on with your colleague I explained that we have recently moved and we are living in [outside Ireland] at the moment and em our policy with you em is due for renewal – runs through to 1 January
Agent 2	1 January yeah
First Complainant	Yeah, what really I want to do is - I want to discuss what options are available to us to continue the cover em that we have had with you – we have been a customer with you for a number of years and I don't want to start again with you
Agent 2 interrupts	And are you planning on moving back to Ireland at some stage [First Complainant]
First Complainant	Well it's, it's, it's hard, it's hard to know we have only been here a few months and it's, it's, it's em - I definitely don't want to rule out that possibility.
Agent 2	Of course not at this early stage, right well what I would say to you [First Complainant] is Number 1, if you are spending more than 180 days out of the country every year your hospital policy is of no use to you because you can't use it, so and by the sounds of it, the plan is to spend more than 6 months out of the country so what I think you need to look at is an international policy.

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Now this is something that would cover you while you are abroad and then when you move back home you could go back on your domestic policy.

First Complainant Uh uh

Agent 2 Yeah now what I am going to need to do to get someone to talk to you about that, is I'll need to pop you across to the international department. Now there is availability – will you hold the line and I will put you straight through.

First Complainant Yeah that's fine thanks

Agent 2 No problem. You will hear a short compliance statement, give them your policy number again and then em you can em - they will be able to help you with that query, alright?

First Complainant OK

Agent 2 Thank you bye bye

Agent 3 Good morning [Provider] Healthcare, you are through to [name redacted] may I have your policy number?

First Complainant Yeah it's [redacted]

Agent3 Thank you and can I ask you to confirm your name and address please?

First Complainant confirms his name and address…

Agent 3 That's perfect thank you very much then and how can I help you today?

First Complainant Well, you are the third person I have spoken to so hopefully [inaudible]

Agent 3 Laughs, ok

First Complainant Basically the situation I have explained to two of your colleagues em we have been a customer with yourselves for a number of years. Our current policy the renewal date of 31 December or 1 January

Agent 3 Aha

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First Complainant That's the situation. In April time of this year we moved and we are currently living in the [location redacted] and em it's really a question now the policy is coming up for renewal we wanted to discuss what the options are in terms of continuing, I mean we want to continue to be customers with yourselves obviously em because we have established em a record there.

Agent 3 Uh uh

First Complainant So it's a question of what, what options are available to us to allow that option to continue

Agent 3 Uh uh Well ok I suppose what happens when – when an Irish resident is going overseas for 180 days or 6 months or more, eh then the domestic health insurance that you've had up until now the [name of health insurance plan] or any level of cover you are on here becomes invalid because you have to be an Irish resident to be covered on the [name of plan] so what would happen in that case is we have a policy called [Provider] International which is designed specifically for the likes of yourself [first Complainant] – someone – an Irish resident living abroad if you have an intention of returning to Ireland. So as long as you intend returning to Ireland and you are abroad for maybe 2 years, 5 years, 10 years whatever it is as long as you intend returning to Ireland it keeps you within the system so that you can be covered abroad and move back here and be covered here…

First Complainant interrupts Well I think that's exactly the situation I mean we have been living on [location redacted] now for 6 or 7 months but I certainly don't want to burn my boats in terms of saying that we will never return to Ireland em you can tell by my accent that I am not exactly Irish but my wife is and em you know I certainly, we certainly know that ruling that out is a possibility so that's what we are looking for – we are looking for something that keeps that option open – we will sort the continuity of health insurance with yourselves and whenever if and when we return to Ireland then we can revert to the ways things were before

Agent 3 Aha ok right then well then in that case I need to just ask you a couple of questions to find out what the international policy would cost you

…

A lengthy conversation ensues about the cover available under the international policy and the Complainants' requirements and medical history.

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…

First Complainant So what is the best way to progress this? Could you e-mail me some detail or something that I can review what it is and em I mean

Agent 3 interrupts Well you are already away more than 6 months now [First Complainant] so I would recommend just changing over to the international policy as soon as possible and you know getting you on the right level of cover if it's something you feel you are going to be doing. You know get the wheels in motion as soon as possible to get you on the right level of cover you don't need to wait until your renewal date in January to do that because you know basically the agreement we had back last January has changed now the fact that you have moved out of the country means that we can make changes to your cover to best suit your needs so we can make that change now anytime I would do it now as soon as possible and em that way we set up the international policy, we send you out the documentation to review, you have a 30 day cooling off period to do that and then basically you stay on the international policy as long as you need it as long as you still have an intention of being back in Ireland at some point. After a few years we will write and ask you to get some sort of written documents every you know every year to keep the policy active I think that's every 7 years but

First Complainant interrupts Right

Agent 3 but in the meantime you are covered for as long as you need it em

First Complainant Fine

Agent 3 Uh uh

First Complainant Em that sounds fair enough well can we go ahead on that basis?

Agent 3 Yeah of course you can yeah uh uh. So just to go through a couple of the details about how it works you know, you know, a few key things you need to know so obviously you were saying there that you served your waiting period and things like that so that is a key point about the international policy it means that when you go on the international policy that history that you have built up over the years on this policy goes with you so at the minute the only waiting period you have is you still have a couple of months left for any [inaudible] conditions that you have before joining in 2006 so up until April 2016 anything that you had prior to April 2006

First Complainant Right

/Cont'd…

Agent 3 is what you are still waiting on cover for. That's the only thing you have at the minute and that is going to be kept as it is em the only other thing then is a four month rule on the international policy. You have to be on the international policy before any planned hospital treatment that's covered. That's why I was asking earlier if there is anything that you are waiting on an appointment for

Complainant interrupts No

Agent 3 So that should be ok.

First Complainant No very definitely not

Agent 3 Yeah that's good. Em so then I mentioned about the chronic medical conditions so are you happy that the level 1 gives emergency cover only for chronic conditions if there is anything deemed to be chronic that is ongoing in nature requiring long term medication that the actual cost of medication or consultants or GP bills wouldn't be covered but you would have emergency cover up to €10,000 for that

First Complainant Yeah that seems, that seems ok

…

A discussion ensues about cover, costs, optional extras, excesses, cooling off period, payment and bank details.

…

Agent 3 And eh so you are basically covered by the policy straightaway so you have the 30 days though to come back to us if there is any queries or concerns or things you want to change within the policy though and em while, you know even though you are abroad you still have access to all the [Provider] services like our website, [Provider], your [Provider] and the [Provider] nurse line and different things like that as well

First Complainant Yeah ok well I mean that improved slightly. More expensive than I had hoped, but slightly less painful that what I thought might be possible em, no that, that seems em that seems grand, tell me one thing

Agent 3 Uh uh

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First Complainant Last year when we were renewing the policy we flipped it with getting a travel insurance policy which would have been an extra and to honest we never just got around to our [inaudible**]** became more of a priority. Effectively are we saying that new policy we are having effectively includes all the travel insurance arrangements

Agent 3 It does yeah absolutely, it does yeah it's exactly the same

First Complainant Right ok

Agent 3 Aha [inaudible]

First Complainant Well that sounds that sounds good that some of the extras [inaudible]

Agent 3 Yeah well that's it aha and of course you have the repatriation part is part of the International which wouldn't be part of the domestic cover as well you know coming back to Ireland things like that so that's all part of what you are getting with the International yeah

First Complainant Uh uh Ok then that that sounds fair enough em thank you for your help and I'll look forward to receiving the bundle

The call concludes with a discussion about a refund and payments.

Policy Documents

The Provider wrote to the First Complainant on **18 November 2014** in respect of the newly incepted international policy. This letter enclosed the First Complainant's policy documents and advised him to *"… take a little time to look through the information and make sure you're happy with everything."*

Statement of Suitability

The *Important Notice – Statement of Suitability* states:

> *"This is an important document which sets out the reasons why the product(s) or service(s) offered or recommended is/are considered suitable, or most suitable, for your particular needs, objectives and circumstances.*

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Based on the information you provided to us about your affordability requirements, the geographical regions for which you require cover and the level of benefit you want to have access to, the key benefits of the plan we have recommended are set out below. Where your policy was purchased over the phone, details of the information you provided to us are available.

[Provider] International Level 1

Your plan

[The international policy] is designed for people moving, travelling or studying abroad for more than six months. This product is designed to cover your healthcare and travel insurance needs overseas. We'll ensure you get the right medical attention and work with hospitals and doctors throughout your treatment …

Emergency and elective treatments – we've got you covered

We cover your private hospital expenses and treatment costs, and if you have to travel for that treatment, we'll cover that too. Plus, we'll cover elective medical treatment, so you can plan treatment to fit with business and family commitments.

Medical cover

- *We cover you up to a maximum of €3 million per year at home or away*
- *Post-hospitalisation costs: we'll cover the costs for consultations and treatments – up to €2,000*
- *Day-to-day medical expenses: we cover you for things like GP, Physiotherapist, specialist consultation and prescription drugs, up to €500 (an excess applies per medical condition)*
- *We pre-approve treatment and settle hospital bills directly for you*
- *Repatriate to Ireland following certain serious conditions*
- *Emergency dental treatment*
- *Hazardous sports cover*

Travel insurance

- *Travel insurance cover is included on this level. We'll cover you for:*
- *Personal liability – up to* ***€2,000,000***
- *Personal accident – up to* ***€40,000***
- *Legal protection – up to* ***€25,000***
- *Travel cancellation or curtailment – up to* ***€10,000***
- *Cover for luggage – up to* ***€1,500***
- *Money & passport expenses – up to* ***€500***
- *Travel delay – up to* ***€200***
- *24 hour emergency medical helpline and a travel assistance service*

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Chronic illness cover

We'll cover treatment for acute episodes of chronic conditions if the condition flares up, up to €10,000.

Psychiatric cover

We'll cover you for three out-patient psychiatric visits

Coming home

When you decide to come back to Ireland, give us a call and we'll put you back on a domestic healthcare plan with no waiting period and no break on cover for the benefits you previously held. …"

Table of Benefits

The *Table of Benefits* sets out the benefits under Level 1 cover and states that it must be read in conjunction with the *Rules -Terms and Conditions*.

Section B of the table states:

"B Medical & hospital benefits (refer to Section 2 of your Rules – Terms and Conditions)

…

Chronic medical conditions for acute episodes only for each chronic medical condition	*€10,000*

…"

Rules – Terms and Conditions

In the introductory section of the *Rules – Terms and Conditions (1 January 2014)* (the **Rules**), the reader is advised to:

"[t]ake a few moments to refresh Your memory about the cover You have purchases to make sure that You fully understand what is covered and what is not covered. … If there is any aspect of [the policy] You are unsure about then please let Us know."

Section 3 of the Rules explains the 30 day cooling off period. A number of definitions are contained in section 4.

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In particular, it states the following in respect of chronic medical conditions:

> *"**Chronic Medical Condition***
>
> *A Medical Condition which has two or more of the following characteristics:*
> *It has no known recognised cure*
> *It continues indefinitely*
> *It has come back*
> *It is permanent*
> *Requires Palliative Treatment*
> *Requires long-term monitoring, consultations, check-ups, examinations or tests*
> *You need to be rehabilitated or specially trained to cope with it.*
>
> ***Chronic Medical Condition – Acute Episode***
>
> *An event or incident of repaid onset resulting in severe pain or symptoms which is of brief duration that is likely to respond quickly to Medical Treatment to stabilise a Chronic Medical Condition."*

Section 5 of the policy deals with what is, and what is not, covered.

Again, in respect to chronic medical conditions, section 5(2) states:

> *"**What is covered***
>
> *j) Chronic Medical Conditions – Where a Medical Condition is deemed to be Chronic, the maximum benefit We will pay for all and any Medical Treatment covered by this Policy for each Chronic Medical Condition is limited to:*
>
> - *The Acute episodes of a Chronic Medical Condition on Level 1*
> - *The Acute episodes of a Chronic Medical Condition including routine management and Palliative Treatment on Levels 2 and 3. …*
>
> ***What is not covered***
>
> *…*
>
> *h) In respect of the Chronic Medical Conditions benefit of this Policy, We will not pay for any Medical Treatment for an Acute episode of a chronic psychiatric, mental or psychological disorder under Level 1. …"*

Section 7 deals with eligibility and states:

> *"**Eligibility for Membership***

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a) *This Policy is designed for residents of the Republic of Ireland who are living or working abroad for a period of more than 6 months but who intend to return to the Republic of Ireland to take up residency at some point in the foreseeable future.* ***Please note:*** *[the international policy] is not appropriate for Insured Persons in long term residency in countries outside of the Republic of Ireland and Your Policy will automatically cancel upon the end of the 7th continuous Period of Insurance insured on [the international policy], unless You can confirm and provide supporting documentation which confirms Your intention to recommence permanent residency in the Republic of Ireland in the foreseeable future. …"*

The First and Second Complaints

I will deal with the complaint of mis-selling and the complaint relating to the information furnished about the nature and extent of cover provided by the international policy together.

Beginning with the telephone conversation with the Provider's International Department on **17 November 2014**, the First Complainant was advised that as the Complainants had been residing outside of Ireland for more than 180 days, they were not covered under their domestic policy.

As can be seen from the above transcript of that call, when speaking to the Provider's second agent, the First Complainant explained he had recently moved to where he now resides outside of Ireland stating:

> *"… I want to discuss what options are available to us to continue the cover that we've had with you …we've been a customer for a number of years, and I don't want to start again".*

The Provider's agent explained that if the First Complainant was spending more than 180 days outside of the country, his existing domestic Irish policy with the Provider was of no use to him and advised that he may need to consider an international policy. However, she explained that to do this, the First Complainant would have to be transferred to the Provider's International Department.

The Provider, in its response to this Office, explains that the messages played during the transfer of calls are not recorded. However, Provider states that a recorded message with the following regulatory statement is played: *"[The Provider] is tied to [the Insurer] for [the Provider's International Health Insurance] which is underwritten by [the Insurer]."*

When transferred, the Complainant receives the exact same greeting in terms of identifying the Provider as he received from previous agents. This is the name of the provider with which he had his existing domestic health insurance policy.

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In my Preliminary Decision I had stated that while I accept that the compliance recording may have been played during the transfer, though I have no evidence that it was, the Complainant is given absolutely no sense that he is about to embark in a process, that ultimately resulted in him contracting for health insurance with two entirely different insurance entities than the provider that he had his existing health insurance with and that he believed he was engaging with.

The Provider has as part of its post Preliminary Decision submission's given further details regarding its recorded regulatory statement. It notes that in its "*previous response* [the Provider] *provided details on the automated regulatory messaging played when a call is transferred to our Diversified Products line. We now provide the full statement (and also provide a copy of this recording) played to* [the Complainant] *on the 17 November 2014 prior to being transferred to our sales agent".*

The full statement is as follows:

> "[the Provider] *is tied to* [the insurer] *for* [named insurance product] *which is underwritten by* [named entity] *and for* [the Provider's name of location cover] *and* [the Provider's International Health Insurance] *which are underwritten by* the Insurer]. *Any* [named insurance product], [the Provider's name of location cover] *or* [the Provider's International Health Insurance] *quote is valid for today or the period of renewal."*

The Provider submits that the "*automation of this statement ensures consistency in application and reduces the possibility of error if the agent is required to include it on the call"* it is further detailed by the Provider that the "*provision of this information is further supported by the issuance of policy documentation and Terms and Conditions to customers who have a cooling off period (30 days) to review the documentation and make any necessary changes or cancel the policy".*

I have considered the content of the recording of the regulatory statements which was provided as part of the post Preliminary Decision submission. Having considered the content of the statement and the Provider's submissions, it remains my view that the regulatory statement did not give the Complainant a clear sense that he was about to embark in a process, that ultimately resulted in him contracting for health insurance with two entirely different insurance entities than the provider that he had his existing health insurance with and that he believed he was continuing to engage with.

This is evidenced by how the call commenced:

Provider's agent 3*: "Good morning [Provider] you're through to [name redacted]. May I have your policy number.*

Complainant: yea its [number redacted]

/Cont'd…

After the security details are confirmed, the call continues as follows:

Provider agent 3: how can I help you?

First Complainant: We've been a customer with yourselves for a number of years…

The First Complainant told this agent that he had moved from Ireland and that *"… we wanted to discuss what the options are in terms of continuing. I mean we want to continue as a customer of yourselves obviously … what options are available to us to allow that to continue."*

On the call, the First Complainant stated that he wished to continue as a customer of the Provider and wanted to know what options were available to him. Having asked the First Complainant a small number of questions, the First Complainant was advised of two levels of cover available on an international policy, with Level 1 offering a standard level of cover.

An explanation of *chronic medical condition* was given early in the call and again towards the end of the call, which I note is in line with the definition contained in section 4 of the Rules. The extent of the cover for Level 1 and Level 2 was also outlined by the Provider's agent and it was highlighted that Level 2 offered a greater level of cover in respect of chronic medical conditions. The First Complainant explained the differences in the standard of care between Ireland and where the Complainants now reside, the type of medical care available to the Complainants there, and that he wanted to have the option of travelling to Ireland for medical treatments/procedures.

The pricing of the policy was also discussed, and the First Complainant was advised that this type of policy was risk rated and based on age. The cost of Level 1 cover was explained and the benefits accompanying this level of cover was outlined. It is noteworthy that the benefits referred to by the Provider's agent were essentially the same as those contained in the Statement of Suitability dated **18 November 2014**. The First Complainant queried whether there would be a cost saving if the geographical scope of the policy was restricted to the *British Isles* and indicated that he had hoped to keep the price of the policy in line with his domestic policy.

The First Complainant also queried whether the Provider would send him policy details to review. In response to this and again towards the end of the call, the Provider's agent advised him that he would be issued with policy documents to review and that he had a 30 day cooling off period.

I fail to understand why the Provider did not explain and make clear to the Complainant, at any point during this lengthy phone call with three of its agents, that what he was about to be offered was not a continuation of his existing policy or relationship with the Provider.

I accept that the tied agent status of the Provider may have been played on the telephone call while the call was being transferred and was outlined in the documentation sent to the First Complainant on **18 November 2014**.

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However, given the complex relationship between the Provider, the insurer and the underwriter, I believe the Provider should have pointed out, in the clearest possible terms, that it was selling the Complainant a new policy with a different entity before proceeding to sell the Complainant the new international policy.

In particular, I am seriously concerned that it does not appear to have been pointed out to the Complainant that what was being proposed was not simply a transfer from one of the Provider's policies to another of the Provider's policies. What was being discussed was an entirely different and new policy with a different insurer and a different underwriter.

In the remainder of the call the Provider's agent explained the 180 week residency requirement and that international policies were available to Irish residents living abroad but who had an intention of returning to Ireland.

I note the Provider's agent informed the Complainant he could go back on his policy if the Complainants returned to Ireland stating:

> *"as long as you intend returning to Ireland it keeps you within the system so that you can be covered abroad and move back here and be covered here…"*

I also note that the policy document outlined:

> *"When you decide to come back to Ireland, give us a call and we'll put you back on a domestic healthcare plan with no waiting period and no break on cover for the benefits you previously held. …"*

In my Preliminary Decision I noted that despite the above statement, the Provider does not appear to have furnished any evidence that its international insurance policy continues cover for the purpose for the Health Insurance Acts. I believe it was very important in selling this policy to the Complainants that they were fully informed as to whether holding cover under a provider international policy would ensure continuity of cover as provided for under the Health Insurance Acts. I believe they should have been informed that if they lived abroad for more than 180 days, and then returned to live in Ireland, whether they would have to serve a waiting period for pre-existing conditions again in order to be covered by not just the Provider, but also by other insurers.

However, the Provider does not appear to have furnished any evidence of how it explained, either in its letter of 18 November 2014 to the First Complainant or the policy terms and conditions, how its international policy complied with the requirements of the Health Insurance Acts relating to continuation of cover, lifetime cover and, waiting periods.

Specifically, the Provider did not give any indication of how the reinstatement of cover under the Complainants' original policy would be managed should they have returned to Ireland, nor did it indicate the terms on which cover under the original policy would be made available, that is, whether the Complainants' premium on discontinuation of the original policy would have applied (together with any interim premium adjustments).

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In addition, the Provider did not explain whether any waiting periods would have applied on reinstatement of their original policy if the Complainants returned to Ireland or whether the Complainants being covered under the Provider's international policy would count against the 'break in cover' and 'continuous cover' provisions of the Health Insurance Acts if the Complainants chose another health insurance provider on their return to Ireland.

The Provider has, in its post Preliminary Decision submission, commented on the above. The Provider details that regarding my *"reference to* [the Provider's International Health Insurance]*and the Health Insurance Acts, please note* [the Provider's International Health Insurance] *is not a domestic PMI policy governed by the Health Insurance Acts (1994–2015) and is not comparable with any* [Provider's]*,* [named entity] *or* [second named entity] *domestic PMI policies. In 1996, the Voluntary Health Insurance (Amendment Act), provided* [the Provider] *with the power to sell* [the Provider's International Health Insurance]"*.*

The Provider, in its post Preliminary Decision submission, also states it "*cannot legally offer product advice on any competitor's products who operate outside of Ireland. Whilst we do not discuss comparable products available outside of Ireland with customers, we have attached as an example a product that can be purchased in the* [location redacted] *for a customer of the same age profile as* [the first named Complainant] *to illustrate this is a different market to the one in which we operate … which is relevant to the decision. As a non-resident of Ireland* [the first named Complainant] *was no longer able to be covered by an Irish based PMI policy and as such his health needs and coverage within the local system are determined by the local public and private system and associated rules".*

The Provider further states that where *"*[the Provider's International Health Insurance] *policy is deemed suitable for a customer needs, their domestic PMI policy is cancelled and a new* [the Provider's International Health Insurance] *policy is set up.* [the Provider's International Health Insurance] *is only suitable for customers who are residing outside of Ireland for more than 180 days.* [the Provider] *recognise years customers are insured on* [the Provider's International Health Insurance] *and allow them (if returning to Ireland) the opportunity to return to a* [Provider] *underwritten PMI policy with continuity of their waiting periods and underwriting. They have the further benefit of accessing the Irish based system as part of a return benefit".*

While I accept the Provider's statement that "th*e power to waive waiting periods and underwriting is held at the discretion of every health insurer in Ireland"* I am not satisfied with its statement "*It is not our practice to provide advice on a domestic PMI insurer's products or processes and this is the reason it was not discussed on the phone call with* [the Complainant] *on 17 November 2014.* [the Complainant] *specifically requested continuity of his waiting periods and underwriting credit on his return to Ireland and it was explained that this was possible if on* [the Provider's International Health Insurance] cover *when abroad with the intention of returning to Ireland and returning to a* [Provider] *underwritten PMI policy which remains the case".*

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While I acknowledge that the Provider's agent could not give advice or comment in relation to other insurers, I believe the Provider should have made it clear that the "*continuity of* [the Complainant's] *waiting period*" may have been restricted to the services offered by the Provider upon a return to Ireland as other providers will have their own criteria and polices which the Provider cannot advise on.

Further, the Provider did not explain how the provisions of the **General Policy Conditions** under the heading **Eligibility for Membership** would be applied to the Complainants if, at the end of the seven-year period, they did not return to live in Ireland.

I believe it was very important in selling this policy to the Complainants that they were fully and unambiguously informed as to whether holding cover under the Provider's international policy would ensure continuity of cover and lifetime cover as provided for under the Health Insurance Acts. I believe they should have been informed that if they lived abroad for more than 180 days, and then returned to live in Ireland, whether they would have to serve a waiting period for pre-existing conditions again in order to be covered by not just the Provider, but also by other insurers as provided for in the Health Insurance Acts.

During the call, the First Complainant was asked some questions to determine what an international policy would cost. The First Complainant was asked if either Complainant had any medical conditions, were taking medication, attending regular check-ups or if there was anything requiring a prescription to control. The First Complainant replied that there was *nothing really*; advising that he was on light medication for high blood pressure. The First Complainant also confirmed that the Complainants had no planned treatments or appointments.

The Provider's agent advised the First Complainant that there were two levels of cover, with Level 1 being the standard or lower level of cover. The Provider's agent then explained that:

> *"For chronic conditions, now this doesn't necessarily have to be a serious condition, medical conditions that are ongoing in nature and require routine medication to help control them or you know, that would continue indefinitely or something that you have to have a regular check up for or monitoring to control; something long term ongoing but not necessarily, you know, serious at the same time. …"*

Later in the conversation, the Provider's agent stated:

> *"On the Level 1 of the policy, you're covered for €10,000 for emergency in-patient cover only. So if something happened connected to cardiac care, you could be limited to the €10,000. If you're on Level 2 which is a higher level of cover, then you have €15,000 for chronic conditions and that would include cost of medications, any check ups, consultations and emergency or scheduled procedures or treatments. …"*

Following this, the First Complainant explained the difference in the quality of medical care between where he is now resident and Ireland, in that there was a better standard available in Ireland.

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The First Complainant indicated that he wished to have some sort of cover which would allow the Complainants to undergo any necessary medical procedures in Ireland. Responding to this, the Provider's agent suggested that Level 1 cover would be suitable but cautioned that in terms of chronic conditions, Level 2 cover was better. The First Complainant explained that where he is now residing, he would not be required to pay for doctors, consultants or prescription medication regardless of the type of medication or the amount.

The First Complainant stated, referring to the standard of medical care where he is now residing, that *"… everything was more or less there …"* but that the Complainants would be happier if they were not confined to having particular procedures in hospitals there because everything there was national health orientated and private patient treatment was actively discouraged.

The Provider's agent explained that the international policy was a risk rated policy and it would be different for each Complainant as it was based on age. The Provider's agent explained the total cost of the policy would be €6,620 and what this level of cover would entail. The Provider's agent explained that if something happened the Complainants while they were located where they now reside or anywhere in Europe, they would have cover to get emergency treatment, stabilise the condition or to come to Ireland for appointments, scheduled surgeries or follow up treatments. The First Complainant queries whether there would be a cost saving if the geographical scope of the policy was restricted to the *British Isles.* The Provider's agent advised him that it would not be possible to restrict the scope of the policy in the manner suggested. Some moments later, the First Complainant expressed the view that he had hoped to keep the price of the policy in line with his current premium of €5,200. This was followed by further discussions of the Level 1 cover.

The First Complainant queried the best way to progress the cover, asking if the Provider's agent would email him some policy details that he could review. The First Complainant was advised that he would be issued with policy documentation to review and that he also had a 30 day cooling off period. It was explained that the First Complainant would remain on cover as long as he had an intention to return to Ireland within the next seven years and that the Provider may request certain verifying information in that regard.

The First Complainant agreed to proceed with Level 1 cover. Shortly after this, the Provider's agent referred to the level of cover offered under Level 1 in respect of chronic medical conditions, asking the First Complainant if he was happy with the fact Level 1 *"… gives emergency cover only for chronic conditions, if there's anything deemed to be chronic that's ongoing in nature requiring long term medication that the actual cost of the medication or the consultant visits or GP visits wouldn't be covered but you'd have emergency cover up to €10,000 for that."* The First Complainant indicated he was happy with this. Further policy matters were discussed, and the Provider's agent referred again to the 30 day cooling off period which was to allow the terms and conditions to be reviewed by the First Complainant. The cost of the policy was also discussed again.

/Cont'd…

Following this, the First Complainant was issued with correspondence from the Provider dated **18 November 2014**. The documentation sent to the First Complainant explains, in detail, the nature and extent of the cover offered by Level 1, particularly as it relates to chronic medical conditions. The First Complainant did not raise any queries regarding the policy after the telephone conversation on **17 November 2014** or having received the policy documentation.

The First Complainant advised the Provider's agent that he and the Second Complainant were in a reasonable state of health, and that he wanted a policy similar in price to their existing policy.

While I am satisfied the extent of Level 1 cover was adequately explained to the First Complainant, particularly in respect of chronic medical conditions, the Table of Benefits states that Level 1 cover provides cover in respect of chronic medical conditions *for acute episodes only*. This was not explained to the First Complainant during the telephone conversation. I would consider this to be an important aspect of Level 1 cover, and important also in the context of the telephone conversation as the Provider's agent specifically advised the First Complainant about cover for chronic medical conditions. Therefore, I am satisfied that the First Complainant should have been advised that Level 1 cover for chronic medical conditions was limited to acute episodes.

Although the First Complainant should have been advised about this limitation, I note that the First Complainant was advised about the level of cover for chronic medical conditions under Level 1 and Level 2 and that Level 1 cover was limited. The First Complainant was also sent policy information which detailed the precise extent of Level 1 cover which, I am satisfied, should have been reviewed by the First Complainant to ensure he was satisfied with the policy. Had this been done, the First Complainant would have been reasonably aware of the cover offered by Level 1, particularly in respect of chronic medical conditions. Further to this, the Provider has stated that the First Complainant did not disclose to its agent that the Second Complainant had an ongoing medical condition. This has not been disputed by the Complainants.

I believe this information should have been disclosed to the Provider's agent, especially given the nature of the questions asked by the Provider's agent at the beginning of this conversation.

If this information was conveyed, I am satisfied it is likely to have had a bearing on the advice offered by the Provider's agent during the call regarding Level 1 and Level 2 cover.

The Provider wrote to the First Complainant on **19 October 2015** advising him that it was time to renew the policy. The letter enclosed the First Complainant's policy documents and advised him to look through these documents to ensure he was satisfied with everything. Similar renewal correspondence was issued on **16 October 2016**.

/Cont'd…

I note the Provider states that it is satisfied with all aspects of the call and had no concerns in relation to the selling of the international policy. This is disappointing as I believe there were very clear and serious shortcomings in the information given to the First Complainant during the sale and inception of the policy.

The Third Complaint

I will now deal with the cancellation of the policy. The Provider wrote to the First Complainant on **17 February 2017** informing him that due to a change in his bank account details, his direct debit had been cancelled. To ensure the policy would not lapse, the letter advised the First Complainant to contact the Provider.

By letter dated **24 February 2017**, the Provider issued the First Complainant with updated payment details and an invoice. The Provider wrote to the First Complainant on **23 May 2017** to advise him that his policy had been cancelled with immediate effect, as per the enclosed Cancellation Notification, from **15 January 2017** due to non-payment of premiums. In its *Timeline of Events*, the Provider explains that:

> *"Upon review it was identified that while the cancellation of [the First Complainant's] policy was processed on 21st April 2017 there was a delay in issuing the cancellation notice which was documented on our own internal error recording system and subsequently issued to [the First Complainant] on 23rd May 2017. …"*

The First Complainant wrote to this Office on **30 May 2017**:

> *"… I have received a further communication from [the Provider] … This letter effectively informs me that our Policy with [the Provider] has now been Cancelled, due to "non payment" despite the fact we never missed a payment in the preceding 13 YEARS.*
>
> *I invite you to read my email dated 13th February 2017 (now enclosed) and draw your attention to the opening line of the last paragraph. You will note I put [the Provider] on Notice of my intention to "SUSPEND" all further … Premium Payments, until this matter is properly resolved.*
>
> *[The Provider] have never directly responded to my email relating to my intention to SUSPEND PAYMENTS and the content and tone of their letters suggests they are unaware of the background or implications."*

In an email to this Office dated **5 August 2020**, the First Complainant explains:

> *"The sequence of events, regarding the February 2017 Direct Debit as stated in their timeline is incorrect.*

/Cont'd…

> *There was no "change" in my bank details, the Direct Debit was cancelled/suspended pending resolution of my Complaint, regarding a rejected Claim …."*

In my Preliminary Decision I stated that the evidence is that the First Complainant suspended premium payments as there was a dispute regarding a claim made by the Complainants under the policy. The First Complainant emailed the Provider's complaints email address on **13 February 2017** expressing his dissatisfaction in respect of the Provider's decision regarding the claim requesting details of its complaints procedure, advising the Provider that *"[i]n the meantime, I will suspend all further [Provider] payments, until this matter is properly resolved."*

This email was acknowledged by the Insurer on **14 February 2017** advising that it handles complaints in relation to Provider policies. While the First Complainant's email appears to have been treated as a complaint, it did not seem to acknowledge or appreciate the First Complainant's comments regarding his decision to suspend premium payments.

The First Complainant emailed the Provider's complaints email address on **24 February 2017** as follows:

> *"You can imagine my annoyance on returning home, to receive the attached (very prompt and very unwarranted) letter, from your Credit Control Manager …… waiting for me in my post box!*
>
> *I previously put you on Notice that I would "suspend" any further payment of Premiums, till this nonsense in sorted out. … None of this seems to have been conveyed to your Credit Control Manager …… before he sent his insulting epistle. …"*

The Provider has, in its post Preliminary Decision submission, detailed that it wished "*to provide clarity in respect of the ownership of the email address*" which the Complainant used to email. The Provider details that the email was "[Provider's name] [redacted]@[redacted].com". It further states that "*All correspondence to this email address was received and handled directly by the Insurer and not [the Provider]".*

The Provider submits that as per its previous correspondence to my office, it had "*outlined the dates on which* [the Provider] *contacted* [the Complainant] *(by letter) regarding the cancellation of the policy should no payment be received. This is an automated process which commenced prior to* [the Complainant] *contacting the Insurer to advise he was suspending his premium payments".*

It is further detailed by the Provider that "t*here is no mechanism within this process for suspending premium without all policy benefits also being suspended.* [the Complainant] *did not contact* [the Provider] *directly at any point regarding his intention to suspend his premium".*

/Cont'd…

However, it remains disappointing that the First Complainant's decision to suspend payments was not recognised or responded to by the Provider. Equally, as the First Complainant did not receive a response from the Provider regarding his decision to suspend premium payments or any correspondence indicating the Provider's agreement to suspend premium payments (to the contrary, the correspondence issued by the Provider was calling for payment), it was reasonable to conclude that the Provider was not consenting to the First Complainant's decision to stop making payments and that premium payments still had to be paid. Further to this, section 7 of Rules at page 29 deals with *Termination* and states that a policy will automatically end if there is a failure to pay the relevant premium on the due date. However, there does not appear to be any provision in the policy entitling the First Complainant to unilaterally suspend premium payments or do so without the consent of the Provider.

Accordingly, I am not satisfied the First Complainant was entitled to *suspend* premium payments without the consent of the Provider despite putting the Provider on notice of his intention to do so and I accept that the Provider was entitled to cancel the policy.

The First Complainant corresponded with the Insurer regarding his decision to suspend premium payments, and the Provider has submitted "[the Complainant] *did not contact* [the Provider] *directly at any point regarding his intention to suspend his premium". However,* as can be seen and as discussed further below; due to the manner in which the Provider structured its complaint contact details, I believe it was reasonable for the First Complainant to believe he was corresponding with the Provider regarding this particular issue. The lack of clarity as to which entity the Complainants were dealing with from the outset, goes to the heart of this complaint and has caused considerable difficulty and inconvenience for the Complainants.

Therefore, I consider that had those aspects of the First Complainant's emails regarding his decision to suspend premium payments been given proper consideration and responded to by the Provider or the Insurer, the Provider would have been able to advise the First Complainant that premium payments were required to be made. Furthermore, I believe this aspect of the First Complainant's emails warranted a separate and immediate response. It is also disappointing to note there was a delay issuing the Cancellation Notification.

The Fourth Complaint

Finally, I will deal with how the Provider handled the complaint.

The First Complainant made a formal complaint addressed to the Provider's complaints email address, which is in fact the Insurer, on **13 February 2017** in respect of a decision to decline a claim under the policy regarding the Second Complainant.

The complaint was acknowledged by the Insurer by email dated **14 February 2017**. This email expressly states that complaints regarding the policy were handled by the Insurer.

/Cont'd…

A Final Response email was issued by the Insurer on **16 March 2017**. In this email, the Insurer explained that it *"… handle[s] all claims and complaints for [Provider] International Members."* and *"The sale and administration of the policy is dealt with by [the Provider]."*

The First Complainant explains that his complaint contained a mis-selling aspect and this should have been passed by the Insurer to the Provider. The Provider states that it was not made aware of the Complainants' case until **March 2017** and that it related to matters other than the selling of the policy. The Provider also advises that matters relating to underwriting, claims or benefits are handled by the Insurer, and matters in relation to the sale of a product or service are handled by the Provider. The Provider explains that on **15 March 2017**, following a request from the Insurer for a copy of the call from **17 November 2014**, it reviewed the call in full and was satisfied with all aspects of the call and had no concerns in relation to the selling of the international policy.

Section 3 of the 2016 Rules state that: *"If you have any concerns about any aspect of the service You have received please write in the first instance to: [the Provider's Claims Department at Insurer's Irish Address]."*

While the Provider references its Operations Manual in the 2017/2019 Rules and how this demarcates responsibility for various types of complaint, it is not clear exactly where these references are in the 2014 or 2016 Rules and a copy of the Operations Manual does not appear to have been furnished as part of its response to this complaint.

Further to this, there is no evidence of these documents being provided to the Complainants, and it is unlikely that they were as the policy lapsed from **January 2017** with renewal documents being sent to the First Complainant the previous year in **October 2016** which covered the **2016/2017** period of the policy.

In any event, the 2016 Rules suggest that ***all*** complaints regarding the policy are to be addressed to the Provider's Complainants Department at the Insurer's address or the Insurer's email address, which was also contained in section 3. There is no *division of responsibly* stated in any iteration of the Rules furnished to the First Complainant.

Having considered Provider's submissions and the Insurer's Final Response letter, I am satisfied that the First Complainant made a complaint regarding the selling of the policy and the Provider should have been reasonably aware of this in **March 2017**.

In particular, I note the following paragraph in the Final Response email:

> *"As you stated your main area of concern was that on the date that your cover changed to the International policy, you were unaware that the terms and conditions in respect of Chronic Medical Conditions would alter. …"*

A formal response was not received by the Complainants in respect of the selling of the policy until **8 August 2019** following correspondence issued by this Office to the Provider on **2 August 2019**.

/Cont'd…

Therefore, I am satisfied that a complaint was made regarding the selling of the policy. However, difficulties arose owing to the complex relationship and lack of clarity around the role and responsibilities of the three financial service providers responsible for the sale, inception and operation of the Complainants' policy and the manner in which the Provider arranged its complaints handling procedure. This was further complicated by the absence of any demarcation of responsibility for particular types of complaints, accompanied by the absence of designated contact details for the different types of complaints. I accept that the First Complainant's complaint regarding the selling of the policy was not received by the Provider and accordingly, not responded to by the Provider in a timely manner or at all, until the Complainants sought to make a complaint to this Office.

I believe the difficulties that arose in dealing with the Complainants' complaint were a continuation of the confusion caused from the outset as a result of the poor level of information furnished to the First Complainant when he contacted the Provider in 2014 to explain that the Complainants no longer lived in Ireland.

I welcome the statement of the Provider in its post Preliminary Decision submission that "*regrettably in this case there are a number of issues which we realise have caused confusion and distress for* [the Complainants] *arising from how the claim was handled and the length of time taken to conclude the case. It is clear that the communication between the Insurer and* [the Provider] *in respect of the management of this multi-faceted case should have been handled better. We are committed to addressing any shortcomings in this process with the Insurer and we will be requesting that they not only notify us of all complaints received but that a better process is in place to address the core customer concerns whilst respecting the different responsibilities of both parties".*

The Provider has also, as part of its post Preliminary Decision submissions, detailed that as it is "*concerned that as a result of the customer cancelling his* [the Provider's International Health Insurance] *policy, he may no longer have access to important benefits such as repatriation. Also, should* [the Complainants] *decide to return to Ireland they may be subject to waiting periods and underwriting if alternative arrangements have not been made in the interim. Separate from your final decision in relation to the complaint and with this in mind that should* [the Complainants] *decide to return to Ireland within the next 24 months, we will waive any underwriting and waiting periods if returning to a* [Provider] *underwritten PMI policy. Lifetime Community Rating (LCR) will apply however as this is a matter of legislation".* I acknowledge and welcome this gesture by the Provider.

I welcome these gestures by the Provider, albeit that they are coming very belatedly.

That said, it remains my belief that the Provider should have informed the First Complainant, particularly in the call in **November 2014** when he incepted the international policy, that the Provider was, in fact, selling him a new policy with entirely different insurers and underwriters.

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Because of the difficulties that consumers are experiencing in identifying who is providing them with financial services, such as important insurance cover and the serious risk to other consumers of the practice by the Provider in not furnishing information in a clear and accessible manner during the sale of its international policies, and the very real difficulties than can ensue for insured persons, I am bringing my Legally Binding Decision in this complaint to the attention of the Central Bank of Ireland for any action it may deem necessary.

For the reasons set out in this Decision, I partially uphold this complaint and direct the Respondent Provider to pay the sum of €12,000 to the Complainants.

Conclusion

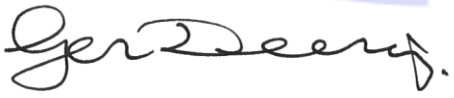
My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially upheld, on the grounds prescribed in ***Section 60(2) (b) and (g)*** because of the unreasonable and improper conduct of the Provider.

Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainants in the sum of €12,000, to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants to the Provider.

I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

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

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



GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

27 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.