An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0369
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Rejection of claim
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Since 2001, the Complainant has held an insurance policy with the Provider called a '**Serious Illness Plan'** referred to in this Decision as "Policy C". Her husband is listed as the life assured. The complaint concerns a declined serious illness claim.

The Complainant's Case

The Complainant, now age 79, says she has held a number of policies with the Provider since the early 1980s.

In particular, the Complainant says that in **2001** she incepted a 'Serious Illness Plan' with the Provider, with her husband listed as the life assured.

Following her husband undergoing open heart surgery in **January 2019**, the Complainant sought to claim a serious illness benefit under her 'Serious Illness Plan' but she says that the Provider rejected the claim and advised that the policy did not include serious illness cover.

In her undated letter to this Office received on **4 June 2019**, the Complainant submits:

> *" … This Policy was sold to us initially as a Serious Illness Policy, and has always been referred to by* [the Provider] *in all* [its] *correspondence to us down through the years as such … Obviously this has been very misleading for us, as we have always understood it to be a Serious Illness Plan …"*

In this regard, the First Complainant notes, for example, that the **Policy Certificate** dated 1 August 2001 states the name of the policy type as *"SERIOUS ILLNESS PLAN"* and that a letter she received from the Provider dated **12 November 2007** in relation to this policy advised:

> *" … Your policy is a Serious Illness policy which and is due to cease on 1st August 2036. The aim of this policy is the provision of protection benefits. These benefits offer protection for you and your family's wellbeing through your lifetime. Therefore, the purpose of your policy is to sustain the risk benefits …"*

The First complainant submits in her email to this Office on 5 June 2020, as follows:

> *" … So it is perhaps understandable that after 20 years of receiving updates all marked Serious Illness Plan, and after years of thinking we were protected in such an event, we are more than perplexed …"*

The Provider, in its final response letter to the Complainant dated **15 February 2019**, says that the policy at issue was originally taken out in **October 1983** and had life cover in respect of her husband as the only policy benefit. The letter advised that:

> *" … In August 2001 this policy was converted into a new policy … Although the name of the product was…Serious Illness Plan, the benefit that converted over for your life remained at just Life Cover.*
>
> *I do acknowledge that the name of this plan would lead to confusion, but in the case of both polices, there was only ever a benefit of Life Cover attached for yourself and at no time did you apply for Serious Illness cover. Therefore any claim submitted for Serious Illness will not be considered, as at no time did you have Serious Illness Cover in place …"*

The Complainant sets out her complaint in the Complaint Form she completed, as follows:

> *"Having had* [a Provider] *policy since 1983, we took out a separate serious illness plan in 2001. We've paid premiums in good faith to* [the Provider]*…for the purposes of protecting ourselves against serious illness, which affected my husband…earlier this year. All the documentation in our possession specifically states Serious Illness Plan, so we are at a complete loss as to* [the Provider's] *refusal to pay out on this policy …*
>
> *Given that my husband's open heart surgery took place in* [a private clinic]*, there have been considerable costs: cardiologists, cardio-surgeon, electro-cardio surgeon, travel & accommodation costs for myself + the family, ongoing physio + cardiologist visits"*.

The Complainant seeks for the Provider to compensate her financially toward costs incurred in relation to her husband's serious illness.

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The Provider's Case

The Provider sets out the following information in relation to the policies the Complainant has held and holds with the Provider:

'Policy A' (xxxxx639):

The Provider says that 'Policy A' was a whole of life policy set up in **October 1983** which provided life cover only, in line with what was requested on the policy application signed by the First Complainant. The First Complainant was the policy owner and her husband the life assured. The name of the product type was a 'Living Assurance Policy'.

The Provider says that 'Policy A' was not subject to annual reviews, rather the Third Schedule, 'Periodic Premium Reviews', of the applicable **Policy Document** provided for a premium recalculation on the tenth anniversary of the policy, and every tenth anniversary thereafter. As a result, a review letter (and the only review letter ever sent in respect of 'Policy A') was sent to the Complainant in 1993 but she declined the premium increase at that time and a further letter sent to her on **20 September 1993** confirmed that the life cover would reduce to **IR£22,000** (twenty two thousand Irish Pounds) from **October 1993**.

The Provider says that annual statements were not mandatory for policies such as 'Policy A' at that time, and therefore none ever issued.

The Provider says that 'Policy A' is the only policy that it has ever sold to the Complainant, and that it remained active until 2001, when it was converted to 'Policy C' (see below).

'Policy B' (xxxxx406):

The Provider says that 'Policy B' was set up by the Provider in **October 1986** and provided life cover only. The First Complainant was the policy owner and her husband the life assured. The name of the product type was a 'Living Assurance Policy'. The Provider says that because the indexation option was not available on 'Policy A', this new 'Policy B' was set up to facilitate the 'Auto Lifelinks' option, which is outlined in the Fifth Schedule, 'Automatic Lifelinks', of the **Policy Document** for 'Policy A'.

The Provider says that 'Policy B' is subject to annual reviews and a policy review letter is sent to the Complainant each year on the policy anniversary date.

The Provider confirms that 'Policy B' was a separate stand-alone policy from 'Policy A' and continued alongside 'Policy A' (and later, still continues alongside 'Policy C'), and that the Complainant paid premiums on both 'Policy A' and 'Policy B' (and later, on both 'Policy B' and 'Policy C') each month.

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'Policy C' (xxxxx821):

The Provider says that 'Policy C' was set up by the Provider in **August 2001** as a direct replacement for 'Policy A' and that this conversion was necessary when the Provider moved to a new administration system. The name of the product type was a '**Serious Illness Plan'**. The Provider says that it does not currently review this type of policy and therefore the premium has remained unchanged since it was converted in August 2001.

The Provider says that though the name of the product was a '**Serious illness Plan'**, there was no change to the policy terms and conditions and the benefit that converted over to 'Policy C' remained the same as 'Policy A', in that 'Policy C' continued to provide life cover only in respect of the Complainant's husband, in line with 'Policy A' and the original 'Policy A' application the Complainant signed in **August 1983**. The Provider is satisfied that this was clearly illustrated on the documents it sent to the Complainant at the time.

In this regard, the Provider says that the Complainant signed an **Acknowledgement Form** confirming that it was in order to convert existing 'Policy A' to a 'Serious Illness Plan'. A **Policy Transfer Comparison Summary** was provided, which clearly stated at the time that there was **IR£22,000.00** life cover on 'Policy A' for a monthly premium of **IR£29.82** (twenty nine Irish Pounds and eight-two Irish Pence) and that there would also be **IR£22,000.00** life cover on the new 'Policy C' for a monthly premium of **IR£28.95** (twenty eight Irish Pounds and ninety-five Irish Pence).

The Provider says it also sent the Complainant a **Policy Certificate** which clearly stated a Life Sum Insured of **IR£22,000.00** in the benefit summary, and that there was no mention of Serious Illness Cover in this benefit summary.

In addition, the Provider wrote to the Complainant on **9 October 2001** confirming that although 'Policy A' now had a new policy number, the 'Policy C' number, all terms and conditions were the same and the policy benefits remained unchanged.

The Provider notes from its records that the Complainant has had the benefit of a number of different independent financial advisors associated with her policies since 1983.

The Provider says the product name 'Serious Illness Plan' was used as a general product name for a product which offered a flexible range of benefits, including serious illness cover, life cover and a range of other optional benefits. The benefits applicable to an individual policy are set based on the benefits which the policyholder requested on the application form.

The Provider says that in this case, as 'Policy C' was set up as a direct replacement for 'Policy A', 'Policy C' issued with whole of life cover only and no serious illness cover was ever included, as this was not on the original 'Policy A' (and indeed was cover the Provider did not begin to sell until **April 1993**).

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The Provider acknowledges that the product name 'Serious Illness Plan' could lead to confusion but says that this product was the only type of protection policy it had at the time that could provide risk benefits for whole of life. It is for this reason that 'Policy A' and similar whole of life policies like it at the time, that could not be facilitated on the Provider's new administration system, were converted to this type of policy. The Provider says that its other protection policy at that time, in 2001, was a 'Guaranteed Term Plan' which was for life cover only, but only for a fixed term and not whole of life, so it would not have been suitable to have converted 'Policy A' to this product type.

The Provider says that it has no evidence whatsoever of the Complainant having requested in 2001 that a new policy be set up, or of her ever applying for serious illness cover with it. In this regard, the Provider confirms that 'Policy A' is the only policy that it has ever sold to the Complainant.

As a result, the Provider cannot consider any claim submitted by the Complainant for serious illness benefit as she does not have, and at no time did she have, serious illness cover in place with the Provider.

In terms of premiums, the Provider says that because the First Complainant was using the same direct debit to pay for both 'Policy A' and 'Policy B', her bank statements would have shown one total amount monthly deduction for the Provider, covering both policies. This would also be the case today, where the First Complainant currently has 'Policy B' and 'Policy C' in place, but the amount would only appear as one Provider debit on her bank statement, despite there being two premiums collected across two policies.

The Provider is satisfied that 'Policy C', and 'Policy A' before that, has at all times operated in line with the terms and conditions outlined in the **Policy Document** and that it provides the benefit proposed and paid for by the Complainant, namely life cover only in respect of her husband.

Jurisdiction of the FSPO

In making her complaint to this Office, the Complainant has asserted that the policy was initially sold to her as a *"Serious Illness Policy"* and she contends that it *'has always been referred to by* [the Provider] *in all* [its] *correspondence to* [her] *down through the years as such."* The Complainant says that this

> *"has been very misleading for* [her]*, as* [she has] *always understood it to be a Serious Illness Plan".*

The Complainant submitted annual policy statements from the Provider from **2002, 2012 and 2018.** The statements set out the *'Policy Type'* as a *'Serious Illness Plan'*.

The Complainant contends that she has paid *"the premiums in good faith"* and is *"at a complete loss as to* [the Provider's] *refusal to pay out on this policy"*.

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It has previously been made clear to the parties, that any conduct of the Provider relating to the sale of the policy at issue and/or advice given to the Complainant when the policy was incepted and/or when the policy was converted, is conduct which occurred before **1 January 2002** and such conduct therefore falls outside the jurisdiction of this Office, pursuant to ***s51(3)(a)*** of the ***Financial Services and Pensions Ombudsman Act 2017*** ("the Act"). Any conduct of the Provider however, which occurred **during or after 2002,** falls within the jurisdiction of the FSPO.

Accordingly, the complaint about the Provider's suggested misrepresentation from 2002 onwards, of the type of policy the Complainant held, forms part of this investigation, being conduct of a continuing nature within the meaning of ***s51(5)*** of the Act, and is taken "*to have occurred at the time when it stopped and conduct that consists of a series of acts or omissions is taken to have occurred when the last of those acts or omissions occurred*"

The Complaint for Adjudication

The first element of the complaint is that from **2002** onwards**,** the Provider continuously misrepresented the type of policy the Complainant held, as a serious illness policy.

The second element of the complaint is that in **2019**, the Provider wrongfully refused to admit and pay the Complainant's serious illness claim.

The Complainant wants the Provider to compensate her financially for the costs incurred in relation to the Insured's surgery, including consultant fees and travel expenses, and for ongoing medical expenses in relation to the associated follow up treatment.

Decision

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

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

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A Preliminary Decision was issued to the parties on **21 September 2021**, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter. In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

I note from the documentary evidence before me that the Complainant completed and signed a Proposal Form for 'Policy A', policy number xxxxx639, on 23 September 1983 for life cover in the amount of **IR£25,000.00** (twenty five thousand Irish Pounds).

I note the **First Schedule** of 'Policy A', dated **4 October 1983**, confirmed, among other things, as follows:

> *" … PRIMARY ASSURANCE:*
> *A SUM INSURED OF £25000 WILL BECOME PAYABLE ON THE DEATH OF THE LIFE INSURED*
>
> *ADDITIONAL INSURANCES: NOT APPLICABLE … "*

I note therefore that 'Policy A' was set up to provide life cover in the amount of **IR£25,000.00**, with the Complainant's husband listed as the life assured. I note there were no other additional insurances or cover sought or applied to this policy.

In her email to this Office on 21 September 2020, the First Complainant submits that:

> *" … Policy No xxxxx639* ['Policy A'] *was indeed taken out in 1983. In 1986 this number was changed to xxxxx406* ['Policy B'] *for administrative reasons within* [the Provider] *…"*

In addition, in her email to this Office of 6 August 2020, the Complainant submits that:

> *" … There was always only one Policy from 1983 until 2001, when we then requested a new policy which was a Serious Illness Policy … "*

I note, however, that the Complainant's recollection of events is not borne out by the documentary evidence before me.

In this regard, the Provider wrote to the Complainant on **20 September 1993** regarding 'Policy A', policy number xxxxx639, as follows:

> *"Thank you for your recent communications whereby you advised that you did not wish to take this increase in premiums on your policy with effect from 1st October 1993.*

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As a result of not accepting the increase the life cover on your policy has reduced to £22,000 with effect from October".

I therefore take the view that the Complainant was aware in September 1993 that 'Policy A', policy number xxxxx639, was still in force at that time.

In addition, the Provider wrote to the Complainant regarding policy reviews carried out on 'Policy B', policy number xxxxx406, on, amongst other dates, **15 August 1992** and on **20 August 1994**, which was before and after the above letter dated **20 September 1993** regarding 'Policy A', policy number xxxxx639, making it clear that the Complainant had at that time two different policies in force with the Provider.

Instead, I note the Complainant asserts that she requested a new serious illness policy from the Provider in **2001**, there is no evidence of a new proposal for cover (application form) completed at that time. I note that the Provider wrote to the Complainant in **August 2001** regarding 'Policy A', as it says it was necessary for the Provider to convert this policy as it had moved to a new administration system.

In this regard, the Complainant signed an **Acknowledgement Form** on **4 September 2001** confirming, as follows:

"I/We, the undersigned, confirm that it is in order for [the Provider] *to convert my/our existing policy number xxxxx639* ['Policy A'] *to* [a Provider] *Serious Illness Plan"*.

I note that the **Policy Transfer Details** document that the Provider sent to the Complainant compared 'Policy A' to the 'Policy C' that it was being converted to, as follows:

	Old Policy	**Converted Policy**
Policy Number:	0428639	10581821
Policy Start Date:	1st October 1983	01-Aug-01
Policyowner:	[The Complainant]	[The Complainant]
Life Insured:	[The Complainant's husband]	[The Complainant's husband]
Plan Type:	Whole of Life	Serious Illness Plan
Current Monthly Premium:	£29.82	£28.95
Additional Benefits:		
Life Cover	£22000	£22000
PHI Benefit	N/A	N/A
Waiver of Premium	N/A	N/A

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I note that the **Policy Certificate** which the Provider says it issued to the Complainant for 'Policy C' (on the basis of it being converted from 'Policy A') is dated 1 August 2001, a month before the Complainant's signed acknowledgement form.

The said Policy C Certificate states:

> POLICY CERTIFICATE
>
> [PROVIDER] SERIOUS ILLNESS PLAN
>
> **Policy Number: xxxxx821** ['Policy C'] …

Benefit Summary	
Life Sum Insured	**£22000.00**
Waiver of Premium Benefit	**Does not apply**
Basis of Cover	**Single Life**
Annual Policy Increase	**Does Not apply**
Insurance Term	**35 years from the start date**

In addition, I note that the Provider wrote to the Complainant on 9 October 2001, as follows:

> *"**Ref:** **Policy Number:** **xxxxx639** …*
>
> *I refer to the above numbered policy and our previous correspondence.*
>
> *Following conversion, this policy will now be referred to as Policy Number xxxxx821* [Policy C] *on our new administration system.*
>
> *I confirm that the terms and conditions of your existing Policy Document still apply and can assure you that your benefits remains unchanged on the new Policy Number.*
>
> *The premium remains the same and your next premium falls due on 01/11/2001.*
>
> *Please quote the Policy Number xxxxx821 on all future correspondence with us in respect of this policy"*.
>
> [Underlining added for emphasis]

I note that a copy of this letter was also sent to the Complainant's Broker at that time.

I am of the opinion that the Provider made it clear in the documents that it provided to the Complainant at the time of the policy conversion in 2001 that the policy cover on the new 'Policy C' was the same as the cover the Complainant had applied and paid for on 'Policy A', that is, life cover only in respect of her husband.

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In addition, the Provider also made it clear that the original **Policy Document** that the Complainant received when she took out 'Policy A' in **August 1983** continued to apply and I am satisfied that this **Policy Document** makes no reference whatsoever to serious illness cover.
In addition, I note that the **Annual Statement** for 'Policy C' dated **20 July 2014** stated:

> *"**A summary of the Protection Benefits***
>
> ***Life Sum Insured*** *€27,935.00*
> ***Basis of Cover*** *Single Life*

The same summary of protection benefits was provided to the Complainant in the **Annual Statements** dated **20 July 2015**, **18 July 2016**, **18 July 2017**, **18 July 2018** and **18 July 2019**, and each made no reference to serious illness cover.

Nevertheless, I appreciate that it must surely have been very confusing for the Complainant that 'Policy C' was consistently called a '**Serious Illness Plan'**, when it did not in fact provide her with any serious illness cover whatsoever. It is disappointing that the Provider did not anticipate such confusion and create a different product name or indeed a different product type, whether at the time it was moving to a new administration system in 2001, or within a reasonable period thereafter.

Indeed, by **2007**, all of the provisions of the Consumer Protection Code 2006 ("CPC 2006")had come into effect and I am conscious that CPC 2006 made clear that:-

> "*A regulated entity must ensure that all information it provides to a consumer is clear and comprehensible, and that key items are brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information."*

Although prior to 2007, the Annual Statements issued by the Provider in accordance with the *Life Assurance (Provision of Information) Regulations 2001* did not breach this regulatory requirement, I am satisfied that with the additional requirement to adhere to the provisions of CPC 2006, the Provider ought to have taken the necessary steps to ensure that the name of the policy would no longer mislead or confuse or disguise the nature of the benefits offered by the cover which the Complainant held.

Indeed, when CPC 2012 came into effect, this repeated the requirement on regulated entities to, amongst other things,:-

> "… e*nsure that all information it provides to a consumer is clear, accurate, up to date and written in plain English. The information must be brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information."*

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Whilst a copy of all of the Annual Statements issued by the Provider to the Complainant after CPC 2012 came into effect, have not been made available, it is clear from the Annual Statements dated **18 July 2018** and **18 July 2019** respectively that the policy type is clearly identified on the fact of these statements as a "*Serious Illness Plan*".

It is completely understandable that in the face of these repeated Annual Statements, the Complainant may have formed the opinion and the expectation that the cover in place under this policy, included benefit in the event of serious illness.

Insofar as the first element of the complaint is concerned therefore, I am satisfied that it is appropriate uphold that element of the complaint, that from 2002 onwards, the Provider continuously misrepresented the type of policy which the Complainant held, as a Serious Illness Policy. Indeed, in my opinion, that misdescription from 2007 onwards, led to a continuing breach by the Provider of its regulatory obligations in accordance with the provisions of the Consumer Protection Codes.

Be that as it may, I am satisfied from the documentary evidence before me, that when the Complainant incepted 'Policy A' in **August 1983** it was for life cover only in respect of her husband and that the policy conversion to Policy C in **2001,** did not alter or expand that cover from the life cover only which had been in place. This was indeed reflected by the premium rate remaining unchanged.

Because the Complainant did not and does not hold serious illness cover with the Provider, under Policy C, I am satisfied that the Provider cannot be required to admit her serious illness claim from 2019 as no such cover was held by the Complainant.

I am satisfied in that regard that it is not appropriate to uphold the second element of the Complainant's complaint that the Provider wrongfully refused to admit and pay her serious illness claim.

In all of the circumstances outlined, I am satisfied that it appropriate to partially uphold the complaint against the Provider, for the reasons outlined above. I consider it appropriate therefore to direct the Provider to make a compensatory payment to the Complainant in the sum of **€4,000**, in recognition of the confusion and inconvenience caused to the Complainant as a result of its misleading and disguising description of the type of the policy she held.

I recommend that the Provider undertake a review of its legacy policies so that it may identify other continuing policyholders who may be in receipt of communications which misrepresent or disguise or obscure the nature of or the limitations to the policy benefits offered by policies held.

In light of the issues arising in this complaint and my concern that there may be other policyholders who have wrongly formed the opinion that they hold serious illness cover with the Provider, because of the Provider's misdescription of the type of policy in place, I intend to draw the attention of the Central Bank of Ireland to my decision in this matter, for such action as it may consider to be appropriate.

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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)(a) & (g).***

- 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 Complainant in the sum of **€4,000**, to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the Provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

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

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

MARYROSE MCGOVERN
Deputy Financial Services and Pensions Ombudsman

13 October 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.