An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0456
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Delayed or inadequate communication Dissatisfaction with customer service
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The complaint concerns a Life Protector Plan incepted in **1997**.

The Complainants' Case

The Complainants state that they took out a Life Protector Plan with the Provider on **1 May 1997**. The first Complainant further states that the premiums payable were deducted by his employer, also referred to as 'the scheme', through payroll, from a pension payment that he was in receipt of on a monthly basis.

The Complainants submit that the premiums increased and the scheme was not notified of these increases and that, as a result, the account subsequently fell into arrears resulting in *"a considerable amount of money to be paid to bring the account up to date"*. The Complainants further submit that the *"Provider accepted that they were wrong when they failed to notify the scheme about the increased premium and that they were the cause of the arrears"*.

The Complainants contend that the Provider offered to *"waive the arrears and allow the premium to recommence"* as an *"offer and a gesture"*. The Complainants further contend that at this stage, not alone was the policy indexed-linked and increasing on an annual basis, but it was also being levied as a result of the Complainants' ages. The Complainants state that the increases on the policy premium just *"became too much"* for them to maintain.

The Complainants say that they dispute that the premiums were indexed-linked as this current policy was a conversion option on a previous policy held with the Provider. They say they had previously informed the Provider by letter on **1 October 1990,** that they did not want to avail of indexation on the original policy. The Complainants further say that there is no indication on the application form used to convert to the new plan, that they wished to avail of indexation and they had expected that the instruction letter sent to the Provider in relation to their non-acceptance of indexation, would remain in place.

The Complainants submit that the Provider informed them that it is reasonable to assume the Complainants were aware that the premiums were increasing each year and that it does not have a record of the Complainants "*notifying us at any time that they were aware of this benefit applied to their plan and they did not write asking them to stop the payment".*

The Complainants further submit that:

> *"It is accepted that the policy was a policy which would allow for the increase in the premium as the risk got greater. However, the indexation and the failure to inform of the increase in premium was the cause of the policy lapsing".*

The Complainants state in their letter to the Provider dated **14 March 2017** that they "*reserve their position with regard to a claim for breach of contract on your part for the upset and distress that has been caused to them".* The Complainants further state that they believe they have been let down by the Provider as they were not kept abreast of the issues.

The Complainants have been advised that the suggested mis-sale of the policy in **1997** is not a matter which comes within the jurisdiction of the FSPO, and the conduct of mis-selling does not form part of this investigation.

The Provider's Case

In its response letter dated **20 December 2017**, the Provider noted that the Complainants:

- Were unhappy with the plan review feature on the plan and the increased payments needed to maintain the benefits;
- Were unhappy that their plan has now lapsed;
- Believed that this lapse has occurred as a result of indexation being applied to the policy.

The Provider states that a detailed explanation of the plan review and the reasons for undertaking such reviews were included in a letter from the Provider to the Complainants dated **20 June 2014**. The Provider also states that it received a review acceptance from the Complainants on **1 July 2014** confirming acceptance of the increased premium. A copy of these documents is contained in the Provider's submission.

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The Provider says that "*in the event that there is a change to the payment to be collected (e.g. by way of indexation or after a plan review)"*, the scheme is notified of the changes in order that the correct amount is deducted and invested back into the plan. The Provider further says that due to an oversight the scheme was not informed of the changes in premium for **2014** and **2015**.

The Provider submits that as a result, between **July 2014** and **July 2016** the payments made to policy were significantly lower than the amounts due, ultimately resulting in a lapse of benefits. The Provider further submits that it wrote to the Complainants on **06 September 2016** to make them aware of the arrears which were then in the amount of €3,181.53 (later growing to €3,585.39) and which were due to be paid in order for the plan to be paid up until **1 January 2018**. The Provider states that due to the fact that the scheme was not notified of the amended premiums, it agreed to waive those arrears and to allow the Complainants to be reinstated in their plan.

The Provider contends that it acknowledges that there is no record of indexation being selected on the application form to convert the original policy and that a copy of the plan schedule is not available. The Provider further contends that it is reasonable to assume that the Complainants were aware of their payments increasing each year and it notes that no request was received from them asking for a cancellation of the indexation element of the plan.

The Provider asserts that Annual Benefit Statements were sent from **2006** onwards on a yearly basis which included details of increased payment and life cover to apply on each anniversary of the policy. The Provider further asserts that the Complainants could choose to opt out of the increased payments in writing within a 10-day period.

In its Final Response Letter dated **4 April 2018** the Provider states that *"I understand from your letter of **23 February 2018** that you believe that indexation was applied incorrectly"* on the policy plan. The Provider further states that the Complainants make reference to a letter dated **1 October 1990** which requests the cancellation of indexation but they reiterate that this cancellation refers to a policy plan that was in place prior to its conversion to the current plan. The Provider asserts that "*we are not in a position to review any issues relating to this plan due to time lapsed",* as this plan is no longer in force since **1997**.

The Provider contends that payments and benefits were increased on the new plan on a yearly basis since the policy inception and that "*it is reasonable to assume that the Complainants were aware of the increases as we received the increased payments over the years".* The Provider further contends that as it received no notification from the Complainants that they did not want indexation to apply to their plan it was therefore *"reasonable to assume that they were happy to continue with this benefit on their plan".*

The Provider states that based on the above information and its response letter dated **20 December 2017**, there is no change to the Provider's position on the matter.

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The Complaint for Adjudication

The complaint is that the Provider:

- Failed to notify the Complainants of increases in the policy premiums for **2014** and **2015,** resulting in the plan falling into arrears;
- Offered poor customer service and communication throughout.

The Complainants want the Provider to refund all monies paid by way of premium to the policy, as set out in their submissions.

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 **27 October 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.

A significant proportion of the Complainants' complaint as originally articulated to this Office relates to matters which fall outside of the jurisdiction of this Office owing to the fact that the matters complained of occurred too long ago. Specifically, insofar as the Complainants allege that a policy was mis-sold to them in **1997** (by reference to an instruction given in 1990), this is not a matter which falls within this investigation, owing to the time limits for making complaints, as set out in ***Section 51*** of the ***Financial Services and Pensions Ombudsman Act 2017*** (in particular ***Section 52(3)(a)).***

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Consequently, the Complainants' complaint that their policy was mis-sold in **1997**, because contrary to their instructions, the premium was indexed-linked (and thus increasing on an annual basis) and that it would be levied as a result of the Complainants' ages, does not fall to be considered here. This position regarding jurisdiction was communicated to the Complainants, who confirmed that they wished this Office to proceed to review the balance of their complaint which was not out of time.

As to that balance of the complaint, this is limited to the administration of the policy from April 2013 onwards (noting that the complaint was made to this Office in April 2019). The matters which can be extrapolated from the Complainants' complaint which fall within this period, are as follows:

- The Provider failed to notify them of increases in the policy premiums for **2014** and **2015** resulting in the plan falling into arrears;
- The Provider offered poor customer service and communication throughout.

With regard to the first issue, the Provider has acknowledged this failing. The Provider initially wrote to the Complainants in mid-2014 regarding the necessity for increased payments but it subsequently transpired that the Provider omitted to request the larger payments from the First Complainant's employer's scheme, from which it had always collected the payments by way of payroll deduction. This resulted in underpayments being made over a period.

A letter of **02 July 2016** notified the Complainants that the plan "*has now gone out of force and your benefits have been cancelled*" owing to outstanding payments. Thereafter, a letter of **06 September 2016** sought the payment of arrears in the amount of €3,181.53. A subsequent letter of **01 October 2016** reiterated the fact that the plan had gone out of force.

Thereafter, extensive correspondence was exchanged on the matter leading to the Provider's Final Response Letter of 20 December 2017 which acknowledged an "*oversight*" on its part in failing to notify the First Complainant's employer's scheme of the increased payments due for the 12-month periods beginning in July 2014 and in July 2015. This resulted in a shortfall of payments on the Complainants' policy in the amount of €3,585.39.

Owing to its own failing, the Provider, in its Final Response Letter of December 2017, (issued directly to the Complainants' solicitor) offered to make up the shortfall and to reinstate the Complainants' policy to the full value it would have retained, if full premium payments had been made. I note that at this time, the Complainants were aged 71 and 69 years respectively. This offer does not appear to have been taken up by the Complainants notwithstanding an extension granted by the Provider in respect of the period for the Complainants to indicate their decision.

I am satisfied that this offer in late 2017, constituted an adequate response by the Provider to this particular issue. In particular, with regard to the status of the policy, the offer of the Provider would have put the Complainants in the position they would have been in, were it not for the Provider's error.

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Of course, the Complainants would also have benefited from retaining full cover in respect of the relevant period, without paying the cost of retaining that cover insofar as the Provider itself had offered to make up the shortfall in the payments from July 2014 to July 2016. They chose however not to accept that offer.

In light of the foregoing, I do not consider it appropriate to uphold this aspect of the complaint, as the issue was acknowledged and adequately dealt with by the Provider, long before the Complainants made this complaint to the FSPO.

The Complainants are also unhappy that the Provider proffered poor customer service and communication. Again, this Office is restricted in terms of its review, to matters occurring from April 2013 onwards. Excluding matters that pre-date April 2013, and excluding the issue regarding the underpayments addressed above, the Complainants do not identify any specific conduct by the Provider said to be objectionable. Rather, it seems they are generally frustrated by the position in which they have found themselves.

From the Complainants' point of view, it is no doubt disappointing that their policy has lapsed, such that their premiums paid to-date are not reflected in any existing policy. However, the Complainants, when notified that underpayments had been received, and when offered the opportunity to reinstate the plan with the Provider, and with the Provider making up all the underpayments, elected not to accept the offer. I do not accept that the Provider should have been required to do anything more than make this offer.

The Complainants are clearly unhappy with the nature of the policy which they purchased in 1997. Such matters however, for the reasons previously explained to the Complainants, fall outside the jurisdiction of this Office.

In the context of the Complainants' decision not to accept the Provider's offer in late 2017, it is noteworthy that in its response to the investigation by this Office, the Provider, having noted that reinstatement of the policy was no longer available, given the passage of time, went on to state as follows:

> *In lieu of the reinstatement opportunity which has passed we would like to offer* [the Complainants] *a Customer Service Award of €2,000 by way of apology for our error in not informing* [the First Complainant's employer] *about the correct deductions on their plan.*

I note that, since the preliminary decision of this Office was issued on **27 October 2021**, a letter dated **15 November 2021** was received from the Complainants' legal representatives advising that the Complainants wished to accept the Provider's Customer Service Award of €2,000. I note that the Provider has since responded that the amount will be paid once the Legally Binding Decision of this Office has been received, and I am pleased to note that position.

Insofar as the particular complaint made against the Provider is concerned however, for the reasons outlined above, I do not consider it appropriate to uphold that complaint.

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Conclusion

My Decision is that this complaint is rejected pursuant to ***Section 60(1)*** 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

30 November 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.