An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0458
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Lapse/cancellation of policy (life) Maladministration (life)
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The complaint concerns the cancellation of benefits under the Complainant's whole of life policy.

The Complainant incepted the policy the subject of this complaint with a financial services provider ("the Insurer") in **1995**. The policy was subsequently transferred to the Provider, against which this complaint is made.

The Complainant's Case

The Complainant explains that in **September 1994**, his mortgage loan provider advised him to take out a life assurance policy with the Insurer in respect of his mortgage loan.

On **1 August 2014**, the Complainant explains that due to financial difficulties, payments in respect of the policy ceased. The Complainant says the Insurer kept the policy alive by drawing monthly payments from the *"assurance fund"* but cancelled the protection benefits. The Complainant submits that the protection benefits should not have been cancelled. The Complainant states that, because the protection benefits were cancelled, he was at a disadvantage, as during this time he was hospitalised following an accident.

The Complainant submits that there were *"enough funds in the Policy"* to keep the protection benefits alive.

The Provider's Case

The Provider states that the Complainant was making a monthly payment of €32.06 (inclusive of levy) in respect of his plan and that there was no change to the plan payment since the plan started on **1 February 1995**. The Provider says the last payment received was a cheque in **November 2014** for the arrears outstanding on his plan at the time. Once applied, the Provider says this payment brought the plan as paid to **1 November 2014**. The Provider says no payments were made by the Complainant after this date.

Before the Complainant stopped making payments to his plan, resulting in benefits being cancelled, the Provider says the Complainant had the following cover:

Life Cover	€50,790.00
Serious Illness Cover	€50,790.00

As a result of the non-payment of premiums, the Provider says the plan went into a 'paid up state' with all plan benefits being cancelled. The Provider states this happened in line with the plan terms and conditions. In this respect, the Provider refers to section 3 of the terms and conditions which sets out what happens when a payment is missed:

> *"**This section details what will happen if you fail to*** (sic) ***a premium payment.***
>
> *If a premium is not paid in full before the expiry of the days of grace then:*
>
> *(ii) If the policy has acquired a surrender value the policy shall be made into a paid up policy in accordance with the provisions of clause 21."*

At section 21, the Provider says the terms and conditions sets out what happens to the Complainant's plan when he stops making payments, as follows:

> *"(b) If the policy is concerted* (sic) *to a paid up policy, all benefits other than the policy fund, shall be cancelled and the amount payable on the death of the life assured shall be equal to the benefit fund (adjusted during the period for which the policy was a paid up policy by such charges as the Actuary may have deemed appropriate to maintain the policy) as at the day following receipt of the company of notice of each."*

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The Provider says this meant the Complainant no longer had the benefit of his life and serious illness cover as it was no longer being paid for by his regular payment. The Provider further says the value that had accumulated on the plan up to that point where the Complainant stopped making his regular payments remained invested in his plan fund with his plan fee being deducted from this each month in order to maintain the plan.

The Provider says this value continued over the subsequent years to rise and fall in value in line with the assets in which it was invested.

The Provider says that communication with the Complainant following a plan review as provided by section 19 of the terms and conditions issued by post. The Provider says a plan review was conducted and communicated to the Complainant on **22 December 2014**. The Provider says the outcome of this review was that the plan payment was sufficient to maintain the plan until the next review.

The Provider identifies the Complainant's Independent Financial Intermediary and states that the Provider, as product provider, would not have any records of personal financial reviews undertaken by the Complainant's Financial Intermediary.

As noted above, the Provider says the Complainant's plan was paid up with effect from **1 November 2014** and the last payment received was a cheque in the amount of €97.00 on **3 November 2014**. The Provider says this cheque payment covered the months of **August**, **September** and **October 2014**. In the absence of regular payments being made after **1 November 2014**, the Provider says the plan was automatically paid up in line with section 21 of the terms and conditions. The Provider further says that no consent was required as this is provided for in the terms and conditions.

The Provider has set out a timeline of the Complainant's missed payments leading to section 21 of the terms and conditions being applied.

In this respect, the Provider says the Complainant missed his **February 2014** payment and that it wrote to the Complainant on **10 February 2014**. In this letter, the Provider says it explained that it would collect the February payment along with the March payment when it became due on **1 March 2014**. The Provider advised that the **March** and **April 2014** payments were collected successfully.

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The Provider says the Complainant's payment due on **1 May 2014** was returned unpaid and that the Provider received late notification of this from the Complainant. The Provider says it wrote to the Complainant on **29 May 2014** about this missed payment.

In this letter, the Provider says it confirmed that it received late notification from the Complainant's bank that the May payment was unsuccessful. Normally, the Provider says it would present for the May and June payment together in **June 2014**, but because of the late notification, it would present for the June payment as normal on **1 June 2014** and then present two payments in **July 2014** (May and July) to make the plan paid to date.

The Provider says the Complainant's June payment was returned by his bank as unpaid and that it wrote to the Complainant on **10 July 2014**. The Provider says that because of this, there were three months outstanding on the plan (**May**, **June** and **July 2014**). In the absence of the reply from the Complainant, the Provider says it wrote to him on **24 July 2014** about the outstanding payments.

Following this, the Provider says, as a gesture, it credited the Complainant's plan with payments to take his plan as paid to date (**1 August 2014**). The Provider says it presented to the Complainant's bank account on **1 August 2014** for his monthly payment of €32.06, but this was returned unpaid by the bank. The Provider says it presented again on **1 September 2014** for the August and September payments, and similarly, these were returned as unpaid.

The Provider says it wrote to the Complainant on **3 September 2014** about the missed payments. The Provider has cited certain passages from this letter in its Complaint Response. On **30 September 2014**, the Provider says it received an email from the Complainant's Financial Intermediary which advised that a cheque payment was on its way to the Provider and that the Complainant wanted to change his payment frequency from monthly to annually. The Provider says this email confirmed that an amount of €384.72 (€32.06 x 12) to cover the annual cost would be sent to the Provider in the next few days.

On **3 November 2014**, the Provider says it received a cheque which covered three months payments (**August**, **September** and **October 2014**) and once applied, brought the plan as paid to **1 November 2014**.

On **4 November 2014**, the Provider says it emailed the Complainant's Financial Intermediary to explain that the Complainant's plan started on **1 February 1995** and in order to amend the billing frequency from monthly to annually, the Complainant would need to send the payments due to take his plan as paid to **1 February 2015** (**November** and **December 2014** and **January 2015**) and that the billing frequency could then be

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amended with effect from the plan anniversary (**1 February**). The Provider says it also confirmed that it required a written instruction from the Complainant in order to amend the billing frequency. The Provider says it did not receive any instruction to amend the billing frequency or annual cheque payment from the Complainant.

On **8 December 2014**, the Provider says it wrote to the Complainant about the outstanding payments on his plan. The Provider has cited certain passages from this letter in its Complaint Response. In the absence of a response, the Provider says it sent a final reminder to the Complainant on **15 January 2015**. In this letter, the Provider says it highlighted the payments outstanding on the plan and in the absence of these payments, the plan was made 'paid up' in line with the terms and conditions. The Provider says it confirmed that:

> *"If we do not receive all outstanding premiums by 27 January 2015 we will be unable to reinstate your policy."*

The Provider says it did not receive a reply to this letter and the plan was made 'paid up' with benefits being cancelled in line with second 21 of the terms and conditions.

The Provider says the Complainant's benefits (and not his plan) were cancelled in line with section 21 of the terms and conditions in **2014** once he stopped making payments to his plan and as they were cancelled, there was no option to reinstate them. The Provider further says that the benefits were not maintained by the plan fund and that the plan does not provide for benefits to be maintained by the plan fund in the absence of regular payments.

The Provider says the Complainant's fund value remained active and invested after the cancellation of the benefits (life and serious illness cover), and the fund value following the cancellation of the benefits became the sole benefit on the plan.

In respect of correspondence sent to the Complainant dated **8 December 2014** and **23 December 2014**, the Provider says these letters are about two very different and separate items. The Provider says the letter of **8 December 2014** was in relation to missed payments, and the letter of **23 December 2014** was in respect of a scheduled plan review as provided for by section 19 of the terms and conditions.

The Provider says the letter of **23 December 2014** should have confirmed that the Complainant's regular payments was €32.06 and not €0.00. The Provider has apologised for this and for any confusion this may have caused.

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In terms of the plan benefits, the Provider says there was never a Hospital Cash, Health Benefit or Accident Cover. The benefits were life cover and serious illness cover. The Provider says the Complainant's life cover benefit would have paid a lump sum on his death and the serious illness cover would have paid a lump sum on being diagnosed with, and meeting the definition of, a specified illness as set out in the terms and conditions. In its Complaint Response to this office, the Provider says that while the Complainant's Annual Benefit Statements from **December 2015** to date are very clear that there are no benefits attaching to the plan (other than the fund value), the covering page incorrectly notes the benefits outlined on the next page (of which there are none) have been kept in place by the fund value. The Provider says this is, of course, incorrect. The Provider says it wishes to apologise for any confusion this may have caused. For this, the Provider has offered the Complainant a Customer Service Award of €1,000.00.

The Complaints for Adjudication

The complaints are that the Provider wrongfully or unreasonably:

1. declined to reinstate the benefits in relation to the Complainant's policy; and

2. allowed the policy to lapse.

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.

A Preliminary Decision was issued to the parties on 3 November 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

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days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

In the absence of additional submissions from the parties, within the period permitted, I set out below my final determination.

Background

By letter dated **10 February 2014**, the Provider wrote to the Complainant regarding a missed payment in respect of his policy, as follows:

> *"We understand your bank was unable to pay your last premium of €32.06 (inclusive of Government levy) due on 1 February 2014. They returned the debit to us marked Refer to Debtor.*
>
> *We realise this may have been an oversight on your part. We are happy to assure you that your benefits will remain in place as long as full payment is made when we automatically debit your account again on the same date next month for all outstanding premiums.*
>
> *If you have any questions, or would like further information on your policy, we recommend that you contact your Financial Advisor* […]*. Alternatively, you can contact our Customers Services Team* […]*."*

It appears that this premium payment was subsequently made by the Complainant.

The Provider wrote to the Complainant again on **29 May 2014**, in respect of a further missed payment, as follows:

> *"Your Bank has asked us to contact you because the direct debit presented to your account in May was unsuccessful. This means that there is currently one month's premium outstanding on your policy.*
>
> *Unfortunately, there was a delay in us receiving notification of the unpaid direct debit and therefore we have only presented for your June premium on the 1st of June instead of the outstanding May premium and the June premium. We apologize for any inconvenience caused.*

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Upon receipt of the June premium payment and in an effort to bring your premium payments up to date, we will present to your bank account on the 1st of July for your July premium plus the outstanding May premium.

Upon confirmation that the above debits are paid your policy will be paid to date."

A copy of this letter was also sent to the Complainant's Financial Intermediary.

Further to its letter of **29 May 2014**, the Provider wrote to the Complainant on **10 July 2014** to advise that the **June 2014** premium payment had been returned unpaid and, as such, the Complainant's policy was paid to **1 May 2014**. To reinstate his policy, the Complainant was advised that the Provider required payment in the amount of €96.18 for the May, June and July premiums within 10 days. A copy of this letter was also sent to the Complainant's Financial Intermediary. It appears that a response was not received to the letter of **10 July 2014**.

A 'Reminder Letter' was issued by the Provider on **24 July 2014**, which stated, in relevant part, as follows:

"We would be grateful if you could reply to us by the 10 August. Your policy is currently on Paid up status."

A copy of this letter was also sent to the Complainant's Financial Intermediary.

It appears that the Complainant did not bring his premium payments up to date following the above correspondence nor does there appear to have been any contact from the Complainant or Financial Intermediate in response to the Provider's correspondence. However, in its Complaint Response, the Provider advises that it credited the Complainant's policy such that his premiums payments were brought up to date as of **1 August 2014**.

By letter dated **3 September 2014**, the Provider wrote to the Complainant regarding the payment of policy premiums and the cancellation of policy benefits, as follows:

"We recently contacted you about your policy premium payments. Unfortunately, as you have missed another premium payment, and you now have a total amount of €64.12 of premium due, your cover and benefits have been cancelled.

What should I do now?

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It's easy to restart your policy straight away, so that you can continue to ensure financial security for you and your family. By paying the full amount of premiums due, within the next 50 days, we will restart your policy without asking any questions.

To restart your policy, all you have to do is make sure that you have paid us the total amount of premiums outstanding within 50 days of the date on this letter. […]

What other options are available?

If you are not ready to restart your policy right now, you have the following options:

- *If you do not apply to reinstate your policy within 50 days, you can choose to stop paying your premiums but leave your policy fund value invested. Your policy value will remain invested in your chosen funds and will be managed by our fund management service.*

Before you make your decision, we recommend that you talk to your Financial Advisor […] *who will be able to advise you on the best option for you.*

[…]

What happens if I do not contact* [the Provider] *within 50 days?

If we do not hear from you within 50 days of the date on this letter, we will keep your policy invested in your chosen funds and we will continue to manage your funds through our fund management service. However, all cover and benefits provided by your policy will stop.

[…]

IMPORTANT - If payment of all outstanding premiums is not made in full within the next 50 days you will not have the option of restarting your policy. You may apply for a new policy but please note that a new policy may not offer the same benefits as your current policy and a new application will be subject to approval from our underwriter."

By separate letter dated **3 September 2014**, the Provider wrote to the Complainant's Financial Intermediary to notify it of the nature of the above letter issued to the Complainant.

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On **30 October 2014** (57 days after the Provider's letter of **3 September 2014**), the Complainant's Financial Intermediary wrote to the Provider by email, as follows:

> *"Please find attached copy of cheque that is in the post to you today for the above policy number.*
>
> *The client doesn't have a laser card and therefore couldn't do the payment over the telephone. Please accept this and confirm policy will not go out of force.*
>
> *The client is also requesting to have the payment going forward from 1st October 2014 to an annual premium. They are farmers and they find it easier to pay bills on an annual basis because of credits into their account happens on an annual basis. He will forward a cheque for €384.72 in the next couple of days."*

The Provider responded to this email on **3 November 2014**, in part, as follows:

> *"This money has been received in & the policy can be reinstated.*
>
> *However the premiums will need to be paid up to the policy anniversary on February 1st 2015 in order to change it to annual cash as previously advised."*

In response to this, by email of the same date, the Complainant's Financial Intermediary, wrote, as follows:

> *"If the client were to send you payment by draft for the next year will you pay it onto the policy? They have the funds now to pay it and might not have funds in 4 months time but want to have life cover in place."*

By email on **4 November 2014**, the Provider advised, as follows:

> *"We require the outstanding monthly premium to be paid up to the policy anniversary of February 1st 2015 in order to change it to yearly cash and then we can apply the cheque of €384.72.* [The Complainant] *will need to send us a signed letter in order to amend the policy to yearly cash also."*

The Provider wrote to the Complainant on **10 November 2014** acknowledging receipt of payment in the amount of €97.00 on **3 November 2014**. It appears that, at this point in time, the Complainant's policy was paid up to **1 November 2014**.

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By letter dated **8 December 2014**, the Provider wrote to the Complainant in essentially identical terms to its letter of **3 September 2014**. The amount outstanding in respect of premium payments was stated as €63.30.

The Provider wrote to the Complainant again on **15 January 2015**, as follows:

> *"Further to previous correspondence regarding direct debit payments, we have not yet received payment for your outstanding premiums. As a result your policy has been made paid-up.*
>
> *If this is an oversight on your part, we will be pleased to reinstate your benefits, if your outstanding premiums of €191.54 are paid by 27.01.2015.*
>
> […]
>
> *Please note: If we do not receive all outstanding premiums by the **27th of January** we will be unable to reinstate your policy.* […]*."*

In terms of **27 January 2015** being cited as the date by which outstanding premiums were to be received, I note this is 50 days following the Provider's letter of **8 December 2014**. A copy of this letter was also sent to the Complainant's Financial Intermediary.

At the date of the **15 January 2015** letter, it appears the amount due in respect of outstanding premium payments for November, December and January should have totalled €95.36. However, the Provider's letter states the outstanding premium payments totalled €191.54. If the Complainant's policy was up to date as at **1 November 2014**, it is not clear how the Provider arrived at this figure, which appears to be overstated by an amount equivalent to three months premium payments (€96.18; €32.06 x 3).

By letter dated **26 September 2018**, the Complainant wrote to the Provider requesting that his policy be re-activated, as follows:

> *"I refer to the above plan number* […] *and a letter to me dated December 2015.*
>
> *I want the above plan re-activated and I believe I am with in my consumer rights to do this.*
>
> *There was enough money in the policy fund to keep the policy alive.*
>
> *You set out in your letter to me in December 2015 that this course of action would be taken if I could not afford the premiums at the time.*

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Please re-activate the plan immediately."

By letter dated **1 October 2018**, the Provider wrote to the Complainant stating that his policy was active but was in *"a paid up status."* The letter further stated that there were no benefits on the policy but there was a policy value of €2,578.95 as at **30 September 2018**.

The Complainant's Policy

It appears that the Complainant incepted a whole of life 'Broker Options Plan Protection' policy with the Insurer to commence on **1 February 1995**. The benefits provided under this plan were life cover and serious illness cover. A copy of the 'Policy Conditions' have also been furnished.

In the context of this complaint, I note the following sections of the Policy Conditions:

> ***"2. PAYMENT OF PREMIUMS***
>
> […]
>
> *(b) Premiums are payable* […] *on the Commencement Date and at such intervals thereafter as indicated on the Policy Face.* […] *It is the responsibility of the Policyholder to ensure that all Premiums (including those payable by direct debit) are received by the Company.* […]
>
> ***3. PERIOD OF GRACE***
>
> *(a) Thirty days of grace shall be allowed for the payment of each Premium.* […]
>
> *(b) If a Premium is not paid in full before the expiry of the days of grace then:*
>
> *(i) if the Policy has not acquired a surrender value the Policy shall lapse without value but*
>
> *(ii) if the policy has acquired a surrender value the Policy shall be made into a Paid-up Policy in accordance with the provisions of Clause 21.*
>
> […]

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(d) The Company may in its discretion reinstate the Policy within a period of one year after the due date for payment of the first unpaid Premium subject to such evidence of continued good health as the Company may require and the payment of all outstanding Premiums together with such interest thereon as the Company may (sic) *required."*

In respect of a policy being 'paid up', section 21 of the Policy Conditions states, as follows:

"Subject to the terms of this Policy and after Premiums have been paid in respect of two full Policy Years

(a) […]

(b) If the Policy is converted to a Paid-Up Policy, all benefits other than the Benefit Fund, shall be cancelled and the amount payable on the death of the Life Assured shall be equal to the Benefit Fund ([…]*) as at the day following receipt of the Company of notice of each."*

Analysis

The Policy Conditions make clear that it is the Complainant's responsibility to ensure policy premiums are paid. The Policy Conditions also set out what will happen to a policy, in particular policy benefits, if premium payments are not properly maintained.

In circumstances where a policy has a surrender value and a premium is not paid within the 'period of grace', section 3(b)(ii) of the Policy Conditions provides that a policy shall be made into a 'paid-up policy' in accordance with section 21. As can be seen from the wording of section 21, if a policy is converted to a paid-up policy, all benefits under the policy shall be cancelled except for the 'Benefit Fund', that is, the fund value. In this respect, I note from the annual statement issued to the Complainant dated **3 February 2014**, the Complainant's policy had a surrender value.

It appears that the last premium payment made by the Complainant towards the policy was in the amount of €97.00, which was received by the Provider around **3 November 2014**. The effect of this payment was to bring premium payments up to date as of **1 November 2014**. It appears that no further premium payments were received by the Provider after this payment.

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While the Financial Intermediary notified the Provider of the Complainant's wish to pay the policy premium on an annual basis in an email of **30 October 2014**, I note that the Financial Intermediary was subsequently advised that in order to do this, premium payments would have to be paid up to the date of the policy anniversary (**1 February 2015**) and that a signed letter was required from the Complainant. However, I note that neither the required premium payment nor the signed letter were received by the Provider. As such, it was not possible to change the payment frequency on the policy.

As at the Provider's letter of **8 December 2014**, two premium payments were outstanding. In this letter, the Complainant was advised that his policy benefits had been cancelled and of the requirement to bring his premium payments up to date within 50 days if he wished to reinstate the policy benefits. It appears from the evidence that the Complainant did not engage with the Provider on foot of this correspondence nor does it appear that the required premium payments were made in the 50 day period. As a result, the time for reinstating the policy benefits had expired.

In these circumstances and having regard to the Policy Conditions, I accept that the Provider was entitled to cancel the Complainant's policy benefits. Further to this, I also accept that the Complainant was not entitled to have the policy benefits reinstated.

The evidence shows that throughout the year **2014**, the Complainant missed a number of premium payments. On considering the Provider's conduct during this period, I note that the Provider wrote to the Complainant and his Financial Intermediary in respect of the missed payments and advised of the impact this would have on the policy, including the cancellation of policy benefits and the ability to reinstate these benefits.

The Provider also appears to have taken quite a reasonable approach to the Complainant's failure to make the required premium payments during **2014**. For instance, having regard to the Policy Conditions, it appears the Provider may have been entitled to cancel the policy benefits arising from the non-payment of the premium payments that were due in **May**, **June** and **July 2014**. However, rather than pursuing this course of action, it appears the Provider essentially forgave the outstanding premium payments and Complainant's policy benefits remained in place. Further to this, the Provider sought to cancel the policy benefits in its letter of **3 September 2014** due to the non-payment of the **August** and **September 2014** premium payments. Although the Complainant did not seek to reinstate the policy benefits within the 50 day period allowed by Provider, I note the Provider accepted payment of the outstanding premiums seven days after the expiry of this period in **November 2014** and appears to have reinstated the policy benefits.

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By letter dated **26 September 2018**, the Complainant sought to have his policy benefits reinstated. It appears from this letter that the Complainant understood his policy benefits would be maintained by the fund value. The basis for the Complainant's belief was the annual statement issued by the Provider in **December 2015** and such further statements issued in the years that followed.

In a submission dated **2 June 2021**, the Complainant states, among other things, as follows:

> *"I refer to six letters enclosed dated December 2015, December 2016, December 2017, and December 2018 December 2019 December 2020.*
>
> […]
>
> *I refer in particular to paragraph 3 in the above letters and I quote "Your benefits outlined over the page have been kept in place as we have been able to deduct the cost of providing them from the Fund Value of your plan.*
>
> *This has gradually reduced your Fund Value which means that your cover will cease when your Fund Values runs out."*
>
> *I relied on and continue to rely on the reassurances in the above quoted paragraph regarding the status of my policy."*

In this respect, I note that the cover letter enclosing the **December 2015** annual statement states, as follows:

> *"As a valued customer, we need to let you know that we have not yet received payment on your plan since 01 November 2014. Your benefits outlined over the page have been kept in place as we have been able to deduct the cost of providing them from the fund value of your plan. This has gradually reduced your fund value which means that your cover will cease when your fund value runs out.*
>
> *You made an important decision originally to take out this protection which provides a great sense of security for you and your family and we may have options to assist you in maintaining your cover."*

On the pages that follow the cover letter, no policy benefits are identified and the only apparent benefit noted as being provided by the policy is the fund value.

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It is my opinion that the manner in which the cover letter is drafted is ambiguous, confusing and contrary to Provision 4.1 of the ***Consumer Protection Code 2012*** ("the Code") which requires the Provider to ensure that all information it provides is clear, accurate and up to date. Furthermore, I am not satisfied that the Provider acted with due skill, care and diligence in the best interests of the Complainant (as mandated by Provision 2.2 of the Code) when issuing annual statement(s) drafted in this manner.

The cover letter states that certain policy benefits were being maintained by the Complainant's fund value. However, this statement is incorrect. This is because the Complainant did not have any policy benefits in **December 2015** and also because the Complainant's policy does not appear to operate on the basis that, in the event of non-payment of premiums, policy benefits would be sustained by the fund value. Further to this, I do not accept that the absence of any policy benefits on the pages that followed the cover letter is sufficient for the purpose of making the Complainant aware that no benefits were in fact being provided by his policy nor do I consider it reasonable for the Complainant to have concluded, on the basis of the above cited passages, that the absence of any benefits being noted on the annual statement meant that no benefits were attaching to his policy.

On the whole, I am not satisfied that the **December 2015** annual statement communicated, in a clear and correct manner, the true position regarding the Complainant's policy benefits. It is my opinion that the information conveyed in the annual statement is unclear and ambiguous, and inconsistent with the manner in which the policy is intended to operate as set out in the Policy Conditions.

Further to this, essentially identical statements appear to have been issued to the Complainant in **December 2016** to **December 2020**. Quite surprisingly and very disappointingly, in its Complainant Response, which is dated **7 October 2020**, the Provider acknowledges that the cover page incorrectly states that the benefits on the following page were being kept in place by the fund value. However, despite acknowledging this error in **October 2020**, the Complainant was nonetheless issued with an erroneous annual statement in **December 2020**. It is quite disappointing to see that no efforts were made by the Provider to amend its annual statements once it became aware of this issue.

The Complainant says, in reliance on the **December 2015** annual statement, he understood that policy benefits would be maintained by the fund value. However, while misleading information was conveyed in the **December 2015** (and subsequent) annual statements, I am of the view that the policy benefits were cancelled, and the date for possible reinstating the benefits had passed, approximately one year prior to the **December 2015** annual statement.

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Therefore, regardless of the information contained in the **December 2015** annual statement, the Complainant did not have any policy benefits (or any entitlement to policy benefits) in **December 2015**. Therefore, I am not satisfied that any confusion caused by the annual statements which issued from **December 2015** led to the cancellation of the policy benefits nor did this adversely impact the Complainant's entitlement to have the benefits reinstated.

Further to this, it is my opinion that the **December 2015** annual statement must not be viewed in isolation and must be considered in the context of the correspondence that issue to the Complainant during **2014** and early **2015** in respect of the non-payment of premiums, the cancellation of policy benefits and the ability to reinstate policy benefits. On reviewing this correspondence, I do not accept that these errors meant that the policy benefits remained in place and were being maintained by the fund value.

In addition, the Complainant specifically identifies the **December 2015** annual statement as the basis of his belief that policy benefits would be maintained by the fund value. It appears that no such statements were contained in the annual statements dated **3 February 2014** or **2 February 2015**.

In light of these annual statements, the correspondence issued to the Complainant in **December 2014** and **January 2015**, and the absence of any premium payments being made from **November 2014**, it is not clear how the Complainant came to the view that policy benefits would be maintained prior to the **December 2015** annual statement.

Accordingly, while there are concerning shortcomings in respect of the annual statements issued to the Complainant from **December 2015**, I do not accept that this affects the Provider's entitlement to cancel policy benefits in **December 2014** nor does it change the fact that the Complainant was no longer entitled to have the policy benefits reinstated following **27 January 2015**.

Therefore, I am not satisfied that the Provider wrongfully or unreasonably refused to reinstate the Complainant's policy benefits nor am I satisfied that the Provider wrongfully or unreasonably allowed the Complainant's policy to lapse.

Goodwill Gesture

In its Complaint Response, the Provider has apologised for any confusion caused by the **December 2015** annual statement and has offered a Customer Service Award of €1,000.00 to the Complainant.

/Cont'd…

It is my opinion that the annual statements issued by the Provider from **December 2015** were poorly drafted, inconsistent with the actual operation of the Complainant's policy and were a source of confusion for the Complainant. More concerning is that the Provider has not indicated that any steps would be taken to address the manner in which annual statements issued to the Complainant are drafted. This gives rise to the broader concern that such statements continue to be issued to the Complainant; and have issued and continue to issue to other customers of the Provider who hold similar policies or whose policies are in a similar position to the Complainant's policy.

Accordingly, I am not satisfied that a customer service award alone is sufficient to address the concerns arising from the annual statements issued by the Provider from **December 2015**. In addition, I also note certain errors in the Provider's letter of **23 December 2014** and **15 January 2015**. In the letter of **23 December 2014**, the premium amount is incorrectly stated as €0.00. In the letter of **15 January 2015**, the outstanding premium payments appear to have been overstated.

Therefore, I partially uphold this complaint. In doing so, I make the following directions:

I direct that the Provider review the annual statements to be issued to the Complainant regarding his policy to ensure that the information contained in these statements is clear, accurate, up-to-date and correctly reflects the status of the policy.

I direct that the Provider rectify the annual statements to be issued to the Complainant regarding his policy such that the information contained in these statements is clear, accurate, up-to-date and correctly reflects the status of the policy.

I direct that the Provider review the annual statements it issues to all customers holding a similar policy to the policy that is the subject of this complaint, to ensure that the information contained in these statements is clear, accurate, up-to-date and correctly reflects the status of the particular policy.

I direct that the Provider rectify the annual statements to be issued to all customers holding a similar policy such that the information contained in these statements is clear, accurate, up-to-date and correctly reflects the status of the particular policy.

I direct that the Provider pay compensation in the amount of €2,000 to the Complainant.

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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)(b)*** as the conduct complained of was unreasonable in its application to the Complainant and on the ground specified in ***Section 60(2)(g)***.

Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017:***

I direct that the Provider review the annual statements to be issued to the Complainant regarding his policy to ensure that the information contained in these statements is clear, accurate, up-to-date and correctly reflects the status of the policy.

I direct that the Provider rectify the annual statements to be issued to the Complainant regarding his policy such that the information contained in these statements is clear, accurate, up-to-date and correctly reflects the status of the policy.

I direct that the Provider review the annual statements it issues to all customers holding a similar policy to the policy that is the subject of this complaint, to ensure that the information contained in these statements is clear, accurate, up-to-date and correctly reflects the status of the particular policy.

I direct that the Provider rectify the annual statements to be issued to all customers holding a similar policy such that the information contained in these statements is clear, accurate, up-to-date and correctly reflects the status of the particular policy.

I direct that the Provider pay compensation in the amount of €2,000 to the Complainant 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.

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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

1 December 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.