An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0466
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Results of policy review/failure to notify of policy reviews
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant incepted a Whole of Life policy with the Provider in **June 1988**. The policy was amended in **1990** to include Serious Illness Benefit and Hospital Cash Cover. Early in **2018**, the Complainant's Hospital Cash Cover expired as he had reached 65 years of age. However, this did not result in a reduction in premium payments. In **May 2018**, the Complainant amended the frequency of his premium payments from quarterly to half-yearly payments. Subsequent to this, the Provider acknowledged the change in payment frequency and confirmed the Complainant's half-yearly premium payments as €1,534.67. In **September 2018**, the Provider advised the Complainant that, due to an error, the premium amount stated in its correspondence was the quarterly amount and not the half-yearly amount.

The Complainant's Case

The Complainant explains that he signed a review agreement with the Provider for *the next 5 years* which would bring the Complainant to the year **2023** until the next review. The Complainant states that the Provider sent correspondence to him where the agreed terms were that the Complainant would pay half-yearly premiums of €1,534.67. The Complainant set up a standing order to facilitate these payments. These terms were also agreed with the Provider's financial adviser during a meeting with the Complainant in a Dublin hotel.

The Complainant has submitted correspondence from the Provider which shows that an error occurred in respect of the frequency of his premium payments. The Complainant submits that his premium payments were agreed to be on a half-yearly basis.

However, the Provider has advised the Complainant that, due to an error, it did not amend the payment frequency from quarterly to half-yearly and the premium quoted in respect of the Complainant's policy was based on quarterly payments and not half-yearly payments.

The Complainant also outlines he was informed that hospital cover under his policy ceased when he reached the age of 65. However, the Complainant was not advised of this by the Provider.

The Provider's Case

The Provider explains that when the Complainant's policy commenced on **1 July 1988** it provided for life cover only. Serious Illness Benefit and Hospital Cash Cover were added in **1990** and the amount of life cover was also increased. The Hospital Cash Cover expired with effect from the Complainant's 65th birthday in line with section 29(d) of the policy terms and conditions. The maximum term this benefit can be held for is to the age of 65. The Provider advises that it wrote to the Complainant on **27 April 2018** stating that such cover was no longer on his policy.

The Provider explains the Complainant's policy was reviewed in **2012** in line with its terms and conditions. At this time, the Complainant selected Option A, which meant his level of life cover remained unchanged at €127,877 with premium payments increasing to €631.29 per quarter. The chosen option was applied in **2012** and the Provider wrote to the Complainant stating that his next policy review would be in **2018**.

The Provider advises that the Complainant had recently retired around the time of the **2018** policy review and he met with one of the Provider's financial advisers on **1 May 2018** to facilitate the amendment of the payment method under the policy from salary deductions to direct debit. The Financial Adviser collected a direct debit mandate from the Complainant during the meeting in which the Complainant confirmed he wished to pay the premium on a half-yearly basis from his personal bank account.

The Provider states the expiry of Hospital Cash Cover was also discussed at this meeting and why there was no immediate change in policy premiums when this benefit ceased. The Financial Adviser contacted the Provider on **3 May 2018** about the expiry of this benefit and a letter issued to the Complainant on **8 May 2018** enclosing a copy of the policy terms and conditions.

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The policy was reviewed in **2018** as scheduled and the Provider wrote to the Complainant on **3 May 2018** with his policy options. At this time, the policy was index linked to give cover of €155,436 with premiums of €767.34 per quarter. The Provider states that while the Financial Adviser discussed the review feature on the Complainant's policy, he did not discuss any plan review options at this meeting. The Complainant's Options Letter issued 2 days later on **3 May 2018**. It states that there were no figures available to the Financial Adviser for discussion at the meeting.

The completed direct debit mandate was received by the Provider's head office on the same day as the Options Letter issued, **3 May 2018**. The Provider wrote to the Complainant on **4 May 2018** to confirm that his bank details had been updated.

The Provider submits that the letter of **3 May 2018** was correct and set out the Complainant's options at the time which were subject to quarterly premium payments. The Provider advises that the premiums quoted in this letter reflect the fact that Hospital Cash benefit expired in **April 2018**. The Provider advises that when the Options Letter issued to the Complainant, the Financial Adviser tried to contact the Complainant by phone but was unsuccessful in his attempts.

The Provider explains that as a plan review option was not chosen by the Complainant, it wrote to the Complainant on **1 June 2018**. The Provider explains that while this letter correctly recorded the billing frequency as half-yearly, the figure presented was incorrectly stated as the quarterly amount.

The Complainant selected Option A, which was to keep the same level of cover and increase the premium until **2023**. It was on receipt of this that the Provider identified the options given to the Complainant incorrectly presented the quarterly payment as being half-yearly.

The Provider states that the correct payment of €1,534.67 per half-year was collected by direct debit on **2 July 2018** to take the policy to **1 January 2019**. The Provider wrote to the Complainant on **3 September 2018** to inform him about the error in the June letter. The Provider explains the letter agreed that, as the policy was paid until **1 January 2019**, no changes would need to take place until that time. The Provider's letter also provided the Complainant with a new set of review options. In the absence of the Complainant choosing one of these options, the premium remained the same and life cover under the policy reduced to €113,377 with effect from **1 January 2019**. The Provider wrote to the Complainant on **3 January 2019** to confirm these matters. The Provider explains that the policy index linked on **1 July 2019** and the premium increased to €1,595.45 with life cover increasing to €119,046.

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The Complaints for Adjudication

The complaints are that the Provider:

1. Wrongfully sought to collect a higher premium than agreed;

2. Wrongfully removed Hospital Cash Cover from the policy; and

3. Proffered poor customer service.

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 11 January 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, the parties made further submissions to this office, copies of which were exchanged between the parties.

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

I note that in response to the Complainant's post Preliminary Decision submission dated **24 January 2021,** the Provider has detailed that it is "*of the opinion that the complainant is now raising a new issue that was not addressed in the original complaint. Therefore we feel the complainant should be raising a separate complaint about this with our Complaints Department to allow us to investigate and respond accordingly separate to the finding and decision on this open complaint".*

It is my understanding that the Complainant, in his post Preliminary Decision submission, is raising issues with what he believes are "*discrepancy of different calculations*" while the policy was being "*paid through a group scheme from the* [Complainant's former employer]".

As detailed above, the complaints that have been investigated and adjudicated upon are that the Provider:

1. Wrongfully sought to collect a higher premium than agreed;

2. Wrongfully removed Hospital Cash Cover from the policy; and

3. Proffered poor customer service.

As no complaint had been originally made regarding "*discrepancy of different calculations*" while the policy was being "*paid through a group scheme from the* [Complainant's former employer]", and as no such complaint was investigated by this office, this has not formed a part of the adjudication of the current complaint, and it remains open to the Complainant should he wish to make a complaint to the Provider regarding this.

The Change in Payment Frequency

The Complainant met with the Financial Adviser on **1 May 2018**. The Financial Adviser has prepared a written statement in respect of this meeting, and acknowledging the meeting took place 19 months prior to his statement, states:

> *"I arranged to meet [the Complainant] as he was retiring and wanted to discuss his policy going forward. We agreed to meet at [a Dublin hotel] on the 01/05/2018.*

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This was not a formal meeting as I did not have the policy review document at that time. This was issued by the company some days later. We did meet up to:

- *complete a direct debit form to collect the premium from his bank account as he was retiring from his work scheme*

- *discuss stopping his plan from index linking*

- *discuss his hospital cash benefit ceasing and why no reduction in premium*

In relation to this hospital cash benefit I advised him that the company would write to him to explain why this happened.

I also advised that the premium review document (with the new premium required) would be sent to him by post, and once received I would contact him to go through this document. I advised him that his premium would increase on this review due to his age and the sum assured.

After the plan review documentation was sent I tried to contact [the Complainant] to discuss his options but did not receive a response from him.

A review document was issued on 03/05/2018 with the correct details, but a second document was sent on the 01/06/2018 due to [the Complainant's] preference for frequency of payment and this was incorrect."

The Complainant completed and signed a direct debit mandate dated **2 May 2018**. On this mandate, the Complainant selected a payment frequency of *half-yearly*.

The Provider wrote to the Complainant on **3 May 2018** advising him that his premium payments were no longer sufficient to maintain the current level of cover under the policy.

Two options were offer to the Complainant:

"Option A – Keep the same level of cover and increase your payments until 1 July 2023

Life covered	***[The Complainant]***
Current Life Cover	*€155,436.00*
Estimated payment to keep your cover the same until your next review in 2023	*€1,099 per quarter …*

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Option B – Reduce your level of cover and keep your payment the same until 1 July 2023

Life covered	***[The Complainant]***
Reduced Life Cover	*€114,504.00*
Your current payment	*€767.34 per quarter …*

…"

The letter enclosed an Options Form which was to be completed by the Complainant and returned to the Provider.

The Provider wrote to the Complainant on **4 May 2018** to confirm that premium payments had been transferred to the direct debit facility. The letter also acknowledged that:

"You selected on your direct debit mandate to deduct the premium half yearly.

Your half yearly premium is €1534.67. This is due half yearly from the start date of your policy which for you is July each year.

The first payment due is €767.34 this will bring your plan period to 1 July 2018. This will be taken from your account on 14 May 2018.

Your next payment will be a half yearly amount of €1534.67 and this will be deducted on 1 July 2018 and will bring your plan [to] 1 January 2019. …"

During a telephone conversation on **16 May 2018**, the Provider's agent confirmed that the Complainant's premium was a half-yearly premium of €1,534.67. However, when discussing the Provider's Options Letter at about 30 minutes into the conversation, the Complainant was advised that the premium was €1,099.53 per quarter and the half-yearly payment would be €2,199.06.

An Options Form was not received by the Provider and a further letter, similar to the May letter, issued to the Complainant on **1 June 2018**. The June letter contained the same table as outlined above. However, it quoted the premium for Option A as *€1,099 per half-year* and Option B as *€767.34 per half-year.*

The Complainant completed and signed an Options Form dated **25 June 2018**, choosing Option A and returned it to the Provider. This Options Form was the one enclosed with the June letter. This was received by the Provider on **26 June 2018**.

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The Provider wrote to the Complainant on **3 September 2018**, in respect of the error contained in its June correspondence, explaining as follows:

> *"Following a recent review of our records, we noted that there were some errors in the communications we issued to you regarding your recent policy review.*
>
> ***What happened?***
>
> 1. *We issued a policy review letter to you dated 3 May 2018. In this letter you were advised that your premium was insufficient to maintain your current level of cover. We gave you the option to either increase your payments or reduce your benefits.*
>
> 2. *During this time, we were also changing the way your plan was being paid. It was changing from Scheme Direct Debit, the frequency of your payments was also changing from quarterly to half yearly.*
>
> 3. *When we issued a reminder letter in relation to your policy review, an error occurred whereby the figures quoted did not take into account the change in frequency of your payments. This meant that when you selected Option A, which was to increase your payment to maintain your current benefits, the figure you chose was based on a quarterly payment. This means that there is a shortfall in the required premium to maintain your benefits until your next review in 2023.*
>
> *We are sorry this occurred and for any confusion or inconvenience caused.*
>
> ***What are we doing?***
>
> *As your plan is paid until the 1 January 2019 we are not going to ask you to make any changes at this time. [The Provider] will cover any shortfall in your premium until 1 January 2019.*
>
> *In order to correct this we will need to provide the correct quotes. …*
>
> *Please review the below options and return the enclosed acceptance form as soon as possible. …"*

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Hospital Cash Cover

The Complainant applied to add Hospital Cash Cover to the policy in **April 1990**. As a result of this amendment to the policy, the Complainant was issued with new policy conditions (the **1990 Conditions**) which replaced the original policy conditions (the **1988 Conditions**). Section 29 of the 1990 Conditions deals with Hospital Cash Cover. Section 29(d) states that:

> *"Hospital Cash Cover for a Life Assured will cease on the 65th birthday of that Life Assured. …"*

The Provider wrote to the Complainant on **27 April 2018** to inform him that, pursuant to the terms and conditions of the policy, the maximum term allowable for Hospital Cash Cover was up to the age of 65. The letter stated that the cover expired in **April 2018**. The letter also explained this would not affect the quarterly premium *"… as the expiry of the benefit was built into your payment when you took out the plan."*

Referring to a telephone call from the Complainant on **3 May 2018**, the Provider furnished the Complainant with a copy of the 1990 Conditions under cover of letter dated **8 May 2018**.

The Complainant raised a query regarding the Hospital Cash Cover during a telephone call on **16 May 2018** as he could not find a reference to Hospital Cash Cover in the original policy conditions issued in **1988**. By letter dated **18 May 2018**, the Provider wrote to the Complainant explaining that Hospital Cash Cover was not a benefit under the policy when originally incepted but was added to the policy and a copy of the 1990 Conditions were enclosed with this letter. The Complainant also requested details of payments into the policy during this telephone conversation. This information was furnished by the Provider in a separate letter dated **18 May 2018**.

During a telephone conversation on **21 May 2018**, the Complainant explained that he never received the 1990 Conditions. The Complainant then queried when Hospital Cash Cover was added to the policy and requested the correspondence from the time this cover was added. It was explained that a new application form was received in respect of Hospital Cash Cover in **April 1990**.

The Complainant questioned whether he signed any such application form and asked if the Provider had a copy of the application form. It was accepted by both parties during the call that the addition of Hospital Cash Cover would have resulted in an increase in premiums. Leading on from this, the Complainant questioned why the premium did not reduce when this cover expired.

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The Provider's agent explained that on this type of policy, the Complainant had a set premium and, as it was unit linked, the Complainant paid units into the fund and the cost of the various benefits on the policy would be deducted from the units. The Provider's agent explained that at the time of the call, all that was being deducted in terms of units was the cost of the life cover. The Provider's agent stated, later in the conversation that, when benefits cease, premiums for policies such as the Complainant's would never reduce.

Following this conversation, the Provider wrote to the Complainant on **22 May 2018** enclosing a copy of his application form to add Hospital Cash Cover to the policy, explaining when Hospital Cash Cover was added to the policy, it expired pursuant to the terms and conditions on **26 April 2018**, and this did not affect premium payments as the expiry of this benefit was built into the policy.

The Complainant telephoned the Provider on **21 June 2018** in respect of the Hospital Cash Cover benefit. This conversation was similar to the one that took place on **21 May 2018**. The Complainant also told the Provider's agent that he did not receive the documentation requested during the previous month's conversation. The Provider's agent advised the Complainant that a letter issued on **22 May 2018** and outlined the contents of the letter to the Complainant. The Provider's agent advised the Complainant that the letter would be re-issued. The Complainant stated that when the Hospital Cash Cover ceased, there should have been a reduction in the premium. The Provider's agent explained that the cost of the Hospital Cash Cover was built into the cost of the policy and this would have been factored into the Complainant's premium calculation at the start of the policy.

On foot of a telephone conversation on **5 September 2018**, a formal complaint way logged by the Provider in respect of the matters giving rise to this complaint. This was acknowledged by the Provider on **7 September 2018** and a Final Response letter issued on **13 September 2018**.

Analysis

The Provider advises that the direct debit mandate was received by its head office on **3 May 2018**. This was submitted for the purpose of setting up a direct debit on the Complainant's personal bank account and changing the frequency of premium payments from quarterly payments to half-yearly payments.

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Also on **3 May 2018**, the Complainant received correspondence advising him that his current level of premium payments were insufficient to maintain the level of cover under the policy and offered the Complainant two options to address this. As can be seen, each payment option quoted the premium amount on a quarterly basis.

The day after this, on **4 May 2018**, the Complainant received another letter advising him that his *half-yearly* premium was €1,534.67. This half-yearly payment amount was also confirmed early-on in a telephone conversation on **16 May 2018**. However, as noted above, the Provider's agent appears to have also correctly advised the Complainant as to the half-yearly premium amount at a later stage in the conversation, but neither party seem to have picked up on the fact that two different half-yearly amounts were quoted.

While the correspondence issued by the Provider on **1 June 2018** correctly stated the payment frequency as being half-yearly, it incorrectly quoted the premium amount as being based on quarterly payments. The Complainant completed the enclosed Options Form choosing Option A which stated the half-yearly premium as €1,099.00. This was incorrect and the correct amount should have been approximately €2,199.00.

The Provider notified the Complainant of this error on **3 September 2018** and provided the Complainant with updated quotes. While the amount of €1,099.00 paid by the Complainant was only sufficient to maintain cover on a quarterly basis, the Provider agreed to make up the shortfall and effectively treat this payment as a half-yearly payment, meaning the Complainant was covered under the policy until **1 January 2019**.

It is quite clear that an error occurred in respect of communicating the correct premium due under the policy. While the Provider has accepted responsibility for this error and acknowledged it was contained in the letter issued on **1 June 2018** and apologised for this, it has not addressed the fact this error was also contained in its letter of **4 May 2018** nor has it addressed the conflicting information communicated to the Complainant on **16 May 2018**.

Further to this, the Provider has not offered an explanation as to precisely how the error arose or why the Complainant was not notified of the error until **3 September 2018**. This is particularly disappointing because the Provider appears to indicate in its Formal Response that the error was identified when the June Options Form was returned by the Complainant, which I note was received by the Provider on **26 June 2018**.

In his statement, the Financial Adviser explains that he did not have the policy review document at the time of the meeting on **1 May 2018** but advised the Complainant that this would be sent to him by post. As can be seen, policy review correspondence issued to the Complainant after this meeting on **3 May 2018**.

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Therefore, while I accept based on the evidence, that a change in payment frequency was discussed and agreed at this meeting, I do not accept that the amount(s) payable by the Complainant in respect of the policy were agreed at this meeting.

Having considered the correspondence issued to the Complainant during **May** and **June 2018** and the telephone conversation on **16 May 2018**, the Complainant was presented with conflicting and inconsistent information regarding his premium. However, the manner in which the information was conveyed by the Provider was such that it ought to have been somewhat apparent to both the Complainant and the Provider that the information was inconsistent.

Therefore, both parties were mistaken as to the precise payment terms on which the policy was being renewed, and given the nature of Whole of Life policies, this would constitute quite a fundamental mistake. In the circumstances, and although this mistake was caused by the Provider, I am not satisfied there was an agreement whereby the Provider offered, and the Complainants accepted, to renew the policy based on half-yearly payments of €1,534.67.

The Complainant added Hospital Cash Cover to his policy in **April 1990**. The evidence indicates that the Complainant did not have a clear recollection of applying for this cover or signing the relevant application form. Further to this, the Complainant did not recall receiving the 1990 Conditions that issued on foot of this policy amendment.

However, following certain telephone conversations with the Provider during **May** and **June 2018**, the Complainant was provided with correspondence relating to the addition of this cover and the signed application form.

During these telephone conversations, the Complainant expressed the view that there was no mention of the expiry of Hospital Cash Cover in the terms and conditions he had. This is because the Complainant appeared to be referring to the 1988 Conditions. The 1988 Conditions do not contain any provisions in respect of, or purport to offer, Hospital Cash Cover. While the Complainant maintained that he never received the 1990 Conditions, in light of the Complainant's poor recollection of the addition of this cover to his policy, the application form signed by the Complainant and a letter issued to the Complainant in respect of this cover dated **17 May 1990**; I accept that it is likely that the Complainant was furnished with a copy of the 1990 Conditions.

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Section 29(d) of the 1990 Conditions states that Hospital Cash Cover would expire on the Complainant's 65th birthday. The Complainant turned 65 in **April 2018** and the Provider wrote to him on **27 April 2018** to advise him that his Hospital Cash Cover had expired. This also appears to have been discussed with the Financial Adviser during the meeting on **1 May 2018**, and in subsequent telephone conversations and correspondence with the Provider.

Accordingly, I am not satisfied that the Provider wrongfully removed Hospital Cash Cover from the Complainant's policy or failed to notify him of its expiry.

In the telephone conversations outlined above, the Complainant sought an explanation as to why it was that, as Hospital Cash Cover had expired, his premium not reduce. The answer given by the Provider was that the expiry of this cover was factored into the premium calculation when this cover was originally taken out and units for Hospital Cash Cover would cease to be deducted from the units in the Complainant's fund in this regard.

Section 15 of the 1990 Conditions deals with *Charges* and states:

> *"On the Date of Commencement of the Assurance and on each monthly anniversary thereof, the Company shall:*
>
> *(a) (i) calculate the charge to provide life assurance cover equal to the Death Benefit during the following month.*
>
> *(ii) calculate the amount of Ancillary Benefit Charge necessary to provide the Ancillary Benefits for the following month.*
>
> *(b) debit from the Unit Account on that date a number of Units which at the Bid Price current on the said date shall reduce the Accumulated Fund by an amount equal to the aggregate of the following sums:*
>
> *(i) …*
>
> *(ii) the Ancillary Benefits Charge*
>
> *…*

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> *The Death Benefit Charge and the Ancillary Benefits Charge will be calculated taking account of some or all of the following factors:-*
>
> *The excess if any of the Death Benefit over the Accumulated Fund, the age(s) and sex of the Life or Lives Assured, the level of Ancillary Benefits being provided under the Policy and such rates of mortality and morbidity as the Company in its absolute discretion deems equitable to reflect inter alia the smoking habits of the Life or Lives Assured."*

At section 2(e), *Ancillary Benefits* is defined as:

> *"… any of the benefits described in paragraphs 26, 27, 28 and 29 of the Policy. "Ancillary Benefits Charge" means that charge payable for the Ancillary Benefits calculated in accordance with Paragraph 15."*

In light of the policy definition of *Charges* and having considered the telephone conversations between the Complainant and the Provider together with the correspondence issued on foot of these conversations, I am not satisfied the Complainant's query in respect of the cost of Hospital Cash Cover has been properly explained. In particular, while units in respect of *Ancillary Benefits* are to be deducted from the *Unit Account*/*Accumulated Fund*, it is not clear why or how the policy is subject to a set premium or that, as suggested by the Complainant, the premium should not reduce as a result of the expiry of Hospital Cash Cover.

In the circumstances, I believe that Provider should clarify, by reference to the relevant policy terms:

1) how the Complainant's unit linked policy operates;
2) how the Complainant's premiums operate and are calculated;
3) how premium payments operate and are treated;
4) how the Ancillary Benefits Charge is calculated and operates;
5) how Ancillary Benefits that expire are treated and how this is factored into the premium calculation and the Ancillary Benefits Charge, with particular reference to Hospital Cash Cover.

The Complainant is also dissatisfied with the level of customer service received from the Provider. Having considered the content of the various telephone conversations concerning this complaint, I am satisfied the Provider's agents dealt with the Complainant in a professional and courteous manner and endeavoured to address his queries.

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I am also satisfied that any corresponded issue to the Complainant, especially on foot of these telephone conversations and in respect of his formal complaint, were promptly issued.

Therefore, outside of any customer service issues identified above, I accept that the Provider gave a reasonable level of customer service to the Complainant.

Goodwill Gesture

The Provider states that:

> *"We are very sorry for the incorrect information in our letter of 1 June 2018 and for any inconvenience it has caused. By way of apology we would like to offer [the Complainant] a €500 Customer Service Award for this error."*

In light of the matters set out in this Decision, I do not consider the goodwill gesture offered by the Provider is adequate compensation for the Complainant. Therefore, I partially uphold this complaint and direct the Provider to pay the sum of €2,000 in compensation to the Complainant.

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), (e), (f) and (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 €2,000, 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.***

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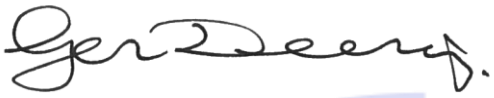
The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.



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.