An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0554
Sector:	Insurance
Product / Service:	Payment Protection
Conduct(s) complained of:	Mis-selling (insurance) Failure to provide correct information Poor wording/ambiguity of policy
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint relates to the asserted mis-selling of a Payment Protection Insurance Policy taken out by the Complainants. The policy was originally taken out on **5 April 2015** with a third party provider which was subsequently taken over by the Provider, against which this complaint is made, in **September 2018**.

The Complainants' Case

The Complainants state that when they purchased the insurance policy they informed the original provider that they were both self-employed individuals. The Complainants further state that when the Second Complainant broke his ankle in 2018, they put in a claim on their insurance policy to cover the balance on their credit card account. The Complainants' position is that it was only then they discovered that the Second Complainant was not an insured party on the policy. The First Complainant submits that *"if it was explained or mentioned to me at the time of the purchase that I was the only one insured I would never have taken out the insurance ….."*. The Complainants further submit that, as they did not need to make a claim on the policy over the past 13 years, this is why it was only in **September 2018** that they became aware of the situation.

The Complainants contend that they were not informed that their policy had been taken over from the original insurer based in Ireland by an insurer based in England.

The Complainants further contend that:

> *"if insurance companies changed from one country to another the insured should be asked if they are happy with that change or given the option to stay or leave".*

In the First Complainant's submission of **27 May 2020** she states she would not have taken out the insurance if she had been made aware that it was only herself was insured. The First Complainant says it does not make sense when the Second Complainant was the income earner and she was at home. The Complainant submits that she would never have taken out an insurance on herself, and questions, why she would do that. The First Complainant states that over the years she could have claimed but did not, as she thought her husband was insured. The Complainant states that when she contacted the Provider regarding the Second Complainant's accident, it was then she became aware. She asserts that at no time did the Provider advise her to claim in her own right, as he was out of work, she was not earning either.

The First Complainant questions why, with all the people she spoke to from the Provider, they could not advise her, or help her out after all the years of paying for the insurance.

The First Complainant questions why anyone would pay money into an insurance for all those years and get nothing in return, when you needed it most. The First Complainant states that what the Provider's documents on insurance provide for, and what was said to her the day she took out the insurance, are very different.

The Complainants want the Provider to reimburse the payments made to the policy, and to pay compensation.

The Provider's Case

The Provider states that the First Complainant, is the Payment Protection Insurance (PPI) policy holder.

The Provider explains that Payment Protection Insurance meets the demands and needs of those who wish to ensure that their minimum monthly repayments will continue to be met in the event of accident, sickness, death or involuntary unemployment or becoming a carer up to the age of 65, and hospitalisation or death between the ages of 65 to 70.

The Provider states that the inception date of the policy on the First Complainant's account was the **5 April 2005**. The Provider says that the policy remains active on the First Complainant's account and that this has been brought to the Complainant's attention. The Provider states, that, to date the First Complainant has not informed it that she wishes to cancel the policy. The Provider states that as the Complainant does not currently hold a balance on her account, no premiums are being charged.

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As regards the claim, the Provider states that the policy documents issued to the Complainants detail the full terms and conditions of the policy. The Provider says that the policy documents which were issued to the Complainants advised on the first page that the customer must make sure to read the policy document carefully, to ensure that they are eligible for the cover and also to ensure that they know what the policy does and does not cover.

The Provider states that following inception of the policy on the First Complainant's account on **5 April 2005**, the policy was issued to the First Complainant. The Provider states the policy document states that to be eligible for the cover you must be the first named person on the Agreement. The Provider submits that in the meaning of words in Part 1 of the policy document, 'Agreement' is defined as Your credit card agreement with the Cover holder – the policy also refers to "You" or "Your" throughout the policy and does not state that the policy covers any authorised user or family member should they become unemployed.

The Provider states that the Second Complainant is an authorised user on the Complainant's account only, and is not a party to the credit agreement. The Provider says that for the avoidance of doubt, this is not a joint credit agreement where both parties are jointly and severally liable for the repayments of the debt. The Provider states that it is the First Complainant as the main cardholder who is responsible for the balance and payments to the account. The Provider states that the Second Complainant is under no obligation nor is he responsible for any payments to the account, therefore he would not be covered under the policy.

The Provider states that the maximum monthly benefit paid out under a successful claim would have been 3% of the outstanding balance or €30.00, whichever is greater. For unemployment insurance, the claimant must be out of work for a continuous period of 30 days, after which one monthly benefit would become payable. The Provider states that if the Second Complainant had been eligible to make a claim under the policy and his claim had been successful, the insurers would have paid out approximately €56.12 per month, for a period of 3 months - a total payment of €168.36. The Provider says that this payment would have been made directly to the account. The Provider submits that as the Second Complainant was out of work for 16 weeks, the claim would have paid after the first 30 days and ended after 3 months once he returned to work.

The Provider states that notwithstanding the relevant terms and conditions, it has offered to refund all of the premiums paid by the Complainants. The total refund which the Provider is willing to offer the Complainants is €1,141.35. The Provider states that for the avoidance of doubt, the refund of the premiums is significantly more than the amount that would have been paid out had the authorised user been eligible to claim in August 2018.

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As regards the sale of the policy, the Provider states that the policy was sold in 2005 on a non-advisory basis.

The Provider states the Consumer Protection Code 2006 or 2012 were not in place in 2005 and as such the "knowing the customer and suitability" provisions of chapter 5 were not applicable at that time.

The Provider says that following inception of the policy on the Complainant's account in April 2005, the policy was issued to the Complainant, and on Page 1 of the policy document, the following is stated:

> *"This Policy gives details of **Your** insurance which has been arranged for **You** by [original provider].*
>
> *• Please read this Policy carefully and keep it in a safe place.*
> *• Make sure that **You** are eligible for this insurance cover.*
> *• **You** should make sure that **You** know what this Policy does and does not cover".*

The Provider submits that the policy document stated that to be eligible for the cover you must be the first named person on the Agreement. And in the meaning of words in Part 1 of the policy document, 'Agreement' is defined as Your credit card agreement with the Cover holder – the policy also refers to "You" or "Your" throughout the policy.

In relation to the Complainant's comments that the references to 'You' and 'Your' does not clarify who is insured, the Provider refers to Part 1 of the policy document, Part 1 – Meaning of Words. It states the below in relation to 'You' and 'Your' referenced throughout the policy document –

> *"**YOU, YOUR**" : the person who has applied for this insurance and has agreed to pay the premium under this Policy and who at the **Start Date** :-*
>
> *i. is the first named person on the **Agreement**; and*
> *ii. is over the age of 18 and under the age of 70; and*
> *iii. meets the eligibility requirements".*

The Provider states the First Complainant, as the main cardholder, is the first named person on the agreement, and therefore she is the only one covered under the PPI policy.

The Provider says the policy also detailed the following under Your Right to Cancel;

> *"If after reading this Policy You do not want to continue with this insurance call …. within 30 days of receiving this Policy. We will cancel Your insurance cover. If You have not made a claim, We will refund any premiums paid. If You cancel Your Policy after more than 30 days no refund of premiums will be paid."*

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The Complainants contend that they were not informed that their policy had been taken over from the original insurer based in Ireland to the now insurer based in England and states that:

> *"If insurance companies changed from one country to another the insured should be asked if they are happy with that change or given the option to stay or leave".*

The Provider's response to the above is that in November 2010 the Provider wrote to the First Complainant and included a copy of the new policy. It stated that it informed her that from January 2011 the insurance provider was changing from the then underwriter to the present underwriter.

The Provider states that the policy document gave the First Complainant the opportunity to cancel the cover if she was not happy with the new policy or the change of insurers.

The Provider says that there were no material changes to the terms and conditions of the policy, other than the insurance provider.

As regards its Final Response letter stating that the complaint was time barred, the Provider states that when it issued the Final Response letter on **17 September 2018** it was of the view that the complaint was time barred as it considered that it did not relate to a long-term financial service and did not relate to life insurance.

The Provider remains willing to refund all premiums charged to the account, which it states to be €1,141.35, plus an amount of 3% of the total value of the premiums paid and that this offer remains open to the Complainant to accept.

The Complaint for Adjudication

The complaint is the suggested mis-selling in 2005 of a payment protection insurance policy, with an element of life assurance cover. As a result, I am satisfied that the alternative time limit set out in **section 51(a)(ii) of the Financial Services and Pensions Ombudsman Act 2017**, applies to this complaint.

The Complainants contend that they only became aware of the fact that cover was in place for the First Complainant alone, not the Second Complainant, at the time of making a claim under the Policy in August/September 2018. Having considered the submissions from the Complainants and the Provider, I identified nothing to indicate that the Complainants were aware, or ought reasonably to have been aware, of this situation prior to 2018, when the Complainants say they first became aware. Accordingly, I determined that:

- the complaint concerned a *"long-term financial service"*;
- the alternative time limit encompassing the "date of awareness" applied;

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- no evidence was introduced to indicate that the Complainants were aware of the conduct complained of prior to **2018;** and
- the complaint was made to this office in **2018**, within the alternative time limit.

For those reasons, I concluded that the complaint fell within my jurisdiction and could proceed to formal investigation.

Accordingly, the complaint is that the Provider mis-sold the Payment Protection Insurance policy at the inception of the policy as the Provider failed to inform the First Complainant that the Second Complainant was not insured, and that she was the only one insured under the policy.

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 **29 November 2021**, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

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Analysis

The Provider states that the sale of the policy to the First Complainant was made over the telephone *"on a non-advisory basis".* A "non advice sale" or an "execution only sale" is where the customer identifies the product they wish to purchase and positively elects to proceed with the sale, without advice from the Provider.

In order for me to accept that this was a "non advice sale", I would expect some evidence from the Provider to support this assertion. For example, I would have expected a follow up letter from the Provider, referring to the telephone call, that the First Complainant had specifically looked for the policy in question, and that no advice had been given in relation to the Payment Protection Policy. A simple assertion is not sufficient.

I would also have expected that the Provider would have furnished evidence as to who was covered by the policy. Disappointingly, the necessary documentary evidence showing who was to be covered on the policy has not been furnished by the Provider to this office.

I note that there was a time lapse of about four years from when the credit card was taken out in 2001 and the sale of the Payment Protection Insurance, in 2005. It is unclear who made the initial contact regarding Payment Protection Insurance, that is, whether it was the First Complainant or the Provider. I accept that as both products were to be linked, the application of the policy should have reasonably been better set out by the Provider for the Complainants in 2005.

This office sought a copy of the proposal form completed at the inception of the policy. The Provider's responses to this request was that it was not applicable, and that the policy was sold in 2005.

A copy of documentation completed with the Complainants at the time of the sale in 2005 was sought from the Provider by this office. That documentation could, for example, include the Factfind, Personal Financial Review, Recommendation made, Reasons Why Letter or any other documentation relating to the sale of the product, advices given, and assessments made as to suitability and affordability of the policy.

The Provider's response to the above request was "Not applicable – policy sold in 2005".

This office sought a copy of the credit card account opening application that the Provider had for the Complainants. The Provider's response for this information was that, as the account was opened in 2001 with the original provider, the Provider did not have that information in relation to the First Complainant's account.

When this office sought the credit card agreement that should have been given to the Complainants when the account was opened in February 2001, the Provider's response was that the First Complainant completed the application over the telephone.

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The Provider submitted a credit card agreement which it said *was applicable* to the First Complainant when the account was opened in February 2001. This agreement did not specifically identify the account holder/s by name or otherwise and appears to be a generic document for its customers.

It is most unsatisfactory that the Provider has been unable to supply this office with a copy of the information that should have been in place, or which was given, or ought to have been given to the Complainants in 2001 or 2005.

I would have expected the Provider to furnishing a recording of the telephone call between the Provider and the First Complainant at inception of the policy. I would have expected the Provider to furnish a copy of the letter which followed the sale of the policy in 2005.

I would have expected to see in that follow up letter, evidence of the Provider setting out, what was and what was not advised in the telephone call. I would have expected to see evidence of the Complainants being informed as to what was meant by a *"non advisory"* sale. I would have expected the Provider to furnish system notes relative to the application for the credit card, and for the Payment Protection Policy.

I would have expected the Provider to retain a copy of all information it obtained from the Complainants, and a copy of any documentation that issued to the Complainants, that was relevant to its contract and interactions with the Complainants.

The Provider did not furnish any of the above information. I note that the Provider took over the business from a previous financial service provider. This is absolutely no justification for the Provider not maintaining and furnishing to this office when requested, important and necessary records. I would have expected that this information would have transferred to the Provider, when the business changed hands.

Irrespective of what regulatory codes were or were not in place, I accept that there is a general practice of, and requirement for, retaining documentation / information relative to a customer and the service provided. It is disappointing that the Provider could not furnish the documentation specific to this policy and in particular the documentation in relation to the identification of the account holders.

As a result of the lack of documentary evidence, I am unable to establish with any certainty what was discussed between the original provider and the First Complainant during the telephone call of **5 April 2015**. The evidence sought by this office and not furnished by the Provider, could have greatly assisted in establishing who was to be covered by the policy, and provided clarity as to its suitability.

The Policy states that it is the *first named person on the* ***Agreement*** that is covered, but the Provider has not furnished any document setting out who the first named person on the Agreement is. All I can determine is that, if the policy was only going to cover the First Complainant, and the Second Complainant was the key earner in the partnership (in the sense that the work he was doing was the mainstay of the business), the Payment

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Protection Policy was not a suitable product to cover the eventuality of the Second Complainant being unable to work. I also accept that the working arrangement relative to the Complainants' business should have formed some part of the conversation relative to the provision of the cover.

As regards the Provider notifying the Complainants of the change of ownership of the business, I note the Provider states it informed the Complainants of this in November 2010. However, the Provider did not respond to the Complainants' further position regarding a non notification by the Provider of a transfer of the business that appears to have subsequently taken place.

The remedy initially sought by the Complainants was a return of all premiums paid to the Provider. Some two years into the complaint the Provider did offer to refund the premiums + 3% interest. This offer was made without any admission of responsibility and was left open for the Complainants' acceptance. The Complainants rejected this offer, and in addition to the initial remedy, the Complainants sought compensation for the Provider's overall handling of the matter.

While I accept that the Provider's offer would generally be the remedy directed where a mis-sale is established and in such circumstances, I might be minded not to uphold the complaint, however, because of the lack of documentation that should have been retained by the Provider and the inconvenience caused, I believe that additional compensation is merited for the delay and inconvenience for the Complainants caused by the Provider's conduct in not retaining / not furnishing the information relative to the setup of the policy.

Having regard to all of the above, I uphold this complaint and direct the compensatory payment of €300 (three hundred euro) in addition to the Provider's offer of a return of all premiums + 3% interest.

Because of my concern at the Provider's position that it does not have documentation because it acquired the account from the previous owner, I intend to bring this issue to the attention of the Central Bank of Ireland, for any action it may deem necessary.

Conclusion

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

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainants in the sum of €300 (three hundred euro) in addition to the Provider's offer of a return of all premiums + 3% interest, to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants to the Provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to

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in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

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

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

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

21 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.