An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0556
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Disagreement regarding Settlement amount offered Miscellaneous
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant entered a mortgage loan agreement with a financial services provider in **2006** (the **Bank**). A requirement of this agreement was that life assurance/mortgage protection cover be in place to cover the outstanding loan balance in the event of the death of the Complainant. The Complainant incepted a life policy in **October 2006** with the Provider which was part of a block policy. The Complainant submits that on **29 November 2010**, the Provider, the insurer against which this complaint is made, reduced the level of cover under his plan without his consent and failed to notify him of the changes to his plan. The Complainant maintains that he was simply making an enquiry in respect of a reduction in the level of cover.

The Complainant's Case

The Complainant explains that the Provider reduced the level of cover under his policy without *express permission*. The Complainant states that he only made a policy enquiry in **2010** during a meeting with the Bank which was arranged to discuss the arrears on his loan account. He asserts that the Provider never followed up on his enquiry.

The Complainant outlines that he only became aware of the reduction in cover in **2014** when he made a claim under the policy following a cancer operation. The Complainant

says that the original cover under the policy was €150,000.00 for mortgage protection and €150,000.00 for serious illness cover, which was reduced to €100,000.00 and €60,000.00 respectively.

The Complainant says he was advised by the Provider that it was the Bank who amended his policy, explaining:

> *"I didn't meet with anybody to discuss my policy.*
> *I didn't meet with anybody to sign new policy.*
> *I never received new policy to this date."*

The Complainant also explains that the Provider lodged the payment in respect of his claim under the policy to the loan account despite being asked to issue a cheque to his address.

The Provider's Case

The Provider states that on **29 November 2010** the Complainant attended one of the Bank's branches for a meeting. The Provider says it is understood that this meeting was in respect of a Standard Financial Statement. The Provider advises that the Bank has asserted that it did not offer any advice to the Complainant as to whether he should or should not reduce cover, and was not acting as an insurance intermediary or tied agent of the Provider in this instance.

During this meeting, the Provider says the Bank's agent telephoned the Provider's Customer Care Services Team on behalf of the Complainant and asked if the Complainant could discuss his policy. The Provider says the Complainant queried if it was possible to make alterations to the level of cover under the policy in order to reduce his monthly premium. The Provider says that on the specific request of the Complainant, a quote was provided verbally over the phone to reduce Life Cover from €150,000.00 to €110,000.00 and Accelerated Specified Illness Cover from €150,000.00 to €60,000.00, with a reduction in monthly premium from €86.05 to €50.70, a saving of €35.35 per month.

The Provider says the Complainant is recorded on the telephone call as accepting the quote and indicating that he wished for the reduction to be implemented. The Provider says its agent advised that as the Bank was the plan owner/assignee, written confirmation was required from the Bank to effect the reduction in cover and it was suggested that the Complainant ask the Bank to notify the Provider that it agreed to the reduction in cover. The Provider says the Complainant agreed to proceed on that basis.

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The Provider says it was able to proceed with the requested reduction on the basis of a recorded verbal request because the Complainant was the only named life assured on the policy, once authorisation was provided by the legal owners.

On **2 December 2010**, the Provider says it received an email confirmation from the Bank indicating it was agreeable to the requested reduction. The Provider says it carried out the authorised reduction request on **11 December 2010** and confirmed this with the Bank. The Provider submits that as the mortgage protection cover plan was set up as a block arrangement, with the Bank as the sole beneficiary and legal owner of the policy, all correspondence is directed to that institution only. The Provider says it is not the practice of the Provider to communicate directly with a life assured, under block plan arrangements, other than the initial provision of the life assured's Membership Certificate and associated documentation upon commencement of the policy. The Provider submits that the Complainant would have noted a reduction of €30.35 in his monthly mortgage related payments to the Bank, which included the premium for the policy.

On **10 June 2014**, the Provider says it received a completed Specified Illness Claim Form in respect of the Complainant. The Provider says the claim was subsequently accepted on **26 June 2014** and a cheque of €60,000.00, which was the amount of Accelerated Specified Illness Cover attaching to the policy at the time of the claim, was issued to the Bank as the sole beneficiaries and plan owner.

Subsequently, the Provider says on **26 February 2015**, the Complainant raised an official complaint regarding the reduction in the benefits attaching to his plan in **December 2010**. The Provider says its response to the complaint was to point to the telephone call demonstrating that the Complainant made a verbal request to have the benefits reduced in order to reduce the monthly premium and that this was confirmed and approved by the plan owner, the Bank.

On the basis of the above, the Provider says it is fully satisfied that it has administered the Block Life Cash Cover Plan in accordance with the terms and conditions of the contract and with the full authorisation of the plan owner. The Provider further says that this alteration was initiated at the request of the Complainant.

The Complaints for Adjudication

The complaints are that the Provider:

> Amended the level of cover under the plan without the Complainant's express permission; failed to notify the Complainant of the changes to his plan; and

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failed to comply with the Complainant's instruction to issue him with a cheque in respect of his claim.

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 23 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 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.

In addition to this complaint, a complaint was also received by this Office in respect of the Bank's conduct surrounding the amendment of the Complainant's life policy (the **Linked Complaint**). In such circumstances, this Office wrote to the Complainant by letter dated **24 March 2021** requesting his consent to the sharing of the evidence in respect of each complaint with the Respondent Provider to the linked complaint. The Complainant gave his permission to the sharing of evidence by email of the same date.

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Accordingly, this Office wrote to the Provider on **8 April 2021** to inform it of the Complainant's agreement to the sharing of evidence between the Respondent Providers to the linked complaints. Following this, the relevant documentation was forwarded to the Provider on **9 April 2021**.

The Relationship Between the Provider and the Bank

By letter dated **12 August 2015**, the Office asked the Provider to confirm whether the Bank was acting as a tied agent of the Provider. In response to this, the Provider advised by email dated **13 August 2015** that:

> *"*[W]*hen selling this plan,* [the Bank] *were acting as tied agents of* [the Provider] *however, in relation to the mortgage or banking side, they are separate to* [the Provider] *and are not affiliated with* [the Provider] *when dealing with mortgages or banking matters."*

In an email to this Office on **7 October 2016**, the Provider further advised that:

> *"1. The representative of* [the Bank] *who met with the Complainant on 30 November 2010 to complete a Repeat Standard Financial Statement – SFS, which is carried out by the bank when customers are in mortgage arrears, was not acting as a tied agent of* [the Provider] *but as a Mortgage Advisor of* [the Bank] *and advising the Complainant on his mortgage arrears and his ability to manage his financial outgoings. As part of the Standard Financial Statement process the Mortgage Advisor looks to have the customer reduce all unnecessary outgoings so as to facilitate the clearing of his mortgage arrears. It would appear that the Complainant agreed that he should reduce his Life cover and Specified Illness Cover in order to free up some of the premium to help reduce his arrears. The advice given was not life assurance related but mortgage related.* […]*."*

During the course of the adjudication of this complaint, by letter dated **4 December 2020**, this Office sought further information from the Provider regarding the nature of its relationship with the Bank in respect of the Complainant's policy. By letter dated **23 December 2020**, the Provider responded, advising that when the Complainant effected the policy in **2006**, the Bank was a tied agent of the Provider for the sale of life, pension and investment products. The Provider explained that, as a product provider, it is responsible for the administration of the policy in line with its terms and conditions, and for the provision of customer service and claims processing throughout its term.

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The Provider further explained that the Bank is today, and was in **2006**, a tied agent of the Provider and that all underwriting and customer service activities are the responsibility of the Provider.

Background

The Complainant entered a mortgage loan agreement with the Bank pursuant to a Letter of Approval dated **6 July 2006**. On foot of the Bank's requirements, the Complainant incepted a 'Life Cash Cover (Block) plan' with the Provider. By letter dated **3 October 2006**, the Provider wrote to the Complainant enclosing his 'welcome pack' which included a 'Certificate of Membership'. The Certificate of Membership outlined the Complainant's cover under the policy, as follows: €150,000.00 for Life Cover and €150,000.00 for Accelerated Specified Illness Cover.

On **29 November 2010**, it appears the Complainant attended one of the Bank's branches to complete a Standard Financial Statement. At a certain point in this meeting, the Complainant's life policy was discussed.

This resulted in the Bank's staff member contacting the Provider by telephone and indicating in a very brief exchange, that the Complainant wished to discuss his policy. The phone was then given to the Complainant. This was a short conversation and once the initial formalities were dispensed with, the conversation proceeded as follows:

Complainant: *I'm just in the bank here querying about reducing the life cover that I have and the serious illness cover.*

Provider's Agent: *You can actually do that. We would be able to reduce the benefits on the policy. Do have an idea of what you'd like them reduced to?*

Complainant: *Yes. I was thinking of the life insurance, I was thinking of dropping it to €110,000 and the serious illness, I was thinking of dropping it to €60,000.*

Provider's Agent: *Bear with me and I'll just give you a wee quote on that now.*

Ok, by reducing the life cover to 110 and your serious illness to 60, it's giving a new premium of €50.70 per month.

Complainant: *Fifty euro and seventy cents*

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Provider's Agent: *That's down about roughly 36.20.*

Complainant: *Ok can I go ahead and do that?*

Provider's Agent: *You can however we will need written confirmation from* [the Bank] *to say it's ok to do that and they are actually the plan owners. So if you ask them to send us over notification to say that it's ok to do so. It's ok to reduce the life cover to 110 and serious illness to 60, we can go ahead and do that.*

Complainant: *Ok. Thanks very much indeed.*

Provider's Agent: *No problem at all. Now the only thing is what I would suggest, now before I could do that is, well I can put the notification on the system that you rang and when you rang to do that and then when the letter comes in from them we can go ahead and do that. Can you just hold for a moment till I double check that I don't need you to ring in again. One moment.*

Complainant: *No problem.*

Provider's Agent: *Well I'm going to note it on the system that you want the benefits reduced. Alright? So when we get the notification in from* [the Bank] *we should go ahead and do that for you. But what I suggest you do is maybe give us a ring back in a week and make sure that it is done if you haven't heard anything from us.*

Complainant: *Ok.*

Provider's Agent: *Is that ok?*

Complainant: *That's perfect.*

Provider's Agent: *So it's 110 and 60.*

Complainant: *Yeah.*

Provider's Agent: *No problem at all. I'll do that for you now and put it on the system until we get the notification from the bank.*

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Complainant: *Thanks very much indeed.*

Provider's Agent: *You're welcome. Thank you for calling.*

The Bank's staff member emailed its Mortgage Department on **30 November 2010** in respect of the amendment to the Complainant's policy, as follows:

> *"The above mtg holder has requested from* [the Provider] *that his life policy be reduced to €110K level term and €60K SIC they need a note from* [the Bank] *to go ahead with this is it in order to proceed?"*

The Bank's Mortgage Department responded to the relevant staff member on **2 December 2010**, agreeing to the above policy amendments, as follows:

> *"We would be agreeable to customer reducing life cover to 110,000 and SIC to 60k"*

Following this, the Bank wrote to the Provider by email on the same day, explaining:

> *"The above customer is looking* [to] *reduce the amount of cover on their policy, they have called and were told they need the agreement of the mortgage department.*
>
> *Below is agreement from department."*

In response to this email, on the same day (**2 December 2010**), the Provider advised:

> *"I have reduced the benefits as requested below.*
>
> *This will take over night to be processed, a letter will issue out to client outlining the new benefits."*

In a submission accompanying the Complaint Form, the Complainant describes the meeting with the Provider on **29 November 2010** as follows:

> *"My appointment was with* [the Bank] *to fill out S.F.S. form*
>
> [The Bank's staff] *member explained*
> *My mortgage as €100K & my policy's were €150K. Life cover & serious illness.*

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Staff member.

Advised me to ring [the Provider] *to inquire about changing my policy, and that if the figures was agreeable,* [the Provider] *would send me the proposals to my address, for me to view + sign.*

Then it would have to be passed by [the Bank] *because life cover would have to match amount of my mortgage €100k.*

That was the last I heard about it and received no post or forms. […]*."*

In a submission dated **2 April 2020**, the Provider states that:

"[U]*nder a Group Mortgage Protection Scheme the life covered under the arrangement has no automatic entitlement to communication other than their initial documentation at the outset.*

As such no documentation issued to [the Complainant] *as the life covered following his request to amend the level of cover* […]

- No updated documents were issued to [the Bank] *as plan owner.*

[The Bank] *is a corporate institution and there is no requirement for us to issue such documentation to a corporate institution.*

- Under [the] *plan* [the Provider] *simply provided the cover on* [the Complainant's] *life for* [the Bank]*.* [The Provider's] *contract is with* [the Bank] *and not* [the Complainant] *as the life covered. There is no requirement for us to instruct an institutional plan owner to communicate with the life assured."*

In an email to this Office on **5 April 2020**, the Complainant explained, as follows:

"The understanding that I have of what happened on the 29th November 2010 is I was asked to go to [the Bank's] *branch to fill out a SFS* […] *form with* [the Bank staff member]*. During this procedure she informed me of an option to reduce my policies I had in place with* [the Provider]*. This was mentioned as my Life Insurance policy at that time was at €150K and mortgage repayment price was ay €110K so it would make sense to reduce this along with serious illness cover.*

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It was made clear to me that doing so I would need to require information off [the Provider] *and then* [the Bank] *would set this in place but only agreeing in writing and having the right of a 14 day cooling off period. I called* [the Provider] *in* [the Bank's] *Branch to query my options and see if it was possible to do. When on this phone call to* [the Provider] *I had advised the employee that it was OK on my behalf, me being of the understanding that this would be passed onto* [the Bank] *to be passed onto me that it had been put in place. I was advised by* [the Provider] *that if I didn't hear from them to maybe call maybe call them in a week I didn't call them. I never heard from* [the Provider] *after this phone call to say that any agreement had been set in place.*

When finished on the phone to [the Provider], [the Bank's staff member] *advised me that they needed to give* [the Provider] *permission to amend the agreement on my behalf in writing, do up an amended policy agreement for me to sign and that I would be called up to have a meeting with her during that week to go through all of this. After this meeting then she would send her consent onto* [the Provider]. *This meeting never happened, I never signed any paperwork and never gave* [the Bank's staff member] *permission to give her consent on my behalf to* [the Provider]. *So as this never occurred, I was of the understanding that my policy remained the same and wasn't reduced until years later. I didn't notice any amendments on my incoming statements as it was such a low reduction off a high amount that I was paying each month and were all under the one figure.* […]*."*

Analysis

On considering the telephone conversation which took place between the Complainant and the Provider's agent on **29 November 2010**, I note that when the Provider's agent provided the Complainant with a quotation for reduced cover, the Complainant responded by saying *"Ok can I go ahead and do that?"*. The Provider's agent then explained to the Complainant that the permission of the Bank was required in order to carry out the amendment and, once this permission was obtained, the amendment would be implemented.

In terms of obtaining the Bank's permission to the amendment, I note the Complainant was advised by the Provider's agent to *ask* the Bank to forward its permission to the amendment to the Provider. However, I note the Complainant was not advised that the Provider would contact the Bank and seek the relevant permission for the amendment. As the above email correspondence from the Bank indicates, the Bank's staff member sought permission for the amendment from the Mortgage Department on **30 November 2010**.

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In this respect, I also note that there does not appear to have been any communication between the Provider and the Bank in the period between the telephone conversation on **29 November 2010** and the of **30 November 2010**.

Therefore, on considering the evidence, it appears that the Complainant is likely to have discussed the policy amendment with the Bank's staff member to such an extent as to cause this staff member to seek permission for the amendment. In circumstances such as this, I am not satisfied that the Complainant was simply making an enquiry regarding the level of cover in place under his policy. It is my opinion the Complainant was following the instructions given to him by the Provider's agent. Accordingly, it is my opinion that the Complainant's conduct is consistent with the Complainant having earlier instructed the Provider's agent to amend the level of cover under the policy.

In the Complainant's email of **5 April 2020**, he indicates that he was agreeable to the policy amendment but understood he there would be further communication on the matter. In this email, the Complainant states, as follows:

> *"When on this phone call to* [the Provider] *I had advised the employee that it was OK on my behalf, me being of the understanding that this would be passed onto* [the Bank] *to be passed onto me that it had been put in place."*

Although the Complainant may have understood that he would receive further communication or documentation prior to any amendment taking place, on considering the telephone conversation with the Provider's agent, I note that the Complainant was not advised by the Provider's agent that any further form of consent was required from him or that any documentation was required to be completed or signed by him or the Bank prior to implementing the amendment. Therefore, I accept that the Complainant should have been reasonably aware that the policy amendment would take effect once the Provider received the Bank's permission.

Accordingly, while it may have been the Complainant's intention to simply make an enquiry regarding a reduction in the cover under his policy when he spoke with the Provider's agent on **29 November 2010**, having considered this telephone conversation, I accept that the Complainant instructed the Provider's agent, and agreed, to amend his policy. In this respect, I do not accept that any further permission or consent was required from the Complainant, and I am satisfied that the verbal confirmation given during the telephone conversation was sufficient for the purpose of authorising an amendment to the policy.

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In response to this complaint, the Provider's position is that it was not obliged to write to the Complainant in respect of the policy amendment. In this respect, I note from the evidence that no correspondence issued to the Complainant advising him of the changes to his policy.

During the telephone conversation on **29 November 2010**, the Provider's agent stated, as follows:

> *"But what I suggest you do is maybe give us a ring back in a week and make sure that it is done if you haven't heard anything from us."*

Having considered this conversation, I am satisfied that the above statement, reasonably understood, would have the effect of creating an impression that the Complainant would receive some form of communication or correspondence from the Provider regarding the policy amendment in the days following this call. While the Complainant was also advised to contact the Provider (and I note he does not appear to have done so), I do not accept that this excuses the fact that no further communication was received from the Provider regarding the policy amendment.

Significantly however, in an email from the Provider to the Bank on **2 December 2010**, the Provider expressly stated that *"a letter will issue out to client outlining the new benefits."*

However, there is no evidence of any such letter having issued nor has any explanation been offered as to why this letter was not issued. Furthermore, this email demonstrates an intention on the part of the Provider to issue a letter to the Complainant regarding the policy amendment and such an intention is very much inconsistent with the position adopted by the Provider in its Complaint Response.

Insofar as concerns the ***Consumer Protection Code 2006***, I note the following General Principles set out at Chapter 1:

> *"A regulated entity must ensure that in all its dealings with **customers** and within the context of its authorisation it:*
>
> *1 acts honestly, fairly and professionally in the best interests of its **customers** and the integrity of the market;*
>
> *2 acts with due skill, care and diligence in the best interests of its **customers**;*
>
> […]

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12 complies with the letter and spirit of this Code."

Having regard to the above General Principles, I would consider it reasonable to expect the Provider to have written to the Complainant confirming that the amendment to his policy had taken place and to advise him of the reduced cover in place under the policy. It is my opinion that the Provider's conduct in terms of the absence of communication with the Complainant following the telephone conversation on **29 November 2010** is inconsistent with the above-cited General Provisions.

Furthermore, I do not accept that the absence of an explicit requirement to communicate with the Complainant in respect of the amendment to the policy means that it was not reasonable to expect the Provider to have communicated with the Complainant in respect of the amendment. In light of the above analysis and regardless of the fact that there may not have been an express obligation to communicate with the Complainant, it is my opinion that it was reasonable to expect the Provider to have communicated with the Complainant to advise him that the policy amendment had taken effect and to provide him with updated policy details.

Accordingly, I am of the opinion that had the Provider issued the appropriate correspondence to, or communicated with, the Complainant, any confusion arising from the telephone conversation on **29 November 2010** could possibly have been avoided or resolved. However, I am also mindful that had Complainant followed up with the Provider as advised, any confusion on the part of the Complainant could have been resolved.

In its Complaint Response, the Provider states that all correspondence regarding the policy is directed to the Bank as legal owner/assignee of the policy. In its Timeline of Events, the following is noted by the Provider in respect of **11 December 2010**:

> *"The Provider carried out the authorised reduction as requested on 11 December 2010 and confirmed this to the Plan Owner,* [the Bank]*. As this mortgage protection cover plan was set up as a Block arrangement, with* [the Bank] *as the sole beneficiaries and legal owners of the plan, all correspondence is directed to that Institution only."*

However, contrary to this, in a submission dated **2 April 2020**, the Provider states that no updated documentation was sent to the Bank nor is there a requirement to issue such documentation to a corporate institution. The position was repeated by the Provider in a submission dated **21 April 2020**, where the Provider further states that the applicable Consumer Protection Code did not require the Provider to issue correspondence to a corporate institution, being the Bank.

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Subsequent to this, by letter dated **25 June 2021**, this Office requested that the Provider clarify the means by which it confirmed the policy amendment with the Bank, as outlined in the Timeline of Events. The Provider responded to this request on **2 July 2021**, as follows:

> *"We received confirmation from* [the Bank] *as institutional plan owner on 2 December 2010 that they were agreeable to* [the Complainant's] *request to amend the level of serious illness cover on their plan.*
>
> *No formal confirmation or communication issued to* [the Bank] *about the change in cover once processed and there was no requirement on us to do so. We had a clear and explicit request from* [the Complainant] *for his level of serious illness cover to be reduced with the plan owner (*[the Bank]*) giving their consent to this change on 2 December 2010.*
>
> *I refer to our submission of 2 April 2020 which sets out in detail why formal confirmation of the change was not issued to either* [the Complainant] *as the life covered under the plan or to* [the Bank] *as the institutional plan owner.*
>
> *Apologies for any confusion caused by our submission of 14 July 2017 where it was noted that we confirmed the change to the plan owner following their email of 2 December 2010."*

However, irrespective of whether the Complainant's policy was part of a group scheme or the absence of any express obligation to communicate, it is my opinion that it was also reasonable to expect the Provider to write to the Bank to confirm the amendment to the Complainant's policy.

In essence, the Provider's position appears to be that it was not required to write to either the Complainant or the Bank in respect of the policy amendment. However, in light of the above discussion, I consider this to be a most unreasonable approach. Accordingly, I am satisfied that the Provider failed to notify the Complainant that the policy amendment had taken effect. I am also satisfied that the Provider failed to notify the Complainant as to his updated policy details.

In terms of the Provider's investigation of and response to this complaint, I wish to draw attention to the above-mentioned email sent by the Provider on **2 December 2010**.

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In its Timeline of Events, the following information in provided in respect of **2 December 2010**:

> *"The Provider received an e-mailed confirmation from* [the Bank]*, that* [the Bank] *were agreeable to the requested reduction. Please find copies of the various emails referenced above enclosed under Section 20 of the Schedule of Evidence."*

From a review of the Timeline of Events, I note there is no reference to the email sent by the Provider to the Bank on **2 December 2010**. Further to this, on reviewing the documentation contained in the Schedule of Evidence furnished by the Provider, this email was not included. The Provider's email of **2 December 2010** was discovered while the documentation submitted as part of the Linked Complaint was being reviewed.

It is not clear why this email was not mentioned in the Provider's Complaint Response or Timeline of Events, nor is it clear why this email was not submitted as part of the documentation furnished by the Provider in response to this complaint. In particular, it is not clear why the Provider did not locate this email as part of its investigation of this complaint, an email which was sent on the same date as, and in response to, the Bank's email of **2 December 2010**.

It is my opinion that had reasonable efforts been made to locate all relevant communications with the Complainant and the Bank, this email would have been uncovered. However, I find the Provider's inability to locate this to be particularly concerning and disappointing, particularly in light of the significance this email has in terms of the extent to which it evidences an intention on the part of the Provider to write to the Complainant in respect of the policy amendment and the extent to which this email presents a contrary position to that maintained by the Provider regarding the absence of any requirement to communicate with the Complainant in respect of the policy amendment and its position that it is not the practice of the Provider to communicate directly with a life assured in respect a block policy.

In terms of the Complainant's instruction that he be issued with a cheque in respect of his claim, I note that the Provider furnished the Complainant with a 'Specified Illness Claim Form' under cover of letter dated **3 June 2014**. A completed claim form was received by the Provider on **9 June 2014**. Following this, a cheque in the amount of €60,000.00 was issued by the Provider to the Bank on **26 June 2014**.

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In the Provider's letter of **3 October 2006**, the Complainant was advised that the welcome pack included, amongst other documents:

> *"Your **certificate of membership** which details the specific arrangement with* [the Bank]*. The ownership of this plan and all the rights attached to this plan belong to* [the Bank]*."*

Further to this, on the Certificate of Membership, the Bank is listed as the *Proposer* and the Complainant is the *Life covered*. Under the policy terms and conditions, it is stated that in the event a claim is accepted, the benefit under the policy will be paid to the Proposer. This term is further defined as the *"*[t]*he person or company* […] *who is legally entitled to the policy benefits* […]*."*

Having considered the matter, I cannot see evidence of any instruction or requests from the Complainant that he be issued with a cheque in respect of his claim. In any event, I accept that the policy was assigned to the Bank and, as such, any benefits payable under the policy were to be paid to the Bank. Accordingly, I do not accept that the Complainant had any entitlement to have the benefits payable on foot of this claim paid directly to him nor am I satisfied that the Provider was obliged to comply with such a request.

For the reasons set out in this Decision and for the unreasonable conduct of the Provider, I partially uphold this complaint and direct the Provider to pay a sum of €3,000 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)*** as the conduct complained of was unreasonable in its application to the Complainant.

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 €3,000, 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.

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I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

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

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

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.