Decision Ref:	2021-0566
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Delayed or inadequate communication Rejection of claim - pre-existing condition
Outcome:	Substantially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant joined her employer's group pension and insurance scheme (the **Scheme**) in **May 2013**. This Scheme is underwritten by an Insurer. The Provider, against which this complaint is made, is the financial adviser/broker for the Complainant's employer. In **July 2014**, the Complainant enquired with the Provider about the Permanent Health Insurance aspect of the Scheme believing this cover was in place. The Provider advised the Complainant that she was not covered under this aspect of the Scheme. The Complainant maintains the Provider failed to advise or notify her that she did not have Permanent Health Insurance.

The Complainant's Case

The Complainant explains she began work with her employer in **2012** and in **April 2013**, decided to look into joining the company pension scheme. The Complainant completed a questionnaire about her health and gave full disclosure about her previous medical history: this included a back surgery and anti-depressants.

On **30 April 2013**, the Complainant states she received a benefits document from the Provider outlining her cover. On **27 May 2013**, the Complainant received a letter from the Insurer enclosing a benefits document and *"… this very clearly outlined I was covered for (1) Income during ill-health (2) Death Benefit (3) Pension Scheme in both documents."* The Complainant also states she was never asked to undergo a medical examination or informed that any restrictions applied to her policy.

The Complainant refers to the documents received from the Insurer, in particular page 3 of the Group Retirement Plan, stating that *"I understand a sentence which states I would be informed if any restrictions apply."* The Complainant submits she did not receive any other documentation from the Provider, the Insurer or her employer to advise her that she was not covered under the policy. The Complainant advised that *"I had made the natural assumption that [the Insurer] had reviewed my application and my completed medical questionnaire and had duly issued the cover on completion of the medical underwriting. I don't know if this assumption is correct, but regardless it is not relevant to my claim."*

In mid **2014**, the Complainant explains that having been dealing with chronic pain for three months, *"I had to go sick from work and try to find a solution to my back pain."* It was at this point the Complainant decided to look into how she would claim long-term sick leave if she was not able to return to work. The Complainant contacted the Provider to enquire about the claims process. However, the Complainant was not planning to make a claim at that time as she wanted to return to work but *"… for peace of mind I decided to investigate what I needed to do."*

The Complainant states *"[t]his was the moment things seemed wrong …"* as the Provider confirmed to her over the telephone that she was not covered and never was. The Complainant outlined to the Provider that she had a document explaining she was covered but was still advised she was not covered. This was 14 months after the Complainant joined the Scheme. The Complainant states she was advised by the Provider *"… that their Benefits form … clearly states that 'the cover is subject of Medical Underwriting' before the Insurance can be confirmed."* The Complainant submits this is not what the form says. The form states *"… cover under the scheme may be subject to medical underwriting before the cover can be confirmed."*

The Complainant then went to her employer and met with the Financial Controller who was responsible for the administration of the scheme and who was very surprised, and was unaware the Complainant was not covered for long-term disability benefit. The Complainant states the Financial Controller explained:

> *"… the standard engagement process in all other cases where any of the benefits of the scheme were either reduced or rejected were as follows.*
>
> 1. *Staff member fills out the application form and medical questionnaire.*
>
> 2. *Subsequently, **IF** any of the benefits are rejected or reduced [the employer] received a Special Terms letter from [the Provider] that [the Insurer] have rejected or reduced benefits for a staff member.*
>
> 3. *This special terms letter had to be signed by the then Managing Director … confirming that the [employer] group scheme understands and accepts these reductions for a staff member.*

/Cont'd…

> 4. *[The Provider] also contact the staff member directly to inform them of the restrictions but to ensure that the staff member was aware, [the employer] would also contact the staff member and advise them of their reduced cover.*
>
> *The above was the standard process which had been in operation for a number of years. Other than point 1 above, none of the standard processes were followed … and neither I nor [the employer] received any specific correspondence or notification that there was any issue with my Insurance cover."*

The Complainant cites the following passage from the Provider's Permanent Health Insurance Member's Certificate:

> *"Payment of any disability benefit is subject to [the Provider's] underwriting requirements. Consequently, you may be asked to undergo medical examination in respect of part of your benefits. The amount of benefit may be restricted if you fail to satisfy any medical or other requirements of the underwriting. You will be informed if any restrictions apply in your case."*

The Complainant submits the Provider nor the insurer never asked her to undergo a medical examination and she was never informed of any restrictions that applied to her cover. The Complainant refers to the *Standard Process* where her employer would receive a Special Terms letter outlining any such restrictions and the Managing Director would sign the letter and return it to the Broker to confirm the employer's understanding of the restrictions. No Special Terms letter was received by the Complainant or her employer and no such letter had been furnished by the Broker.

The Complainant states she *"… felt very let down by [the Provider] and [the Insurer] to be honest as I had absolutely assumed I was covered."* The Complainant remarks that she paid the same premium as everyone else in her company and was never advised that long-term disability benefit was not included in her policy: neither the Complainant nor her employer were notified of this. The Complainant submits she *"… received that exact same documents as all staff that were covered so to me, I paid the same, I received the same documents and therefore I must be covered."*

The Complainant then advises her employer asked her to leave the matter with them and they would look into it. The Complainant outlines that she has since had another back operation and returned to work early in **2015**. The Complainant explains the Provider *"… kept advising myself and my company that due to 2 medical complaints on my form that I was NEVER going to get cover. I understand the whole pre-existing thing but surely I would have been notified if they were not going to cover me, it says so in both my policy documents that I received when I joined. [The Provider] did not take any responsibility for not informing me or my employer of this and basically told me I don't have a case."*

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In early **2016**, the Complainant outlines that her back pain returned and *"... again I was trying to work."* The Complainant explains she is the main earner in her home and having no income would be a massive blow to her family. The Complainant states that in late **2016**, she underwent another back operation and was out of work until early **2017**. The Complainant states that between **April 2016** and **January 2017**, *"... my employer was trying to see if they could do something on my behalf but in the end they didn't get anywhere ..."* The Complainant wishes to make clear that her employer *"... is not at fault in anyway, in fact they have been nothing but supportive of my illness and they tried their best to get [the Provider] to do something."*

Referring to a Final Response letter received from the Insurer, the Complainant observes *"... this clearly advised me that [the Insurer] had informed [the Provider] and it looks like [the Insurer] are not at fault ..."* The Complainant remarks that, in this letter, the Insurer explains cover for permanent health had been deferred for two years and it had written to the Provider on **4 October 2013** explaining this. The Complainant states there was further correspondence with the Insurer and the Provider on **10 October 2013** where it is stated that a special terms letter was sent to the Provider to be forwarded to the Complainant and her employer which was not received.

The Complainant states she is *"... complaining about the following points*

- *They never made myself and or my employer aware in writing or by phone call that I was not covered for long-term illness*

- *I was paying the same amount into the pension scheme as those who were covered.*

- *I am not covered at all for long-term disability even with calling out the pre-existing conditions, and if I was made aware of this perhaps I would have got some long term disability cover with another vendor, but by the time I was made aware it was too late."*

In resolution of this complaint, the Complainant *"... want[s] to be compensated for not been given information that I was covered and now 2 more back operations I will never get covered. I want compensation to be re-instated as covered or for [the Provider] to compensate."*

The Provider's Case

The Provider's Role

The Provider received an instruction to seek to admit the Complainant to the Scheme in **April 2013**. The Provider advises that it is the financial adviser to the Scheme and its involvement with respect to the Complainant arises in its capacity as financial adviser to the Complainant's employer and dealt with the Complainant in its capacity as agent on behalf of her employer.

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The Complainant's Membership of the Scheme

The Provider explains there are three elements of cover to the Scheme: Pension, Death in Service Benefit, and Permanent Health Insurance. The issue in this complaint is the Permanent Health Insurance in that the Complainant asserts she was misled into believing she had Permanent Health Insurance and grounds this assertion on the basis that she was not told she did not have cover. The Provider observes that the Complainant does not identify the consequences which flow from this. In particular, the Complainant does not make any claim that her position would have been different in any way if she had been so advised.

The Provider states the documents submitted in response to this complaint show that the Complainant was told she did not have Permanent Health Insurance *"… in the sense that she knew at all material times that the application was being processed, and was subject to underwriting requirements."* The Complainant participated in that process and, contrary to her submissions and complaint, she was never led to believe that she had Permanent Health Insurance. The Provider states *"… it is unsustainable to assert any complaint based on the absence of notices that she did not have cover, where the documents that she did have made it plain that no cover was agreed or granted to begin with."* The Provider adopts the position that insofar as Permanent Health Insurance was postponed on underwriting grounds, the Complainant is at absolutely no loss and now seeks to retrospectively pursue a remedy that will result in her obtaining cover which she could never have obtained at any time. The Provider submits that it went above and beyond its obligations to negotiate terms for Permanent Health Insurance and Death in Service Benefit, with some success.

The Provider refers to *a critical paragraph* in the Complainant's submission dated **5 May 2018** where the Complainant explains she made the assumption that the Insurer had reviewed her application and issued cover on completion of the underwriting process. The Provider remarks that it is *"… grossly disingenuous to suggest that that assumption is not relevant. That assumption is absolutely fundamental to her complaint. That assumption was wrong."* The Provider expresses the view that the Complainant, at no time, laboured under any misapprehension with regard to Permanent Health Insurance. The Complainant knew very clearly that she did not have any form of insurance and the Provider argues that its file clearly demonstrates she was advised of this at all times.

Pro Forma Documents

The Provider also believes it is disingenuous for the Complainant to ascribe value to a statement contained in *pro forma* documents to the effect that insurance *may* be subject to underwriting requirements instead of *will* be subject to underwriting requirements: *[o]bviously, those pro forma documents are used for all applicants to the Scheme."* As *pro forma* documents, the Provider advises they are used for those applicants who join the Scheme upon completing a six month probation period from the commencement of their employment as well as those who do not, and those who join at commencement are *not* subject to underwriting requirements but obtain insurance cover as of right *without underwriting requirements*.

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Time of Joining

The Provider observes the Complainant underwent surgery on her back in **June 2012**, within two months of the date on which she took up employment with her employer. The Provider states that it is most regrettable that the Complainant did not take the option to avail of Permanent Health Insurance and Death in Service Benefit upon her entitlement to membership of the Scheme. The Provider explains had the Complainant taken up membership at that time, none of the present issues would have arisen. The Complainant would have gained Permanent Health Insurance and Death in Service Benefit without having any underwriting requirements.

Statements out of Context

The Provider expresses concern that *"… it is somewhat disconcerting … to read in your [Schedule of Questions] single sentences or phrases harvested out of context from [the Schedule of Documents], although I do appreciate that in order to administer the issues fairy, you are obliged to put the Complainant's case at its highest point fairly to allow the Firm to respond. However, the 'cherry picking' of these phrases by the Complainant in this manner is contrary to the principles of interpretation and also misses a fundamental aspect of the responsibilities as a Financial Services Provider."*

The Provider explains that while a financial services provider must endeavour to simplify matters of a complex nature, *"… they will equally be condemned if they simplify them too far …"* The Provider submits that a skill arises in striking a balance between setting out the issues in full while giving a member a fair opportunity to raise queries and focus on essential points. The Provider states that the information contained in the documents given to the Complainant is driven specifically by the text furnished and set out by the Insurer, and adequately and fairly describe all of the material issues that need to be identified. The Provider indicates it understands that in interpreting a document, the entire of the document must be interpreted together and discrete parts should not be harvested and given separate meaning or primacy, unqualified by context.

File Note

The Provider states, referring to a File Note dated **30 April 2013**, the Complainant was *'advised that benefits would be confirmed following the completion of underwriting.'* The Provider submits this *"… put beyond any doubt whatever that no cover existed until it was confirmed, and makes clear also that no confirmation would issue until underwriting had been completed (not that underwriting **may** take place but that it **would**)."*

The Provider submits the File Note also shows that the Complainant is a person who understands the process in which she was engaged. She had previous life assurance cover and mortgage protection cover, she understood the significance of the enquiries and was discerning in engaging in a discussion as to the Revenue limits, and the appropriate level of AVCs that she might acquire.

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The Provider acknowledges that the File Note discloses the Complainant was not *'well up on investment'* but she was capable of discussing risk level, potential returns and so forth. Finally, the Provider submits the File Note is relevant in disclosing that the Complainant's salary was €45,000 and not €100,000.

Statement of Suitability

The Provider explains the Statement of Suitability states, in respect of the insurance aspect of the Scheme, that an individual *'may be subject to medical underwriting before your cover can be confirmed.'* The Provider asserts this is important in that it demonstrates that cover was not confirmed at that time. The Provider states the Complainant appears to suggest that she laboured under some other understanding that cover had already been confirmed which it states cannot be sustained.

Reference is made to the paragraph contained in the Statement of Suitability directing the Complainant to the Scheme Member's Booklet and Other Scheme Documentation in order to confirm precise benefits. The Provider submits that on **30 April 2013**, the Complainant could not reasonably have laboured under the misapprehension that she already had cover for Permanent Health Insurance when she had only completed the Proposal Form that day.

The Application Form

The Provider states that, based on the information contained in the application form and the information disclosed by the Complainant, it was clear the Complainant was applying for membership of the Scheme and agreed to be bound by the Rules of the Plan. The Complainant, as is clear from paragraph 2, confirmed that she understood *'in the event of her application not proceeding'* information may be retained.

Notification of Membership and Benefits

In the Notification of Membership and Benefits documents enclosed by the Insurer on **27 May 2013** to the Provider, which was forwarded to the Complainant on **29 May 2013**, it is clearly stated in relation to the Death in Service Benefit: *'Note: payment of any Death in Service Benefit* ***is*** *subject to [the Insurer's] underwriting requirements.'* The Provider submits this does not say *may* be subject, it says it *is* subject to underwriting requirements. The Provider observes it does not explain what those underwriting requirements are but instances as one possibility that the Complainant *may* be asked to undergo a medical examination in respect of *'part of your benefit.'*

The Provider explains the Complainant appears to suggest that she made her assumption because she was never asked to undergo a medical examination; but whether or not the Complainant actually undergoes a medical examination is not material to the fact the Complainant was on notice that it *is* subject to underwriting requirements. Consequently, the question of whether or not any medical examination took place does not represent any assurance or basis upon which the Complainant is entitled to make any assumptions.

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The Provider advises the relevant clause goes on to state: *"The amount of benefit may be restricted if you fail to satisfy any medical or other requirements of underwriting. You will be informed if any restrictions apply in your case."* The Provider submits the Complainant places *great store* by the phrase: *"You will be informed if any* ***restrictions*** *apply."* The Provider argues that the Complainant chooses to suggest this implies an immutable representation that, in the absence of such notice of restrictions, she was entitled to *assume* cover was in place. The Provider contends this was an obvious misinterpretation and is self-serving and wrong.

The Provider submits the issue in this complaint does not concern any *restriction* on cover but rather *'whether she obtained any cover at all'* by reason of underwriting requirements. Insofar as the Complainant relies on the *absence* of notification, the Provider explains this cannot be properly construed to alter plain, unambiguous statements made repeatedly throughout the relevant documents that underwriting requirements apply. The Provider points out that the Complainant knew and participated in responding to underwriting enquiries.

A statement on page 3 of this document under the heading *Permanent Health Insurance (Group Retirement Plan) Member's Certificate*, states in relation to Permanent Health Insurance: *"Note payment of any Disability Benefit* ***is*** *subject to [the Provider's] underwriting requirements."* The Provider states, this, once again, is not a statement that cover may or may not be subject to underwriting requirements but rather that it *is* subject to underwriting requirements. The Provider refers to a further statement on page 4 and makes the same point.

The Provider advises this document was prepared by the Insurer and while it may appear technical, it is an unavoidable aspect of such contracts. The Provider also points out that it is not the responsibility of the intermediary to alter or interfere with such documents. However, the Provider submits this document clearly puts the Complainant on notice that cover was subject to underwriting requirements. The Provider remarks that the Complainant was also furnished with contact details of a representative of her employer on whose instruction and behalf the Provider acted as agent in *harvesting* information for the preparation of the Complainant's application.

Underwriting Requirements

The Provider states the Insurer's letter dated **13 June 2013**, and sent to the Complainant on **30 July 2013** plainly states: *"****In order to proceed with the underwriting,*** *we require you to complete an Anaemia Questionnaire and a Mental Health Questionnaire."* The Provider submits its letter emphasises this point by stating: *"****In order to complete your underwriting, you are*** *required to complete the enclosed medical questionnaire."* The Provider remarks that having regard to the level of understanding demonstrated by the Complainant at the time of her interview with the Provider, the Provider believes she cannot under any circumstances have laboured under the misapprehension, at the time she received the letter of **13 June 2013**, she was under cover of insurance.

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There cannot be any doubt those questionnaires clearly put the Complainant on notice that the underwriting process had commenced.

The Provider has cited two sections of the questionnaires completed by the Complainant which demonstrates they were being completed *as part of an application*. The Provider also wishes to correct the Complainant when she states that she completed a Medical Questionnaire on **30 April 2013**. The Provider clarifies this was the application form which does contain certain questions regarding past health. The Provider has also taken issue with and disputes the manner in which the Complainant has sought to characterise the questionnaires.

The Provider advises its position is that the Complainant was, at the latest, fully on notice from **30 July 2014** onward that she was not on cover for any insurance whatsoever. Insofar as the Complainant suggests that she derived comfort from the use *pro forma* documents of the same kind as her colleagues received, the Provider submits the Complainant cannot ignore the specific nature of the medical questionnaires that she alone received and which put her on notice of the Insurer's interest in and interrogation of her special health conditions. The Complainant cannot have misunderstood that these questionnaires were sent to her specifically, and pertained to specific aspects of her heath.

Application and Cover Offered

The Provider explains the Complainant completed her application by completing the medical questionnaires in **September 2013**. These were submitted by the Provider to the Insurer on **18 September 2013**. An offer of Death in Service Benefit only was received by letter dated **4 October 2013** with Permanent Health Insurance being deferred. The Provider states this offer was immediately rejected by it and referring to an email dated **9 October 2013**, contacted the Insurer by phone to remonstrate over the cover offered.

The Provider advises that from this date until **June 2014**, it was engaged in strenuous negotiations to secure cover for the Complainant. This was done not merely in discharge of its duty but within the context of a valuable client and valuable Scheme from which the Insurer received significant income.

There was high level engagement between the parties and by **21 November 2013**, the Provider had spoken to a director within the Insurer which prompted the Head of Group Risk to email the Provider. The Provider met with this individual on **6 November 2013** to principally complain about the cover offered in respect of the Complainant which can be seen in an email from this individual dated **6 December 2013**. The Provider lists 9 meetings with the Insurer between **October 2013** and **May 2014** and advises the Complainant was discussed at each such meeting. The Provider sets out the improvements made to the Scheme following these meetings but advises that these did not work in favour of the Complainant. However, the Provider persisted in making representations to the Insurer. The Insurer finally wrote to the Provider on **3 February 2014** yielding on the loading applied to the Complainant's Death in Service Benefit but not the Permanent Health Insurance.

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The Provider continued in its representations and refers to an email dated **27 May 2014** in this regard.

The Provider advises that it did not forward letters dated **10 October 2013** or **20 February 2014** in which the Insurer expressly stated that the Special Terms Letter of **10 October 2013** had been waived. However, *"[w]ith the benefit of hindsight, [the Provider] clearly regret that the Firm did not send these on at that time to [the Complainant]."* The Provider explains the reason for not doing so was because the Death in Service Benefit had merely been loaded seeking additional premium and the Permanent Health Insurance was merely postponed but neither was refused. As far as the Provider was concerned, the agreement was in active negotiation. It had received a counter offer to which it was invited to respond, which it did.

The Complainant's Enquiry on Cover

The Provider states that its File Note and an email dated **30 June 2014** records a telephone conversation with the Complainant requesting a copy of her policy document. In her submission, the Complainant describes her contact with the Provider as an enquiry about the process of making a claim for permanent disability. The Provider disputes this was the case. The Complainant was seeking a copy of her policy document, the Provider contends, in circumstances where she was aware she had not obtained cover the previous year, had been asked a number of questions that were part of her application, and had never received any confirmation that cover had been obtained. The Provider submits the Complainant was fully on notice of the position from that day onwards.

In concluding this part of its submission, the Provider summaries the position as follows:

1. The Complainant knew she did not have insurance cover when she filed her application to join the Scheme in **May 2013**.

2. A completed application was not submitted until **18 September 2013**.

3. The Provider continued to negotiate on her behalf to obtain insurance thereafter.

4. The Complainant was not notified of the ongoing negotiations which were conducted of the Provider's own initiative and without reward until **2 July 2014**.

5. The Complainant remained a member of the Scheme despite Permanent Health Insurance being postponed.

6. The Provider persisted in making enquiries.

Alternative Cover

On **19 May 2016**, the Provider emailed the Complainant with proposal forms for equivalent Permanent Health Insurance with four financial service providers.

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The Provider advises that it does not have a copy of this email, however, the Complainant telephoned the Provider on **16 June 2016** stating she did not wish to return the other proposal forms until she heard back from the Insurer as she thought this *may go against her*.

The Provider maintains the position this shows it did, in **October 2013**, exactly as the Complainant chose to do two years later in **June 2016**, in that she sought to persist in seeking Permanent Health Insurance which had been postponed by the Insurer until that time. The Provider posits that it makes no logical sense to suggest because the Complainant's back condition had deteriorated in the meantime that she would have gone to market before this deterioration but would not do so now. The Provider suggests the Complainant's need was greater in **2016** and if she chose not to go then, she would not have gone in **2014**. The Provider submits the reality of the Complainant's situation is that ever since **2012**, with the original disclosures, the Complainant's back and mental health issues were a most severe impediment to underwriters and their response was the same, from start to finish.

Concluding Submission

The Provider states the Complainant had no insurance to begin with. She has not been disadvantaged by this and did not have Permanent Health Insurance to date. The Provider submits that had the Complainant applied to join the Scheme within six months of her employment, she would have had cover. On learning that she did not have Permanent Health Insurance, the Complainant took no steps to correct her position. Even after the two year postponement period expired, she expressly instructed the Provider not to do so. The key point the Provider wishes to make in this regard is that the Complainant was not at any loss.

The Provider denies that its conduct was contrary to law or was unreasonable, unjust oppressive or improperly discriminatory. The Provider submits it acted entirely properly throughout.

The Complaints for Adjudication

The complaints are that the Provider:

1. Misled the Complainant as to the status of her Permanent Health Insurance cover and failed to notify and/or communicate with her regarding the status of this aspect of cover;

2. Failed to adhere to and/or follow the standard procedures set out in the Member's Certificate and/or *the standard engagement process*; and

3. Failed to deal with her complaint in a satisfactory manner.

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Preliminary Decision

A Preliminary Decision was issued to the parties on 10 September 2020, 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 the following submissions:

1. E-mail from the Complainant to this Office dated 11 September 2020.

2. E-mail, together with attachment, from the Provider to this Office dated 2 October 2020.

3. E-mail, together with attachment, from the Complainant to this Office dated 5 October 2020.

4. E-mail, together with attachment, from the Provider to this Office dated 8 October 2020.

Copies of the above submissions were exchanged between the parties.

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.

The Complainant, in her post Preliminary Decision submission dated **5 October 2020**, states that "*I disagree that an oral hearing is unnecessary as I feel evidence furnished does disclose a conflict of fact in relation to the Ombudsman's interpretation of the case.* However, 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.

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The Complainant, in her post Preliminary Decision submission dated **11 September 2020**, submitted the following questions:

> *"1. Did* [Provider] *receive* [named insurance company] *documents?*
> *2. Did* [Provider] *or* [named insurance company] *amend their defense subsequently?*
> *3. If any documents / defenses were amended can I have sight of same?*
>
> *In circumstances where amendments took place I have not had sight of same nor have I replied to any new issues or positions that may have been presented".*

In those circumstances and to ensure completeness, I wrote to the Complainant seeking clarification with regard to what evidence or submissions the Complainant had "*not had sight of*".

In response, the Complainant, under cover of her e-mail to this Office dated 26 January 2020, advised "*No, I am fully satisfied I have seen everything, the question came about after* [the Provider] *sent a response in 2019 complaining about the process but it seems to be cleared up so I am happy that I was updated on all correspondence to date".*

Taking into account the Complainant's response above, I am now in a position to conclude the adjudication of this complaint and having considered these additional submissions and all of the submissions and evidence furnished by both parties to this Office, I set out below my final determination.

Following the making of this complaint, the Complainant also submitted a complaint to this Office in respect of the conduct of the Insurer. The conduct complained of in both complaints is essentially identical. During the investigation of this complaint, it was agreed that each Respondent Provider would be furnished with the formal response submitted by the other Respondent Provider. Therefore, in adjudicating on each complaint, I have had sight of and access to the formal responses submitted by each Respondent Provider (the Broker) and the Insurer.

The Complainant has, in a post Preliminary Decision submission dated **11 September 2020,** submitted that "*There is no mention in the* [Preliminary Decision] *about the complaint that* [the Provider] *made to the Ombudsman about the process in relation to this case*".

The "*complaint*" which the Complainant refers to is the Provider's comments and concerns that it was at a distinct disadvantage as the Complainant, due to the separate complaint referenced above, had access to third party information in relation to the Insurer's actions and interactions with the Provider.

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In response to the Provider's submissions, this Office on **20 August 2019** requested permission from the Complainant to share the submissions on her linked complaint against the Insurer, with the Provider against which this complaint is made:

> *"please can you let me know if you are agreeable to us arranging for the evidence on each of your linked complaint files to be placed on the other, excluding any sensitive medical reports, if any, where we don't consider they are be pertinent to the other respective complaint."*

On **22 August 2019** the Complainant confirmed by email that this was acceptable:

> *"I don't see any problem with sharing all information, I have nothing to hide".*

This Office on **12 September 2019** shared the linked complaint file with the Provider. In line with the well-established procedures of this Office all submissions and evidence were shared between the parties, including the Provider's statements regarding this Office on **7 January 2020** and **18 May 2020**.

It should be highlighted that neither a complaint by a complainant or a provider, about this Office has an impact on my adjudication of a complaint about a regulated financial provider.

Eligibility Criteria

The Scheme proposal form dated **December 2005** states that eligibility for membership of the Scheme is contingent on 6 months employment with the Complainant's employer. In terms of *Disability Cover*, the level of cover offered is 2/3 of an employee's salary less any benefits payable under any of the Social Welfare Acts. The deferral period for this benefit is set at 26 weeks. These criteria were chosen by the Complainant's employer as the Plan owner.

Membership of the Scheme

The Complainant's employer contacted the Provider by email dated **26 April 2013**, to advise it of the Complainant's wish to join the Scheme and requested that she be provided with the information necessary for her membership of the Scheme.

The Provider met with the Complainant on **29 April 2013** at her place of employment and completed a *Client Financial Information & Investment Profile*. The Provider has submitted a File Note in respect of this meeting.

The File Note indicates that a *Fact Find* was conducted, a *Reasons Why* letter was received, an application form was completed, and the Complainant was *"… advised that benefits would be confirmed following the completion of underwriting."*

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Statement of Suitability

The Complainant signed a Statement of Suitability dated **30 April 2013**. This document states:

> *"The details of your Pension Scheme benefits are outlined for you under separate headings below.*
>
> ***(1) Income during Ill-health***
>
> *It is important for you to receive an on-going income if you suffer prolonged ill health in the future. This Disability insurance protection will provide an income payment to you if you cannot work due to long term illness.*
>
> *This disability income benefit will be two third of your salary, less a deduction in respect of your social welfare disability benefit.*
>
> *Your disability income payment will increase each year in order to protect the real value of this benefit against the effect of inflation. Your income will commence after you have been out of work for a twenty six week period, and will then be paid to you until your sixty fifth birthday.*
>
> *…*
>
> ***(4) Contribution Protection***
>
> *This insurance protection ensures that your employer and employee pension contributions will continue in the event of you suffering long term illness in the future.*
>
> *If you are unable to work due to prolonged illness, you will then receive an on-going Disability Income each year. …*
>
> ***Summary***
>
> *It is important to note that the insurance cover under the Scheme may be subject to medical underwriting before your cover can be confirmed.*
>
> *The information outlined above represents a general overview of the benefits which are provided under the [Scheme]. However, it is necessary to refer to your Scheme member's booklet and the other Scheme documentation, in order to confirm your precise Scheme Benefits. …*
>
> *I understand the benefits of the [Scheme] and agree to join the scheme at the earliest opportunity.*
>
> *[Complainant's signature]*

/Cont'd…

Encl.

**Fact Find*
**Group Retirement Plan Member Booklet*
**Investment Fund Choice Brochure and Member Update*
**Fund Performance Sheet*
**Employee Application Form."*

Application Form

The Complainant completed and signed an application form dated **30 April 2013**. Section 6 of the application form states:

*"**6. Data protection, Employee declaration and application***

1. *I apply for membership of the Plan, agree to be bound by the Rules of the Plan and authorise deductions from my earnings in respect of any contributions required from me under the Rules of the Plan.*

2. *I understand that in the event of my application not proceeding, information provided in connection with my application will be retained by [the Insurer] …*

3. *…*

4. *…*

5. *I understand that if my proposal for insurance is declined or if [the Insurer] offers me insurance on special terms then this fact will be noted on a central registry …*

6. *I confirm that I have had the meaning of disability as defined in the policy, the benefits available under the policy, the general exclusions that apply to the policy and the reductions that will be applied to the benefit where there are disability payments from other sources explained to me and that I understand these provisions. …"*

The Provider sent the Complainant's application form to the Insurer under cover of letter dated **1 May 2013**.

Notification of Membership

The Insurer wrote to the Provider on **14 May 2013** to advise that the Complainant had been included in the Scheme for Pension, Death in Service, Permanent Health Insurance and Premium Protection benefits with effect from **1 May 2013**.

/Cont'd…

The letter enclosed the following documents: *Summary Schedule of Benefits*, *Notification of Membership Benefit*, *Statement of Reasonable Projection*, *Member Booklet*, and *Disability Information Sheet*. The letter also stated:

> *"Please note that as the member did not join the scheme at the first available opportunity, their application form will be assessed by our Underwriting Department before they are accepted and covered for Death in Service, PHI and PP benefits. Once reviewed, our Underwriting Department will revert back to you on this matter."*

The Insurer wrote to the Provider by letter dated **27 May 2013** having corrected the Complainant's date of birth and enclosed a *Notification of Membership Benefit* and a *Statement of Reasonable Projection*. The Provider wrote to the Complainant on **29 May 2013** enclosing a *Notification of Membership and Benefits*, *Basic Scheme Information Scheme* and *Nomination Form*. The letter states:

> *"I have pleasure in enclosing your Member's Booklet which confirms your entry into the above Pension Scheme at [the Insurer] as at 1st May 2013. …"*

The *Permanent Health Insurance (Group Retirement Plan) Member's Certificate* states:

"Employer's name	*…*
Member's name	*…*
Deferred period	*26 weeks*
Disability benefit	*66.67% of salary less 1 times the state disability benefit for a single person. Subject to a maximum as determined by the policy conditions.*

> *…*
>
> ***Note*** *Payment of any disability benefit is subject to [the Insurer's] underwriting requirements. Consequently, you may be asked to undergo medical examination in respect of part of your benefits. The amount of benefit may be restricted if you fail to satisfy any medical or other requirements of the Underwriter. You will be informed if any restrictions apply in your case."*

Underwriting

The Insurer wrote to the Provider on **13 June 2013** requesting that the enclosed letter and questionnaires be sent to the Complainant. The Complainant's letter states:

> *"We received your Employee Application form with thanks.*
>
> *In order to proceed with the underwriting process we require you to complete an Anaemia Questionnaire and a Mental Health Questionnaire. …"*

/Cont'd…

The Insurer wrote to the Provider on **1 July 2013**, in respect of certain members of the Scheme including the Complainant. The relevant part of this letter states:

> ***"[The Complainant] - Reminder***
>
> *I refer to our letter of 13 June 2013.*
>
> *We have received a report from [the Complainant's] GP recently. We are still waiting on the return of the two medical Questionnaires to enable us to underwrite. Please remind the member to complete this requirement as soon as possible."*

A further reminder was sent by the Insurer on **19 July 2013**:

> *"I refer to our recent letter requesting underwriting requirements for members of the above scheme.*
>
> *The requirements are as follows:*
>
> *…*
>
> *[The Complainant] – Medical questionnaires*

I would be grateful if you would ask these members to complete their requirements and return them to us."

The Provider wrote to the Complainant on **30 July 2013** advising as follows:

> *"In order to complete your underwriting, you are required to complete the enclosed medical questionnaires. …"*

I note that both questionnaires contain the following statements:

> *"Failure to disclose all material facts could render your contract void. Material facts are those which an Insurer would regard as likely to influence the assessment and acceptance of an application form insurance. …*
>
> *I declare that the answers to the above questions are true and complete. I agree that the above questions and answers form part of my current Application to the Company."*

A third reminder was sent by the Insurer to the Provider on **13 August 2013** requesting that the Complainant return the completed questionnaires as these were required for the purpose of underwriting.

/Cont'd…

Completed questionnaires dated **11 September 2013** were returned to the Insurer by the Provider under cover of letter dated **18 September 2013**. The Provider sought certain clarification from the Complainant regarding her medication by email dated **24 September 2013**.

Declinature of Cover

The Insurer wrote to the Provider on **4 October 2013** advising as follows:

> *"Following receipt of all outstanding underwriting requirements, I regret to inform you that [the Complainant's] application for life cover, permanent health insurance and waiver of premium have been postponed for two years.*
>
> *Please note that [the Complainant] is not on cover for any risk benefits.*
>
> *Should [the Complainant] wish to know the reason for the postponement please contact me and I will arrange for our Chief Medical Officer to contact her GP."*

Engagement with the Insurer

The Insurer wrote to the Provider by email dated **9 October 2013** outlining that:

> *"… We would not be in a position to offer this life WOP/PHI. However, on review, Ive managed to get them to offer her life cover with a moderate rating applied due to her medical history. Ive requested a revised Special terms letter to issue. …"*

The Insurer wrote to the Provider on **10 October 2013**, enclosing Special Terms letters and explaining the position as follows:

> *"… [the Complainant's] proposal for Life Cover only has been deferred pending the employer's acceptance of the terms set out below:*
>
> - *That the cost of providing Life Cover of €180,000 will be subject to an extra premium of +100% of the standard charge.*
>
> *Please note that [the Complainant's] permanent health insurance and premium protection cover remains postponed for two years.*
>
> *Please note that we are not on risk for any proposed life cover until we receive signed acceptance of the above terms. …*
>
> *Please find enclosed a special terms letter for the employer and employee. I would be grateful if you would forward these letters. …"*

The Special Terms letters to be issued to the Complainant and her employer are essentially the same as the letter sent to the Provider.

/Cont'd…

A reminder letter dated **20 November 2013** was sent to the Provider by the Insurer advising that a signed Special Terms letter had not been returned. The letter also advised that the Insurer was not *on risk* until the signed letter was received. An email reminder was sent to the Provider on **15 January 2014**.

The Provider has submitted a number of emails in respect of general meetings and discussions which took place with the Insurer regarding the Scheme from around **21 October 2013** to **21 January 2014**. I note that the Complainant is referenced in an email dated **5 December 2013** in respect of the Scheme's eligibility criteria.

The Insurer wrote to the Provider on **20 February 2014** in respect of the Complainant advising that:

> *"I am pleased to confirm that [the Complainant's] proposed death in service benefit has been accepted.*
>
> *Please note that the special terms letter previously issued has now been waived. Therefore, no rating will be applied to [the Complainant's] death in service benefit.*
>
> *…*
>
> *Please note [the Complainant's] permanent health insurance and waiver of premium benefits remain postponed. …"*

The Provider appears to have responded to this letter by email dated **20 February 2014**, without any evidence of having discussed the cover or Special Terms letter with the Complaint or her employer, stating:

> *"Please implement the life cover as discussed at std rate. I will discuss this PHI/WOP issue with [the Insurer's agent]."*

Following an enquiry as to the status of the Complainant's underwriting, the Insurer advised the Provider on **27 May 2014**, amongst other matters, that the Complainant's *"… disability benefits remained postponed."*

Correspondence with the Complainant's Employer

A letter dated **3 February 2014** was sent/addressed to the Complainant's employer on the Insurer's headed paper. However, it is not clear if this was sent directly by the Insurer or through the Provider. The letter states:

> *"… [the Complainant's] proposal for Life Cover only has been deferred pending your acceptance of the terms set out below:*
>
> - *That the cost of providing Life Cover of €180,000 will be subject to an extra premium of +100% of the standard charge.*

/Cont'd…

Please note that [the Complainant's] permanent health insurance and premium protection cover remains postponed for two years.

Please note that we are not on risk for any proposed life cover until we receive signed acceptance of the above terms. …"

Contact with the Complainant

A memo prepared by the Provider records that the Complainant contacted the Provider by telephone on **30 June 2014** looking for a copy of her policy document.

The Provider wrote to the Complainant on **1 July 2014** attaching a copy of the Member's Booklet and advised her that:

"… your disability income benefit is still been underwritten as the implementation of this cover was postponed last year. We will be in a position to recommence the underwriting of this disability cover at the next renewal date. …"

Correspondence with the Insurer

The Provider wrote to the Insurer on **3 July 2014** as follows:

"Unfortunately [the Complainant] rang and [the Insurer] needs to speak to her. Needless to say this is going to be extremely difficult to deal with. If this employee approaches the employer on this issue will almost certainly lose the scheme as we have beaten off competition before and the employer became extremely agitated about this particular cover issue. [The Insurer] was extremely helpful a few months ago in resolving the free cover issue going forward. However, this particular member [the Complainant] is not covered as she has now contacted us on this issue. …"

Complaint to the Provider

The Complainant wrote to the Provider by email on **3 March 2017** explaining that she was submitting a complaint to this Office due to the way her plan was handled. In order to facilitate this, the Complainant requested that the Provider send her a copy of the form completed by her doctor in **2013** and any other correspondence held on file by the Provider. The Provider acknowledged the Complainant's email on **6 March 2017**. The Provider responded to the Complainant's request on **16 March 2017**.

The Complainant wrote to the Provider on **16 June 2017** advising it of the outcome of the Insurer's investigation into her complaint. The Complainant also advised the Provider of the requirement for a Final Response letter before she could make a complaint to this Office. The Complainant then asked the Provider to address the following:

"Can you please advise why I or my employer was never informed in writing that I was not covered, and why I still paid the same cover as everyone else in the company.

/Cont'd…

> *I wish to argue that you need to honour my policy given I was never advised that there were special terms to mine."*

The Complainant wrote to the Provider by email on **13 July 2017**, referring to a letter received from the Provider *"… explaining you had received my email …"* and requested a response to her complaint. While a letter appears to have been issued by the Provider acknowledging the complaint, this does not appear to have been submitted by either party. The Provider responded on **14 July 2017** advising that it was still in the process of investigating the complaint. The Complainant sent a further follow up email on **10 August 2017**.

The Provider responded by email on the same day advising that the complaint was being investigated and the Provider hoped to issue a Final Response letter *shortly*. The Provider wrote to the Complainant by email on **14 August 2017** attaching a copy of its Final Response letter. I note this letter is dated **14 July 2017**.

The First Complaint

The essence of this aspect of the complaint is that the Provider misled the Complainant as to the status of her Permanent Health Insurance cover and failed to notify and/or communicate with her regarding the status of this cover. It is necessary to consider all of the correspondence between the various parties and the documentation as a whole in order to decide this matter. However, I have divided my consideration of this aspect of the complaint into discrete timeframes.

30 April to 29 May

The Complainant met with the Provider on **30 April 2013**. The evidence outlined above demonstrates that an application form was completed and signed at this meeting. The Complainant was also furnished with certain information regarding the Scheme. In particular, the Statement of Suitability. I am satisfied, at this point in time, the Complainant was aware or ought to have been reasonably aware, that her application for membership of the Scheme and enjoyment of the benefits thereunder was contingent on completion of the Insurer's underwriting/acceptance process. This can be seen from the *Summary* section of the Statement of Suitability and the declarations section of the application form. Further to this, the Provider's File Note records that the Complainant was advised *"… benefits would be confirmed following the completion of underwriting."* I note the contents of the File Note do not appear to be disputed by the Complainant.

The Insurer wrote to the Provider on **14 May 2013** to inform the Provider that the Complainant had been included in the Scheme for Pension, Death in Service, Permanent Health Insurance and Premium Protection benefits with effect from **1 May 2013**. There seems to have been an error in respect of recording the Complainant's date of birth and certain updated documentation was sent to the Provider on **27 May 2013**.

/Cont'd…

This was sent by the Provider to the Complainant on **29 May 2013**. It is not clear how the date of birth error came about. However, I am not satisfied that any delay in issuing these documents was necessarily the fault of the Provider.

Comparing the letter issued by the Insurer on **14 May 2013** with the letter issued by the Provider on **29 May 2013**, one thing that is apparent and of concern is the difference in the information conveyed. The Insurer's letter makes clear that underwriting was ongoing and had yet to be completed, meaning that while the Complainant was a member of the Scheme, she was not yet entitled to the benefits under the Scheme. However, the Provider's letter simply confirms the Complainant's entry into the Scheme without qualification.

The *Permanent Health Insurance (Group Retirement Plan) Member's Certificate* enclosed with the Provider's letter set out the benefits under this aspect of the Scheme and contained the following *Note* immediately under the benefits table:

> ***Note*** *Payment of any disability benefit is subject to [the Insurer's] underwriting requirements. Consequently, you may be asked to undergo medical examination in respect of part of your benefits. The amount of benefit may be restricted if you fail to satisfy any medical or other requirements of the Underwriter. You will be informed if any restrictions apply in your case."*

At this juncture, the Provider had written to the Complainant advising that she was a member of the Scheme without identifying any qualifications on membership or benefits. The Complainant was not advised that underwriting was ongoing or that any restrictions were attached to her membership of the Scheme. The Complainant also had a benefits table which did not contain any restrictions on cover.

However, there was a Note under the benefits table. This Note is somewhat ambiguous. It begins by stating *payment* of any benefit is subject to underwriting. The next sentence states the *amount* of benefit may be restricted if an individual fails to satisfy any medical or underwriting requirements. The third sentence states that an individual will be informed if any restrictions apply. Taking into consideration the language used in this Note and the information contained in the benefits table, I am not satisfied the note was sufficient or adequate to have properly informed the Complainant that her case was still subject to the Insurer's underwriting requirements. While the Provider is not responsible for drafting the Note, I am satisfied the Provider should have been familiar with the Scheme documentation forwarded to the Complainant and that it should have communicated more fully, the information contained in the Insurer's letter.

Therefore, as a result of the information available to the Complainant on **29 May 2013** and the manner in which her membership of the Scheme was explained to her by the Provider, I am satisfied this gave rise to the impression that the Complainant was entitled to Permanent Health Insurance under the Scheme from **1 May 2013** and that her case was not subject to underwriting.

/Cont'd…

29 May to 30 July

The Insurer wrote to the Provider on **13 June 2013** requesting that the Complainant complete two questionnaires for the purpose of the underwriting process.

These were not forwarded to the Complainant until **30 July 2013** despite the Insurer issuing two reminder letters in the meantime. The Provider has not offered any explanation for the delay in sending the questionnaires to the Complainant even though two reminder letters were issued. Furthermore, the Provider did not refer to these reminder letters in its formal response to the complaint nor were they submitted to this Office as part of the investigation of this complaint. The existence of these letter became apparent from an examination of the submissions made and documentation furnished by the Insurer.

In light of the Provider's obligations to respond to the investigation of a complaint by this Office, I would consider it reasonable to have disclosed these letters. The fact that the Provider did not do so is most unacceptable.

Having received the Provider's letter and the questionnaires, it is clear that the Complainant would have been aware or ought reasonably have been aware that her entitlement to any benefits under the Scheme were still being underwritten and her application for the various benefits was not yet complete. Notwithstanding this, had the Provider acted more promptly and been more forthcoming in its communication with the Complainant, the Complainant would have been aware of the status of her membership a number of weeks earlier.

4 October to 15 January

The Insurer wrote to the Provider on **4 October 2013** advising that the Complainant's application for life cover, permanent health insurance and waiver of premium had been postponed for two years and the Complainant was not on cover for any risk benefits. This information was not conveyed to the Complainant or her employer.

Following certain representations by the Provider, the Insurer wrote to the Provider on **10 October 2013** regarding the loading to be applied to the Complainant's life cover and advised that Permanent Health Insurance and premium protection cover remained postponed for two years. A Special Terms letter was also enclosed which was to be signed by the Complainant's employer. The Insurer requested that the Special Terms letters be forwarded to the Complainant and her employer. However, these were not sent to either of these parties. Two reminder letters were sent to the Provider in **November 2013** and **January 2014** by the Insurer noting that a signed Special Terms letter had not been received. These reminder letters were not disclosed or referred to by the Provider in responding to this complaint. These were contained in the formal response submitted by the Insurer. This again is most unacceptable.

The Provider has submitted a number of emails in respect of general meetings and discussions which took place with the Insurer regarding the Scheme from around **21 October 2013** to **21 January 2014**.

/Cont'd…

I note that these discussions are essentially general Scheme discussions and the Complainant is only referenced in one email dated **5 December 2013** in respect of the Scheme's eligibility criteria.

On the basis of the evidence, I am not satisfied there is sufficient evidence to support the Provider's position that it engaged in *strenuous negotiations* to secure cover for the Complainant.

The Provider also maintains the position that *the agreement was in active negotiation*. While the evidence does not support this position either, in any event, it was incumbent on the Provider to inform the Complainant and/or her employer regarding the status of her application and also forward correspondence received from the Insurer.

There was no reason or justification for the Provider not to inform the Complainant and/or her employer of the Insurer's letter of **4 October 2013**. More significantly, it is wholly unacceptable that the Special Terms letter was not forwarded to the Complainant or her employer despite the Insurer's explicit request to do so. It is also no justification to seek to rely on the fact that the Special Terms letter was subsequently waived by the Insurer on **20 February 2014**. This would have been totally unknown to the Provider when the Special Terms letter issued. Furthermore, the Provider did not notify the Insurer this was not done or not intended to be done, despite the reminders issued by the Insurer.

3 February to 1 July

A letter dated **3 February 2014** in similar terms to the Insurer's letter of **10 October 2013** appears to have been sent to the Complainant's employer. It is not clear from the evidence, however, whether this letter was sent by the Insurer or the Provider, or whether it was in fact sent at all. Notwithstanding this, I am not satisfied this letter is sufficient to negate or mitigate the conduct of the Provider which preceded this letter.

The Insurer wrote to the Provider on **20 February 2014** confirming that the proposed Death in Service benefit had been accepted and the Special Terms letter had been waived. However, Permanent Health Insurance and waiver of premium benefits remained postponed. The Provider acknowledges that this Special Terms letter was not sent to the Complainant or her employer.

The Provider appears to have responded to this letter by email dated **20 February 2014**, without any evidence of having discussed the cover or Special Terms letter with the Complaint or her employer, stating:

> *"Please implement the life cover as discussed at std rate. I will discuss this PHI/WOP issue with [the Insurer's agent]."*

/Cont'd…

It is completely unacceptable for the Provider not to have advised the Complainant and/or employer about the Insurer's letter. Furthermore, the Provider should not have accepted the Insurer's offer without first having notified or discussed it with the Complainant and/or her employer.

Finally, it was not until **1 July 2014** that the Complainant became aware as to the status of her cover under the Scheme. This was extremely important information which should have been conveyed to the Complainant at the earliest possible opportunity.

Concluding Comment

The Provider assumed a particular role in respect of the Insurer, the Complainant and her employer. The evidence in this complaint, discloses a number of significant failings on the part of the Provider in terms of its communication with the Complainant and her employer regarding the Scheme, and the execution/failure to execute the Insurer's instructions/requests.

There was a failure to accurately convey information from the Insurer, forward documentation promptly or at all, update the Complainant as to the status of her cover, and cover was accepted without first consulting the Complainant.

While there was a certain level of engagement between the Provider and the Insurer regarding the Complainant's cover, I do not accept this offers any justification for the Provider's conduct or mitigates its consequences.

Accordingly, I accept that the Complainant was not sufficiently or adequately informed by the Provider as to the status of her Permanent Health Insurance cover as the Provider failed to notify and/or communicate with the Complainant regarding the status of this aspect of cover.

The Second Complaint

The Complainant maintains the Provider failed to adhere to and/or follow the standard procedures set out in the Member's Certificate and/or *the standard engagement process* outlined in her submission.

In my Preliminary Decision I stated*:*

> *"I am not satisfied the Member's Certificate imposes a specific obligation on the Provider."*

The Complainant takes issue with this in her post Preliminary Decision submission dated **11 September 2020.**

/Cont'd…

The Complainant has submitted that "I have also checked responsibilities of the insurer from a legal perspective – the response I received was as follows;

> *Adjudication takes the position that the Provider had not acted contrary to the standard engagement process. Furthermore, that the members certificate did not impose a specific obligation on the Provider to inform the complainant that there was an issue with her policy.*
>
> *It is submitted under the doctrine of Agency that this position is erred in application and law. The insurer notably relied on the Provider to follow their policy and procedures on their behalf. This is evident where the insurer had requested the provider to send letters to the Complainant. The standard engagement process sets the standard that is expected from a professional body and therefore the provider acted on behalf of the Insurer. The fact the Provider did not follow procedure, or any standard expected of a professional body in a position where the insurer relied on them to do so shows total disregard that falls below standards of any professional body. Lastly, the Insurer relied on the Provider to follow their instructions and procedures.*
>
> *Standard conditions and standard forms protect the insurer's position with regard to their product they sell. They in turn are reliant on the provider to sell the product correctly.* [The Provider] *had not only misrepresented themselves but have also misrepresented* [the insurer]*. The complainant requests a re-examination of complaint No:2 with the understanding that the Provider acted as Agency for the Insurer at all times and filed to apply standard policies and procedures that are evident in all professional bodies".*

The procedures set out in the Member's Certificate in the context of this complaint concern the underwriting process. This is the underwriting process of the Insurer. As such, the Provider is not the entity that must necessarily adhere to or follow the procedures contained in the Member's Certificate regarding underwriting. However, the Note contained on the *Permanent Health Insurance (Group Retirement Plan) Member's Certificate*, does state in the final sentence that *"You will be informed if any restrictions apply in your case."*

The Insurer notified the Provider that restrictions applied to the Complainant's cover under the Scheme and, as I have found in the previous section, the Provider failed to make the Complainant and/or her employer aware of these restrictions. Notwithstanding this, I remain of the view that the Member's Certificate does not impose a specific obligation on the Provider.

The Complainant also asserts that the Provider failed to adhere to and/or follow *the standard engagement process*. While the Complainant has detailed the manner in which the Provider would normally communicate with her employer in respect of members of the Scheme, this does not mean these steps constitute a policy or procedure for communication which the Provider is required to adopt or follow in every case.

/Cont'd…

Simply because the Provider did not follow these steps does not necessarily mean it acted contrary to *the standard engagement process*.

The Third Complaint

The Complainant contacted the Provider on **3 March 2017** to advise the Provider that she was submitting a complaint to this Office in respect of the Provider's conduct and requested that certain documentation be furnished to assist her with her complaint. The Provider acknowledged the Complainant's email on **6 March 2017** and responded to her request on **16 March 2017**. The Complainant has not identified any issues in respect of the Provider's conduct in responding to her request.

A complaint was made to the Provider on **16 June 2017**. The Complainant wrote to the Provider by email on **13 July 2017**, referring to a letter received from the Provider *"… explaining you had received my email …"* and requested a response to her complaint. While a letter appears to have been issued by the Provider acknowledging the complaint, this does not appear to have been submitted by either party. The Provider responded on **14 July 2017** advising that it was still in the process of investigating the complaint. The Complainant sent a further follow up email on **10 August 2017**. The Provider responded by email on the same day advising that the complaint was being investigated and the Provider hoped to issue a Final Response letter *shortly*. The Provider wrote to the Complainant by email on **14 August 2017** attaching a copy of its Final Response letter. I note this letter is dated **14 July 2017**.

The Complainant has not explained precisely how the Provider failed to deal with her complaint in a satisfactory manner. I accept that it is likely the complaint was acknowledged within a reasonable length of time and the Complainant was given regular updates as to the status of her complaint. Section 10.9(d) of the ***Consumer Protection Code 2012*** (the **Code**), states that a regulated entity *"… must attempt to investigate and resolve a complaint within 40 business days of having received the complaint …"* The Provider's Final Response appears to have issued approximately 40 business days after the date the complaint was made. I am satisfied the Provider attempted to investigate and resolve the complaint in line with the timeframe set out in the Code. However, although the Provider declined to uphold the complaint or issue a response the Complainant was dissatisfied or disagreed with, does not mean the Provider failed to deal with her complaint in a satisfactory manner.

In my Preliminary Decision I indicated my intention to substantially uphold this complaint and direct the Provider to pay a sum of €5,000 in compensation to the Complainant. The Complainant has argued in her post Preliminary Decision submissions for a greater amount of compensation. However, in all the circumstances of this complaint I believe the sum of €5,000 to be a reasonable and appropriate amount of compensation.

/Cont'd…

In my Preliminary Decision, I had stated that:

> *"I am very concerned with the Provider's conduct of failing to furnish the Complainant with extremely important and relevant information in accordance with its obligations as a regulated financial service provider. Furthermore, its inability to acknowledge or accept that this conduct is unreasonable concerns me. For this reason, I will be bringing this matter to the attention of the Central Bank of Ireland".*

The Provider has, in its post Preliminary Decision submission dated **25 September 2020,** requested that *"in bringing this matter to the attention of the Central Bank that you might also append this letter".*

When bringing this matter to the attention of the Central Bank of Ireland, I will include the Provider's letter dated **25 September 2020**.

Conclusion

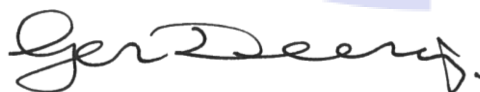
My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is substantially upheld, on the grounds prescribed in ***Section 60(2) (b), (d), (f) and (g)***.

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 €5,000, 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.***

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

20 April 2021

/Cont'd…

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.