An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0000
Sector:	Insurance
Product / Service:	Private Health Insurance
Conduct(s) complained of:	Lapse/cancellation of policy Failure to provide product/service information Failure to process instructions Advice given when switching plans
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant held a private health insurance policy with the Provider. In **December 2018**, the Complainant became a customer of another health insurance provider. He did not cancel his policy with the Provider, and he held cover with both providers for a year. This complaint arises from the Provider's refusal to refund the Complainant's premium for the period during which the Complainant held both policies.

The Complainant's Case

The Complainant states in his complaint of **18 November 2019**:

> *"Around this time last year my wife decided to examine the options available to us where private health insurance is concerned and on the basis of our comparison we decided to switch our existing cover from [Provider]… to the [new provider], with a [new provider] policy coming into force on December 1st, 2018…*
>
> *Unfortunately, I believed my wife cancelled the [Provider] policy, while I thought she had done so, and at renewal time this year I discovered I had paid for both policies."*

On **5 November 2019**, the Complainant received a loyalty call from the Provider. The Complainant stated that he was no longer a customer of the Provider, and the Provider informed him that his policy was still active.

On **6 November 2019**, the Complainant rang the Provider to cancel his policy, and to seek a refund of his premium for the 12-month period that commenced on **1 December 2018**. The Provider refused to refund the premium for this entire period. Instead, the Provider refunded the instalment for **November 2019** only to the Complainant.

The Complainant further states in his complaint:

> *"…[It] is common practice, once cover was not in force, for any insurer to rebate premiums from the date when cover ceased. As I had a [new provider policy] from December 1st 2018 (on which we have made a small claim since) that covered my family, I could not have made a claim on the [Provider] plan. I also confirmed that the Revenue would not grant me the tax relief on the premiums, as they too recognise that two policies cannot exist for the same risk.*
>
> *…I sent them an email on November 6th last, once again confirming that their policy should have been cancelled (and was not on cover) from December 1st and seeking a full rebate."*

In an email to the Provider of **6 November 2019**, the Complainant stated that he may have previously indicated his intention to cancel the policy and to switch providers:

> *"This time last year, my wife and I decided to switch our Health insurance…*
>
> *I remember speaking to [Provider] at the time, as I had to get a Certificate to give to [new provider] and I believe I told you of the cancellation verbally on or about November 26th last."*

The Complainant has not suggested to this Office that he did in fact cancel his policy in 2018. Rather, he has confirmed that the cancellation was overlooked because he believed his wife had arranged for the cancellation and similarly, she believed that he had done so.

In an email of **1 March 2021** to this office, the Complainant stated:

> *"As I mentioned before, I realise that it was my job to let [Provider] know when we switched to [new provider] and I realise that I did not deal with the matter in line with their Terms & Conditions and I further realise that once I did inform them that they acted, once more, in line with their Terms & Conditions.*
>
> *Despite all of the above, my other point, which neither [Provider] nor anyone else can argue with, is that once I made a claim on my new… policy, any claim I would have made against [Provider] for the same cost would have been, rightly so in my view, turned down. Thus, while [Provider] say, as they have repeatedly, that I could have claimed on the policy, any such claim would have been declined, which means that the cover I paid for was not being provided."*

/Cont'd…

In an email to this office on **4 March 2021**, the Complainant submitted:

> *"[The Provider's] argument has been that I could have claimed on the policy during the year after I took the [new provider] alternative, my argument remains that once I made a claim from the [new provider], my ability to claim from [Provider] disappeared.*
>
> *…I could not have claimed from [Provider] for any of the covered medical services that I and my family used that year, as I had already claimed [from the new provider], and so would have to be acknowledged that I paid for services that were not available to me.*
>
> *…The existence of a different insurer, from which all medical claims were made in the year in question, suggests to me that the application of [Provider's] internal rules in this case, represents "unfair practices"…"*

The Provider's Case

The Provider submits that the Complainant held an individual policy with the Provider from **July 2008** to **November 2019**, and paid directly via direct debit during this period. The Provider notes that the Complainant has received numerous rules brochures throughout these years, which specify the Provider's rules around cancelling a policy.

The Provider states that the Complainant changed his level of cover on **17 July 2012**, and received a rules brochure in the post. The Provider says that at page five of this brochure, under '**Ending your membership'**, a rule sets out that the Complainant's contract is for a period of one year, and there would not be a refund on the premium if the Complainant cancels mid-year.

The Provider submits that this provision was also included in the documentation issued to the Complainant when he changed his cover in **May 2013**, **November 2015**, and **June 2016**.

The Provider states that it issued a renewal notice to the Complainant on **31 October 2018**. This documentation included a renewal letter which stated that the Complainant's policy would renew for a further year period, following a direct debit collection on **7 December**. A Credit Agreement contained in the documentation outlined the procedure for cancelling the policy with the Provider. To cancel, the Complainant must give a written notice of cancellation to the Provider within 14 days of receiving the Credit Agreement. The Provider says that this information was repeated in an Insurance Product Information document, contained in the renewal pack.

The Provider states that this procedure is in accordance with its scheme rules, under '**Renewing your membership'**, whereby the customer's membership with the Provider renews automatically each year. The customer renews membership with the Provider by continuing to pay subscriptions after the renewal date.

/Cont'd…

The Provider submits that the Complainant did not make contact to cancel his contract, and the policy was therefore renewed in accordance with the rules. It notes in its response to questions put by this Office that:

> *"The policy was active and indemnity was available to the Complainant during the contract period should the Complainant have made a claim per the Scheme Rules and table of benefits."*

The Provider states that it advised the Complainant on how to cancel his policy, and provided ample time to do so. It submits that the Complainant did not inform the Provider of his policy with another provider until the loyalty call of **5 November 2019**. The Provider's scheme rules prevent the Complainant from receiving a full refund of his policy.

In an undated submission to this Office, the Provider further stated that:

> *"[the Complainant's] assertion regarding a refund of insurance premium in the event of not claiming would completely undermine the underwriting process as it exists."*

This Office asked the Provider if it was satisfied that it had complied with Provision 4.1 of the ***Consumer Protection Code 2012*** (CPC). The Provider was asked how information regarding the cancellation of cover or premium refunds was brought to his attention in a manner that did not 'disguise, diminish, or obscure its importance.' The Provider responded by referring to the notices contained in the renewal documentation provided to the Complainant in **October 2018**. It noted that it had also complied with Provision 4.2 of CPC, by providing "*ample notice and opportunity to the Complainant, prior to their renewal of the 1 December 2018 to cancel their policy".*

When asked by this Office if the Provider was satisfied that it had met its obligations under the General Principles of the CPC, the Provider responded:

> *"Yes, [Provider] are very satisfied that at all times they have met their obligations in making the Complainant aware of how to cancel a policy with [Provider]. This was most recently advised to the Complainant via their renewal notice…*
>
> *Along with the renewal notice, it is also clear from the rules brochures, the Complainant received throughout the years… [Provider's] terms and conditions regarding cancelling a policy mid-year, with no refunds due as outlined…"*

<u>The Complaint for Adjudication</u>

The complaint is that the Provider wrongfully refused to refund the Complainant's premiums for the period of his health insurance cover from **1 December 2018** to **November 2019**.

/Cont'd…

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

I note that the timeline for the events underlying the complaint is as follows:

Date	Event
20/07/2008	Complainant becomes individual customer of the Provider
17/07/2012	Complainant changes level of cover & receives a rules brochure
14/05/2013	Complainant changes level of cover & receives a rules brochure
16/11/2015	Complainant changes level of cover & receives a rules brochure
11/07/2016	Complainant changes level of cover & receives a rules brochure
31/10/2018	Provider sends renewal notice to the Complainant
01/12/2018	Complainant becomes a customer of another provider
01/12/2018	Complainant's policy with the Provider renews from this date, following direct debit instalment
05/11/2019	Provider makes a loyalty call to the Complainant & the Complainant becomes aware that the policy has not been cancelled
06/11/2019	Complainant contacts the Provider to cancel the policy
21/11/2019	Provider refunds the instalment of November 2019

/Cont'd…

The Complainant is unhappy because the Provider has refused to refund him the entire premium for the year of cover from December 2018. The Complainant considers this to be unfair.

Evidence

I note that the Provider's rules booklet of **2012** set out at page five:

> ***"4. Renewing your membership***
>
> *(a) Your membership of the scheme will automatically renew on your renewal date, each year (subject to Rule 10 on page 8) for a further year unless we write to notify you at least 30 days before the end of the year that we have decided to end the scheme. In that case, your scheme membership will end at the end of the year in which we notify you of our decision.*
>
> *(b) You renew your membership of the scheme by continuing to pay your subscriptions after your renewal date.*
>
> *…*
>
> ***6. Ending your membership***
>
> *(a) You have the right to cancel your membership of the scheme by writing to us within 14 days of you receiving your first membership certificate. We will give you a full refund of any money you have paid us as long as you have not made any claims.*
>
> *(b) Your contract is for a period of one year unless we agree to a different period when commencing your policy. If you do cancel mid-year, you will not receive any refund on your premium. In the event of non-payment in accordance with the payment terms of your contract, such non-payment will constitute a breach of contract. In such circumstances, we will not pay any benefits for the contract term and we will seek recovery of the losses and expenses incurred by us as a result of your non-payment."*

In addition, at pages eight to nine of the 2012 booklet, it states:

> ***"11. General terms and conditions***
> *…*
>
> *(h) You should write to tell us if you have any other insurance cover for benefits that you have claimed from us. If you do have insurance cover with someone other than [Provider], we will only pay our share of any benefits."*

/Cont'd…

I note that the Provider's **2013** rule booklet contained slightly differing language under 'Renewing your membership'. At page seven it stated:

> *"**4. Renewing your membership***
>
> *(a) Your scheme membership needs to be renewed by you at the end of each year in order for it to continue, you can renew your membership at the end of each year (subject to Rule 10 on page 13) a further year unless we write to notify you at least 30 days before the end of the year that we have decided to end the scheme. In that case, your scheme membership will end at the end of the year in which we notify you of our decision*
>
> *(b) You renew your membership of the schemes by continuing to pay your subscriptions at your renewal date."*

The section on '**Ending your membership'** and general term and condition (h) were identical to the 2012 rules booklet. The rules booklets provided to the Complainant in **2015** and **2016** had identical provisions to those quoted from the 2012 booklet, above.

In the renewal letter of **15 October 2018**, the Provider stated:

> *"We wish to thank you for your membership and to let you know your policy will renew on December 1st.*
> *…*
>
> ***IMPORTANT INFORMATION***
>
> - ***We have based your renewal on the scheme you currently hold,***
> - ***Please contact us if there have been any material changes in your circumstances or in your health insurance needs.***
> - ***Please contact us before your renewal date to discuss your health insurance needs as we may have a more suitable scheme for you.***
> - ***If you do not contact us prior to your renewal date your current scheme will be renewed for a further 1 year period.***
>
> *Your policy will renew with your first direct debit collection of €[premium amount] on December 7th."*

[My underlining above added for emphasis]

/Cont'd…

I also note that the Credit Agreement of **1 December 2018**, provided to the Complainant with his renewal documents, states:

> *"**IMPORTANT***
> *…*
>
> ***RENEWAL OF YOUR POLICY***
> *Should you renew this policy, the terms of this agreement shall continue to apply other than the amount of the instalments, which will be advised to you prior to renewal.*
>
> ***COOLING-OFF PERIOD***
> *You have the right to cancel this Credit Agreement within 14 days of receiving it by giving WRITTEN notice of your intention to [Provider].*
>
> *…*
>
> *If, during these 14 days, you wish to cancel your health insurance policy we will cancel your policy back to the start date and issue you a refund of any payment that has been made by you under this Credit Agreement. If you cancel the policy in this manner, you will be unable to make any claim on the policy and you will not be liable to make any further payments under this Credit Agreement.*
>
> *…*
>
> ***CANCELLATION NOTICE***
> *(Complete, detach and return this form within 14 days – ONLY IF YOU WISH TO CANCEL THE AGREEMENT)"*

The Insurance Product Information Document, provided to the Complainant with his renewal documents, states:

> *"**When does the cover start and end?***
> *Your contract with [Provider] is for a period of one year unless we agree to a different period when commencing your policy. Your cover starts from your membership start date or renewal date and ends at midnight on the day before the next renewal date. Your membership of the scheme will automatically renew on your renewal date, each year.*
>
> ***How do I cancel the contract?***
> *You can cancel your policy by emailing [Provider email address] or by writing to [Provider address], within 14 days of receiving your welcome or renewal Membership Certificate. The 14 day period starts from the effective date or the renewal date of your policy shown on your Membership Certificate."*

/Cont'd…

Analysis

I note that the Provider has a rule that cancellation of the contract must be given in written form, and within 14 days of the receipt of the Membership Certificate. If the contract is not cancelled during this period, the customer is bound to a one-year policy. The policy terms confirm that refunds will not be given to customers who cancel cover after the 14-day period.

The Complainant is not complaining that he did not have notice of the renewal of the policy, or that he did not have notice of the procedure for cancellation. Instead, the Complainant complains about the application of the above rule to the situation where a customer has taken out health insurance elsewhere with another provider.

I note that the rule on cancellations and refunds is in clear language and does not contain any qualifiers. Indeed the Provider makes clear that:

> *"If you do cancel mid-year, you will not receive any refund on your premium."*

The Provider has submitted booklets from 2012, 2013, 2015, and 2016, all of which contain this rule and were provided to the Complainant.

I believe that the Provider has complied with its obligations under Provision 4.1 of the CPC insofar as this information was adequately brought to the attention of the Complainant, and it was not presented in a way that disguised, diminished, or obscured it. Therefore, I consider that the Complainant was on notice of this rule that plainly has a general application.

In considering the fairness of the rule itself, when applied to a situation in which a customer has taken out an additional policy with another provider, I have had regard to Regulation 3(2) of the ***European Communities (Unfair Terms in Consumer Contracts) Regulations 1995,*** as amended:

> *"(2) For the purpose of these Regulations a contractual term shall be regarded as unfair if, contrary to the requirement of good faith, it causes a significant imbalance in the parties' rights and obligations under the contract to the detriment of the consumer, taking into account the nature of the goods or services for which the contract was concluded and all circumstances attending the conclusion of the contract and all other terms of the contract or of another contract on which it is dependent."*

I have also had regard to Schedule 3 of the Regulations and, in particular, paragraphs 1(b) and (d):

> *"(b) inappropriately excluding or limiting the legal rights of the consumer vis-á-vis the seller or supplier or another party in the event of total or partial non-performance or inadequate performance by the seller or supplier of any of the contractual obligations, including the option of offsetting a debt owed to the seller or supplier against any claim which the consumer may have against him;*

/Cont'd…

…

(d) permitting the seller or supplier to retain sums paid by the consumer where the latter decides not to conclude or perform the contract, without providing for the consumer to receive compensation of an equivalent amount from the seller or supplier where the latter is the party cancelling the contract"

The Complainant argues that, as he had already claimed with another Provider for expenses throughout the year, he could not make a claim to the Provider for the relevant expenses. Therefore, he submits, he was not "*on cover*" with the Provider during this period, and he has paid for an insurance service that he could not have received.

The Provider submits that the Complainant's policy was active throughout this period, and indemnity was available to the Complainant should he have made an appropriate claim. The Provider relies on provision (h) of its General Terms & Conditions, which sets out the procedure for customers to take, in the situation of double insurance. This provision indicates that where a customer is covered by alternative insurance for a claim made to the Provider, the Provider will only be liable for its portion of the claim.

The Provider does not stop or exclude cover in situations of double insurance. Instead, as it has indicated, a procedure exists for the appropriate apportionment of liability and benefits between the providers. As a result, I do not believe that the Provider's conduct falls within the criteria of Schedule 3 of the Regulations, and I do not consider the rule on cancellation and refunds, to be "*contrary to the requirement of good faith"* or to create a significant imbalance to the detriment of the Complainant.

The Complainant had a contractual entitlement to make a claim with the Provider during the period of double cover. The fact that the Complainant was unaware that he had not cancelled his policy, and that it had renewed, did not change his legal entitlement during this period. As noted above, the Complainant does not complain that the Provider did not give him adequate notice of the renewal or cancellation rules, or its rules concerning double insurance cover.

In these circumstances, I accept that the Provider has complied with the General Principles of the CPC and that it acted fairly and professionally. In particular, I note that the Provider refunded the instalment of **November 2018**, despite the scheme rules stating that no refunds would be given for mid-year cancellation.

I am conscious that for every health insurance premium paid by a consumer to a health insurance provider, a proportion of that premium includes a Government health insurance levy payable for an individual member covered by the policy. This levy can change from year to year, in response to variations to the Government budget and the levy collected by the Government in that manner, is used to fund the risk equalisation premium credit which applies to insured persons over age 60.

/Cont'd…

I am also conscious that in respect of the premium collected by the Provider from the Complainant, for the period of insurance cover from December 2018, the Provider was obliged to pass on to the Government, that particular portion of the premium paid, which consisted of the Government levy for those individuals who were covered by the Provider's policy.

The Complainant however, had also paid the Government levy through his new insurance policy with the other health insurance provider. Accordingly, whilst there is no evidence noted by this Office of any wrongdoing by the Provider, and therefore, I do not consider it appropriate to uphold this complaint or to make any direction to the Provider, nevertheless, in my preliminary decision I indicated that it would be helpful if the Provider would issue the Complainant with a letter confirming the amount of the levy paid by the Provider to the Government, in the context of that policy which the Complainant had intended to cancel, but forgot to, and I asked the Provider to issue such a letter to the Complainant.

I note that a letter in those terms was issued to the Complainant by the Provider, and on 6 December 2021, the provider supplied details of that letter to this office, from which I have noted that the amount of the Government health insurance levy for the six individuals insured under the policy, which the Provider collected from the Complainant, for onward transmission, totalled €1,480 for the period of cover from December 2018 to November 2019

These details may be useful to the Complainant should he wish to contact the Health Insurance Authority to explore whether it will be possible to recoup that element of the premium, given that the Complainant will also have paid the Government levy through his newer health insurance policy, for any person who was also covered under the other policy. I note in that regard that the Complainant's policy with the Provider was in respect of not only himself, but also 5 other individuals.

For the reasons outlined above however, I do not consider it appropriate to uphold the substantive complaint.

Conclusion

My Decision, pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is rejected.

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.

MARYROSE MCGOVERN
Deputy Financial Services and Pensions Ombudsman

4 January 2022

/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.