An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0009
Sector:	Banking
Product / Service:	Variable Mortgage
Conduct(s) complained of:	Maladministration Arrears handling - Mortgage Arears Resolution Process
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant entered a mortgage loan agreement with the Provider in **July 2006**. A requirement of the loan agreement was that life assurance/mortgage protection cover be in place to cover the outstanding loan balance in the event of the death of the Complainant. The Complainant incepted a life policy in **October 2006** with an insurance company (the **Insurer**). The Complainant submits that on **29 November 2010**, the Provider advised him to reduce the level of cover under the policy and amended the level of cover under the policy without his consent. The Complainant maintains that he was simply making an enquiry in respect of a reduction in the level of cover.

The Complainant's Case

The Complainant explains that on **29 November 2010**, he had an appointment with the Provider to complete a Standard Financial Statement (**SFS**). During the appointment, the Complainant says he was asked if he would like to contact the Insurer about changing his policy. In response to this, the Complainant say he queried how much he would save by reducing the cover on his policy. The Complainant says Provider's agent explained that this information would be *"sent out in the post for me to consider, sign and send back to* [the Insurer]*."*

However, the prior approval of the Provider was required before any change in the amount of cover under the policy could be made, as a minimum level of cover was required to be in place to cover the balance outstanding on the Complainant's loan.

The Complainant says this is the last he heard on the matter and that he did not receive any correspondence or forms in the post.

In **May 2014**, the Complainant says he made a claim under the policy for serious illness benefit, only to discover that the level of cover under the policy had been reduced by the Provider sometime between **29 November 2010** and **2 December 2010** and without his knowledge.

The Complainant says: *"I was not aware that serious illness was linked to my mortgage (only life cover)."* The Complainant says that, at the date of making this complaint, the most senior member of staff to deal with this matter has been the Provider's branch manager, and the issue regarding the change in the level of cover on his policy has yet to be resolved.

The Provider's Case

The Provider says the Complainant drew down his mortgage loan on **3 October 2006**. In order to draw down the loan, the Provider says the Complainant was required to have adequate life assurance in place to cover the loan amount in the event of his death. In this respect, the Provider refers to the Special Conditions of the Letter of Offer dated **6 July 2006** and section 1.18 of the General Mortgage Loan Approval Conditions.

The Provider says that as the Complainant's loan was for an amount of €150,000.00, he was required to have life assurance cover in place for at least that amount. The Provider says the Complainant completed and signed a Life Cash Cover Application Form on **15 September 2006** and a Life Cash Cover was incepted on **3 October 2006**.

As per the terms of the policy, the Provider says the Complainant availed of Life Cover in the amount of €150,000.00 and Accelerated Specified Illness Cover in the amount of €150,000.00. The Provider notes that while it is a condition of the loan agreement that the Complainant have adequate Life Cover in place, it is not a condition to have Serious Illness Cover. The Provider says the Accelerated Specified Illness Cover was an optional additional benefit chosen by the Complainant.

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The Provider says the Complainant's policy was taken out with the Insurer but was assigned to the Provider to use as security for the mortgage loan. Therefore, the Provider says the Insurer administered and managed the policy but the Provider was the plan owner.

In light of this, the Provider says that any amendments to the policy must be approved by it, in order to ensure that adequate cover in place at all times to discharge the outstanding loan balance.

The Provider says the Complainant's loan fell into arrears in **May 2010**; and on **3 August 2010**, the Complainant attended one of its branches to complete an Alternative Repayment Request Form. The Provider says that as part of this process, it is standard procedure to review a customer's income and expenditure in full, in an effort to ascertain if a customer's outgoings could be reduced. On this occasion, the Provider says the Complainant completed an Alternative Repayment Request Form.

The Provider advises that the Customer Care Advisor with whom the Complainant met no longer works for the Provider and that it is difficult to establish what was discussed during this meeting. However, the Provider says it would not be unusual for a Customer Care Advisor to highlight areas of expenditure that could possibly be reviewed such as utilities, entertainment expenses and insurance premiums. Following a review of the Alternative Repayment Request Form, the Provider says it approved a three month Moratorium Restructure Arrangement which was applied to the loan account on **5 August 2010**.

The Provider rejects the Complainant's position that it instructed him to reduce his Serious Illness Cover. The Provider says that while its agents may suggest certain arears of expenditure that could be reduced, it does not instruct a customer to do so; any decision to amend insurance cover is for the customer alone.

On **29 November 2010**, the Provider says the Complainant attended one of its branches in relation to his Life Cash and Accelerated Specified Illness Cover policy and telephoned the Insurer directly while at the branch. The Provider says the Complainant made contact with the Insurer to discuss the possibility of reducing his monthly policy premium. Following a discussion of the matter, the Complainant gave verbal authority for his Serious Illness Cover to be reduced to €60,000.00. Referring to the telephone conversation between the Complainant and the Insurer and the Insurer's further communications, the Provider observes that the Insurer advised the Complainant that it was its policy to accept verbal consent for policy amendments by telephone.

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The Provider says it was required to consent to the Complainant's request for a reduction in Life Cover as it would need to ensure there was adequate cover in place to discharge the outstanding loan balance. As the loan account balance was approximately €109,000.00 in **November 2010**, the Provider says it was agreeable to a reduction in Life Cover to €110,000.00 and for a reduction in Serious Illness Cover to €60,000.00.

The Provider says it confirmed this to the Insurer on **2 December 2010** and the Insurer proceeded to amend the policy accordingly. The Provider also refers to a reduction in monthly premium payments from €89.26 to €52.79 which was reflected in the Complainant's loan account statements.

The Provider says the contents of the telephone conversation between the Insurer and the Complainant is an issue for the Insurer to address, and it is not for the Provider to comment on the Insurer's policy of accepting verbal consent to policy amendments. The Provider also points to an email from the Insurer dated **2 December 2010**, which shows it was the Insurer's intention to issue details of the policy amendments to the Complainant.

The Provider notes that the Complainant's issue with it is solely in relation to the advice he was given during his attendance at the Provider's branch and that the Complainant feels incorrect advice was given regarding the policy during a discussion of his expenditure. The Provider reiterates that due to the passage of time, it is not possible to establish exactly what was discussed with the Complainant in **August** or **November 2010**. However, the Provider says it would not be unusual for a Customer Care Advisor to discuss the options of reducing expenditure with a customer in financial difficulty. As stated previously, the Provider says it is common for areas such as household utilities, entertainment and insurance to be reviewed in an effort to ascertain if any savings could be made in these arears.

During the telephone conversation with the Insurer on **29 November 2010**, the Provider says the Complainant requested that his Life Cover be reduced from €150,000.00 to €110,000.00 and that his Specified Illness Cover be reduced from €150,000.00 to €60,000.00. As a result, the Provider says when the Complainant made a successful claim on the policy in **2014**, he received a lump sum payment from the Insurer towards his mortgage account in the amount of €60,000.00. The Provider says this payment cleared the Complainant's arrears which stood at €41,003.74 and reduced the outstanding loan balance to €42,083.45.

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The Provider says it rejects the Complainant's assertion that it instructed him to reduce his Accelerated Specified Illness Cover with the Insurer. While the Provider may suggest certain areas of expenditure that could possibly be reduced, the Provider says it does not instruct a customer to do so and any decision to amend a Life or Serious Illness policy is for the customer alone to make.

The Complaints for Adjudication

The complaints are that the Provider:

> Amended the level of cover under the policy without the Complainant's consent; gave incorrect advice to the Complainant regarding his policy on **29 November 2010**; and once discovered, failed and/or refused to meet with the Complainant to discuss the amendment to his policy.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision, I have carefully considered the evidence and submissions put forward by the parties to the complaint.

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on 23 November 2021, outlining my preliminary determination in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that

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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, both parties engaged in further correspondence, copies of which were exchanged between the parties.

Having considered the parties' additional exchanges and all submissions and evidence furnished by both parties to this office, I set out below my final determination.

In his correspondence of 9 December 2021, the Complainant raised issues relating to seeking what he describes as "*redemption*" figures from the Provider.

The Provider, in its response of 15 December 2021, states:

> *"The Bank notes the Complainant's comments in relation to his request for redemption figures in order to agree a settlement amount on his Mortgage loan. Redemption figures are available at any time, at the request of a Borrower, from the Bank's Mortgage Department. In effort to assist, the Bank has arranged for up to date Redemption Figures to be issued to the Complainant directly in the coming days.*
>
> *Please note that the Bank is not in a position to accept an amount less than the full outstanding Mortgage loan balance in settlement of the Complainants' Mortgage loan. In order to address the arrears balance on the Mortgage loan, the Complainant will be required to engage in the Bank's Collections process by completed a Standard Financial Statement (SFS) for assessment. Following a full review of the Complainants' circumstances, the Bank will ascertain if an Alternative Repayment Arrangement (ARA) is appropriate and engage with the Complainant in this regard accordingly. Should the Complainant wish to proceed with this course of action, the Bank will arrange for a point of contact to assist him with this process".*

I accept that the Provider's position in this regard is the correct and reasonable approach.

In addition to this complaint, a complaint was also received by this Office in respect of the Insurer's conduct surrounding the amendment of the Complainant's life policy (the **Linked Complaint**). In such circumstances, this Office wrote to the Complainant by letter dated **24 March 2021** requesting his consent to the sharing of the evidence in respect of each complaint with the Respondent Provider to the linked complaint. The Complainant gave his permission to the sharing of evidence by email of the same date. Accordingly, this Office wrote to the Provider on **8 April 2021** to inform it of the Complainant's agreement to the sharing of evidence between the Respondent Providers to the linked complaints. Following this, the relevant documentation was forwarded to the Provider on **9 April 2021**.

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The Relationship between the Provider and the Insurer

In a letter to this Office dated **18 March 2020**, the Provider advises, amongst other matters, that as the Insurer was a tied agent of the Provider, the Provider's staff member telephoned the Insurer in an effort to assist the Complainant. The Provider states that its staff member did not speak for the Complainant or enter into any discussions on his behalf. In a further letter to this Office dated **20 April 2020**, the Provider states that it:

> *"is satisfied that it is not liable for any acts or omissions under this agreement* [the Tied Agency Agreement] *with respects to this complaint.* [T[*here is no evidence to suggest that the Bank instructed the Complainant to reduce his cover* […]*."*

During the course of the adjudication of this complaint, by letter dated **4 December 2020**, this Office sought further information from the Provider regarding the nature of its relationship with the Insurer in respect of the Complainant's policy. The Provider responded to this letter on **21 January 2021**, explaining that in **2006**, it was a tied agent of the Insurer for life assurance plans, serious illness cover, investment bonds and Personal Retirement Savings Accounts. As a tied agent, the Provider says it exclusively sold Insurer products to customers when arranging life assurance cover and serious illness cover. The Provider says that in **2010**, it was also a tied agent of the Insurer.

However, the Provider says its involvement with the policy was solely at the point of sale. To clarify, the Provider says, it arranged Insurer products for its customers and facilitated the sale of these products in its branches and intermediary network. Once the sale process was complete, the Provider says the customer was referred to the Insurer for all administration and customer service issues going forward. The Provider says this is outlined in detail to all customers in their application forms and policy booklets. The Provider says it is unable to amend or adjust an Insurer policy for a customer, as all such actions must be completed by the Insurer directly. However, the Provider says that as plan owner, it may in some cases object to or support a customer's request to amend a policy.

In relation to the ongoing administration of the Complainant's policy, the Provider says this is set out in the policy documentation. In this respect, the Provider refers to an Insurer declaration contained on the application form signed by the Complainant on **15 September 2006**. The Provider says that while it arranged the sale of the Complainant's policy, the previously mentioned declaration sets out that the Insurer completed the underwriting of the policy.

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The Provider also refers to a Customer Information Notice issued to the Complainant on **3 October 2006** and has cited certain passages from this notice, stating that this notice sets out that the Insurer is to be contacted directly with respect to details regarding the policy and that the Provider had no authority in relation to claims handling or underwriting. The Provider also refers to the policy terms and conditions in respect of the relationship between the Provider and the Insurer.

The Provider says it has no role to play in relation to policy administration and customer service issues and for ongoing administration, policy amendments or customer services. The Provider says the Complainant is required to liaise directly with the Insurer.

Background

The Complainant entered a mortgage loan agreement with the Provider pursuant to a Letter of Approval dated **6 July 2006**. Clause A of the 'Special Conditions' states:

> *"A. Unless otherwise agreed with* [the Provider]*, General Mortgage Loan Approval Condition 1.17 applies to this loan (Mortgage Protection)."*

Clause 1.17.1 of the 'General Mortgage Loan Approval Conditions' states:

> *"The Applicant must obtain adequate Life Assurance or Mortgage Protection for an amount equal to or greater than the amount and term of the Advance.* […] *The Applicant shall be under the sole and exclusive obligation to maintain such Life Assurance or Mortgage Protection in force during the term of the Mortgage and subject at all time to the Terms and Conditions of the Mortgage Deed* […] *and shall be under the sole and exclusive obligation to comply with the terms of such Mortgage Protection or Life Assurance.* […]*."*

On foot of the Provider's requirements, the Complainant incepted a life policy with the Insurer through the Provider. By letter dated **3 October 2006**, the Insurer wrote to the Complainant enclosing, amongst other documents, a 'Certificate of Membership'. This outlined the Complainant's cover under the policy, being €150,000.00 for Life Cover and €150,000.00 for Accelerated Specified Illness Cover.

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On **29 November 2010**, it appears the Complainant attended one of the Provider's branches to complete a Standard Financial Statement with a Customer Care Advisor. I note the Provider states that due to the passage of time, it is not possible to establish exactly what was discussed with the Complainant in **August** or **November 2010**.

However, the Provider says it would not be unusual for a Customer Care Advisor to discuss the options of reducing expenditure with a customer in financial difficulty. The Provider says it is common for areas such as household utilities, entertainment and insurance to be reviewed in an effort to ascertain if any savings could be made in these arears.

The meeting in November 2010 was clearly a very important meeting that dealt with the Complainant's arrears on his mortgage and during which he made decisions that had serious consequences. It is therefore both disappointing and unacceptable that the Provider appears to have no knowledge or record of what its agent informed or advised the Complainant at that meeting.

What is clear is that at a certain point in this meeting, the life and illness policies were discussed. This resulted in the Customer Care Advisor contacting the Insurer by telephone and explaining, in a very brief exchange, that the Complainant wished to discuss his policy.

The phone was then handed to the Complainant. This was a short conversation and once the initial formalities were dispensed with, the conversation proceeded as follows:

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

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

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

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

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

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Complainant: *Fifty euro and seventy cents*

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

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

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

Complainant: *Ok. Thanks very much indeed.*

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

Complainant: *No problem.*

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

Complainant: *Ok.*

Insurer's Agent: *Is that ok?*

Complainant: *That's perfect.*

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

Complainant: *Yeah.*

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

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Complainant: *Thanks very much indeed.*

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

The Customer Care Advisor emailed the Provider's Mortgage Department on **30 November 2010** in respect of the amendment to the Complainant's policy as follows:

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

The Mortgage Department responded to the Customer Care Advisor on **2 December 2010**, agreeing to these changes, as follows:

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

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

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

Responding to this email the same day, the Insurer advised:

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

In an email dated **4 July 2017**, the Customer Care Advisor who met with the Complainant on **29 November 2010** provided the following information in respect of her recollection of the meeting with the Complainant:

> *"Due to the passage of time, I do not recall dealing with* [the Complainant] *specifically in 2010. However, when a customer requests a Life Policy/Serious Illness Policy to be amended, the branch would submit this request to the Bank's Mortgage Department for approval, as the Bank are the Plan Owners for such policies. It would appear from the Bank's records that I sent* [the Complainant's] *request to the Bank's Mortgage Department on 30th November 2010."*

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

> *"My appointment was with* [the Provider] *to fill out S.F.S. form*
>
> [The Provider's staff] *member explained my mortgage as €100K & my policy's were €150K. Life cover & serious illness*
>
> *Staff member.*
> *Advised me to ring* [the Insurer] *to inquire about changing my policy, and that if the figures was agreeable,* [the Insurer] *would send me the proposals to my address, for me to view + sign.*
>
> *Then it would have to be passed by* [the Provider] *because life cover would have to match amount of my mortgage €100k.*
>
> *That was the last I heard about it and received no post or forms.* […]*."*

In a submission dated **22 August 2017**, the Complainant explains that:

> *"*[The Customer Care Advisor] *asked me would I be interested in reducing my policy's.*
>
> *She explained that paperwork would be sent out for me to sign and return, (up to 14 days) and I would receive an amended policy.*
>
> [The Customer Care Advisor] *rang* [the Insurer] *and put me on the phone.*
>
> *When I gave the go ahead on phone that's what I thought I was agreeing to.* […]*."*

In a submission dated **5 April 2020**, furnished in respect of the Linked Complaint involving the Insurer, the Complainant states:

> *"The understanding that I have of what happened on the 29th of November 2010 is I was asked to go to* [the Provider's] *branch to fill out a SFS (Standard Financial Statement) form with* [the Customer Care Advisor]. *During this procedure she informed me of an option to reduce my policies I had in place with* [the Insurer].

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This was mentioned as my Life Insurance policy at the time was at €150K and mortgage repayment price was at €110K so it would make sense to reduce this along with the serious illness cover. It was made clear to me that doing so I would need to require information off [the Insurer] *and then* [the Provider] *would set this in place but only agreeing in writing and having the right of a 14 day cooling off period. I called* [the Insurer] *in* [the Provider's] *Branch to query my options and see if it was possible to do. When on this phone call to* [the Insurer] *I had advised the employee that it was OK on my behalf, me being of the understanding that this would be passed onto* [the Provider] *to be passed onto me that it had been put in place. I was advised by* [the Insurer] *that if I didn't hear from them to maybe call them in a week I didn't call them. I never heard from* [the Insurer] *after this phone call to say that any agreement had been set in place. When finished on the phone to* [the Insurer], [the Customer Care Advisor] *in* [the Provider] *advised me that they needed to give* [the Insurer] *permission to amend the agreement on my behalf in writing, do up an amended policy agreement for me to sign and that I would be called up to have a meeting with her during the week to go through all of this. After this meeting then she would send her consent onto* [the Insurer]. *This meeting never happened, I never signed any paperwork and never gave* [the Customer Care Advisor] *permission to give her consent on my behalf to* [the Insurer].

So as this never occurred, I was of the understanding that my policy remained the same and wasn't reduced until years later.

I didn't notice any amendments on my incoming statements as it was such a low reduction off a high amount that I was paying each month and were all under one figure."

Analysis

Having considered the evidence, it appears that the Complainant attended the Provider's branch on **29 November 2010** for the purpose of completing a Standard Financial Statement. When he attended the branch, the Complainant met with the Customer Care Advisor. The precise extent of the conversation that took place between the Complainant and the Customer Care Advisor is not entirely clear and there is no note or record of the meeting. However, I am satisfied that a discussion of the Complainant's various outgoings and expenses took place. I am also satisfied that this conversation involved a discussion

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surrounding the amounts being paid by the Complainant in respect of insurance premiums, including his life policy premium and his illness policy premium.

Further to this, it is my opinion that the life policy premium and illness policy premium were likely to have been identified as an area of expenditure the Complainant should consider reducing given that the outstanding loan balance was, at that point in time, less than the Life Cover and critical illness amounts currently in place. Life cover was required to be in place by virtue of clause 1.17 of the General Mortgage Loan Approval Conditions.

In terms of the advice received from the Customer Care Advisor in respect of the life policy, I note that at the beginning of the telephone conversation with the Insurer, the Complainant indicated that he was *"in the bank* […] *querying about reducing the life cover that I have and the serious illness cover."*

In the submissions referred to above, the Complainant states the *"*[s]*taff member advised me to ring* [the Insurer] *to inquire about changing my policy"*; she *"asked me would I be interested in reducing my policy's"* and *"she informed me of an option to reduce my policies"*.

Therefore, having considered the evidence, I am satisfied it is likely that a discussion took place in terms of reducing the level of cover in place under the Complainant life and illness policies and that the Complainant was advised of the option of reducing the cover under his policies.

Having considered the telephone conversation with the Insurer, I accept that the Complainant agreed to reduce the level of cover under the policy. In this respect, I note that the Complainant does not appear to have been advised by the Insurer's agent that any further form of consent was required from him or that any documentation was required to be completed or signed by him or the Provider prior to implementing the amendment.

It can also be seen that the Complainant was advised that the policy amendment would be implemented once the Provider's permission was received. In this respect, I note the Complainant was advised to ask the Provider to forward its permission for the policy amendment to the Insurer. However, I note that the Complainant was not advised that the Insurer would contact the Provider and seek the relevant permission for the policy amendment.

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The evidence shows that the Customer Care Advisor contacted the Provider's Mortgage Department on **30 November 2010** in respect of the policy amendment. I note that permission to amend the policy was sent to the Insurer on **2 December 2010**.

From the available evidence, I note that there does not appear to have been any communication between the Insurer and the Provider in the period between the telephone conversation on **29 November 2010** and Customer Care Advisor's email of **30 November 2010**.

I have been furnished with no evidence to support the Complainant's assertion that the Customer Care Advisor told the Complainant, as stated in his submission of **5 April 2020**, that the Provider or the Insurer:

> *"needed to* […] *do up an amended policy agreement for me to sign and that I would be called up to have a meeting with her during the week to go through all of this. After this meeting then she would send her consent onto* [the Insurer]*."*

In the absence of any notes of this meeting, it is difficult to establish exactly how matters transpired. However, I find assertion that advice along these lines was given is inconsistent with the discission which took place during the telephone conversation on **29 November 2010**.

Accordingly, there does not appear to be any evidence to support the assertion that the Provider amended the Complainant's policy without his consent. As noted above, I accept that the Complainant agreed to change the level of cover on his policy during the telephone conversation with the Insurer.

He was then advised of the requirement for the Provider's permission to amend the level of cover and to ask the Provider for its permission to the amendment which, once received, would give effect to the policy amendment. The Provider's permission was later communicated to the Insurer on **2 December 2010**.

It appears from the telephone conversation on **29 November 2010** that the Insurer's agent indicated that the Complainant would be contacted by the Insurer once the policy amendment was implemented. I also note that the Complainant was advised by the Insurer's agent to contact the Insurer in a week to ensure the policy amendment was implement if he did not hear from the Insurer in the meantime.

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While the Customer Care Advisor may have told the Complainant that he would receive correspondence regarding the amendment to his policy, I do not consider this to be inappropriate or unreasonable; particularly as the telephone conversation with the Insurer suggested there would be further communication from the Insurer.

Further to this, I have been presented with no evidence that the Complainant was advised that he was going to receive any form of communication or correspondence from the Provider regarding the policy amendment nor do I accept that the Provider, as plan owner, was required to contact the Complainant regarding the policy amendment once the Provider's permission had been given to the Insurer, particularly as the Insurer stated in its email of **2 December 2010** that a letter would issue to the Complainant outlining the new policy benefits.

In any event, the Complainant was advised to contact the Insurer if he did not receive any further communication. However, there is no evidence of the Complainant making any further contact in this regard.

Accordingly, I do not accept that the Provider amended the level of cover under the Complainant's policy without his consent.

The Complainant states that the Provider failed or refused to meet with him to discuss the amendments to his policy. However, the Complainant has not provided details of any such request being made. Furthermore, insufficient evidence has been presented to support this aspect of the complaint.

However, I do have difficulty with the manner which, during a meeting intended to discuss the Complainant's arrears, such an important decision on his insurance policies was discussed and arrived at without an opportunity for the Complainant to properly reflect on the importance and possible consequences of that decision.

It is clear that the Complainant attended the Provider's branch to deal with significant arrears on his mortgage. It would appear that during that meeting the possibility of reducing his insurance in order to increase his mortgage payments was discussed with the Provider's Agent. It is also clear that the Provider's agent facilitated a call to the insurance company during which the Complainant agreed to reduce his life and critical illness cover.

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Making a decision to reduce life or critical illness cover is a decision which should not be taken lightly. Such a decision should be arrived in a considered way and in an appropriate environment. There are a number of factors that should be taken into account in arriving at such a decision. In my view such a decision requires careful consideration and reflection. I do not believe the Complainant had the opportunity reflect and properly consider his actions during the meeting that was arranged to deal with his arrears with the Provider's agent.

The evidence submitted does not show if there was any consideration by the Provider as to what the Complainant was giving up by way of this particular insurance cover. I also have not been furnished with evidence of the Provider having in place a policy with regard to items that are considered essential to keep in place by way of insurance cover, other than the life cover required by statute. At a minimum I would have expected some guidance as to what would and what would not be considered by the Provider as something that it would not expect the Complainant to forfeit or alter, or that would require greater consideration from the Complainant before forfeiting or altering.

Any discussion between the parties should have taken account of the Complainant's own health history, his age and family health circumstances, the length of time that the policy was in place and the potential to increase cover at a later stage would also be an important consideration. Once the policy was amended, the Complainant's health and age, most probably would have affected his ability to avail of similar cover in the future.

I note that while there is a statutory requirement for life cover to be in place in respect of a mortgage, there is not the same requirement in respect of serious illness cover. The evidence shows that the parties rightly ensured that the mortgage was secured by a life policy sufficient to cover the outstanding mortgage. While there is a statutory requirement for such life cover, I consider that some input from the Provider was also required when discussing considering/ recommending/suggesting cutting back on a policy such as the policy the Complainant had which provided serious illness cover.

The Provider's position is that it may recommend a customer to review their financial commitments including insurance policies. While I accept that the Complainant ultimately made the decision with regard to what to do with the serious illness policy, I also accept that this was an item of expenditure that was most likely identified as something that could be cut back upon during the meeting with the Provider. In such circumstances I would have expected some guidance from the Provider to the Complainant to think carefully before reducing the cover under his serious illness policy.

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The Provider, for example, could have explored with the Complainant his actual need for the serious illness cover based on his health situation and that of his family, in relation to coverable events under the policy. At the very least I would have expected that the Provider to give the Complainant the time and space to consider whether spending the amount on the premium was better than the risk of not having a pay-out should an illness be contracted.

Hindsight has most unfortunately shown that keeping the policy in place would clearly have been the best approach for both the Complainant and the Provider. This is clear because the Complainant subsequently received what appears to have been the new maximum pay-out under the policy.

The pay-out he/the Provider received was €60,000 whereas had he continued paying the policy, it would appear that he may have received €150,000.

The saving he made was €36 per month for reducing both the life cover and the critical illness.

I accept that the greater responsibility rested with the Complainant as to the appropriateness of cancelling the Serious Illness policy mindful of his own health and needs. That said, I believe the Provider could have taken more care in its dealings with the Complainant so that he fully understood the need to weigh up all considerations before reducing the Critical Illness Policy. There can be no doubt that the alteration of the policy has caused considerable loss and inconvenience to the Complainant. While ultimately it was the Complainant's decision as to whether to keep the policy at the level it was, given the overall circumstances, and considering what is fair and reasonable, I consider that the Provider must bear some responsibility given the manner in which the meeting in **November 2010** was conducted.

For the reasons set out in this Decision I partially uphold the complaint and direct the Provider to pay a sum of €15,000 to mark the Provider's unreasonable conduct and the resulting inconvenience and consequences for the Complainant.

Conclusion

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

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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 €15,000, 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, to mark its unreasonable conduct and the resulting inconvenience and consequences for the Complainant.

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

6 January 2022

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

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(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.