An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0040
Sector:	Insurance
Product / Service:	Payment Protection
Conduct(s) complained of:	Claim handling delays or issues Delayed or inadequate communication Dissatisfaction with customer service
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The complaint concerns the level of customer service provided to the Complainant in respect of a claim regarding mortgage payment protection insurance arranged by the Provider and underwritten by the Insurer. A separate complaint was received by this Office in respect of the Insurer.

The Complainant's Case

In a letter provided to this Office by the Complainant's Representative under cover of email dated **25 February 2019**, the Complainant explains that:

> *"My issue with* [the Provider] *is that as "agent" for the insurance company they failed to take the issue seriously enough to ensure I was being dealt with properly. At this juncture I was in substantial arrears because of the delays with the claim."*

The Complainant says her advisor, who is a former Provider branch manager, informed her that she should notify the Provider's insurance department that she was experiencing problems with her Insurance claim in an attempt to resolve an impasse which had arisen.

The Complainant says her advisor expected the Provider would be concerned enough to contact the Insurer to advise it to be more clear about the information required – which she says was very ambiguous and unclear. The Complainant says her advisor was aware the Provider had a business relationship manager who would intervene if a Provider customer was having service problems with its insurance partners. The Complainant says the business relationship manager would usually be available to the branch network and customers calling directly and, once made aware of an issue, would take it up with the insurance company and revert to the customer. The Complainant says the Provider, at that time, took seriously any service issues experienced by customers.

The Complainant says her advisor informed her that if anyone in the Provider's head office accessed her customer information file, they would see all contacts, tasks and interactions because staff are obliged to record these matters. The Complainant says it should therefore dawn on all these people that she was having problems, that there was no reason to doubt the claim, that as a result of the delay arrears were piling up, and sooner or later this would reach a serious level.

The Complainant says the Provider has a strong relationship with a former insurer of her policy according to her advisor and his opinion of this entity was quite positive in relation to its approach to claims.

The Complainant says her advisor informed her that the Provider is collecting 'trailer commissions' for 16 years on one of her policies and 13 years on another. Therefore, the Complainant says there is an implied consumer responsibility that had been in place since the same manager sold her the policy. As the Provider continues to be an agent of the Insurer, the Complainant says it has a responsibility to provide accurate information and help with any problems that arise in connection with her policy. The Complainant says this relationship was not void when the previous insurer sold its business to the Insurer.

In summary, the Complainant says, the Provider's insurance department responded to a letter to state that it had contacted the Insurer and that she was to contact a customer service agent called 'NB'. When the Complainant contacted the relevant Insurer department, she says she was told NB refused to take her call and that NB no longer takes calls or deals with these matters. The Complainant says the Insurer agent she was speaking with then refused to speak with or answer any of her questions, stating that the Insurer had issued a final response letter and that the case was now closed.

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The Complainant says her arrears continued to accumulate. The Complainants says although not all of her arrears were attributable to her unpaid Insurer claim, this served to accelerate the accumulation of the arrears to the point where the Provider's arrears department declared her mortgage loan unsustainable and wrote to her one week before Christmas **2018** informing her that legal proceedings to repossess her house had commenced.

The Complainant says the Provider agent, 'LT', with whom she spoke on **5 May 2018** is aware of the problems with the Insurer but admitted that *'unfortunately the process with them could take longer than they are willing to wait'*. In this respect, the Complainant says: *"What an admission and terrifying prospect to be told."*

The Complainant says the Provider and the Insurer are earning income from her mortgage accounts and will not talk to one another in the detail required to see if her problem could be resolved or even give her a very clear and understandable reason as to how her claim was not a valid one. The Complainant says no one from the Provider's insurance department made any attempt to follow up with her or the Insurer to find out if she had been helped or if the issue had been resolved. The Complainant says she was left once again with the feeling that no one cared enough and too dejected to ring the Provider back as she had lost all confidence that the Provider might help.

The Complainant's Representative explains that the Complainant's mortgage protection policies were sold by the Provider in conjunction with a mortgage loan and subsequent top-up loan. When the Complainant was trying to resolve a complaint with the Insurer, the Complainant's Representative says contact was made with the Provider in an effort to resolve the issue. The Complainant's Representative says the Provider made very little effort to help. The Complainant's Representative refers to correspondence with the Provider dating back to **2015** in support of the position that the Provider has been unhelpful for a number of years and states that there has been a number of issues in relation to the Complainant's accounts held with the Provider in the past. The Complainant's Representative submits that there has been a clear pattern of disregard for the Complainant as a customer *"which shows a pattern of dissatisfaction which* [the Complainant] *has received."*

The Complainant's Representative has also set out the impact the conduct the subject of this complaint has had on the Complainant, her son and her daughter (the Complainant's Representative). In resolution of this complaint, Complainant's Representative says the conduct complained of has been ongoing since **2017** and the Complainant wants matters to be resolved as soon as possible.

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The Complainant's Representative says that:

> *"The aim to have the mortgage policy paid for the time* [the Complainant] *was out of work as stated in her claim form that was issued to* [the Insurer]. *At this point I would also think it is well within our rights to seek financial compensation for the effect this had had* (sic) *on* [the Complainant's] *life. She was extremely unwell and stress is a huge trigger for* [the Complainant's] *illnesses, this has caused a delayed recovery which has meant a delayed return to work and loss of income."*

In a submission dated **22 January 2020**, the Complainant's Representative explains, as follows:

> *"*[C]*onsidering that* [the Provider] *provided me with a name of a correspondent* [NB] *who refused to speak to or assist* [the Complainant] *at all. This alone caused huge delays and immense undue stress and worry to* [the Complainant] *and had* [the Provider] *provided a better standard of customer service there would not have been such a delay now or then. I would also like to point out that* [the Provider] *as the broker of this MPPI policy not only have a duty of care to assist* [the Complainant] *in all aspects of policy's she holds with them but especially where* [the Provider] *are collecting trailer commission each year the policy renews. Which I would like to note they are, so they are gaining financially from this policy and provided very little to no support to* [the Complainant] *or myself when I became involved.*
>
> […] *Yesterday the 21/01/2020* [the Complainant] *received the attached letter from the bank threatening to cancel her life assurance and home insurance as she has been unable to meet arrears payments. I would like to stress* [the Complainant's] *arrears issues have been made exponentially worse due to this whole complaint.* […]
>
> *In relation to the preferred outcome, I would request that the claim be honoured with* [the Insurer] *and due to the complete lack of customer service to* [the Complainant] *as a vulnerable consumer, as defined in the consumer protection code and utter disregard for respect to* [the Complainant] *as well as the unprecedented stress and strain this has caused on her life, for compensation to be awarded to her."*

In a submission dated **3 March 2020**, the Complainant's Representative advised that the Provider was threatening to cancel the Complainant's life cover but that the Complainant had drafted a separate complaint in respect of this.

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By email dated **7 April 2020**, the Complainant's Representative advised, as follows:

> *"I would also like to highlight that* [the Provider] *have still been putting pressure on* [the Complainant] *in regards her mortgage and threatening to cancel her life assurance policy which I may add they have absolutely no right to do. Feel* (sic) *has been making her greatest effort to clear the arrears on and be as compliant as she can.* […] *I think it is noteworthy to the blatant bullying and harassing tactics they are applying to* [the Complainant] *while they have full knowledge of this complaint and it's seriousness and how it effects her ability to deal with her arrears.*
>
> *I would request their treatment of* [the Complainant] *on a whole be noted on this complaint as it is very clear they are at this point bullying and harassing her and choosing to show absolutely no leniency and goes against their claim that they have been assisting* [the Complainant] *at all points when they* (sic) *behaviour and actions shows the contrary.*
>
> *I am extremely unhappy with their treatment of* [the Complainant] *from the outset of this complaint and I want to highlight that they have a duty of care to provide a service to* [the Complainant] *as they are collecting trailer commissions on her policies."*

The Provider's Case

The Provider delivered its Complaint Response under cover of letter dated **5 May 2020**. The Provider explains that on **6 February 2018**, the Complainant made a complaint by telephone regarding her dissatisfaction with the claims procedure in relation to her Mortgage Payment Protection Insurance ("MPPI") policy held with the Insurer. On **28 February 2018**, the Provider says it issued correspondence to the Complainant advising that all mortgage payment protection policies offered by the Provider were exclusively underwritten and administered by the Insurer and that the Provider had no involvement in the policy or claims administration. The Provider says it advised that its relationship manager had been contacted in relation to the matter, someone had been appointed to handle the complaint and that person would contact the Complainant in due course.

On foot of the above correspondence, the Provider says it received further correspondence from the Complainant dated **23 April 2018**. Amongst the issues raised, the Provider says, was that the Complainant had not been contacted in relation to her complaint with the Insurer. The Complainant further advised that when she contacted the Insurer, the person with whom she spoke from the Insurer's office refused to answer her questions and stated that the case was now closed.

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The Provider says on receipt of this correspondence, it contacted the Insurer so as to assist the Complainant in any way it could.

Following contact with the Insurer, the Provider says on **11 May 2018** it issued correspondence to the Complainant acknowledging her dissatisfaction with the claims process and the lack of contact from the Insurer in relation to her complaint. The Provider says it confirmed that the Insurer was responsible for the administration and assessment of all claims and that the Insurer was not in a position to share details of the claim with the Provider. The Provider says it confirmed to the Complainant that it had spoken to the Insurer and requested that the Insurer re-issue confirmation of what was required from the Complainant in order to assess her claim. The Provider says it confirmed to the Complainant that there had been no change in underwriting criteria since the Insurer took over from the previous insurer in **December 2015**, so existing policy terms and conditions applied.

The Provider says it is not involved in the assessment and process of any claims other than providing a claim form if requested and that a claim form would have been completed by the Complainant and submitted to the Insurer for assessment and processing. The Provider says it cannot insist that a claim is upheld by the Insurer. However, the Provider says it was *annoyed* that the Complainant was not contacted by the Insurer with regard to her claim as was advised to the Provider would happen. On discovering this, the Provider says it contacted the Insurer.

The Provider says it sold the MPPI policies to the Complainant. The Provider says as part of the loan application process, it would have advised the Complainant of all available insurance products and of all the relevant conditions associated with them. The Provider says it would have advised the Complainant that while home and life assurance products were a requirement of the loan, these did not have to be taken out with the Provider. The Provider says it would also have advised the Complainant that with respect to MPPI, this was an optional product and was not a requirement or condition of loan approval. The Provider says it would have provided the Complainant with the relevant policy terms and conditions on inception of the policies including the relevant cooling-off period each time and that it would have issued revised terms and conditions and correspondence to the Complainant as was required when a change in underwriters occurred or there was an amendment to the policy terms. Although it issued the policy documentation, Provider says it was not involved in the assessment or processing of claims whatsoever, which was within the remit of the Insurer only.

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The Provider refers to page 14 ('**4. How to Claim**') and page 18 ('**8 Our promise of service**') of the terms and conditions dated **January 2012**. The Provider also refers to the most recent 'draft' policy terms and conditions dated **January 2018**, where all updated contact information can be viewed. In a submission dated **9 June 2020**, the Provider advised (at paragraph 8) that it only had available a template copy of these terms and conditions.

The Provider submits that it is clear from the documentation and correspondence which issued to the Complainant since the inception of her policies in **October 2002** and **February 2005** that the relevant Insurers were the underwriters of the policies. The Provider says it is the Complainant's responsibility to review all documentation and correspondence issued to her by the Provider. The Provider says if the Complainant had any questions regarding the documentation issued to her, she was free to contact the Provider at any stage with any queries she may have had. The Provider says in the Complainant's letter of **23 April 2018**, she confirmed that she had a previous claim, so had gone through the claims process before. Thus, the Provider says, the Complainant would have been aware that the Provider had no involvement with the assessment of any claims. The Provider refers to the previously mentioned policy terms and conditions and states that all information regarding claims and whom to contact is clearly explained within this documentation.

In **2003**, the Provider explains that a previous insurer ("the Underwriter") appointed it as their non-exclusive agent to market and sell policies. The Provider says it only offered Payment Protection Insurance ("PPI") through the Insurer at the time and the Insurer continues to be its sole provider of PPI to date.

In relation to commission and remuneration received from the Insurer, the Provider says it has a remuneration arrangement in place with its insurance partner for the introduction of MPPI business. Following the introduction of the ***Consumer Protection Code*** in **January 2012**, the Provider says it has been obliged to advise customers that it receives remuneration. In this regard, the Provider says it wrote to all PPI customers in **November 2011** enclosing an updated 'Mortgage Payment Protection Terms and Conditions' effective from **January 2012** which stated:

> *"*[The Provider] *is paid for the service provided to you by means of a remuneration arrangement with* [the Insurer]*, trading as* [trading name]. *The details of such renumeration are available on request."*

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The Provider says the amount of commission received over the terms of the policies to **April 2020** was approximately €1,295.00 in respect of loan account ending 081 and €463.00 in respect of loan account ending 573. As part of its remuneration arrangement, the Provider says it also previously received a share of the profits, which is worked out after all claims and insurer's costs have been paid across the customer base. The Provider advises that this information is not available at individual customer level.

The Provider says the Complainant completed a loan application and a MPPI form each time to avail of the MPPI policies. Unfortunately, the Provider says the 'AIR' application form in relation to loan account ending 081 cannot be located. The Provider says that as per the application forms, the Complainant was set as a 'PAYE' customer, thus being charged the higher MPPI rate of premium. However, on foot of the complaint and following investigation of the Complainant's file, the Provider says it seems that her employment status changed to that of a 'Self-Employed' customer, thus the Complainant should be paying the lower self-employed premium rate. The Provider says it is the responsibility of the Complainant to notify the Provider of any changes in her circumstances so that her policies could be amended accordingly. Despite this, the Provider says on discovering this issue during its investigation of the present complaint, it requested evidence of when the Complainant became self-employed so a possible refund of the difference in premium paid between the two rates could be calculated.

The Provider says it is satisfied its Final Response Letter dated **11 May 2018** along with other correspondence issued to the Complainant represents its response to the complaint. The Provider reiterates it is not involved in the claims process nor can it insist on the Insurer honouring the Complainant's claim. However, if there was any other way the Provider could assist the Complainant, it says it would endeavour to do so.

The Complaints for Adjudication

At this point, I consider it necessary to clarify the conduct which has been investigated and adjudicated as part of this complaint. In the Complaint Form, the Complainant stated that the conduct she is complaining about occurred on **3 October 2017** and that she became aware of the conduct on **8 February 2018**. In this respect, I note the Complainant first contacted the Provider in respect of her claims and her dissatisfaction with the Insurer on **6 February 2018**. On considering the parties' submissions, I am satisfied that the conduct complained of relates to the level of assistance or customer service provided to the Complainant by the Provider in respect of her MPPI claims.

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In the course of the submissions furnished by the Complainant's Representative, a number of issues were raised and subsequently considered by the Provider and the Complainant's Representative which relates to matters that occurred prior to **February 2018** and prior to the Complainant's claim in **October 2017**. Having considered the conduct complained of in the Complaint Form, I do not consider the issues raised by the Complainant's Representative in these submissions in respect of matters which occurred prior to **February 2018** form part of the conduct to be investigated and adjudicated upon as part of this complaint.

Accordingly, the complaints are that the Provider:

> Failed to assist the Complainant with her mortgage payment protection insurance claims; and failed to provide a proper and appropriate level of customer service to the Complainant in respect of her mortgage payment protection insurance claims.

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

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In addition to present complaint, a complaint was also received by this Office in respect of the Insurer's conduct surrounding its handling of the Complainant's claims ("the Linked Complaint"). In such circumstances, this Office wrote to the Complainant's Representative by letter dated **20 December 2019** requesting consent to the sharing of the evidence in respect of each complaint with the Respondent Provider to the linked complaint. The Complainant's Representative indicated her consent, on behalf of the Complainant, to the sharing of evidence by email dated **23 January 2020**. This Office wrote to the Provider on **13 March 2020** to inform it of the Complainant's agreement to the sharing of evidence with the Respondent Provider to the Linked Complaint, and the relevant documentation was forwarded to the Provider the same day.

It should be noted that the Complainant's representative has made a post Preliminary Decision submission on the above linked file dated **15 December 2021.** It was detailed in the email containing the submission:

> "*Please find attached some quires (sic) and questions we have in relation to the complaints. Please note that we feel the attached is applicable to both* [the linked complaint reference] *complaint as well as* [the current complaint reference]".

While I have considered the content of this post Preliminary Decision submission for both of the Complainant's complaints, I find that it was most applicable to the above referenced linked complaint.

Background

The Complainant completed a loan application form dated **3 September 2002** in respect of loan account ending 081. A Provider arranged MPPI policy was taken out in respect of this loan with cover effective from **23 October 2002**. The Complainant completed a further loan application form dated **11 February 2005** in respect of loan account ending 573. Provider arranged MPPI cover was also put in place in respect of this loan with cover effective from **17 February 2005**.

The Complainant submitted claim under the MPPI policy to the Insurer around **5 October 2017**. It appears that two claim references were generated in respect of this claim – one in respect of each of the Complainant's loan accounts.

By letter dated **7 December 2017**, the Insurer wrote to the Complainant in respect of claim reference 820 (loan account 573) declining the claim. This was followed by further communication between the Complainant and the Insurer regarding her claim(s).

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In particular, the Complainant was advised during a telephone conversation with the Insurer on **5 February 2018** that additional information submitted in **January 2018** had not been assessed and that it looked as though the matter had been *"actioned off"*. It appears that a formal complaint was logged by the Insurer in light of this.

On **6 February 2018**, the Complainant telephoned the Provider explaining that she wished to log a complaint with the Provider regarding the manner in which the Insurer was handling a complaint in respect of her claim. The Provider's agent told the Complainant that she would have to contact the Insurer in respect of such a matter. In response to this, the Complainant stated that it was the Provider who sold her the policies in question. Having verified the Complainant's details, the Provider's agent asked that the Complainant explain her complaint. The Complainant proceeded to outline the background to her claim and how matters had progressed with the Insurer to date. In particular, the Complainant noted that information sent to the Insurer in **January 2018** was not actioned. The Provider's agent then advised the Complainant that a complaint would be logged.

The complaint appears to have been acknowledged by the Provider in an undated letter which, according to the Schedule of Evidence submitted by the Provider, issued on **6 February 2018**. In this respect, I note in a timeline accompanying the Complaint Form for the Linked Complaint, the Complainant records receiving a letter acknowledging her complaint from the Provider between **6 February 2018** and **8 February 2018**.

The Provider emailed 'NB' (an agent of the Insurer) on **28 February 2018** advising that the Complainant had contacted it expressing her dissatisfaction with the service provided by the Insurer regarding her claim. This email continued by setting out a summary of the complaint and advised that the Provider had written to the Complainant explaining that the Insurer would be dealing with her complaint.

The Provider also wrote to the Complainant on **28 February 2018**, as follows:

> *"All Income Protection Insurance offered by* [the Provider] *Insurance Services is exclusively underwritten and administered by our insurance partners* [the Insurer] *and* [the Provider] *have no involvement in the policy or claims administration. However, I acknowledge that your business is with* [the Provider] *and an unsatisfactory experience with* [the Provider] *or any of our partners is unacceptable.*
>
> *Therefore, on receipt of your complaint, I contacted our relationship manager in* [the Provider] *and I have been advised that* [NB] *has been appointed to handle your complaint and she will contact you.* […]*."*

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An Insurer agent wrote to the Provider by email on **6 March 2018** advising that the Insurer had spoken to, and emailed, the Complainant that day and advised her as to the information required from her accountant and GP for the purpose of validating her claim. The Insurer also advised that a Final Response Letter would issue 'soon'.

By letter dated **23 April 2018**, the Complainant wrote to the Provider (which appears to have been in response to its letter of **28 February 2018**), as follows:

> *"I brought the matter to the attention of the* [Provider] *Insurance department as you have a relationship with your partners as their agent. I bought this policy from* [the Provider] *16 years ago and therefore as you continue to earn commission from my purchase, you have a responsibility for it as far as I am concerned.*
>
> *Arising from your last letter, the person that you directed me towards was your relationship manager at* [the Insurer] *'*[NB]*'.*
>
> *At the same time my claim application was coming to a head without any satisfactory communication explanations and I asked to be put through to* [NB]*, who had made no attempt to contact me after I received your letter.*
>
> [The Insurer] *refused to put me through to her and she, I was told would not take my call stating that she no longer takes calls or deals with these matters. The lady I was speaking with '*[F]*', then refused to speak with me or answer any of my questions. Stating they had issued a final response letter and the case was now closed.*
>
> *That about sums up the value both companies seem to hold on the title of Relationship Manager.*
>
> *The complaint has arisen as a result of the manner in which* [the Insurer] *have been handling my claim and as* [the Provider] *are the insurance partner in this instance I felt you should be aware of the lack of progress with this case as I am your mortgage customer.* […]
>
> *I am appalled at the service and the treatment I have received.* […]
>
> *I have been informed by a financial service professional that as* [the Provider] *are collecting trailer commissions for 16 years on one policy and 13 years on the other policy, you have a responsibility to provide accurate information and help in any problems that arise in connection to my policy.*

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> *The claim had neither been dealt with or reviewed appropriately.* […]
>
> *It is quite obvious to me that since* [the Insurer] *took over* [the Previous Insurer] *the underwriting criteria has changed making the process impossible* […]. *This is something* [the Provider] *should have been aware of and if you were you've acted carelessly with my rights as your customer.* […]*."*

Acknowledging receipt of this letter, by letter dated **4 May 2018**, the Provider advised the Complainant that it had requested a meeting with its 'Insurance Partners' for the coming week and that it would be in contact with her following the outcome of this meeting.

A conference call took place between the Provider and the Insurer on **9 May 2018** regarding the Complainant and her dissatisfaction with the declinature of her claim and how it was handled. During the call, the Insurer set out its handling and assessment of the claim.

At a certain point in the conversation, one of the Provider's agents suggested that the Insurer write to the Complainant setting out the information required to validate her claim. It was agreed between the parties that the Insurer would issue correspondence to this effect.

On **11 May 2018**, the Provider wrote to the Complainant explaining that:

> *"We acknowledge your dissatisfaction with the claims process and the lack of communication received from* [the Insurer] *to date.*
>
> *However, we confirm that* [the Insurer] *as the underwriters of your MPPI policies are responsible for the administration and assessment of all claims, and are not in a position to share details of any claim with us.*
>
> *We confirm that we have spoken to* [the Insurer] *and requested that they reissue confirmation of what is required from you in order for them to assess you claim.*
>
> *We advise that there has been no change to the underwriting criteria since* [the Insurer] *took over from* [the Previous Insurer] *in December 2015 and so the existing policy terms and conditions still apply.* […]*."*

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Analysis

It appears that when the Complainant made her claim in **October 2017**, the applicable policy terms and conditions were the 'Mortgage Payment Protection Terms & Conditions' dated **January 2012**. I note that a copy of the Terms and Conditions were forwarded to the Complainant's Representative by the Insurer by email dated **2 June 2017**.

On the cover of these terms and conditions, I note it is stated that the policy is *"brought to you"* by the Provider and the Previous Insurer. However, the evidence is that the Insurer became the insurer/underwriter of the policy from **December 2015**. As such, I consider any reference in this document to the Previous Insurer to be a reference to the Insurer.

Section 1 of the 2012 terms and conditions contain a number of definitions. At page 5, the terms 'we', 'us' and 'our' are collectively defined as meaning the Previous Insurer, as follows:

> *"means* [the Previous Insurer]*, for* ***disability, unemployment, hospitalisation*** *and* ***critical illness*** *cover."*

Section 4 of the terms and conditions explains how to make a claim, as follows:

> ***"4 How to claim***
>
> - ***Ask for a claim form***
>
> ***You*** *should contact* [the Provider] *or* [the Previous Insurer] *at* […] *or phone* ***us*** *on* […] *to ask for a claim form.* […]
>
> - ***Fill in the claim form***
>
> *Please fill in the claim form fully and accurately, and return it to* ***us*** *at* […]*.* ***We*** *may also ask* ***you*** *for other information and documents to help* ***us*** *process* ***your*** *claim.*
>
> […]
>
> - ***What happens after you send us your claim form?***
>
> ***We*** *will process* ***your*** *claim and if* ***we*** *need more information from* ***you*** *or someone else,* ***we*** *will write and explain this to you.* ***We*** *will then write and tell* ***you*** *if* ***we*** *have accepted or rejected* ***your*** *claim.* […]*."*

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Section 8 of the terms and conditions states, as follows:

> *"**8 Our promise of service***
>
> *Customer service is very important to **us** and **our** aim is to give a first-class service at all time. If **you** have any enquiry about **your** policy or claim, please contact:*
>
> [Contact detail for the Previous Insurer]
>
> *If **you** have any complaint about **your** policy or claim, please contact:*
>
> [Contact details for Previous Insurer]
>
> *If **you** have any other type of enquiry or complaint, please contact:*
>
> [Contact details for the Provider]
>
> […]
>
> [Provider] ***Mortgage Payment Protection Insurance*** *cover is arranged by* [the Provider] *in its capacity as a multi agency intermediary and is provided by* [the Previous Insurer]*."*

In respect of the terms and conditions dated **January 2018**, it is not clear whether these terms and conditions were in effect at the time the Complainant made her complaint to the Provider. In this respect, I note that a 'draft' copy of these terms and conditions were furnished by the Provider as part of its Complaint Response dated **5 May 2020**. In the accompanying Schedule of Evidence, it is stated that these terms and conditions issued to active policy holders in '2019'.

At page 5 of the 2018 terms and conditions, the terms 'we', 'us' and 'our' are collectively defined as meaning the Insurer, as follows:

> *"means* [the Insurer]*, and where applicable another* [Insurer] *Group Company appointed to administer this insurance policy."*

Section 4 and section 8 of this policy document are essentially identical to the provisions cited above, with the references to Previous Insurer being replaced with the Insurer.

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On considering the 2012 terms and conditions, it is my opinion that the Insurer was responsible for the administration of the Complainant's policy/policies and the assessment of her claims. It appears that the role of the Provider is limited to the provision of a claim form (section 4), certain matters relating to monthly premium/monthly benefit adjustments (section 7) and enquires/complaints not related to the policy or a claim, which are stated to be the responsibility of the Insurer (section 8). Although the Complainant's MPPI cover was arranged by the Provider and the Provider received certain remuneration in respect of the policy/policies, I do not accept this necessarily means that the Provider had a duty of care to assist the Complainant with the difficulty experienced with the Insurer regarding her claims.

In respect of enquiries and complaints, the 2012 terms and conditions state that claim and policy enquiries and claim and policy complaints are to be directed to the Insurer. However, any other type of enquiry or complaint can be directed to the Provider.

As the complaint made by the Complainant to the Provider on **6 February 2018** concerned the Insurer's handling of her claim/complaint, I accept that this was a matter the Complainant could seek to raise with the Provider.

However, it is my opinion that as the Provider was not strictly responsible for the administration of the Complainant's policy/policies or the assessment of her claims, its ability to assist the Complainant and resolve the issues she was experiencing with the Insurer was limited.

A complaint was logged by the Provider on **6 February 2018** and an acknowledgement letter appears to have been received by the Complainant between **6 February** and **8 February 2018**. A formal response issued to the Complainant within 16 business days on **28 February 2018**. In its formal response, the Provider explained that the policy/policies were underwritten and administered by the Insurer and that the Provider had no involvement in the policy/policies or claims administration. In this letter, the Provider also explained that it had contacted its relationship manager in the Insurer (NB), that NB would handle her complaint and that NB would be in contact with the Complainant.

The Provider's letter suggests that contact was made with the Insurer in the period between **6 February** and **28 February 2018**. However, it is not clear from the available evidence, what contact was in fact made during this period. In this respect, while I note the Provider was in contact with NB by email on **28 February 2018**, it is not clear when the Provider was advised that NB would be handling the Complainant's complaint.

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There was further contact between the Provider and the Insurer on **6 March 2018**, where the Insurer advised the Provider that it had been in contact with the Complainant by telephone and email regarding the information required to validate her claim and the issuing of a Final Response Letter.

On considering the matter, while it is not clear precisely what steps were taken by the Provider to investigate and resolve the complaint between **6 February** and **28 February 2018**, I accept, based on the available evidence, that efforts were made by the Provider to raise the Complainant's dissatisfaction with the Insurer regarding the manner in which her claims were being handled. However, as noted above, the Provider has a limited role in the administration of the Complainant's policy/policies and has no apparent role in the assessment of claims. Therefore, it is my opinion that the Provider could not necessarily do any more than bring the Complainant's dissatisfaction and concerns to the Insurer's attention, which it did. The Provider then wrote to the Complainant to inform her of its position, and the Insurer's position, in relation to the policy/policies and that it had made contact with the relevant relationship manager within the Insurer.

The Complainant wrote to the Provider again on **23 April 2018**. In this letter, the Complainant explained that she had not been contacted by NB and further explained the difficulty experienced in attempting to speak with NB when she telephoned the Insurer.

The Complainant also highlighted the difficulty encountered when speaking with another of the Insurer's agents, the handling of her claim, and suggested there had been a change to the underwriting criteria.

The Provider acknowledged the Complainant's letter nine business days later on **4 May 2018**, advising that it had requested a meeting with the Insurer. A conference call took place on **9 May 2018** where the Complainant's case was discussed. In particular, I note it was agreed that the Insurer would write to the Complainant outlining the information required to validate her claim. The Provider wrote to the Complainant on **11 May 2018** explaining that the Insurer, as underwriter of the Complainant's policy/policies, was responsible for the administration and assessment of claims, that it had spoken with the Insurer and requested that correspondence regarding her claim be issued, and that there had been no change to the underwriting criteria since the Insurer took over the policy/policies in **December 2015**.

While the Complainant may have experienced further difficulty with the Insurer following the Provider's letter of **28 February 2018**, I do not accept that the Provider is responsible for the Insurer's conduct in this regard.

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It is my opinion that the matters raised in the Complainant's letter of **23 April 2018** concerned the Insurer's conduct and I do not accept that the Provider is responsible for this conduct. The Provider had limited ability to assist the Complainant in terms of the issues she was experiencing with the Insurer. In this regard, I accept that reasonable efforts were made by the Provider to engage with the Insurer following the Complainant's letter of **23 April 2018** and that the Provider promptly wrote to the Complainant following the conference call with the Insurer.

Goodwill Gesture

In its Complaint Response, the Provider says that although it has no part to play in the underwriting/claims process, *"the Provider would like to recognise the length of time that this matter has been outstanding for the Complainant."*

In this respect, the Provider says it wishes to offer a goodwill gesture of €500.00 to the Complainant in full and final settlement of this complaint.

On considering the matter, I consider this to be a reasonable gesture by the Provider.

For the reasons set out in this Decision, I do not uphold this 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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

31 January 2022

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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.