An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0068
Sector:	Insurance
Product / Service:	Term Insurance
Conduct(s) complained of:	Mis-selling (insurance) Delayed or inadequate communication Complaint handling (Consumer Protection Code) Dissatisfaction with customer service
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint concerns a life assurance policy, with life cover of €50,000, which was sold to the Complainant and his wife, who is now deceased in **February 2015** (the **"2015 Policy"**).

The Provider is an independent intermediary who sold the 2015 Policy to the Complainant and his late wife. The Policy was underwritten by a named insurer (the "**Insurer**").

The Complainant's Case

The Complainant submits that the Provider called to his home on **12 February 2015,** and that during this meeting he and his late wife disclosed to the Provider, that she had been diagnosed with cancer [Date Redacted] *"…. and was [treatment redacted]".* The Complainant also contends that at this time his wife had lost her hair, that her illness was clearly visible and that the Provider knew this and sympathised with them.

The Complainant asserts that at this time, in **February 2015**, he and his late wife already had a life assurance policy in place with life cover of €40,000, purchased from the Provider in **2012** (the "**2012 Policy**"), and underwritten by a third party insurer (the "**Former Insurer**").

The Complainant contends that the Provider recommended, due to his wife's cancer diagnosis, that they *"would be better off changing"* to another policy. The Complainant

contends that the Provider advised them that the 2015 Policy which is the subject of this complaint, was a *"better option to go for"* and said that if the Complainant and his wife signed up *"he would arrange all the paperwork when he went back to the office"*. The Complainant states that he and his wife agreed to this, and that they did not complete or see the medical section of the Application Form.

The Complainant states that when his wife passed away [date redacted], he sent the insurer all the documents required to process his claim under the 2015 Policy. He further states that the Insurer reverted to advise that it would not pay the claim, because the deceased's medical history was not disclosed to it during the policy application. The Complainant submits that the Insurer explained that, had it been aware of his late wife's illness, it would not have offered life cover to his late wife.

The Complainant further submits that he contacted the Provider on **24 August 2018**, but that the Provider would not assist him and *"brushed [him] off"*, and that the Provider did not respond to numerous attempts to contact him after this point.

The Complainant says that the Provider had been his insurance broker for more than twenty years and had arranged previous life assurance policies for them, including:

- a policy in **2000** (the **"2000 Policy"**);
- a policy in **2009** (the **"2009 Policy"**);
- the 2012 Policy; and
- the 2015 Policy.

The Complainant submits that he

> "*found a document from a previous out of date* [2012] *policy that* [the Provider] *arranged for us, and he states in it that I consume 5 units of alcohol a week, when in fact* [the Provider] *was told on every occasion when we took out a policy, that I have not drank any alcohol at all since 1991. He obviously just filled in what he saw appropriate information to disclose himself on these policies*".

<u>The Provider's Case</u>

The Provider issued a Final Response Letter to the Complainant on **8 April 2019**, stating that the reason the Complainant's policy was taken out in 2015 was to replace a policy incepted in 2000 *"…which was due to mature in 2016"*. The Provider further stated that the Complainant *"would have been left with no cover",* had the 2015 Policy which is the subject of this complaint, not been incepted.

In subsequent submissions to this Office the Provider states that the purpose of the 2015 Policy was not to replace the 2000 Policy. The Provider submits that he visited the deceased on **10 February 2015** *"to do a review"*, and that they agreed on the 2015 Policy *"which carried a longer term which is what she required",* and which had extra life cover. The

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Provider states that the Complainant's and his wife's existing 2012 Policy was replaced by the 2015 Policy, "*to extend the current term by an extra 3 years…as they were getting older*".

The Provider submits that in **February 2015**, he *"went through all the necessary financial and medical questions"* with the Complainant and the deceased, *"and arranged for both to sign the application"*. The Provider contends that *"at no time"* was it disclosed to him that that deceased had a serious illness.

The Provider says that the 2015 Policy documentation was then issued to the Complainant and his late wife by the Insurer *"with a Cooling Off Notice"*, and *"if the clients wanted to disclose information in relation to their health then was the time to do it"*. The Provider further submits that as he did not hear from the Complainant during the cooling off period, he *"took it that everything was in order and the policy was put into force"*.

The Provider stated in the Final Response Letter:

> *"I strongly deny any negligence in putting the…. policy in place"*.

The Provider contends that the deceased *"should have informed me that there was medical conditions which she did not"*. He states that he has to *"trust people on the answers which they give me to the questions which I raise as a Broker as per the application form"*. The Provider further states that the Complainant and the deceased knew *"exactly"* the information required as he had worked through the application form with them *"in great detail"*.

The Provider states that if any medical information had been disclosed to him, that he would *"have put it on the application"* before submitting it to the Insurer.

In relation to his previous engagements with the Complainant prior to the inception of the 2015 Policy, the Provider states that he has done business with the Complainant since **2000**, when the Complainant and his wife took out an endowment savings policy which also carried a death benefit. The Provider states that the 2000 Policy matured on **2 October 2016**.

The Provider contends that he sold the Complainant and the deceased a life assurance policy in **2009**, underwritten by the Former Insurer. He further states that this policy was *"put in place alongside the [2000] policy. The reason for this is because the deceased felt there was not a sufficient amount of life cover on the [2000] policy which was due to mature in 2016"*.

The Provider states that he *"did have consent to visit the clients by appointment. The appointment was made by telephone with* [the deceased]*"*.

In his submission to this Office, received 17 October 2019, the Provider stated that he was in contact with the deceased in **February 2012** *"to do a review on her Life Insurance and the reason for this is because I noticed on her* [2000 Policy] *that the minimum death benefit was €16,500 which was quite low"*. He states that after two or three years *"it would be normal to revisit a client/clients and review their policy."*

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The Provider states that the deceased *"took out a policy with* [the Former Insurer] *in **March 2012** for both herself and her husband"*. The Provider submits that this policy was for a ten year term, and that it was *"extra life cover which* [the deceased] *required"*.

The Provider states that *"the reason the policy from* [the Former Insurer] *which was taken out in 2009 was cancelled in 2012 was to extend the current term by an extra 3 years".*

The Complaint for Adjudication

The complaint is that the Provider:

1. failed in **February 2015** to accurately record details of the deceased's illness at the time when the 2015 Policy was incepted, as a result of which the insurer voided the policy cover, for reasons of material non-disclosure;

2. gave the Complainant poor advice in **February 2015**, as a result of which the Complainant and his wife cancelled an existing life assurance policy with the Former Insurer, which had been in place since 2012 and which would have given rise to a benefit of €40,000 at the time of her death [date redacted] and

3. supplied poor customer service, communication and complaints handling.

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 formed the view that the submissions and evidence furnished disclosed certain conflicts of fact, such that an Oral Hearing was desirable to assist in resolving those conflicts.

Accordingly, an Oral Hearing took place on **16 June 2021,** at which the parties gave their sworn evidence. It was determined at that Oral Hearing that further written particulars were also required by this Office, and on **8 July 2021**, these details were requested from the parties. Thereafter, a further exchange of submissions and evidence took place. This office is now satisfied that the submissions and evidence furnished are sufficient to enable a Decision to be made in this complaint.

A Preliminary Decision was issued to the parties on **31 January 2022**, outlining the preliminary determination of this office in relation to the complaint. The parties were

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advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter. In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

At the outset, and by way of background I consider it helpful to outline the various policies that were arranged by the Provider for the Complainant and his wife:

	Policy Number	Life Cover	Insurer	End Date
2000 Policy	*****00611	€16,500 plus savings element	A named third-party insurer	Matured on 6 October 2016
2009 Policy	*****193	€20,000	The Former Insurer	Lapsed on 7 August 2012 for non-payment of premiums
2012 Policy	*****485	€40,000	The Former Insurer	Cancelled in February 2015 on the written request of the Complainant and his late wife
2015 Policy	*****943	€50,000	The Insurer	Voided by the Insurer on 29 August 2018

2000 Policy

The 2000 Policy included life cover of €16,500, as well as a saving element.

2009 Policy

The Provider met with the Complainant and his wife on **12 November 2009** at their home to carry out a review, during which he recommended the 2009 Policy with a ten year term. The 2009 Policy provided life cover of €20,000.

While this complaint does not relate to the sale of the 2009 Policy, nonetheless the Provider has outlined why he recommended the 2009 Policy, and has submitted documentation to this Office relating to the sale of the 2009 Policy. The Complainant has also made submissions in this regard. It is also clear that the Provider relies on certain documentation dating from 2009, in the context of his dealings with the Complainant and his late wife, with respect to the 2015 Policy.

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Furthermore, in my view, consideration of the sale of the 2009 Policy is of assistance in understanding the context and background in which the sale arose of the 2015 Policy (which is the subject of this complaint) and in order to help in understanding the issue regarding the suitability of the 2015 Policy, for the Complainant and his late wife.

The Provider states that he recommended the 2009 Policy because the life cover on the 2000 Policy "*was a little low*" and because the 2000 Policy was due to mature in 2016 "*and if you let it run the full course and you'd end up with no life cover".*

During the course of the Oral Hearing the Provider supplied a Declaration Form for the 2009 Policy which was signed by the Complainant and his wife on **12 November 2009**, and a 'reasons why' letter dated **11 November 2009**, which outlined that

> "[a]*fter examining your current financial situation and based on your existing financial needs (from the information you have provided me with) ...My examination has identified:*
>
> - *a shortfall in the cover you currently have, in order to fully protect your dependants against the financial impact of your untimely death or critical illness ….*
>
> *Therefore, I recommend that you take out the* [Former Insurer] Term Assurance Plan…."

The date of the 'reasons why' letter (**11 November 2009**) suggests that the Provider recommended the 2009 Policy before the Complainant and his late wife signed the declaration on **12 November 2009**. In response however, to the Complainant's representative's question regarding how the Provider made a recommendation before he met the Complainant and his late wife, the Provider responded that he had made an error, and that the 'reasons why' letter should have been dated **12 November 2009**. The Provider explained that

> "*I didn't, I didn't sign,* ***I didn't date it and sign it the day I was with the clients. I would have explained it to them, go through the letter afterwards and I put the wrong date on it****, put the wrong date afterwards on it."*
>
> [My Emphasis]

The Provider then stated that while he signed the reasons why letter after the meeting (and put the wrong date on it), he had given the Complainant and her husband an unsigned copy of the reasons why letter recommending the 2009 Policy, which he had brought to the meeting.

When I asked the Provider how he knew before the meeting, what product he was going to recommend, the Provider responded

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[Provider] *Well I was going, in this, in that question I was going for to review the life cover, the existing policy that was there and that's, that's basically all I was going to do. Also, I would update them on whatever other products were available or illness and I would leave brochures and say this is, this is what's available*.

[Ombudsman] *But you've already decided.*

[Provider] *Well I wouldn't, I wouldn't have decided fully until I got to the meeting with them and I would know from talking, especially to* [the Complainant's late wife]*, what's required, which was only life cover, it was always only required there.*

……

So I would, I would have spoken to [the Complainant's late wife] *what's going to happen, you know, what I was going to do, I haven't seen you for three years, I have your date of birth, I'll put together some figures and we'll do, we'll do a review and have a chat and see which one you want? I would always offer two or three quotes"*

The 'reasons why' letter dated **11 November 2009**, refers to how the Provider recommended the 2009 policy ""[a]*fter examining your current financial situation".* However, it is clear that, in that instance, no such examination of the Complainant's and his late wife's financial situation had occurred when this letter was prepared, before the meeting with the Complainant his late wife. It is entirely unclear how the Provider could have known what product(s) the Complainant and his late wife would require, in advance of meeting with the Complainant his late wife, to discuss their individual circumstances, needs and requirements. The Provider's evidence also made clear that his "reasons why" letter for the 2009 policy was not contemporaneous to the discussions with the Complainant and his wife, although ***Provisions 24 and 25*** of the ***Consumer Protection Code 2006***, which were in force at the time the 2009 Policy was sold, provide that

"24. Before providing a product or service to a consumer, a regulated entity must gather and record sufficient information from the consumer to enable it to provide a recommendation or a product or service appropriate to that consumer. The level of information gathered should be appropriate to the nature and complexity of the product or service being sought by the consumer, but must be to a level that allows the regulated entity to provide a professional service….

25. A *regulated entity must gather and record details of any material changes to a consumer's circumstances before providing that consumer with a subsequent product or service*."

No evidence was available to this Office that the Provider complied with these obligations in 2009. While the documents on file included an undated Financial Planning Review (which is discussed in greater detail below) during the Oral Hearing for the investigation of this complaint made to this Office about the 2015 policy, the Provider was unable to say with any degree of certainty, what year this Financial Planning Review form had been completed; it was notable that this undated Financial Planning Review form was missing

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important information relating to the Complainant's and his late wife's financial circumstances and objectives.

In the course of the investigation of this complaint, in response to a question regarding whether the Provider had informed consent to visit the Complainant and his late wife at their home, in February 2015 (when selling the 2015 Policy), the Provider submitted in evidence a file note dated **13 November 2009** which states the following:

> "*I was speaking with* [the Complainant's late wife] *by telephone and we have set up an appointment for me to come and see both of them complying with Provisions 3.37 and 3.38 of the* ***Consumer Protection Code 2012***".
>
> [my Emphasis]

The Provider suggested during the course of the Oral Hearing, that this telephone call setting up an appointment to visit the Complainant and his late wife took place before he met with them on **12 November 2009** in respect of the 2009 Policy**.**

When the Provider was questioned by the Complainant's representative at the Oral Hearing about why the file note of the telephone call seeking the Complainant's and his late wife consent to visit them at their home was dated **13 November 2009**, the day after the meeting at their home occurred, the Provider response was that the file note was incorrectly dated:

> "[n]*o, I would have made that before, beforehand. It would have been -- I would have made that beforehand. That would be, that would be an error on that one there on the 13th. The date of the 13th November I didn't make that call, I would have made that the previous week, the previous --…. The 12th of the 11th was the -- the 12th -- the 29th March -- I would have made, I would have made the call a week beforehand, a week before going into* [the Complainant and his late wife].

However, while the Provider stated that the file note was incorrectly dated, the Provider continued to maintain that the file note was prepared in **November 2009**:

> [Ombudsman] *Are you telling me that this note was prepared in November 2009*?
> [Provider] *Yes.*

However, I do not accept the Complainant's evidence in this regard. The file note dated **13 November 2009**, refers to "*complying with Provisions 3.37 and 3.38 of the Consumer Protection Code 2012*". In my opinion, it would have been impossible for the Provider to have been aware in 2009, of certain provisions of the ***Consumer Protection Code 2012***, that had not yet come into existence. Indeed, it was not until 28 October 2010, that the Central Bank published Consultation Paper CP47 containing the proposed amendments to the then existing ***Consumer Protection Code 2006***. When questioned on this point at the Oral Hearing, the Provider stated that:

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> "[p]*utting that, putting that together I prob, afterwards, yes, I probably did put that, put this together, yes, but I would have had, I would have had notes on that when I, when I, when I called in November and I would have put it on this afterwards, yes*"

It is clear from the evidence that the Provider created a file note of the telephone call some years after the event, and then backdated it to **November 2009**. In my opinion, the earliest possible time when the Provider is likely to have prepared the file note in question, was in 2012, given the reference to the ***Consumer Protection Code 2012***.

It may indeed have been later, as I note that in the course of the investigation of this complaint, this Office raised a question on **2 March 2020**, asking the Provider to clarify whether he had informed consent to visit the Complainant and his late wife in **February 2015**, and if so, to provide "*evidence of this consent, along with a note setting out the Provider's compliance with Provisions 3.37 and 3.38 of the Consumer Protection Code 2012 (as amended)"*.

It is disappointing that the Provider, under oath, maintained that the document was prepared in **November 2009**, and only admitted that this was not correct when it was put to him that it was impossible for him to have done so, in **November 2009**, given the reference in the file note to the ***Consumer Protection Code 2012.*** This issue has called into question the reliability of the Provider's evidence, in his response to the investigation of this complaint.

The Complainant's evidence at the Oral Hearing was that the Provider dropped in for a visit (without an invitation) in 2015, and while the Provider was there, the Complainant and his late wife asked him a question about their existing policies. The Complainant stated that "*I didn't tell him, I didn't tell* [the Provider] *to come, he just came… and while he was there, I took advantage".*

In these circumstances, I accept the Complainant's evidence that the Provider, when he visited the Complainant and his late wife at their home in 2015, to arrange the 2015 Policy breached ***provisions 3.37 and 3.38*** of ***the Consumer Protection Code 2012***, which state:

> *"3.37 A regulated entity must not make an unsolicited personal visit, at any time, to a consumer who is an individual.*
>
> *3.38 A regulated entity may only make a personal visit to a consumer who is an individual if that consumer has given informed consent to being contacted by the regulated entity by means of a personal visit. A regulated entity must obtain informed consent separately for each personal visit and must maintain a record of this consent."*

In relation to the cancellation of the 2009 Policy, I note that the documentation on file includes a letter dated **24 April 2012**, cancelling the 2009 Policy, which appears to be signed by the Complainant and his late wife.

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The Complainant's representative stated in a submission to this Office received on 20 May 2019, that

> *"…* [[the 2009 policy] *was cancelled by* [the Provider] *in 2012, the signatures aren't* [the Complainant and his wife's] *though as you can see, so someone fraudulently signed from* [the Provider's] *office."*

This Office has no jurisdiction to investigate any allegation of fraudulent activity. Fraud is a criminal offence and the FSPO is not in a position to investigate or to give the appropriate sanctions in relation to such instances. Consequently, and as accepted by the Complainant in a submission dated 11 July 2019, this Office will not investigate any allegation that the Complainant's and his late wife's signature on the 2009 Policy cancellation letter, was fraudulently forged.

A question arose however during the Oral Hearing, as to the date on which the cancellation letter was signed by the Complainant and his late wife. The Complainant's representative called into question that the letter was signed by the Complainant and his late wife on **24 April 2012,** because she said that the Complainant's late wife had undergone an emergency operation 3 day's earlier.

In addressing this issue, the Provider stated that in fact, the Complainant and his wife signed the 2009 Policy cancellation letter in **March 2012**, when the Provider had called to their home to complete the Application Form for the 2012 Policy, and that once the 2012 Policy application had been accepted by the Former Insurer, at that point the Provider dated the 2009 Policy cancellation letter **24 April 2012**:

> [Ombudsman] *....so are you telling me they sign the letter and there is no date on it?*
> [Provider] *Yes.*
> [Ombudsman] *And then when you hear it's white smoke; the policy documents have come through the letter box you put the date on the letter?*
> [Provider] *Yes, yes.*

I do not consider it appropriate or reasonable practice to post-date documents in this manner. Post-dating the letter in this manner contravenes ***provision 11.1*** of ***the Consumer Protection Code 2012*** which requires that

> "[a] *regulated entity must ensure that all instructions from or on behalf of a consumer, including the date of both the receipt and transmission of the instruction, are recorded*."

I am conscious that when the 2009 Policy cancellation letter bearing the date 24 April 2012, was submitted to this Office in evidence, the Provider did not explain that the letter

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had been dated, after the letter had been pre-signed at an earlier time. This gave rise to the incorrect impression that the Complainant and his wife signed the cancellation letter on **24 April 2012,** when this was not the case**.**

It is clear that the pre-signing/post-dating of this letter gave rise to considerable confusion and upset to the Complainant, who understandably was concerned by the fact that the Provider appeared to be maintaining that the letter was signed at a time when his wife was in [location redacted], when in fact this was not the case; the Provider has acknowledged that the letter was not signed by the Complainant and his late wife on **24 April 2012.**

I note however, that the documentation on file includes a letter from the Former Insurer to the Complainant and his late wife dated **7 August 2012**, which states that the policy had lapsed as the premiums had been unpaid since **18 April 2012**. This would tend to suggest that in fact, the 2009 Policy lapsed as opposed to having been cancelled. It is unclear how this arose, or whether it was the case that the 2009 Policy cancellation letter was never sent to the Former Insurer by the Provider, or never actioned by Former Insurer. However, I do not consider that it is necessary to reach a conclusion on this point for the purposes of the adjudication of this complaint.

<u>2012 Policy</u>

The Provider met with the Complainant and his wife again in **2012** to incept the 2012 Policy which included life cover of €40,000.

While this complaint does not relate to the sale of the 2012 Policy, nonetheless I take the view that an examination of the documentation and evidence supplied to this Office by the parties, in relation to the sale of the 2012 Policy, is helpful in understanding the context and background to the sale of the 2015 Policy.

Furthermore, I consider it appropriate to examine the sale of 2012 Policy, in order to assess the Complainant's complaint that the Provider's poor advice in 2015, resulted in the cancellation of the existing 2012 Policy, which the Complainant contends would have given rise to a benefit payment of €40,000 at the time of the Complainant's wife's death in July 2018.

The Complainant submits that he and his late wife met with the Provider in **February 2012**, at the Complainant's home. While initially the Provider in a submission dated 17 June 2020, stated that the meeting occurred during the second week in February 2012, in the course of the Oral Hearing the Provider stated that this meeting occurred on **29 March 2012**.

The Provider states that that the Complainant and his late wife did not disclose her cancer diagnosis to him when they completed the Application Form on **29 March 2012**. The Provider contends that this demonstrates that "*there was a history of* [the Provider] *not being advised of the diagnosis, not only in 2015 but also in 2012*".

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However, the Complainant states that his late wife's illness was not disclosed when the Application Form for the 2012 Policy was completed in **February 2012**, because the Complainant's late wife was not diagnosed with cancer until [date redacted] **2012**.

In the Application Form for the 2012 Policy, dated **29 March 2012**, the following questions were answered "NO":

- a question about whether the Complainant or his late wife have or ever had cancer;
- a question about whether the Complainant or his late wife have or ever had "*depression, stress, anxiety…*";
- a question about whether the Complainant or his late wife, in the last 5 years, had or have high blood pressure;
- a question about whether the Complainant or his late wife "*had any medical investigations, scans or tests within the last 5 years*?" ; and
- a question about whether the Complainant or his late wife were "*receiving or awaiting ongoing medical treatment, referral, medical investigation, test results, surgical procedure or intending to seek medical advice or treatment*".

However the Complainant's late wife's medical records detail that the Complainant's late wife attended her doctor on various occasions in **2011**, and that she was certified unfit to work from **March 2011** onwards "..*due to Anxiety reaction*", that she had high blood pressure in or around **June 2011**, and that she was referred to A&E for certain tests in **September 2011**.

The Complainant's late wife's medical records also detail that on **30 January 2012,** she received a referral from her doctor**,** for an urgent assessment, to the out- patient department of a Hospital and that she attended a Consultant on **9 February 2012**, who booked her for certain medical examinations in **March 2012**. The Complainant was diagnosed with cancer on [date redacted] **2012**.

It is therefore clear that, whether or not the application form was completed in **February 2012** (before the Complainant's wife cancer diagnosis, as the Complainant has stated) or in **March 2012** (as Provider states) the Application Form did not contain important details regarding the Complainant's late wife's medical history.

The Former Insurer which supplied the 2012 policy, has confirmed that its system notes detail that a copy of the Application Form (including the medical questionnaire) was sent to the policyholders by post on **2 April 2012**, although the Former Insurer was unable to locate a copy of the covering letter.

At the Oral Hearing the Complainant initially denied receiving the Application Form for the 2012 Policy stating that "*I didn't get any paperwork*".

However, the Complainant subsequently stated the following, under cross-examination

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[Provider's Rep.] *And also in April 2012 you received the policy documents from* [the Former Insurer]*, isn't that correct?*
[Complainant] *I have them there in me file with us, yeah*.

[Provider's Rep.] *….it contains all of the information that has been submitted about medical history. I'm just wondering why at that point you didn't either contact* [the Former Insurer] *or* [the Provider] *and say this is wrong, there's been a diagnosis here?*
[Complainant] I *don't know now why? When I received word about my wife getting cancer do you think that that was my main thing to look up policies and look up dates?*
([the Complainant] *gets upset)*

It is clear from the evidence that **April 2012,** was a very difficult time for the Complainant and his wife, given her recent cancer diagnosis. The Complainant also explained during the Oral Hearing that he had some difficulty with reading.

These factors may explain why the Complainant and his late wife apparently failed to read or correct the erroneous medical information contained in the Application Form for the 2012 Policy, a copy of which appears to have been sent to them by the Former Insurer, at the time of the policy inception.

Even if this Office were to accept that that the Application Form was completed in **February 2012** before the Complainant's late wife's cancer diagnosis, and if this Office were also to accept that Complainant and his late wife did not read (or did not receive) a copy of the Application Form sent to them by the Former Insurer, I do not accept the Complainant's position that a claim on the 2012 Policy (seeking death benefit of €40,000 following the Complainant's wife's death in **July 2018**) would have been successful, because the Application Form for that policy, contained no details of the Complainant's wife's medical history, including her anxiety diagnosis, high blood pressure or her referral in **January 2012** to a Consultant.

Consequently, I do not accept the Complainant's contention that the 2012 Policy would necessarily have given rise to a benefit payment of €40,000 at the time of the Complainant's wife's death in **July 2018** if it had continued in being at that time, and not been replaced by the 2015 Policy.

I am also conscious that quite apart from the incorrect medical information, the Application Form for the 2012 Policy dated **29 March 2012** contained other inaccuracies.

On the Application Form, the Provider answered the question: "[i]*s this application to replace an existing* [Former Insurer] *policy*", by selecting "NO". The Provider gave the following explanation for selecting "NO", when questioned about that at the Oral Hearing:

[Provider] *At the time -- "is this to replace a* [named Insurer] *policy? Yes or no" -- well at the time, at the time and that being "no" it was giving, it*

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was giving the application time to go through and see was it accepted, and then the other one would be then after that. You'd never cancel, you'd never cancel a policy until the new one is up in force….

I submitted the application to see was it going to be accepted, accepted, accepted at ordinary rates and that [the Complainant and his late wife] *would get the cover and once they were, once they were accepted, I informed them that you've been accepted at ordinary rates for the 2012, you can now cancel the 2009 one"*

…….

[Ombudsman] *So that's an, that's an incorrect answer then and it's a deliberate incorrect answer because you've just explained that you would do that in order to ensure that the new policy came into place?*

[Provider] *Yes.*

……..

[Ombudsman] *Do you have any understanding as to why an insurer would ask that question?*

[Provider] *Well the existing policy would be there because of the cover and it would exceed limits, the limits of cover and it would exceed…..The medical limit. There could be a full medical required or a PMA, or whatever. So if someone, if a medical level for a certain age was we'll say €100,000 and you wanted €200,000 well then they would require maybe a nurse medical or a PMA or a full medical, that's the only reason.*

[Ombudsman] *So this is relevant information for the insurer?*

[Provider] *Yes.*

The Provider's position appears to be that he had not yet cancelled the 2009 Policy, when the 2012 Policy Application Form was completed, and this is the reason why he answered "NO" to the question, "[i]*s this application to replace an existing* [Former Insurer] *policy*".

However, in my view this answer was clearly incorrect, as the Provider was aware when the 2012 Policy Application Form was completed, that the purpose of 2012 Policy was indeed to replace the existing 2009 Policy. In fact, the Provider has acknowledged that he deliberately supplied incorrect information in reply to this question, in order to:

> "*giv[e] the application time to go through and see was it accepted.*"

It is troubling that the Provider acknowledges deliberately suppling incorrect information to insurers as a matter of practice. Whatever the Provider's reasoning for this, it was wholly inappropriate to do so, and this practice calls into question the Provider's dealings with insurers on behalf of his clients.

It was clearly incorrect for the Provider to state on a proposal for life assurance that the Complainant was not seeking to replace an existing life assurance policy, when in fact, to

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the Provider's knowledge the existing 2009 Policy would be imminently cancelled and replaced by the 2012 Policy, once the 2012 Policy application was accepted by the Former Insurer.

During the investigation of this complaint, the Provider also supplied an undated term assurance recommendation, which states:

> "[a]*fter examining your current financial situation and based on your existing financial needs (from the information you have provided me with) ... My examination has identified:*
>
> - *a shortfall in the cover you currently have, in order to fully protect your dependants against the financial impact of your untimely death or critical illness ….*
>
> *Therefore, I recommend that you take out the* [Former Insurer's] Term Assurance Plan …."

This undated term assurance recommendation was supplied in response to a request from this Office for:

> "[a] *copy of the Suitability Statement that was issued by the Provider to the Complainant in February 2015"*

The Provider stated in response to this request that "*we gave the client Term Assurance Recommendation*" and he enclosed a copy of the undated term assurance recommendation.

Whilst this Office had requested the suitability statement in respect of the 2015 Policy, the undated term assurance recommendation appears to relate to either the 2009 Policy or the 2012 Policy, as it recommended the Former Insurer's term assurance policy and it was the Former Insurer which supplied both the 2009 and the 2012 Policies.

The Provider stated during the Oral Hearing that while he wasn't sure of the correct date of the term assurance recommendation letter, he believed it "*would have been back in again 2009 and 2012"*, and that he sourced this document on Best Advice, the platform from where the Provider obtained quotes.

It is very disappointing to note that the Provider initially incorrectly supplied a document relating to the 2009 or 2012 Policy, in response to a request from this Office for documentation relating to the 2015 Policy. (The Provider subsequently supplied an undated recommendation for the Insurer which supplied the 2015 Policy).

Furthermore, when questioned at the Oral Hearing, the Provider confirmed that the undated term assurance recommendation which he had offered as evidence during the investigation of the complaint, was not in fact relevant. Instead, he submitted that the

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dated 'reasons why' letters which the Provider first made available in evidence during the Oral Hearing, were in fact the relevant recommendation letters.

In my opinion, this demonstrates a considerable degree of carelessness with respect to the Provider's document management and calls into question the adequacy of the Provider's record keeping, in circumstances where the Provider appears to have been unable to produce relevant and correct documentation in a timely manner, in response to requests from this Office.

Turning now to the 'reasons why' letter dated **29 March 2012**, which the Provider first submitted to the FSPO during the Oral Hearing in June 2021, this 'reasons why' letter outlined why the Provider recommended the 2012 Policy. The Provider states that this letter was prepared after the meeting with the Complainant and his late wife on **29 March 2012.** The Provider, however failed to offer any explanation as to why the 'reasons why' letters were not submitted to the FSPO, until the day of the Oral Hearing.

It is disappointing that the Provider supplied documents to this Office in such a haphazard and confusing manner. It is also notable that the content of the 'reasons why' letter dated **29 March 2012**, is identical to the 'reasons why' letter dated **11 November 2009**. Both letters state that the Provider's examination has identified:

> "…[a] *shortfall in the cover you currently have, in order to fully protect your dependants against the financial impact of your untimely death or critical illness* ..."

When asked about why the letters were identical, and whether they had been prepared at the same time, the Provider explained that they were not prepared at the same time but that the 'reasons why' letter was "... *a standard letter that I would have…."*

Provision 5.19 of the ***Consumer Protection Code 2012***, outlines that prior to arranging a product, a regulated entity must prepare a written statement outlining the reasons why a product or service offered is considered to be suitable. In particular this statement, must reflect information gathered relating to the consumer's needs and objectives, personal circumstances and financial information. I do not consider that the provision of a "standard letter" satisfies these requirements. A generic standard form letter is unlikely to accurately reflect why the 2012 Policy was recommended, having regard to the Complainant's own personal needs, objectives and personal and financial circumstances, and against the background of the then existing 2009 policy.

No evidence is available to this Office that the Provider complied with the "knowing your customer" obligations outlined in ***Chapter 5*** of the ***Consumer Protection Code 2012,*** and in particular ***provision 5.1 and 5.3***. Although the documents made available to this Office include an undated Financial Planning Review, the Provider was unable to say during the Oral Hearing with any degree of certainty, what year this review form had been completed. In addition, the Financial Planning Review was missing important information relating to the Complainant's and his late wife's financial circumstances and objectives

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2015 Policy

The Provider met with the Complainant and his wife on **12 February 2015** with respect to the sale of the 2015 Policy. During the Oral Hearing, the Complainant described this particular meeting with the Provider, in the following terms:

> "[the Provider] *arrived at my door in February 25, '15…. As he did, he came all the time, just while he was in the area he'd drop in for to give advice or update policies or whatever. He came into our house and said "how was things, how is everyone? Does anyone need any advice or any updates" or, and my wife was there in the … Our sit, our kitchen ... we told him that* [the Complainant's wife] *had cancer…. he said, he sympathised, he said "ah sorry to hear that"…." So I said "we got a letter from the insurance saying that it was going up", or something. So he looked at that and said, he looked at his own thing and he said "I have a better policy, I've a better policy that would, with more cover and it would suit your needs, it is more beneficial" and with* [the Complainant's wife] *being sick, and I trusted* [the Provider] *for over 25 years. We've, he'd come in any, as I said, any time and he had updates or, so I've always took his advice…. So when he, we signed the policy and that's grand and he said "I'll fill in the rest when I go back to me, to the office ….*"

The Provider described the advice he gave to the Complainant and his late wife, and the reason he recommended the 2015 Policy, in the following terms, at the Oral Hearing:

> "*[a]gain I was doing the review, again I was coming back to them after three years with the review, the review from the 2012, the 2012 policy they had with* [the Former Insurer] *and also I would ask, I asked them as well "do you still have the* [2000 Policy] *in force?"… Well the* [2012 Policy] *would have been on three, on three years, so again it would have been a seven year term remaining so I would be thinking of the longer term, the future, the future for* [the Complainant and his wife] *having a longer term and sufficient amount of life cover. Also the* [2000 Policy] *was coming to, coming to an end in around that time, in around that time in 2000 and, 2016……I advised them that you were going to have a shortfall on insurance when the policy finished, the* [2000 Policy] *finished and you got paid, the insurer got paid the maturity, maturity amount that you would no longer have that life cover……The reason they wanted, the reason they wanted the* [2015 Policy] *was because the* [2000 Policy] *was finishing and they wanted to be in a position to be able to spend the funds that were coming from the* [2000 Policy], *which would be approximately 12* [€12,000] *to €15,000 so they wanted to, they wanted to continue to take out the* [2015 Policy] *for another term of ten years and move on. That was the reason behind having the* [2015 Policy]."

There are two aspects that must be considered with respect to the sale of the 2015 Policy. Firstly, the question of whether the Provider failed to accurately record details of the deceased's illness at the time when the 2015 Policy was incepted, as a result of which, the Insurer voided the policy for reasons of material non-disclosure. Secondly, the question of

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whether the Provider gave the Complainant and his wife poor advice at the point of sale, resulting in the cancellation of the 2012 Policy.

Documentary Evidence

There is limited documentary evidence available in respect of the sale of the 2015 Policy which occurred on **12 February 2015**.

This is likely attributable, at least in part, to what in my opinion appears to have been, a poor understanding by the Provider of his record keeping obligations. When the Provider was asked during the Oral Hearing, about his record keeping obligations, the Provider responded that he was obliged to retain records for six years "[f]*rom the time the policy commences*".

However, the obligation outlined in ***provision 11.6*** of the ***Consumer Protection 2012*** is that:

> *"A regulated entity must retain details of individual transactions for six years after the date on which the particular transaction is discontinued or completed. A regulated entity must retain all other records for six years* ***from the date on which the regulated entity ceased to provide any product or service to the consumer*** *concerned."*
>
> [My Emphasis]

It is clear that the Provider was operating under a fundamental misapprehension as to how long he was required to retain records for. This gives rise to a concern not just in relation to the Provider's record keeping in respect of the Complainant, but also potentially his record keeping in respect of his dealings with all his clients.

In response to a request from this Office for a copy of the Provider's notes from the meeting that took place at the Complainant's home in **February 2015**, the Provider responded "[p]*lease see Fact Find enclosed*". The Fact Find / Financial Planning Review document supplied by the Provider is undated, and is signed by the Complainant and his late wife.

At the Oral Hearing the Provider gave the following evidence regarding the Financial Planning Review:

[Ombudsman]:	*This next document and it's headed "Financial Planning Review Confidential" but I need your help with this, because there is no date on it. So please can you explain to me whether this document was something that came into being in 2009 or in 2012 or in 2015?*
[Provider]:	*This document,* ***this document is, is, is for, is from 2009 and maybe before that****, maybe before that.*
	….

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[Provider]: *I wouldn't be a, I wouldn't be a, I wouldn't be 100% sure because there's no date, there's no date on that, there's nothing.*

…..

[Ombudsman]: *But it has no details on it in terms of what its purpose is. So can we turn to the third page and a little bit down from the top it says: "Agreed financial priorities for immediate action".*

[Provider]: *Hmm.*

[Ombudsman]: *But there are no financial priorities. There was no action to be taken....*

…..

[Provider]: *I didn't update that from my notes that I would have had in with the meeting with* [the Complainant and his wife] *…*

[Ombudsman]: *But I don't understand. They signed this, you must have gone through it at the time*

[Provider]: *I did but I didn't fill it out, I didn't fill it out,* ***I didn't fill it out there on the day with them,*** *I didn't fill out all the details on the fact find, the personal, the personal details and the occupation and the existing but I didn't, I didn't put in the other details that I should have put in, the other details on it.*

…….

[Ombudsman]: *Did you complete a fact find at that time* [in February 2015]?

[Provider]: *As far as, as far as I'm aware I did, yeah*

…..

[Ombudsman]: *so why did you not send us the 2015 fact find?*

[Provider]: *I must have mislaid it at the time. Just I would have, I should have sent it to you*.

…….

[Ombudsman]: *And is that* [Financial Planning Review] *something that you fill in when you get back to the office or do you fill it in with your clients in the course of the meeting?*

[Provider]: *I'd fill in some of it and I would take, take notes and that but I would add on to it when I would get back to my office, yes.*

…..

[Ombudsman]: ***So it is your practice to complete some of it ……at the meeting with your clients. You ask them to sign it when it's partially completed and then your practice is to fill in the details when you get back to the office.***

[Provider]: ***Add on to it, I would add on, I would add on, yes, personal details and financial details, yes.***

[Ombudsman]: Okay, so you agree with me that **that's your practice?**

[Provider]: ***Yes.***

[My Emphasis]

It is clear from the Provider's oral evidence that the submission of the undated Financial Planning Review to this Office, on the basis that it related to a meeting with the Complainant and his wife in **February 2015**, was entirely unreliable, in circumstances

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where the Provider was unaware as to the date on which the Financial Planning Review was completed and he appeared to be of the view that the Financial Planning Review was likely to have been completed years before 2015.

Apart from the fact that it is unclear as to the date on which the Financial Planning Review was completed, I was noted that the Financial Planning Review document, was only partially completed. The evidence shows that the Provider failed to record basic information relating to the Complainant and his late wife's income, expenditure and financial priorities. This calls into question the thoroughness of the review conducted at the time when this Financial Planning Review form was completed, whenever that may have been, and leaves open the question as to whether the Provider had gathered sufficient information to make a meaningful recommendation to the Complainant and his late wife, as to what product would be suitable for them at that time.

While the Provider maintains that he did complete a fact find in 2015, he did not supply this Office with a copy of any such fact find. Given the absence of documentation relating to this suggested fact find and the unreliability of the Provider's evidence in submitting the undated Financial Planning Review (on the basis that it related to a meeting with the Complainant and his wife in **February 2015,** when in fact the undated fact find is likely to have dated from an earlier time) I am not satisfied that the Provider has established that he completed a fact find in 2015.

In these circumstances I take the view that in **2015**, the Provider failed to comply with the 'knowing the consumer' requirements set out in ***Chapter 5*** of the ***Consumer Protection Code 2012***. I am not satisfied that the Provider gathered and recorded sufficient information from the Complainant and his late wife, prior to arranging the 2015 Policy or that that the Provider gathered or recorded details of any material changes to Complainant's and his wife's circumstances prior to arranging the 2015 Policy, as required by **provision 5.1** and **5.3** of the ***Consumer Protection Code 2012.***

Even if I were to accept (which I do not) that the Provider completed a fact find in 2015, but mislaid it, the Provider's failure to retain this document was contrary to

- **provision 11.6** of the ***Consumer Protection Code 2012*** which as I have explained above provides that a regulated entity must retain records for six years from the date on which the regulated entity ceased to provide any product or service to the consumer concerned; and

- **provision 11.7** of the ***Consumer Protection Code 2012*** which states:

  "A regulated entity must maintain complete and readily accessible records; however, a regulated entity is not required to keep records in a single location."

Furthermore, it is clear that the Provider's practice, when conducting financial planning reviews is to ask clients to sign the review form when it is partially completed, and then for the Provider to finish filling in the form at some later point in time. This practice can only

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be described as entirely inappropriate, being one which serves to deprive his client of the opportunity to ensure that the information recorded in the financial review, is accurate and complete and thereby relevant.

It is a matter of serious concern for this Office that the Provider indicated in his oral evidence, that as a matter of course in 2015, he completed financial planning reviews with his clients in a wholly unsuitable manner. Similarly, it is a serious concern that he appeared to be unaware of the serious risks that this practice would lead to inaccuracies in the data captured within financial planning review forms, not to mention creating the entirely mis-leading assumption that the Provider's clients had signed the form, having read and agreed with the accuracy of the details recorded.

During the course of the investigation of this complaint, the Provider also submitted an undated Recommendation to this Office, outlining why he recommended the Insurer's life insurance policy. The Provider stated during the Oral Hearing that he sourced this document on Best Advice, the platform used by the Provider to obtain insurance quotes.

The Provider's failure to date the Recommendation, and many of the other documents submitted to this Office, demonstrates serious errors with the Provider's record keeping process, contrary to his obligations under **provision 11.7** of the ***Consumer Protection Code 2012*** which requires that regulated entities must maintain complete records.

I am also conscious that the Recommendation, appears generic in tone. The Recommendation contains no references to the Complainant's and his wife's individual needs or financial circumstances, perhaps because the Provider failed to gather any information about the Complainant's and his wife's income, expenditure and financial priorities at that time. In these circumstances, I fail to understand how the Provider was in a position to identify "*a shortfall in the cover you currently have, in order to fully protect your dependants against the financial impact of your untimely death or critical illness*", as stated in the Recommendation. The evidence available fails to demonstrate how the Provider could have known whether there was such a shortfall.

I am satisfied therefore that the Provider failed to comply with ***provision 5.19*** of the ***Consumer Protection Code 2012***, which outlines that prior to arranging a product, a regulated entity must prepare a written statement outlining the reasons why a product or service offered is considered to be suitable, which reflects the information gathered relating to "..*the consumer's i) needs and objectives, ii) personal circumstances; and financial information*…".

I am also satisfied that the Provider's conduct in recommending the 2015 Policy without firstly obtaining and assessing basic financial information relevant to the Complainant and his late wife, or without completing a suitability statement, was entirely unreasonable, and demonstrates a complete absence of care as to the manner in which the 2015 Policy was sold.

The documentation on file does however include an Application Form dated **12 February 2012**, which is discussed in greater detail below.

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Disclosure of Cancer Diagnosis

The Complainant maintains that when the Provider met with them on **12 February 2015**, they informed the Provider that the Complainant's late wife had cancer, and he says that his late wife was visibility ill, having lost her hair. The Complainant further maintains that he and his wife signed a blank Application Form at the meeting with the Provider, and that the Provider filled in the Application Form at a later date.

However, the Provider submits that at no point did the Complainant or his wife disclose her cancer diagnosis, when he visited them on **12 February 2015** to do a review, although he went through all the questions with them on the Application Form. The Provider states that he was entirely unaware from the Complainant's wife's appearance that she was undergoing cancer treatment, and that he "*didn't notice anything with the visit".*

Question 2.1 of Part 2 of the 2015 Policy Application Form asks whether the Complainant or his wife currently have or have ever had "*cancer (malignant tumour), leukaemia, Hodgkin's disease or lymphoma"*. The answer given for both the Complainant and his wife was "NO", although the Complainant's wife was in fact suffering from cancer.

The Complainant and his wife signed the Application Form on **12 February 2012**, including a declaration that the information on the application form was "*true and complete*".

When the Provider's representative queried at the Oral Hearing, how the Complainant could sign such a declaration when the Application Form was blank, the Complainant responded that he could not see the declaration and that "*I'm not good at reading at the best of times"*. Consequently, I am satisfied that the fact that the Complainant signed this declaration does not of itself alone, demonstrate that the Application Form had been fully completed, and that the Complainant had read the Application Form. I am not in a position to make any finding as to why the Complainant's late wife signed this declaration, as sadly, she has since passed away.

There is a stark contradiction between the evidence of the Complainant and the Provider, regarding whether the cancer diagnosis was disclosed to the Provider.

During the course of the investigation of the complaint, the Complainant submitted photos of his wife [date redacted] **2015**, showing that the Complainant's wife had very little hair at that time. In these circumstances it is difficult to understand how the Provider "*didn't notice anything with the visit",* although I accept that the Provider would not have known the particular cause of the Complainant's wife's hair loss, unless the cancer diagnosis was disclosed to him.

In my opinion, the Provider's evidence to the Hearing was unreliable and unconvincing. There were serious discrepancies and inconsistencies in his evidence throughout the Hearing, and he acknowledged that his practice (in respect of financial review forms) was to add information after his client had signed the form. It is also clear to me from the

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evidence that the Provider mis-dated more than one document submitted in evidence, and failed to disclose at the time of submitting that evidence, that he had done so.

I therefore accept the Complainant's evidence, that in 2015, he signed a blank Application Form for the Provider to later fill out, and I am satisfied that this is likely what occurred at that time.

Taking all these matters into consideration, on balance, I accept the Complainant's evidence regarding the disclosure of the cancer diagnosis. I consider it more likely than not that the Complainant and his late wife disclosed the cancer diagnosis and that the Provider failed to record this information on the Application Form which they had signed.

I acknowledge that towards the end of the Complainant's cross examination at the Oral Hearing, the Complainant agreed with a submission made by his representative dated 7 May 2020 which stated that "[the Provider] *always filled in application forms with [the complainants] on the day of the review*". However, I am conscious that at times the Complainant demonstrated some difficulties in understanding the questions asked of him during the Oral Hearing, and that the Complainant's very firm evidence throughout the rest of the Oral Hearing was that the Application Form was filled out by the Provider after the meeting on **12 February 2015.**

It is clear however, that on **16 February 2015** the Insurer sent the Complainant and his late a copy of the Application Form, (which included the incorrect medical information inputted by the Provider). The Insurer stated in its covering letter that:

> "*it is your responsibility to ensure the data is correct, you should check it and if you do not agree with any of the data you should make the amendment, sign the document and immediately return it to us.*"

The Complainant and his late wife failed to do so. While I acknowledge that the Complainant has stated that he has difficulty with reading, this was a very serious omission on the part of the Complainant and his late wife.

> *<u>Advice Given in Respect of the 2015 Policy:</u>*

Turning to the suitability of the advice that the Provider gave the Complainant and his late wife, when he recommended the 2015 Policy, he initially stated in his Final Response Letter dated **8 April 2019**, that the 2015 Policy was taken out

> "*to replace* [the 2000 Policy] *which was due to mature in 2016. On the maturing of this policy (which was due to pay out€15,000/€20,000)* [the Complainant and his late wife] *would have been left with no cover.*"

It is now clear that the information supplied by the Provider in the final response letter was incorrect. The 2015 Policy in fact replaced the 2012 Policy, not the 2000 Policy, and the Complainant and his late wife would not have been left without cover when the 2000

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Policy matured, if the 2012 Policy had remained in force (rather than replaced with the 2015 Policy).

The Provider subsequently maintained that the reason he recommended the 2015 Policy was to "*extend the term*" of the life cover, by 3 years because the 2012 Policy's 10 year term would expire in 2022, whereas the 2015 Policy 10 year term would expire in 2025. This explanation is similar to the explanation offered by the Provider for recommending the 2012 Policy (i.e. the Provider recommended the 2012 Policy as there was only 7 years remaining on the 2009 Policy and he wished to "*keep the long term out".)*

In my view, it was highly inappropriate for the Provider to recommend the cancellation of an existing policy and the inception of a new policy in 2015 if the Complainant and his late wife had disclosed her cancer diagnosis to him. This is because it is very unlikely that any insurer will offer life cover to any individual following a cancer diagnosis (if that diagnosis is disclosed). In such circumstances it would be extremely important for any such person diagnosed with a serious illness, to maintain in place any existing life cover.

Even if I were to accept that the Provider was unaware of the Complainant's wife's cancer diagnosis, I am still of the view that it was inappropriate for the Provider to recommend the 2015 Policy in the absence of any clear reason why he should do so.

I do not accept the suitability of the Provider's approach to replacing existing life policies approximately every 3 years, in order to "*extend the term*". In general, the cost of life insurance increases with the age of the proposer. This because, generally speaking, older individuals will carry more risk for the Insurer, which increases the cost of the insurance put in place. This point was specifically acknowledged by the Provider at the Oral Hearing when he stated:

> "*…Well, the money that has gone into the policy that you've paid into the term policy is gone, you're starting a new plan. You're older, it's going to be dearer if you want the same amount of cover, specific amount of cover or if you want a certain term, if you want ten years or more, longer term …"*

More fundamentally, there were very significant risks for the Complainant and his wife in replacing an existing life assurance policy with a new policy in 2012 and 2015. The Complainant and his wife had to go through medical underwriting when applying for the 2012 Policy and the 2015 Policy, at a time when they were older and more likely to have developed medical conditions. Any new medical condition that they had developed since last taking out existing life cover would have to be disclosed to the relevant insurer, creating the risk of being declined for cover or being charged a higher premium, or having certain exclusions placed on the policy cover. Indeed, it seems highly likely that if the Complainant's wife's medical history had been properly disclosed on the 2012 or the 2015 proposals, the insurers would have declined to cover her.

The Provider acknowledged during the Oral Hearing that both the 2012 Policy and the 2015 Policy had a conversion option, that if selected, would have allowed the Complainant and his wife to convert the cover under the policy into a new policy running for a longer

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period (without undergoing medical underwriting or supplying evidence or good health at the time of the conversion). It does not however appear that this conversion option was selected.

The Provider acknowledged at the Oral Hearing that he was unable to supply any record or evidence that he had outlined the conversion option to the Complainant and his late wife.

In these circumstances, I satisfied that the Provider failed to demonstrate in any meaningful way that the 2015 Policy he recommended to them was suitable for the Complainant and his wife. By replacing the Complainant's and his wife's life insurance policy at three year intervals, the Provider in my opinion, exposed the Complainant and his late wife to the risk of undergoing medical underwriting, or being declined cover. This practice also potentially increased the cost of the Complainant's and his late wife's insurance.

The Provider gave evidence during the Oral Hearing, that he did not advise the Complainant and his late wife to cancel the 2012 Policy when he sold them the 2015 Policy, saying:

> "[t]*hat was their decision. That was, that -- I didn't advise them on that, that was their decision. I never advised them, I never advised them to cancel any policy with any insurance company.*"

I do not accept this. The Provider was aware that the 2015 Policy was intended to replace the 2012 Policy. Indeed, the Provider signed a declaration on the 2015 Policy stating that:

> "*…I have advised the client as to the financial consequences of replacing an existing policy with this policy by cancellation or reduction and of possible financial loss as a result of such replacement*"

> *<u>Complaints Handling and Customer Service</u>*

After the 2015 Policy was cancelled by the Insurer in **August 2018,** for non-disclosure of material facts, the Complainant's representative made a complaint to the Provider on **24 August 2018** by phone. The Complainant's representative states that:

> "[the Provider] *was extremely rude and said there was noting he could do about it. I asked why he advised* [the Complainant and his wife] *to change over their policies knowing [the complainant's late wife] was ill. After numerous attempts to phone him again, i then contacted* [the Provider] *again on October 1st by Email to let him know i had referred the …matter to the Ombudsman, and would be doing the same in regards to him. I did not get a response. I then phoned him on October 11th to ask if he had got my Email and i spoke to him then. He said he was sorry that this has happened. That he has insurance for this type of thing, and he would respond in the next few days. I still have not got a reply."*

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The Complainant made a complaint to this Office on **19 October 2018**. Despite repeated requests from this Office, the Provider did not issue a final response letter until **8 April 2019.** The Provider has not supplied this Office with evidence of any earlier written communications to the Complainant addressing the complaint.

The Complainant's representative questioned the Provider in respect of the delay in issuing the final response letter at the Oral Hearing:

> [Complainant's Rep] *Well could you answer why it took you six months to issue [the complainant] with a response letter?*
> *….*
>
> [Provider] *I have no response. I don't, I can't recall this, I don't recall these things, I don't, you know, I don't.*
>
> [Ombudsman] *You don't remember why you didn't respond....*
> *……*
>
> [Provider] *No, I don't. I was annoyed at the time the way I was abused and my partner, my secretary she says "I don't know how you're taking that?" Just, no, I was abused, I was abused on the phone. I'm not going to say what was said, it's not fair.*
> *……*
>
> [Ombudsman] *So the question was why it took six months? Just, I'm just giving you an opportunity to answer that.*
>
> [Provider] *I can't, I can't, I can't remember, I can't recall on that, I can't remember on that*.

It is clear that the Provider was unable to offer any explanation for his failure to respond to the Complainant's complaint, although the Provider's evidence at the Oral Hearing, suggests that the Provider failure to respond was motivated in part by his dislike of the manner in which the Complainant's representative had addressed him during the course of a call in **August 2018**. Consequently, I am satisfied that the Provider failed to comply with ***provision 10.9*** of the ***Consumer Protection Code 2012*** which provides that

> *"A regulated entity must have in place a written procedure for the proper handling of complaints. ... At a minimum this procedure must provide that:*
>
> *a) the regulated entity must acknowledge each complaint on paper or on another durable medium within five business days of the complaint being received;*
> *b) the regulated entity must provide the complainant with the name of one or more individuals appointed by the regulated entity to be the complainant's point of contact in relation to the complaint until the complaint is resolved or cannot be progressed any further;*

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c) the regulated entity must provide the complainant with a regular update, on paper or on another durable medium, on the progress of the investigation of the complaint at intervals of not greater than 20 business days, starting from the date on which the complaint was made;

d) the regulated entity must attempt to investigate and resolve a complaint within 40 business days of having received the complaint; where the 40 business days have elapsed and the complaint is not resolved, the regulated entity must inform the complainant of the anticipated timeframe within which the regulated entity hopes to resolve the complaint and must inform the consumer that they can refer the matter to the relevant Ombudsman, and must provide the consumer with the contact details of such Ombudsman; and
e) within five business days of the completion of the investigation, the regulated entity must advise the consumer on paper or on another durable medium of:
i) the outcome of the investigation;
ii) where applicable, the terms of any offer or settlement being made;
iii) that the consumer can refer the matter to the relevant Ombudsman, and
iv) the contact details of such Ombudsman."

General Observations

In my opinion, the standard of service supplied to the Complainant and his late wife by the Provider fell far below the standards expected of a regulated financial service provider.

The evidence discloses very serious failings throughout the Provider's dealings with the Complainant and his late wife, in relation to record keeping, customer service, complaints handling and in respect of the suitability of the advice supplied to the Complainant and his late wife. In particular, I am satisfied that the Provider contravened ***provisions 3.37, 3.38, 5.1, 5.3, 5.19. 10.9, 11.1, 11.6 and 11.7*** of the ***Consumer Protection Code 2012***. I am satisfied that Provider's conduct in this regard was unreasonable within the meaning of ***section 60(2)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017***.

I am also of the view there were considerable inconsistencies throughout the Provider's submissions to this Office and in the Provider's evidence during the Oral Hearing. The Provider gave contradictory evidence during the Hearing, particularly in relation to the provenance of documents submitted in evidence to this Office.

Furthermore, the Provider's own evidence confirms that throughout the relevant period, leading up to the sale of the 2015 Policy, he engaged in a number of practices that can only be described as highly inappropriate, such as mis-dating or failing to date documents, adding details to forms that customers had already signed and creating a very significant risk that incorrect information (potentially including medical information) was incorrectly captured on insurance proposals.

In my opinion, the Provider in responding to this complaint, also demonstrated a complete lack of understanding as to when it is appropriate to recommend replacing an existing life

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insurance policy with a new life insurance policy. Owing to his evidence in that regard, I have very significant concerns that he may have reviewed other clients' life assurance needs at similar intervals.

Having considered the evidence in this matter at length, I am satisfied to conclude that the Provider failed to accurately record details of the deceased's illness on the 2015 Policy proposal and that the Provider gave the Complainant poor advice when arranging the 2015 Policy.

In my opinion, this resulted in (i) the 2015 Policy coming into being without an accurate disclosure of material facts and (ii) the Complainant and his wife cancelling an existing 2012 life assurance policy with the Former Insurer (though, for the reasons previously outlined above, I do not accept the Complainant's position that the 2012 Policy would in fact have given rise to a life assurance benefit payment of €40,000 at the time of the Complainant's wife's death in **July 2018**).

Having considered the matter at length, and for the reasons outlined above, I am satisfied that it is appropriate to:

1. Uphold the complaint that the Provider failed in **February 2015** to accurately record details of the deceased's illness at the time when the 2015 Policy was incepted, as a result of which ultimately, the insurer voided the policy cover, for reasons of material non-disclosure. I recognise however that the Complainant and his late wife themselves also bear an element of responsibility for failing to check the accuracy of the information captured on the proposal form, when the Insurer sent a copy to them, at the time of the policy inception in 2015.

2. Uphold the complaint that the Provider gave the Complainant poor advice in **February 2015**, as a result of which, the Complainant and his wife cancelled an existing life assurance policy with the Former Insurer, which had been in place since 2012 (whilst not accepting the Complainant's position that a benefit payment would have been made on this policy had it remained in place at the time of his late wife's death).

3. Uphold the complaint that the Provider supplied poor customer service, communication and complaints handling.

In assessing the appropriate level of compensation to be directed for payment, I am mindful that at a time of particular vulnerability, the Complainant and his late wife placed a very significant level of trust in the Provider, that he would recommend suitable insurance cover for them. There was no reason for the Complainant and his late wife to question the wisdom of the Provider's advice to incept new life assurance cover, as frequently as every three years.

I am also mindful that the Provider's failings impacted the Complainant over an extended period, and not just during the sale of the policy in 2015. The Provider's failure to adequately respond to the Complainant's complaint about the 2015 Policy, after his wife's

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death in 2018, seems likely to have caused considerable inconvenience at a time of acute distress for the Complainant.

Furthermore, I am satisfied that the Provider's record keeping failures, including the manner in which the Provider mis-dated documents such as the 2009 Policy cancellation letter, likely contributed to confusion and inconvenience to the Complainant when pursuing his complaint to this Office since October 2018.

On the evidence before me, and bearing in mind the gravity of the failings identified in the Provider's conduct, I take the view that it is appropriate to make a direction to the Provider to make a significant compensatory payment to the Complainant, to reflect the inconvenience and loss suffered by him, arising from those very serious failings. To mark that decision, my directions are as stipulated below.

In addition, having regard to the Provider's serious failings identified above, some of which are of a potentially systemic nature, I have referred this matter to the Central Bank of Ireland, for such action as it may consider to be appropriate.

Conclusion

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

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainant in the sum of **€35,000** (thirty five thousand euro), to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the Provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

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

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

MARYROSE MCGOVERN
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN (ACTING)

22 February 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.