An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0088
Sector:	Insurance
Product / Service:	Term Insurance
Conduct(s) complained of:	Failure to process instructions
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant incepted a life assurance policy with the Provider on **1 December 2004** that provided her with life cover in the amount of **€4,000,000.00 (four million Euro)** and specified illness cover of **€750,000.00 (seven hundred and fifty thousand Euro)** for a term of 15 years, to **1 December 2019**.

This complaint concerns the Provider's refusal in **November 2019** to allow the Complainant, prior to the expiry date of her maturing policy, to convert **€500,000.00 (five hundred thousand Euro)** of her specified illness cover to a new life assurance plan without the need for medical underwriting.

The Complainant's Case

The Complainant's Financial Adviser contacted the Provider in **September 2019** as the Complainant was seeking to convert **€1,000,000.00 (one million Euro)** of her life cover benefit and **€500,000.00 (five hundred thousand Euro)** of her specified illness cover to a new life assurance plan without the need for medical underwriting. She sought to do this before **1 December 2019**, the expiry date of her maturing policy. The Provider advised, however, that only the life cover benefit could be converted because the policy terms and conditions did not allow for the specified illness cover to be converted.

The Financial Adviser says the Complainant ought to have been permitted to covert her specified illness cover because, on at least three separate occasions, these being **1 October 2013**, **21 November 2018** and **18 July 2019**, the Provider confirmed by email that the Complainant had an entitlement to convert **€1,000,000.00 (one million Euro)** life cover and **€500,000.00 (five hundred thousand Euro)** specified illness cover without medical evidence.

For example, in its email to the Financial Adviser on **1 October 2013**, the Provider advised:

> *"… The maximum amount of Life Cover that can be converted is €1 million & the maximum amount of illness cover is €500k …"*

In addition, the Financial Adviser refers to the Provider's **Conversion Option – financial advisor flyer** that provides, among other things, as follows:

> *"**All you need to know about** **[the Provider's]** **Conversion Option***
>
> *When your customer is exercising their conversion option you need to be aware of the restrictions that apply to that conversion. Below is a table of plan types, dates and restrictions applicable to those plans … "*

In the column relating to the plan type that is the Complainant's policy, this flyer provides, as follows:

"Date planned started	*01/10/2004 to 04/10/2009*
Sum assured restriction	*Maximum life cover €1m per person* *Maximum* [Specified Illness Cover] *€500,000 per person"*.

The Financial Adviser submits that as the Complainant's policy start date of **1 December 2004** postdates **1 October 2004**, that the Complainant should therefore be allowed to convert up to **€500,000.00 (five hundred thousand Euro)** of her specified illness cover to a new life assurance plan, in line with the information the Provider provided in its **Conversion Option – financial advisor flyer**.

In its email to the Financial Adviser on **14 November 2019**, the Provider advised that:

> *"As* [the Complainant's] *original plan…was keyed on our system before September 2004 the terms and conditions that apply, and* [the Complainant's] *plan documents specify that only Life Cover can be converted here. Unfortunately, there is no option available to convert the Specified Illness".*

The Complainant's Financial Adviser submits that the relevant date in determining the terms and conditions that are applicable to the Complainant's policy is the start date of the cover, that being **1 December 2004**, and not the date the application for cover was made, **11 May 2004**, nor the date on which the application might first have been entered into the Provider's system, which the Provider has advised was *"before September 2004"*.

/Cont'd…

In any event, the Financial Adviser says that this *"before September 2004"* date referred to by the Provider ignores the fact that the Complainant wrote to the Provider on **12 October 2004** to change the application for cover she had made on **11 May 2004** by increasing the level of life cover she was seeking from **€1,000,000.00 (one million Euro)** to **€4,000,000.00 (four million Euro)** and the level of specified illness from **€500,000 (five hundred thousand Euro)** to **€750,000.00 (seven hundred and fifty thousand Euro)**.

In that regard, the Financial Adviser says this change to the original application for cover would have necessitated a new entry in to the Provider's system at some point after **13 October 2004** and therefore the terms and conditions that ought to have applied to the Complainant's policy are those that applied to her plan type with starting dates between **1 October 2004** and **4 October 2019** and which in accordance with the Provider's **Conversion Option – financial advisor flyer**, would allow the Complainant to convert up to **€500,000.00 (five hundred thousand Euro)** of her specified illness cover to a new life assurance plan without the need for medical underwriting.

In advance of her policy maturing on **1 December 2019**, the Complainant exercised the option to convert her life cover benefit.

In the **Complaint Form** she signed, the Complainant seeks for the Provider to *"put in place specified illness cover for* [her]*"*.

The Provider's Case

The Provider says that on **11 May 2004** the Complainant applied to the Provider for a life assurance policy, by way of her Financial Adviser, a tied agent of the Provider, for life cover in the amount of **€1,000,000.00 (one million Euro)** and independent specified illness cover of **€500,000.00 (five hundred thousand Euro)** for a term of 15 years, with a Conversion Option (Guaranteed Life Cover Again) attached.

The Provider says that at the time of her application in **May 2004**, the rules of this particular plan were such, that only the life cover could be converted into another life assurance policy without the need for medical underwriting, in that the terms and conditions at that time did not allow for the conversion of specified illness cover.

The Provider says the underwriting process for applications seeking significant sums of cover do take longer to underwrite because both financial and medical underwriting is required.

The Provider says that on **14 October 2004**, during the underwriting process of the Complainant's original application, it received a request from her Financial Adviser to increase the proposed life cover on the application to **€4,000,000.00 (four million Euro)** and the independent specified illness cover to **€750,000.00 (seven hundred and fifty thousand Euro)**. The Provider says this was a simple amendment to the existing application the Complainant had completed on **11 May 2004** and did not constitute a new application.

/Cont'd…

The Provider accepted the Complainant's application for cover and her policy commenced on **1 December 2004** and it wrote to her on that date with a copy of the **Policy Schedule**, a **Customer Information Notice for Policy ****469** (containing information specific to her policy), the **Policy Customer Information Brochure** and the **Policy Terms and Conditions**.

The Provider says that when the Complainant applied for her life assurance policy in **May 2004**, the option to convert the specified illness cover was not a feature of the plan at that time. In that regard, the Provider refers to Section 8, 'Additional Information in Relation to Your Policy', of the **Customer Information Notice for Policy ****469,** sent to the Complainant on 1 December 2004, that stated, among other things, that:

> *"**Guaranteed Life Cover Again (Convertible Option)***
>
> *This valuable option allows you to take out another* [Provider] *protection plan with the same level of life cover provided under this plan, without having to provide medical evidence. It is not possible to take out a new plan that provides Specified Illness Cover under this convertible option".*

The Provider also refers to Para. 18, 'Guaranteed life cover again', of the applicable **Policy Terms and Conditions** (edition ROI 4/03) that provided, among other things, that:

> *"If the schedule shows that guaranteed life cover again applies for a life assured you can covert the life cover benefits on this policy into another life policy without the life assured providing evidence of their health. You cannot get specified illness cover under the new policy. You must convert before the expiry date. The following conditions apply …*
>
> - *Specified illness cover benefits cannot be converted to the new policy".*

The Provider says that it is satisfied that the policy documents were explicitly clear that the policy only allowed for the conversion of the life cover benefit and does not provide for the conversion of specified illness cover.

The Provider says that if the option to convert specified illness cover, had been a feature of the policy, then there would have been an additional cost over the life of the policy for the option to do so and in that regard, the Provider confirms that the Complainant was never charged for the ability to covert her specified illness cover as this was not a feature of her policy.

The Provider acknowledges that as a result of an administration oversight, it incorrectly informed the Complainant's Financial Adviser by telephone on **25 September 2013** and by email on **1 October 2013**, **24 March 2014**, **21 November 2018**, **18 July 2019** and **25 September 2019** that the specified illness cover could be converted.

/Cont'd…

The Provider accepts that its handling of enquiries from the Complainant's Financial Adviser on the conversion options, should have been better and that it did, on occasion, incorrectly confirm that the specified illness cover could be converted, when this was not possible, as it is contrary to the terms and conditions of the Complainant's policy. The Provider apologises for this and for the inconvenience that it caused.

For its lapse in service when its communication was poor, the Provider, in its **Final Response** of **3 June 2020**, offered the Complainant a customer service payment in the amount of **€1,000.00 (one thousand Euro)** by way of an apology. In its **Formal Response** to the complaint investigation by this Office dated **16 April 2021**, the Provider increased this offer to **€2,000.00 (two thousand Euro)**.

The Provider says that its poor communication at times does not give any entitlement for the policy terms and conditions not to be applied and that these terms and conditions must always prevail.

In relation to the **Conversion Option – financial advisor flyer** that the Complainant's Financial Adviser refers to, the Provider says this flyer was first published in **August 2012**, some eight years after the Complainant's policy application was made and her cover commenced. The Provider says the flyer is not specific to any plan and is intended to be a generic high-level guide to assist financial advisers on conversions and some of the rules that apply on conversions. The Provider says that in the case of policy specific queries, the terms and conditions of the policy in question should always be referred.

The Provider says the Complainant's policy issued under the terms and conditions that applied to her chosen product type at the time when her application was received on **11 May 2004**, thereby providing her with the exact plan that she applied for, at the time she applied for it. As a result, the Provider says the start date of the Complainant's policy is irrelevant because her policy would always have issued under the exact same terms that were in force on the date of application, irrespective of the eventual start date or any date when she sought to amend the application.

The Provider confirms that the policy put in place at the time was that which was applied for by the Complainant in her application of **11 May 2004** and when she applied for her policy, the applicable terms and conditions did not allow for the specified illness cover to be converted.

The Provider says the provision of incorrect information does not create an entitlement for the policy terms and conditions to be amended or for them not to be applied. The Provider is sorry for the instances where it incorrectly informed the Complainant's Financial Adviser that it was possible to convert her specified illness cover when it was not. The Provider says the policy terms and conditions must he upheld by all parties and while its inaccurate communications are very unfortunate and disappointing, those communications do not amend the terms and conditions in any way.

/Cont'd…

The Provider confirms that the customer service payment in the amount of **€2,000.00 (two thousand Euro)** that it offered to the Complainant, in recognition of the times it provided incorrect information in relation to her conversion options, remains open to her to accept.

The Complaint for Adjudication

The complaint is that the Provider wrongfully refused in late 2019, to allow the conversion of the specified illness cover element of the Complainant's life assurance policy.

The Complainant says that the policy commenced at a time when the conversion option sought by the Complainant was, or ought to have been, provided for in the policy documentation issued to her by the Provider and the Provider had, on a number of occasions during the term of the policy, informed the Complainant that this conversion option was available to her and had advised her of the terms on which that option could be exercised.

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 **17 February 2022**, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter. In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

I note from the documentary evidence before me that the Complainant applied for a life assurance policy by way of Plan Type X with the Provider on **11 May 2004**. During the underwriting process of this application, the Complainant wrote to the Provider on **12 October 2004** to increase the amount of life cover benefit and specified illness cover sought, and the Provider amended the Complainant's application as requested.

/Cont'd…

Following the completion of the underwriting process, the Complainant's life assurance policy with the Provider commenced on **1 December 2004**.

The Provider advises that the policy was issued on **1 December 2004,** under the terms and conditions that applied to Plan Type X at the time when the Complainant made her application on **11 May 2004**, thereby providing her with the exact plan that she applied for, at the time when she applied for it.

In that regard, I note that the policy terms and conditions that issued to the Complainant on **1 December 2004** were those that were applicable to Plan Type X on **11 May 2004**, when she first applied for the cover. These terms and conditions allowed for the conversion of the life cover benefit to a new life assurance plan, without the need for medical underwriting but did not allow for the conversion of any specified illness cover.

It would appear that from **1 October 2004**, new terms and conditions for Plan Type X allowed for the conversion of the specified illness cover as well as the life cover benefit. As the start date of her policy was **1 December 2004**, which postdates the introduction of the new rules for Plan Type X on **1 October 2004**, the Complainant contends that her life assurance policy should have issued with the new terms and conditions that would have enabled her to convert her specified illness cover.

It is also suggested that the Complainant's written request to the Provider on **12 October 2004** to increase the amount of life cover benefit and specified illness cover constituted a new application date.

I accept the Provider's position that the Complainant's policy issued under the terms and conditions that applied to the chosen plan type at the time when her application was received on **11 May 2004**. I am satisfied that the Provider provided the Complainant with the exact plan that she applied for at the time she applied for it.

In that regard, I am mindful that the Complainant applied for her life assurance policy in **May 2004** through her Financial Advisor and it is possible that her decision to apply for Plan Type X with the Provider, was informed by the conversion options that applied to that particular plan type, at that time.

I am also of the view that if the new rules for Plan Type X that were introduced on **1 October 2004** had removed the option to convert the life cover benefit instead of adding the option to convert the specified illness cover, then the Complainant could have rightly argued that those new terms did not apply to her policy, despite its commencement date of **1 December 2004**, as it did not represent the plan she had applied for on **11 May 2004**.

In addition, I do not accept that the Complainant's written request to the Provider on **12 October 2004 (**to increase the amount of life cover benefit and specified illness cover) constituted a new application. Rather I take the view that this was an amendment to her original application and in that regard, there is no evidence before me to indicate that the Complainant completed a new application form in **October 2004** or that a new underwriting process commenced at that time.

/Cont'd…

As a result, even though the start date of the Complainant's life assurance policy was **1 December 2004**, I am of the opinion that the plan she applied for, was the product that was available on the date she signed the **Application Form** on **11 May 2004**, and it is important to note that her policy was priced accordingly, and not priced on a revised version of the plan that subsequently became available from the Provider, from **1 October 2004** onwards.

I note from the documentary evidence before me that the Provider emailed the Complainant's Financial Adviser on **8 October 2004** as follows:

> *"… - just to confirm* [the Complainant] *has been accepted medically at ordinary rates for cover of EUR1m life and EUR500k* [and] *SIC with conversion on Life only over 15 years.*
>
> *Financial information is outstanding before we can issue"*

Following receipt of the outstanding financial information, I note that the Provider wrote to the Complainant on **1 December 2004** enclosing a copy of her **Policy Schedule**, a **Customer Information Notice for Policy ****469** (containing information specific to her policy), the **Policy Customer Information Brochure** and the **Policy Terms and Conditions**. The cover letter advised, among other things, that:

> *"…* [The] *plan is designed to meet your protection needs and we are confident it will meet those needs. However, if you do not wish to proceed for some reason, you may cancel it by writing to* [the Provider]. *If you do this within 15 days from the date we send you this letter, any premiums remitted to us will be fully refunded …"*

In addition, the 'Introduction' section of the enclosed **Policy Terms and Conditions** included the following:

> *"**'Cooling-off' period***
>
> *If, after taking out this policy, you feel it is not suitable, you may cancel it by writing to us at:*
>
> [address redacted]
>
> *If you do this within 15 days from the date we send you your policy (or a copy), we will refund any premiums you have paid. We strongly recommend that you consult with your broker or* [Provider] *advisers before you cancel your policy".*

Section 8, 'Additional Information in Relation to Your Policy', of the **Customer Information Notice for Policy ****469** states, among other things, that:

> *"**Guaranteed Life Cover Again (Convertible Option)***

/Cont'd…

> *This valuable option allows you to take out another* [Provider] *protection plan with the same level of life cover provided under this plan, without having to provide medical evidence. It is not possible to take out a new plan that provides Specified Illness Cover under this convertible option".*
>
> [Underlining added for emphasis]

In addition, Para. 18, 'Guaranteed life cover again', of the applicable **Policy Terms and Conditions** provides, among other things, that:

> *"If the schedule shows that guaranteed life cover again applies for a life assured you can covert the life cover benefits on this policy into another life policy without the life assured providing evidence of their health. You cannot get specified illness cover under the new policy. You must convert before the expiry date. The following conditions apply …*
>
> - *Specified illness cover benefits cannot be converted to the new policy".*
>
> 0[Underlining added for emphasis]

I am satisfied that the **Policy Terms and Conditions** the Provider issued to the Complainant on **1 December 2004** made it clear to her that the specified illness cover could not be converted to a new policy.

If the Complainant, having read the **Policy Terms and Conditions**, was unhappy with any feature of her policy, including the fact that the terms and conditions clearly did not allow for the conversion of the specified illness cover, it was open to her to cancel the policy and if she did so within 15 days of its commencement, the Provider would have fully refunded any premium that she had paid.

I note the Provider acknowledges that because of an administration oversight, it incorrectly informed the Complainant's Financial Adviser by telephone on **25 September 2013** and by email on **1 October 2013**, **24 March 2014**, **21 November 2018**, **18 July 2019** and **25 September 2019** that the specified illness cover could be converted.

Administrative errors of this nature are very unsatisfactory and can cause considerable confusion, as it has done in this instance. The fact that the same incorrect information was furnished to the Complainant's Financial Adviser on a number of occasions over a six-year period is particularly disappointing. The Complainant ought to be able to rely on the expertise of the Provider with regard to information concerning the administration of her policy.

Despite the fact that the Provider provided the Complainant's Financial Adviser with incorrect information during the term of her policy, the Complainant's life assurance policy must at all times be administered in accordance with the policy terms and conditions that the Provider issued to her on **1 December 2004** when her policy commenced.

/Cont'd…

In that regard, I am satisfied that the Provider was entitled to refuse to allow the Complainant to convert her specified illness cover, and in doing so that the Provider acted in accordance with the applicable policy terms and conditions it issued to the Complainant on **1 December 2004** and which made clear to her that the specified illness cover could not be converted.

I note the Provider has apologised for its lapse in service when its communication was poor and in its **Final Response** of **3 June 2020 it** offered the Complainant a customer service payment in the amount of **€1,000.00 (one thousand Euro)** by way of an apology. In its formal response to the complaint investigation by this Office dated **16 April 2021**, I note the Provider increased this offer to **€2,000.00 (two thousand Euro)**.

Having regard to all of the above, I take the view that the evidence does not support the Complainant's complaint that the Provider wrongfully failed to allow the conversion of the specified illness cover element of her life assurance policy. I am disappointed however, by the very poor communications from the Provider to the Complainant's Financial Advisor. There were repeated communications indicating that it would be open to the Complainant to exercise an entitlement to convert her serious illness cover to another policy.

Bearing in mind the manner in which the policy had come into being, over a protracted period and the potential confusion caused by the start date of the policy, following an amended application in October 2004, many months after the Complainant had originally applied in May 2004, I am satisfied that these communications are likely to have created a very significant level of confusion and inconvenience to the Complainant because of the incorrect information made available at those times.

In those circumstances, I do not accept that the Provider's compensatory offer of €2,000 is sufficient to mark the level of inconvenience caused to the Complainant. Accordingly, whilst I do not consider it appropriate to uphold the substantive complaint that the Provider has wrongfully failed to permit the conversion of the specified illness cover element of the policy, nevertheless, I take the view that it is appropriate to partially uphold this complaint, to take account of the particularly poor and misleading communication from the Provider to the Complainant over the relevant period. I am satisfied that these communications fell short of the appropriate standard which the Complainant was entitled to expect and they were unreasonable, within the meaning of ***Section 60(2)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017***.

In those circumstances, I consider it appropriate to partially uphold this complaint to direct the Provider to make a compensatory payment to the Complainant, as directed below.

Conclusion

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

/Cont'd…

- 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 €4,000 (four thousand euros) 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)

11 March 2022

PUBLICATION

Complaints about the conduct of financial service providers

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.

Complaints about the conduct of pension providers

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will **publish case studies** in relation to complaints concerning pension providers in such a manner that—
(a) ensures that—

/Cont'd…

(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.