An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0090
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Failure to process instructions Claim handling delays or issues
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainants incepted a joint life assurance policy with the Provider on **1 October 1989**.

The complaint relates to the Provider overcharging the Complainants for their policy, on the basis that the Provider recorded the First Complainant as a smoker. He says this is incorrect as he is not a smoker and that he declared in the **Policy Application** he completed on **5 September 1989** that he is not a smoker.

This Office, in accordance with ***Section 51(3)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, can only consider conduct that occurred during or after **2002**.

The Provider calculated the Complainants' policy premium monthly, as per Para. 15, 'Death Benefit Charge and Policy Charges', of the applicable **Provisions, Privileges and Conditions Policy Booklet**. This complaint is that the Provider charged the Complainants the incorrect premium since **2002**, on the basis that it recorded the First Complainant as a smoker which the Complainants say is factually incorrect.

The Complainants' Case

The First Complainant, now age 80, says that he declared himself as a non-smoker when completing the **Policy Application** to the Provider on **5 September 1989**, with the Second Complainant, now age 77, declaring herself as a smoker. In that regard, the First Complainant answered the question *"What is your average tobacco consumption per day?"* as *"None"* and the Second Complainant answered *"10 per day"*.

The Complainants say that the Provider has incorrectly recorded the First Complainant on the Complainants' policy as a smoker and given that there is an increased cost in providing life cover where the life assured is a smoker, they say that the Provider has overcharged the First Complainant for his life cover since the commencement of the policy.

The Complainants set out their complaint in the **Complaint Form** they completed, as follows:

> *"*[The First Complainant] *has been charged as a smoker and never put* [himself] *down* [as] *a smoker* [in the **Policy Application**] *and has the policy long term … he has lost* [vast] *amount of money in this policy …* [The Provider] *seem confused on dates and the actual policy".*

As a result, the Complainants state in the **Complaint Form** that they seek from the Provider:

> *"the correct rates to be applied and a full refund of all additional payments made."*

The Provider's Case

The Provider says that its records indicate that on **19 September 2019**, the Complainants' Representative telephoned the Provider to query its smoking status records for the Complainants and asked for a copy of the Complainants' original **Policy Application** to be sent to him. This was posted the same day.

On **20 September 2019**, having received the copy of the **Policy Application**, the Complainants' Representative telephoned the Provider about its smoking status records again, as at face value he considered that its system records were incorrect and he wanted the matter investigated. The Representative enquired as to why smoker rates were showing on the Provider's system as being applied to both of the Complainants, when the First Complainant was recorded as a non-smoker on the **Policy Application** he completed on **5 September 1989**. The Agent agreed to look into this query and a short time later emailed the Representative to advise that the best course of action would be to have the query set up as a formal complaint for investigation. As a result, the Representative telephoned later that same day asking for a complaint be set up and this was done.

On **24 September 2019**, the Provider emailed the Complainants' Representative to confirm receipt of the complaint.

On **1 October 2019**, the Provider telephoned the Complainants' Representative to discuss the complaint.

On **2 October 2019**, the Provider sent its **Final Response Letter** to the Complainants' Representative. This advised that the charging structure in respect of the First and Second Complainant's smoking status was correct and has been correctly applied at all times since the commencement of their policy in 1989.

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The Provider says that at the time when the Complainants' policy was written in the 1980s, it was normal in the insurance industry for smoker rates to be applied to both lives if they lived in a household where one if them smoked, so as to take account of the non-smoker being exposed to second-hand smoke from the smoker in that household and the effects that such exposure has on mortality.

The Provider says that although it acknowledges that the industry has since changed and moved to underwriting the smoking habits of each life covered separately, as either a smoker or non-smoker, at the time when the Complainants' policy was written, it was normal for plans to be written in such a way that smoker rates applied to both lives if one life in the household smoked, as it was deemed to be a smoking household. The Provider says that this practice was in accordance with paragraph 15, 'Death Benefit Charge and Policy Charges', of the applicable **Provisions, Privileges and Conditions Policy Booklet**, as follows:

> *" … The Death Benefit Charge will be calculated taking account of (a) all excess if any of the Death Benefit over the Accumulated Fund (b) the age(s) and sex of the Life or Lives Assured and (c) such rates of mortality as the Company in its absolute discretion deems equitable to reflect inter alia the smoking habits of the Life or Lives Assured".*

The Provider says that the Complainants' policy provided for separate smoker and non-smoker rates, in that either both lives were listed as smokers or both lives were listed as non-smokers, but that it did not provide for one life cover to be underwritten as a smoker and the other life as a non-smoker.

In that regard, the Provider says that in order to qualify for non-smoker rates, both lives needed to be non-smokers, with this smoking status being confirmed by way of both lives completing the following 'Non-Smokers Declaration' included in the **Policy Application**:

> *"**NON-SMOKERS DECLARATION***
>
> *If you wish to apply for non-smokers terms which are available under the* [policy] *…please complete the following declaration.*
>
> *I/We, the undersigned Life to be assured, declare that:*
> 1. *I/We have not smoked any cigarettes within the last 12 months*
> 2. *I/We do not intend to smoke cigarettes at any time in the future DATE _____*
>
> *Signature of the Life to be assured _____*
>
> *Signature of the Proposer (if other than the Life to be assured) _____*
>
> *Signature of the Life to be assured (B) (For Joint Life Only) _____".*

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The Provider says that the inclusion of this Declaration in the **Policy Application** confirms that non-smoker rates were available, however as the Second Complainant disclosed when completing the application that she is a smoker, the Non-Smokers Declaration was not applicable to the Complainants, and they correctly did not complete it at that time.

In its response to the formal complaint investigation by this Office dated **5 May 2021**, the Provider acknowledged that some of the information in its **Final Response Letter** dated **2 October 2019** was incorrect, in that it mistakenly referred to the start date of the Complainants' policy as 1 October 1998, and that it unfortunately and erroneously advised that:

> *" … I feel it is important to let you know that you are not being disadvantaged by having both plan owners noted as smokers. I can confirm that normal rates were not applied to the cost of providing you with life cover.*
>
> *To ensure you are not being disadvantaged, we use aggregate rates to calculate the cost of providing you with life cover This means that you are not charged smoker rates for both plans. The cost of* [the Second Complainant] *being a smoker is averaged out over the two plan owners. Therefore you are not paying any extra payments for* [the First Complainant] *being noted as a smoker".*

The Provider also says that it incorrectly referenced aggregate rates again, when it spoke with the Complainants' Representative by telephone on **1 October 2019**.

The Provider is very sorry for these administrative oversights and for any confusion caused. By way of an apology for this, the Provider offered the Complainants a customer service award in the amount of **€1,000.00 (one thousand Euro)**.

While some of the information in its **Final Response Letter** was not correct, the Provider says that the First Complainant has not been overcharged and that the smoker rates which were applied to the Complainants' policy from the outset, were always correct. In that regard, the Provider says that the Second Complainant was a smoker and consequently, the Complainants' household was deemed to be a smoking household and smoker rates were applied to both the First and Second Complainant, in accordance with the practice in place at that time when the plan was written and the policy commenced, and in accordance with the policy terms and conditions

The Provider says that in the interest of treating all its customers who have contracts written under similar terms fairly, it cannot meet the Complainants' request for a premium refund. The Provider notes that all payments made to the Complainants' policy, paid for the valuable life cover that they have benefitted from since the inception of the policy and that the policy continues to provide them with this valuable benefit.

The Provider confirms that its offer of a customer service payment in the amount of **€1,000.00 (one thousand Euro)** remains open to the Complainants to accept.

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The Complaint for Adjudication

The complaint is that the Provider charged the Complainants the incorrect premium for their policy since **2002**, on the basis that the Provider recorded the First Complainant as a smoker which the Complainants say is factually incorrect.

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 Complainants were 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 substantive submissions from the parties, within the period permitted, the final determination of this office is set out below.

I note that the Complainants incepted a joint life assurance policy with the Provider on **1 October 1989**. The Complainants say that the Provider has since that time incorrectly recorded the First Complainant on the Complainants' policy as a smoker. They say that given that there is an increased cost in providing life cover when the life assured is a smoker, the Provider has overcharged the First Complainant for his life cover since the commencement of the policy.

I note from the documentary evidence before me that at pg. 2 of the **Policy Application** that the Complainants completed on **5 September 1989**, the First Complainant answered the question *"What is your average tobacco consumption per day?"* as *"None"* and the Second Complainant answered, *"10 per day"*.

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I note the Declaration at pg. 3 of this **Policy Application** states, among other things, that:

> *"I/We, the Life to be assured and Proposer, declare that the above statements (including any statements written down at my/our dictation) are TRUE AND COMPLETE"*.

The evidence shows that the First Complainant and the Second Complainant signed this Declaration on **5 September 1989**.

I note that the Provider says that at the time the Complainants' policy was written, it was normal for plans to be written in such a way that smoker rates applied to both lives if one life in the household smoked, as it was deemed to be a smoking household. The Provider says that this practice is in accordance with paragraph 15, 'Death Benefit Charge and Policy Charges', of the applicable **Provisions, Privileges and Conditions Policy Booklet**, as follows:

> *"… The Death Benefit Charge will be calculated taking account of (a) all excess if any of the Death Benefit over the Accumulated Fund (b) the age(s) and sex of the Life or Lives Assured and (c) such rates of mortality as the Company in its absolute discretion deems equitable to reflect inter alia the smoking habits of the Life or Lives Assured".*

The Provider says that the Complainants' policy provided for separate smoker and non-smoker rates, in that either both lives were listed as smokers or both lives were listed as non-smokers, but that it did not provide for one life to be underwritten as a smoker and the other as a non-smoker.

I accept that in accordance with the practice at that time in 1989, the Complainants' policy was written in such a way that, where there were two lives to be assured, both of these lives had to be non-smokers in order to avail of the non-smoker terms available under the plan. In that regard, I note that pg. 3 of this **Policy Application** contains the following 'Non-Smokers Declaration':

> *"**NON-SMOKERS DECLARATION***
>
> *If you wish to apply for non-smokers terms which are available under the* [policy]*…please complete the following declaration.*
>
> *I/We, the undersigned Life to be assured, declare that:*
> 1. *I/We have not smoked any cigarettes within the last 12 months*
> 2. *I/We do not intend to smoke cigarettes at any time in the future DATE _____*
>
> *Signature of the Life to be assured _____*
>
> *Signature of the Proposer (if other than the Life to be assured) _____*
>
> *Signature of the Life to be assured (B) (For Joint Life Only) _____"*

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I am satisfied that when the policy was incepted, in order to avail of the non-smokers terms which were available under the plan, both the First Complainant and the Second Complainant had to have been in a position to sign this Declaration. As the Second Complainant declared that she was a smoker at the time when they applied for the policy, I am satisfied that the Complainants were not in a position to sign this Declaration to apply for non-smokers terms at that time.

The Complainants' life assurance policy with the Provider is a contract like any other, it is based on the legal principles of offer, acceptance, and consideration. The Provider may offer terms, and these terms can be accepted by those seeking insurance, who then elect to pay the premium requested, in consideration of the cover.

The cover offered to the Complainants by the Provider was cover on the basis of their joint smoker status, and this is the basis upon which the policy came into being, when the Complainants elected to proceed. As the Complainants did not both complete the non-smoker declaration, I am satisfied that it was correct for the Complainants' policy to be incepted with smoker rates applying to both the First Complainant and the Second Complainant.

In addition, I am satisfied that the Provider is entitled to continue to calculate premiums in the same manner it always has, since the commencement of the policy, in accordance with the **Provisions, Privileges and Conditions Policy Booklet** agreed between the parties. I note the Provider acknowledges that the insurance industry has since moved to underwriting the smoking habits of each life covered separately as either a smoker or a non-smoker. In light of this evolution of approach, it may be the case that the Provider might be willing to revisit how it currently calculates the cost of providing life cover for the First Complainant, given that he has been a non-smoker since the commencement of the Complainants' policy some three decades ago; however, such an approach is entirely at the commercial discretion of the Provider.

I take the view that it would be helpful and appropriate for the Provider to set out for the Complainants what options they may now have, if any, under Paragraph 18, 'Conversion Option', of the **Provisions, Privileges and Conditions Policy Booklet**, in order for them to continue to avail of life cover at a rate that may be more affordable to them. I note that the Provider acknowledged in its response to the formal complaint investigation by this Office dated **5 May 2021** that some of the information in its **Final Response Letter** dated **2 October 2019** was incorrect. In that regard, the Provider mistakenly referred to the start date of the Complainants' policy as 1 October 1998, though I note that this was correctly stated elsewhere in the letter as **1 October 1989**.

In addition, I note that the Provider erroneously advised the Complainants that they were not disadvantaged by both of them being noted as smokers on the policy because the Provider used aggregate rates to calculate the cost of providing them with life cover. In that regard, the Provider incorrectly stated that the cost of the Second Complainant being a smoker is averaged out over the First and Second Complainant and that the Complainants were therefore not paying any extra premium for the First Complainant being noted as a smoker on the policy.

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In addition, recordings of telephone calls have been furnished in evidence. I note that the Provider also incorrectly referenced aggregate rates when it spoke with the Complainants' Representative by telephone on **1 October 2019**, the day prior to issuing its **Final Response Letter**.

It is unsatisfactory that the Provider furnished the Complainants and the Complainants' Representative with incorrect information following its initial investigation into the Complainants' complaint. A policyholder ought to be confident that a complaint made to an insurer will be investigated thoroughly and should be able to rely on the expertise of the insurer that the response to such an investigation will be correct and complete.

I note that the Provider has apologised for these errors and for any confusion caused, and that by way of an apology it offered the Complainants a customer service payment in the amount of **€1,000.00** (one thousand Euro). As the Complainants were in no way financially disadvantaged by the errors of the Provider, I consider this to be a reasonable offer. In that regard, it will now be a matter for the Complainants to advise the Provider whether they wish to accept this offer.

Having regard to all of the above, I am satisfied that the evidence does not support the complaint that the Provider has charged the Complainants the incorrect premium for their policy since **2002**, because the Provider recorded the First Complainant as a smoker, which the Complainants say is factually incorrect.

Accordingly, on the evidence before me I do not accept that it is appropriate to uphold this complaint.

Conclusion

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

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

MARYROSE MCGOVERN
Financial Services and Pensions Ombudsman (Acting)

11 March 2022

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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—

(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.