An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

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| **Decision Ref:** | 2022-0231 |
| **Sector:** | Insurance |
| **Product / Service:** | Whole-of-Life |
| **Conduct(s) complained of:** | Poor wording/ambiguity of policy<br>Failure to advise on key product/service features<br>Rejection of claim<br>Mis-selling (insurance) |
| **Outcome:** | Partially upheld |

## LEGALLY BINDING DECISION
## OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The First Complainant and his wife, the Second Complainant, incepted a **Protection Portfolio Policy** with the Provider on **23 January 1998**. The Complainants have been advised that this Office cannot examine any element of their complaint relating to the sale of the policy in **September 1997**, as the conduct giving rise to that element of the complaint, falls outside the time limits set out in ***Section 51*** of the ***Financial Services and Pensions Ombudsman Act 2017***.

The complaint concerns the Provider's decision, more recently, to decline serious illness indemnity in respect of the First Complainant's [type redacted] surgery and also the Second Complainant's [type redacted] surgery.

## The Complainants' Case

The First Complainant contacted the Provider in **December 2016** to query whether his [type redacted] surgery was covered by the Complainants' **Protection Portfolio Policy**. The Provider advised that this particular surgery was not covered by the serious illness policy benefit and that in order for cover to apply, the Complainants would have had to have selected the "*living cover benefit*" when applying for the policy, which they had not.

Subsequently, after the Second Complainant underwent [type redacted] surgery, the First Complainant contacted the Provider in **June 2017** to complaint that neither his [type redacted] surgery nor the Second Complainant's [type redacted] was covered by their policy.

While the Provider advised that the conditions giving rise to their respective surgeries were not covered by their policy, the Complainants say that both procedures are listed in the applicable **Protection Portfolio Policy Booklet** as qualifying surgical procedures under the living cover benefit section of their policy.

The First Complainant sets out the Complainants' complaint in the **Complaint Form**, as follows:

> *"…18 years after commencement* [of the policy]*, a claim for a serious medical and life-threatening event was claimed, only to be informed* [by the Provider] *it was excluded as this was a living cover benefit to which I hadn't subscribed. The Policy booklet is an absolute disgrace written in appallingly misleading and confusing terminology so much so that the* [Provider's] *Insurance Adviser I corresponded with in August* [2018] *told me (in writing) that I was covered and there is no reason it shouldn't pay out. He had never seen the archaic terms and conditions booklet I was given back in 1998 and said if* (sic) *such a document didn't exist in this format anymore. [ My wife also underwent significant* [type redacted] *surgery one month later with the same outcome in terms of claim qualification. It really galls me to have paid well over €40,000 in premiums and to be informed, when confronted with some serious medical issues, for which we thought we had qualifying insurance, to be informed we allegedly did not…"*

The Complainants refer to the email of **7 August 2018** that the First Complainant received from an Insurance and Investments Advisor with the Provider, stating:

> *"…I'm saying your policy covers a [condition redacted] pay out of 10% of the lump sum. So if you can prove medically you had a* [condition redacted] *than there's no reason why it wouldn't pay out…"*

The First Complainant submits in the **Complaint Form** that in order to resolve this matter, he would:

> *"…like to see full settlement of both my wife and my serious medical event claims…"*

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

The Provider says that the Complainants incepted a **Protection Portfolio Policy** with the Provider on **23 January 1998** which, at that time, provided them with life cover on a single life basis in the amount of **IR £93,000.00** and death of spouse cover in the amount of **IR £33,000.00**, as well as accelerated serious illness cover in the amount of **IR £93,000.00 (ninety-three thousand Irish Pounds)**.

The Provider says that as at **February 2021**, the policy benefits of both life cover and accelerated serious illness cover were **€98,500 (ninety-eight thousand five hundred Euro)**.

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In its **Formal Response** to the complaint investigation by this Office dated **22 February 2021**, the Provider set out the following timeline of events in relation to the Complainants' complaint:

It says that on **14 November 2016**, it sent a **Serious Illness Claim Form** and a copy of the **Protection Portfolio Policy Booklet** to the Complainants, following a recent query from them.

On **14 December 2016**, the Provider says the First Complainant emailed to ascertain whether his [type redacted] surgery was covered under the policy.

On **15 December 2016**, the Provider says it explained in its email response that in order for cover to apply to the surgery in question, the First Complainant would have had to have selected the "*living cover benefit*" when applying for the policy, and that this was not so selected. This email also explained that the serious illness policy benefit did not cover the particular surgery.

On **7 June 2017**, the Provider says that the First Complainant emailed to explain that he was intending to claim under the policy in respect of his [type redacted] surgery and also the Second Complainant's [type redacted] that she had undergone earlier that year, but had learned that neither event was covered by the policy. The First Complainant complained about this and stated that when the Complainants had purchased the accelerated serious illness policy cover, they had been led to believe that they had bought comprehensive living cover benefits.

On **13 June 2017**, the Provider says that its Complaints Department responded to the Complainants to confirm that the matter was under investigation.

On **4 July 2017**, the Provider says its Complaints Department wrote to the Complainants to advise that having reviewed the complaint in light of the information set out in the First Complainant's email of **7 June 2017**, it remained satisfied that the surgeries are not covered by the policy. This letter also explained that if they were dissatisfied with the response, the Complainants could refer their complaint, to the Financial Services and Pensions Ombudsman.

The Provider says that on **4 January 2018**, the First Complainant, following his recent telephone call to the Provider, emailed to complain that the [type redacted] surgery and [type redacted] surgery were not covered by the policy and stated that the **Protection Portfolio Policy Booklet** was not easy to understand.

On **9 January 2018**, the Provider says it emailed the First Complainant advising him to forward any further queries in relation to his complaint, to its Complaints Department.

On **1 February 2018**, the Provider says the First Complainant responded by email reiterating his previous complaint.

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On **2 February 2018**, the Provider says it confirmed to the First Complainant that the Complainants had the right to refer the matter to this Office, and that his email had been forwarded to the Provider's Complaints Department.

On **19 August 2018**, the Provider says that the First Complainant wrote to its Complaints Department to complain once again that the [type redacted] surgery and [type redacted] surgery were not covered by the policy. He stated that the **Protection Portfolio Policy Booklet** was misleading and unclear and requested an internal appeal by the Provider regarding its position on the scope of the policy cover.

On **22 August 2018**, the Provider says it wrote to the Complainants to confirm that the matter was under investigation and that it would make its final decision in relation to the appeal, soon.

On **12 September 2018**, the Provider issued its **Final Response** to the Complainants, as follows:

> *"Our records confirm that in September 1997, you met with a* [redacted] *Advisor in* [location] *in relation to your protection requirements. During this meeting, you completed and signed a proposal form for this product, a quotation was given to you outlining the benefits and premium required to maintain your benefits. I can confirm that this policy commenced in January 1998.*
>
> *Upon commencement of the policy, the Company issued policy documents to you, which we asked you to read to ensure that the policy was suitable to your requirements. Your policy schedule outlined the benefits applicable on this policy. If at this stage you were dissatisfied with any element of this policy you could have cancelled the policy by availing of the cooling off period associated with the policy.*
>
> *Each year in January you are issued with an Annual Statement which outlines your policy details and advises of the benefits applicable on your policy. I have enclosed a copy of some of these statements for your records, 2017, 2016, and 2015.*
>
> *All the documentation issued to you confirmed that you have Accelerated Serious Illness benefit. The procedure you outline in your letter* [type redacted] *Operation is not covered under this benefit and therefore a claim is not valid.*
>
> *If you had Living Cover Benefit on your policy you may have been eligible for a payment of ten per cent of the amount that the life assured is covered however as you are aware you have never had this benefit on your policy.*
>
> *I am sorry to note your dissatisfaction with your…plan and your recent claim. I have noted your comments in this regard. However, having reviewed you policy the Company is satisfied that we acted in good faith on your instructions to set up this policy. Your policy is being administered in line with the terms and conditions.*
>
> ***I'm not satisfied with this outcome. Who can I speak to?***

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*I hope that these responses address the issues you raised in your complaint. If you are not satisfied, you can refer your complaint to the Financial Services and Pensions Ombudsman. We will cooperate with any investigation they carry out…"*

The Provider says that neither of the Complainants completed a claim form in this case, as the Provider had indicated to them that a claim in respect of either the [type redacted] surgery, or the[type redacted] surgery, would not be covered by the policy.

As a result, the Provider notes that the Complainants did not submit any supporting medical information in relation to these procedures. In addition, the Provider says it has no record of the First or Second Complainant having contacted it in advance of their respective surgeries, to enquire whether those procedures were covered by the policy.

The Provider says that the information on the policy cover was notified at the time the policy was taken out and when the **Protection Portfolio Policy Booklet** and **Policy Schedule** issued shortly after. The Provider says it believes that the cover included was clear at that time. The Provider says that if the Complainants had selected living cover benefit on the **Application Form** when applying for the policy, they would have been eligible for a payment of 10% of the death benefit in respect of the First Complainant's [type redacted] surgery. The Provider notes that the living cover benefit was not selected on the **Application Form**. The Provider says it is satisfied that the policy established was, as it had been applied for, and that it has administered the policy in accordance with its terms and conditions.

The Provider says that the Complainants chose accelerated serious illness cover as an option under their **Protection Portfolio Policy**. The Provider notes that Condition 20, **'Serious Illness Cover Benefit',** at pg. 25 of the applicable **Protection Portfolio Policy Booklet** provides that serious illness cover is in respect of the medical conditions and surgeries referred to in Condition 19.5.1 only, as follows:

*"**Serious Illness Cover – Summary** …*

*20.2 This benefit provides for the payment of a lump sum to you if the insured life (or lives) is diagnosed as having one of the specified medical conditions, as detailed in Section C, sub-section 19.5.1."*

In this regard, the Provider notes that Condition 19, '**Living Cover Benefit'**, states at pg. 17 of the **Policy Booklet** that:

*"19.5 **What is covered by this benefit***

*19.5.1 The full amount is paid out under this section if one of the following medical conditions is diagnosed or one of the following operations is carried out: … "*

The Provider notes that [type redacted] surgery and [type redacted] surgery are not one of the operations listed in sub-section 19.5.1.

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The Provider says that details of the serious illness, which is covered by the policy, are set out in Condition 20 of the **Protection Portfolio Policy Booklet**, which in turn refers to the medical conditions listed in sub-section 19.5.1. Although the Provider acknowledges that serious illness cover does extend to some of the surgeries that are referred to in the definition of "serious illness cover benefit", the Provider explains that unfortunately, it does not extend to the surgeries that the First and Second Complainant underwent. Although "living cover benefit" provides cover for a longer list of illness and surgeries, the Provider notes that the Complainants did not select the option of "living cover benefit" at the time when the policy was taken out. The Provider has confirmed that if living cover benefit had been selected when the policy was taken out (which was not the case) an amount of 10% of the death benefit would then have been payable in respect of the First Complainant's [type redacted] surgery.

In relation to the First Complainant's comments that *"the* [Provider's] *Insurance Adviser I corresponded with in August* [2018] *told me (in writing) that I was covered and there is no reason it shouldn't pay out"*, the Provider noted in its **Formal Response** to the complaint investigation by this Office dated **22 February 2021** that the First Complainant had met with one of its Insurance and Investments Advisors in a Provider branch. The Provider said that this Advisor emailed it on **17 September 2018** setting out his account of his meeting with the First Complainant and confirming that he had emphasised that the First Complainant should contact the Provider's Claims Department to discuss any claims.

The Provider notes that the First Complainant later furnished the Financial Services and Pensions Ombudsman on **16 June 2021** with an email from the Advisor dated **7 August 2018**, wherein the Advisor stated:

> *"…I'm saying your policy covers a* [type redacted] *pay out of 10% of the lump sum. So if you can prove medically you had a* [type redacted] *than there's no reason why it wouldn't pay out. If you had something similar, but not*[type redacted] *, I would appeal the claim decline that you received.*
>
> *You would address your appeal to* [the Provider's Claims Department address] *or send them an email to* [the Provider's claims email address]*. Alternatively, to make the claim you contact* [telephone number redacted]*".*

In its letter to this Office dated **7 July 2021**, the Provider says that the email raising a question of its Advisor was not provided so it is difficult to comment to any great extent on the exchange of emails that took place at the time.

The Provider says that while it accepts that the Advisor's statement was quite broad and did not specifically reference the fact that living cover benefit would be needed for the 10% amount to be payable for [type redacted] surgery, it says it does not believe that the Advisor's email is a confirmation by the Provider that a claim had been or would be admitted.

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The Provider says it is clear that the Advisor did not have all the facts at the time and was responding to an email enquiry, and it notes that he clearly uses language such as *"if you can prove medically"*.
In referencing an appeal, the Provider notes that the Advisor provided contact details for its Claims Department. The Provider says it is clear from the email that the Advisor is not the party who determines the outcome of claims or appeals. Indeed, the Provider notes that the **Protection Portfolio Policy Booklet** issued to the Complainants at the time when the policy was taken out, was clear as to how a claim is to be made and it does not suggest that claims are assessed and determined by sales intermediaries.

In addition, in its letter to this Office dated **31 August 2021**, the Provider says the Advisor's comments in his email of **7 August 2018** that the 10% amount would be payable for [type redacted] surgery is correct, if the Complainants had selected living cover benefit when the policy was taken out. In this regard, the Provider says it does not believe that the Advisor misinterpreted the information in the **Protection Portfolio Policy Booklet** but rather, wrongly understood or assumed that the Complainants had selected living cover benefit when applying for the policy, which was not the case.

While it accepts that the **Protection Portfolio Policy Booklet** dates back many years, the Provider does not believe that the policy terms and conditions therein are confusing. The Provider says that regrettably in this case, the Complainants did not select living cover benefit when applying for their **Protection Portfolio Policy**. While the conditions suffered by them are not covered on this occasion, the Provider says that their **Protection Portfolio Policy** continues to provide the Complainants with lots of other valuable cover and they can be assured that it will be happy to assess any claims that may arise in the future.

## The Complaint for Adjudication

The complaint is that in 2016/2017, the Provider wrongfully declined serious illness indemnity to the Complainants in respect of the First Complainant's [type redacted] surgery and the Second Complainant's [type redacted] surgery.

## 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

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of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on **23 June 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 that the Complainants incepted a **Protection Portfolio Policy** with the Provider on **23 January 1998**. The **Policy Schedule** states that:

> *"This Policy records that* [the Provider] *will in consideration of the payment by* [the Complainants] *to* [the Provider] *of Contributions as provided herein, grant the benefits described in this Policy in accordance with the particulars below and subject to the Conditions attached hereto".*

The **Policy Schedule** then sets out the Complainants' policy cover, as follows:

> *"**BENEFITS OF THIS POLICY***
>
> | | |
> |---|---|
> | *Death Benefit:* | *Initial Amount of Life Cover (Death Benefit): IR£93,000.00* |
> | | *Type of Death Benefit: Single Life* |
> | *Death of a Spouse:* | *Amount of Cover IR£33,000.00* |
> | *Serious Illness:* | *Amount of Cover IR£93,000.00* |
> | | *Type of Cover: Accelerated* |
> | *Waiver of Premium:* | *Does not apply".* |

I note that Section 4, '**What Benefits are Available'**, at pg. 5 of the applicable **Protection Portfolio Policy Booklet** provides, as follows:

> *"4.1 The following benefits listed in sections 4.2 to 4.6 are available under this type of policy. Your **policy schedule** will tell you which benefits you have chosen for your policy. Detailed descriptions of each benefit are set out in Section C of this document. You should read the detailed description of each benefit"*
>
> [My emphasis]

This section then proceeds to set out the different benefits available under the policy product, as follows:

> *"4.2 Death Benefit …*
> *4.3 Death of a Spouse Benefit …*

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*4.4 Living Cover Benefit …*
*4.5 Serious Illness Benefit …*
*4.6 Waiver of Premium".*

I am satisfied that the Complainants' **Protection Portfolio Policy**, in accordance with the policy cover listed on their **Policy Schedule**, provided them since 1998, and continues to provide them with Death Benefit, Death of a Spouse Benefit and Serious Illness Benefit and that the policy does not provide them with either Living Cover Benefit or Waiver of Premium.

I note that Section B of the **Application Form,** that the Complainants signed on **30 September 1997,** as outlined below, makes clear that the Complainants could have applied for a Living cover plan (which offered Life cover with Living cover) or a Flexi life cover plan (which offered Life cover with Serious illness cover).

I note that the **Application Form** was completed for the Flexi life cover option, with Serious illness cover:

**Plan details:**

| **Living cover** | | **Flexi life cover** | |
|---|---|---|---|
| Life cover | £ | Life cover | £ 93,000 |
| Living cover | additional ☐ accelerated ☐ £ | Serious illness cover | additional ☐ accelerated ☑ £ 93,000 |
| Hospital cash benefit | Yes ☐ No ☐ | Waiver of premium | Yes (No) |
| Waiver of premium | Yes ☐ No ☐ | Spouse cover (for your husband or wife) | £ 33,000 |
| Spouse cover (for your husband or wife) | £ | Term of the plan (minimum 10 years) | 20 years |
| Term of the plan (minimum 10 years) | years | | |

I am also satisfied that the cover of the **Protection Portfolio Policy Booklet** demonstrates on its face that it is setting out the policy conditions for <u>both</u> the **Flexi-Life Plan** and the **Living Cover Plan**. In that regard, and in accordance with Clause 4.1 quoted above, from pg. 5 of the **Policy Booklet**, only the benefits listed on the Complainants' **Policy Schedule** apply to their policy, and I am satisfied that Living cover benefit is not one of those benefits so listed.

I note that almost twenty years after incepting the policy, the First Complainant underwent [type redacted] surgery, and the Second Complainant underwent [type redacted] surgery. When the Complainants contacted the Provider to ascertain if their respective medical conditions or surgeries were covered by the Complainants' **Protection Portfolio Policy**, the Provider advised the First Complainant that they were not.

In relation to the First Complainant's [type redacted] surgery, I note that the Provider has advised that if the Complainants had opted for "living cover benefit" when applying for the policy, he would have been entitled to a payment of 10% of the death benefit on proof that he had undergone the surgery in question.

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The Complainants' **Protection Portfolio Policy**, like all insurance policies, does not provide cover for every eventuality. Rather the cover available will be subject to the terms, conditions, endorsements and exclusions set out in the policy documentation.

I note that Condition 20, 'Serious Illness Cover Benefit', at pg. 25 of the applicable **Protection Portfolio Policy Booklet** provides that serious illness cover is in respect of the medical conditions and surgeries referred to in Condition 19.5.1 only, as follows:

> *"**Serious Illness Cover – Summary** …*
>
> *20.2 This benefit provides for the payment of a lump sum to you if the insured life (or lives) is diagnosed as having one of the specified medical conditions, as detailed in Section C, sub-section 19.5.1 …*
>
> ***What is covered by the benefit***
>
> *20.5 The medical conditions listed and described in Section C sub-section 19.5.1 are covered. The exclusion listed in Section C sub-section 19.6 apply".*

In this regard, the Provider notes that Condition 19.5, 'What is covered by this benefit' states at pg. 17 of the **Policy Booklet** that:

> *"19.5 **What is covered by this benefit***
>
> *19.5.1 The full amount is paid out under this section if one of the following medical conditions is diagnosed or one of the following operations is carried out: …"*

Condition 19.5.1 then lists the medical conditions of Heart Attack, Stroke, Cancer, Kidney Failure, Major Organ Transplant, Multiple Sclerosis, Motor Neurone Disease, Loss of sight in both eyes and Total disability, with each condition clearly defined, and also AIDS (Needlestick Injury/Blood Transfusion), which is also subject to the policy definition and is only available to persons employed in the listed occupations. <u>These are the only illnesses, defined in the policy, to be covered by the serious illness cover.</u>

I take the view therefore that the Provider was correct to conclude that neither the First Complainant's [type redacted] surgery nor the Second Complainant's [type redacted] surgery met the definition of any of the medical conditions listed under Condition 19.5.1. and as a result, no serious illness cover is available to the Complainants in respect of their particular surgeries.

The Complainants refer to the email of **7 August 2018** that the First Complainant received from a Provider Insurance and Investments Advisor, wherein the Advisor stated:

> *"…I'm saying your policy covers a* [type redacted] *pay out of 10% of the lump sum. So if you can prove medically you had a* [type redacted] *than there's no reason why*

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*it wouldn't pay out. If you had something similar, but not a*[type redacted] *, I would appeal the claim decline that you received.*

*You would address your appeal to* [the Provider's Claims Department address] *or send them an email to* [the Provider's claims email address]*. Alternatively, to make the claim you contact* [telephone number redacted]*".*

In this regard, I accept the Provider's position that when the Advisor advised that the First Complainant was entitled to a 10% payment of the life cover for [type redacted] surgery, it is likely that this Advisor did so on the assumption that the Complainants had opted for life cover benefit, when they were incepting their policy. Such an error cannot impose policy cover where such cover does not exist within the policy terms and conditions. I am also mindful that prior to the Advisor's email of **7 August 2018**, the Provider had previously confirmed to the First Complainant on two separate occasions, on **15 December 2016** and again on **4 July 2017**, that the Complainants' policy did not provide the First Complainant with cover in respect of his [type redacted] surgery.

I take the view nonetheless, that this email sent to the Complainants by the Provider's Advisor, based on an "assumption" was far from ideal, and it indicates to me that the Advisor did not take adequate time to understand the nature of the query being raised. This was unfair to the Complainants, in my opinion, as they were struggling to understand why they were not covered and, in my opinion, this response seems likely to me to have simply added to their confusion and inconvenience, leading them to believe that their cover was perhaps being misinterpreted and misunderstood by the Provider. This, in my view, was unjust, within the meaning of ***Section 60(2)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017***.

Accordingly, although I am satisfied that, because of the particular cover which the Complainants selected in 1997/1998, they are not covered for a benefit payment for the surgeries which they underwent almost twenty years later, nevertheless I take the view that this error in communication from the Advisor to them on **7 August 2018**, had an impact on their position and the Provider has a case to answer to them in that regard. For that reason, I consider it appropriate to partially uphold this complaint and to mark that decision, I consider it appropriate to direct the Provider to make a compensatory payment pursuant to ***Section 60(4)(d)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, 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).***

- Pursuant to ***Section 60(4)(d) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider make a compensatory payment to the Complainants in the amount of **€1,000** (one thousand

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Euros) to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants 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)**

15 July 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—
  (i) a complainant shall not be identified by name, address or otherwise,
  (ii) a provider shall not be identified by name or address,
  and

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