Decision Ref:	2022-0235
Sector:	Insurance
Product / Service:	Payment Protection
Conduct(s) complained of:	Maladministration Dissatisfaction with customer service
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint arises from an **Executive Income Protection Plan** incepted in 2012 through the Provider, an insurance intermediary. The Complainant was not the policyholder, but she makes this complaint in her capacity as an actual or potential beneficiary of a *"long-term financial service"* within the meaning of the ***Financial Services and Pensions Ombudsman Act 2017***. The Policyholder was the Complainant's employer. The Complainant, as the life assured, completed the application for cover through the Provider. The complaint is that the Provider maladministered the application for the **Executive Income Protection Plan**.

The Complainant's Case

The Complainant completed and submitted an income protection **Claim Form** to the Insurer in **May 2018**. Following its claim assessment, the Insurer wrote to the Complainant on **23 July 2018** to advise that it was declining her income protection claim and voiding her cover under the **Executive Income Protection Plan** from inception, as she had failed to disclose her full medical history when applying for the cover. The Complainant sets out her complaint in the FSPO **Complaint Form** she completed, as follows:

> *"I wish to complain about my broker…* [with the Provider]. *In Jan 2012 he completed an application to* [the Insurer] *for an Income Protection Policy on my behalf. My broker presumed that a PMA* [(GP Report)] *would be carried out, so he ticked the Underwriting Medical questions all "No", resulting in the Insurance Company declaring that I had non-disclosure on my application form. My broker did not take due care and attention in completing the application form"*.

In her complaint papers to this Office, the Complainant also advised that:

> *"On the 26th January 2012 my broker asked me to sign a number of Applications for* [a different insurance provider] *and for, income protection with* [the Insurer]*. He never explained to me that this signature was for Declaration that medical questions were correct, I understood my signature was just to start the process for applying for the policies.*
>
> *My Broker had completed a previous policy to* [a different insurance provider] *in November 2011. I now believe that My Broker copied my details to my Application form for Income Protection in January 2012 from my previous application to* [the different insurance provider] *in November 2011, as all details are the same with the same errors.*
>
> *My Broker enquired if I was taking any medications for any complaint, the names of my Doctor, I told him I was not taking any Medications, in great health and that the most recent doctor was* [GP 1] *in 2010 and* [GP 2] *previous to that.*
>
> *My Broker informed me that a PMA would be completed, so he never asked me any Medical underwriting questions on the Income protection Form or on any of the other applications, he was completing at the same time.*
>
> *I trusted my Broker that he was doing his job correctly, and ensured that all was correct to sign, and in good faith I signed without reading the part of the Applications marked "X" for on each policy.*
>
> *I never received a copy of my application Form or a copy of his online application form for approval before they were submitted to* [the Insurer].
>
> *In July 2018, once my claim was rejected, I asked my Broker for a copy of my Application that he submitted to* [the Insurer] *in 2012. I noticed immediately; the following were incorrect. Section 6 all Medical questions were marked NO incorrectly, my weight was incorrect, my date of birth was incorrect, my start date was incorrect also.*
>
> *My Broker made the grave presumption in 2012 that a PMA would be carried out, so he ignored the Medical underwriting questions and ticked No to every single question, which has now resulted in* [the Insurer] *claiming non disclosures in my income protection Application Form.*
>
> *My Broker was unfamiliar with the Application form in 2012 and never realised there was an option for a Tele medical until 2018 … On Friday 5th of April, I rang me* (sic) *Broker to say "I needed to get him to answer some queries re the Income Protections application form that he completed in 2012, that I need this for my appeal to the* [Financial Services] *Ombudsman against* [the Insurer]*. My Broker replied "No problem at all send me an email with your queries and I will meet you on Monday the 8th of April in my office and have the queries answered".*

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On Monday the 10th (sic) *of April as I was driving in to see my Broker, his Partner* [named redacted] *rang me to say he was cancelling my meeting with* [the Adviser]*, he wanted to review my file. On Tuesday the 9th of April I received a very distressing email form* (sic) [the Partner]*. I replied to* [the Partner] *on the 10th of April 2018 …*

To Date, I have not been allowed by [the Provider] *to have any further dealings with My Broker …*

I have spoken to the other insurance company whose applications was also signed up on the 26 January 2012 the same date as the Income Protection application, to find that both [GP 2] *and* [GP 1] *were listed as my Doctors …"*

The Complainant notes that as part of her appeal to the Insurer (concerning its decision to decline her income protection claim and void the **Executive Income Protection Plan**) the Provider's Adviser wrote to the Insurer on **13 August 2018**, as follows:

"In 2012, when this Income Protection Policy was being applied for, [the Complainant and I] *were also discussing Executive Pensions, Death In Service and the tax efficiencies of funding a pension versus taking the bonus owed to* [the Complainant] *via income tax. As you can imagine, in the age of compliance, the amount of paperwork that had to be covered at the meeting, as well as the topics to be discussed, were onerous. Furthermore this meeting took place in the* [Complainant's place of employment] *and, to the best of my knowledge took almost two hours. This was partially due to the fact that* [the Complainant] *was called from the meeting on a few occasions, in order to deal with a number of issues that had occurred as part of the day-to-day running of her* [place of employment].

As the Income Protection Plan application was the last to be completed and a vast amount of paperwork was being covered, I remember telling [the Complainant] *that she would have to do a medical at a minimum and that a PMA would be carried out. I made this assumption based on the client being in her mid-50s (approx.) and the sum assured was quite high. As we are not privy to underwriting requirements that trigger PMAs or medicals, etc., this was an assumption based on my experience. I have known* [the Complainant] *for a number of years and believe if the questions were put to her properly she would have answered to the best of her ability and with 100% truthfulness.*

This case has made me look at life assurance applications in a different manner. For instance many questions asked on an application form may contain as many as 12 sub-questions within each question. This, in hindsight, is rather alarming as it is very easy to see why clients could say no to something when they might not hear every single part of the question posed. To use this case as an example, the amount of paperwork and topics that had to be covered on the day would necessitate meeting the client individually to discuss each particular piece of business in order for the client to be 100% au fait with what was going on, especially the way the questions are designed …

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After this application was completed a Nurse Medical was carried out at [the Complainant's] *home which, in hindsight, is a more suitable atmosphere to conduct a piece of business as opposed to her place of employment. During the Nurse Medical* [the Complainant] *answered yes to some of the questions that she answered no to on the application that was submitted. I am completely baffled, after carrying out further due diligence, to find out that* [the Insurer]*, once they had conflicting information, did not carry out a PMA on* [the Complainant]*. Instead,* [the Insurer] *waited until* [the Complainant] *was at her most vulnerable and in a state of claim to do their due diligence that, I wholeheartedly believe, should have been carried out in 2012, especially when there was conflicting information between the application form and Nurse Medical.*

I also note that part of the reason for your declining the claim was the non-disclosure by [the Complainant] *of the fact that she was claiming a difficulty in remembering things in 2012. This, again, shows in the client's defence that this is not non-disclosure but merely poor memory recall.*

NB – it defies logic that an individual in their 50s, or indeed any age, is 100% liable for the answers to questions asked on an application form while the assurance company is not liable for ensuring that proper due diligence is carried out before they take any premiums from an individual. This is even more valid when neither the client nor myself, the assurance broker, are trained medical professionals. However the nurse who carried out the medical for [the Insurer] *is a trained medical professional and the assurance underwriters, who carry years of medical underwriting experience, have no accountability in any shape or form. I find this grossly unfair and am at a loss as to why the medical professionals did not do a PMA at the time, based on reasons already outlined. In my professional opinion the 2004 issue was grief only and not depression which would indicate that the non-disclosure outlined in your letter bear no resemblance to the reason why the client is claiming and, if dealt with prudently in 2012 through PMA, could have led to a back exclusion on the client (admittedly severe exclusions would have applied) and would have facilitated a successful claim in 2018".*

In her letter to this Office dated **17 March 2020**, the Complainant submits, among other things, that:

"… [The Adviser] *completed my application form himself and it is my belief that I was not present when the application form was being filled in, I can demonstrate this by the incorrect answers that were given in the first two pages of the application form. I was never asked medical questions, I was only presented with the banking and Declarations forms to sign, along with a number of Bank and Declaration forms for two other policies from* [a different insurance provider] *at the same time. I would like to point out that I did not date my signature, all dates were added in by my broker …*

/Cont'd…

At no point in time was I asked the medical questions by [the Adviser]*. I was not present when the application form was filled in by my broker. I only signed the banking and Declarations Forms …*

[The Adviser] *assured me at all times that* [the Insurer] *would reverse their refusal, when he explained to them how he did not give enough attention in filling in the application form, and that I never tried to withhold information. He assured me that* [the Insurer] *were incorrect in not doing a medical or a PMA before the policy started. In fact when I was in his office hand writing my response to the rejection letter from* [the Insurer]*, I specifically said to* [the Adviser] *that I need to explain to* [the Insurer] *that you completed the application form and only asked me to sign the Declaration and bank parts of the Application form. His reply was "if you say that I could get struck off, just say I was not giving you enough attention when I was doing the application form" as his secretary was typing up my letter to* [the Insurer]*, I felt I had no option at that time as I trusted him to act in my best interests at all times …*

I only pleaded with [the Adviser] *to tell* [the Insurer] *the truth that I only signed the application form, I did not complete the application form or any of the medical questions …*

I understand looking back now that I should have been more diligent at the time when [the Adviser] *was getting me to sign the applications* (sic) *forms for all of the policies that he did with me. However, I trusted him implicitly and thought that at all times he was acting in my best interests. However, I now know that this is not the case and that he should have gone through the medical questions in detail with me".*

In addition, in her letter to this Office dated **13 August 2020**, the Complainant submits, among other things, that:

" … The Broker completed an online income protection application…on the 30th January 2012 without the claimant being present to answer or confirm any questions and returned this application [to the Insurer] *without having its Declaration section 6 signed by me.*

Broker never prepared the claimant for the Nurse Medical [arranged by the Insurer] *in February 2012, failed to advise the claimant to have available details of past visits to Doctors, or any information regarding injuries or examinations in preparation for Nurse Medical.*

Broker failed to request that [the Insurer] *contact my medical Doctor for information on receipt of letter on the 9th of February 2012 from* [the Insurer]*, requesting histology information, or to advise the claimant to do so, instead choosing to allow a member of his staff deal with such medical questions.*

Broker never provided the claimant with a copy of the application form or online application form in 2012 to allow the claimant review and retain a copy.

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> *Broker never showed the claimant the application <u>questions for verification</u> on the important letter of the 6th of March* [2018] *from* [the Insurer] *prior to start of policy, thus denying the claimant the opportunity to rectify any inaccuracies of information supplied to* [the Insurer] *…*
>
> *I signed in good faith Declaration section 7 of the income protection policy 2012 as requested by my broker this was detached from the application form when I sign it, and I never saw the remainder of this application form until it was presented at appeal stage in July 2018. I trusted my broker to be honest and truthful in all his dealings and to protect my best interest …"*
>
> [Original underlining]

The Complainant also says that the Adviser forged her signature and date of that signature on the **Executive Income Protection Plan Application Form** and altered the **Application Form** to suit his own ends. In relation to the elements of her complaint contending fraudulent activity, this Office wrote to the Complainant on **23 April 2021** to advise that:

> *"… We would ask you to note **Section 52 of the Financial Services and Pensions Ombudsman Act 2017** (the "Act") which prescribes as follows:-*
>
> > *"(1) The Ombudsman may decline to investigate, or discontinue an investigation of, a complaint where, in the opinion of the Ombudsman – …*
> >
> > *(d) there is or was available to the Complainant an alternative and satisfactory means of redress in relation to the conduct complained of" …*
>
> *Forgery is a criminal offence, and the Financial Service and Pension Ombudsman (the "FSPO") is not in a position to investigate or to give the appropriate sanctions in relation to such a wrong. This Office is neither established nor equipped to deal with situations involving fraudulent actions including forgery. Any allegations of forgery/fraud are more appropriately dealt with by An Garda Siochána or in a Court of Law.*
>
> *Consequently, we must inform you that the assertion that you have made that the Provider "forged [your] signature" is not something that this Office has jurisdiction to investigate …"*

The Complainant agreed on that basis that there would be no investigation by this Office of forgery and instead, the investigation of this Office would concern only the complaint that the Provider maladministered her application for cover under an Executive Income Protection Plan, in 2012.

The Complainant states in the **Complaint Form** that in order to resolve this complaint she seeks for:

> *"… my policy to be reinstated or compensation for my loss …"*

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The Provider's Case

The Provider says that the Complainant, with the assistance of one of its Advisers, completed an application for income protection cover on **26 January 2012** with the Insurer, by way of an **Executive Income Protection Plan**. The Complainant was the life assured and the Policyholder was her employer. The policy commenced on **6 March 2012**.

The Provider says that both the Complainant and her husband were first referred to the Provider in **late 2011** by the Complainant's accountant. The Provider says the first meeting between its Adviser and the Complainant occurred in the Provider's offices, where the Complainant expressed her priorities as retirement planning and income protection.

In terms of income protection cover, the Adviser says he initially recommended to the Complainant that this be established on a personal basis but the Complainant advised that a substantial bonus was owed to her and that her employer was not in a position to discharge this obligation in a single payment, so the recommendation then changed to having the Complainant's employer establish and pay for her income protection cover instead of any bonus payment. The Provider says that its Adviser recommended to the Complainant that the most effective method for this was to establish an **Executive Income Protection Plan**.

The Provider says that the **Executive Income Protection Plan Application Form** was completed by the Adviser in conjunction with the Complainant at their next meeting on **26 January 2012**, which took place at the Complainant's place of employment.

The Provider does not accept the Complainant's contentions that she was not present when the Adviser filled in the **Application Form** or that she was only handed the Declaration and the direct debit mandate pages of the application to sign. In this regard, the Adviser confirms that the Complainant was present and fully participated in the process.

The Provider says that the information required for the **Application Form** is detailed and includes personal information, company information, occupational information, and medical information. It says that because the Complainant was at that time a new client and it had not at this point established any protection policies for her, it would not have possessed any of the information required to complete the **Application Form** and thus it would have been necessary to gather such information directly from the Complainant.

The Provider says it is normal practice for it to always inform its clients of the importance of answering all of the application questions fully, because providing misleading information or failing to disclose medical information will always lead to a claim being declined. The Provider says it is also experienced enough to know that income protection has quite a stringent underwriting process and that it never wants to undermine its credibility with the various underwriters, by submitting questionable application forms, which would lead to delays in clients' applications being processed.

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In relation to the Complainant's comment that her PPS number and date of entry into service with her employer were incorrectly recorded in the **Application Form**, the Provider says that if these details are incorrect, then they were recorded in error.

In relation to the Complainant's comment that she informed the Adviser that her *"…most recent doctor was* [GP 1] *in 2010 and* [GP 2] *previous to that"*, the Adviser says that the Complainant only referred to GP 1 when completing the **Application Form** and that neither the Adviser nor the Insurer were aware that GP 2 had been her regular GP until this doctor was presented as such by the Complainant when making her income protection claim.

The Adviser says that he directly asked the Complainant all of the medical questions in the **Application Form** and that she answered *"No"* to each of them.

In relation to the Complainant's comments that:

> *"… My Broker made the grave presumption in 2012 that a PMA would be carried out, so he ignored the Medical underwriting questions and ticked No to every single question … "*,

the Provider says that it does not accept the Complainant's contention that the medical questions were all answered *"No"* on the basis that the Adviser presumed that the Insurer's underwriters would seek a Private Medical Attendant's Report (GP Report).

The Provider says it is solely a matter for an insurer to decide whether a PMA (GP Report), or any medical underwriting, is required and that the Adviser does not have the ability to decide whether one will occur. The Provider says that how an insurer approaches medical underwriting is entirely within that insurer's operational guidelines, which it would never be privy to, though the Adviser says that based on his experience, he did inform the Complainant that some level of medical underwriting would be required due to the sum insured.

The Provider notes that, in this instance, rather than seeking a PMA (GP Report) the Insurer opted for the more thorough option of a face-to-face Nurse Medical and that this examination occurred at the Complainant's home on **7 February 2012**. The Provider says that the Complainant had the opportunity at this Nurse Medical to verify, clarify or add to the medical information already supplied in her **Application Form**.

The Provider says it was not its responsibility to prepare the Complainant for the Nurse Medical, noting that this assessment is independent of the Insurer and the Adviser and in this regard, the Nurse Medical was scheduled by the Insurer directly with the Complainant.

The Provider says it would not be privy to the information disclosed by the Complainant during this Nurse Medical, though the Insurer did seek for the Provider to obtain written clarification from the Complainant regarding her disclosure at the Nurse Medical that she had had a hysterectomy, prior to it confirming that it was happy to offer terms of cover. In relation to her disclosure at the Nurse Medical that she had previously undergone a hysterectomy, the Insurer wrote to the Provider on **9 February 2012**, as follows:

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> *"Following additional disclosure by* [the Complainant] *at her Nurse Medical please ask her to confirm **in writing** the reason for her hysterectomy, histology, treatment*

The Provider then arranged for the following handwritten note signed by the Complainant to be sent to the Insurer:

> *"*[The Complainant] *had a hysterectomy due to fibrosis, there was no follow-up treatment, histology was benign and no ongoing problem".*

In this regard, the Provider says it has no control or influence on the underwriting process and that this is completely within the responsibility of the Insurer, and that it is the Insurer which decides what level of underwriting is required, as well as what level of information is required and from whom. The Provider says that in asking the Complainant to sign a handwritten note regarding her hysterectomy, it was complying with the Insurer's request of **9 February 2012**.

The Provider says the Complainant had two opportunities to fully disclose her medical history, one with the Adviser when completing the **Application Form** on **26 January 2012**, the other during her Nurse Medical on **7 February 2012**. While it appreciates that she may not have wanted to disclose this type of information to a financial adviser, the Provider says that the Complainant did have the opportunity in a private setting to be completely forthright and fully disclose her medical history to the independent medical practitioner during her Nurse Medical.

In relation to the Complainant's comment that she was not provided with a copy of the **Application Form** by the Adviser, the Provider notes that it is normal practice for it to give all its clients copies of all documentation involved in any application process and says that the Complainant appears to have received a copy of every other document from this application process. In addition, the Adviser also confirms that the Complainant had the opportunity to read over the **Application Form** prior to signing it.
The Provider reiterates that the Nurse Medical on **7 February 2012** afforded the Complainant the opportunity, separate to completing the **Application Form**, to provide full and correct information, but notes that it has since become apparent that the Complainant was not truthful during that medical assessment. The Provider says that at no point was it aware of the significant levels of medical nondisclosures by the Complainant, until it became aware that the Insurer had declined her income protection claim in **July 2018**.

The Provider says that the Adviser fully supported the Complainant during the contestation of her income protection claim with the Insurer, but that it then became very obvious from the Insurer's correspondence that there had been significant nondisclosure of the Complainant's medical history on the **Application Form** and separately, at the Nurse Medical. The Provider says that the good relationship between the Complainant and the Adviser, soured in **April 2019**, when the Adviser informed the Complainant that he would not carry out certain requests she had made, in order for her to bolster her complaint with the Insurer.

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The Provider says that the Adviser disengaged with the Complainant and informed the Managing Director, who instructed him to have no further dealings with her. In this regard, the Managing Director emailed the Complainant on **8 April 2019** to confirm that the Adviser would no longer be dealing with her case and that all communications would now go through the Managing Director. Following further communications, the Managing Director emailed the Complainant on **9 April 2019** to confirm that the Provider would not engage in any fraudulent activity and that any further requests would be dealt with through its legal advisers.

The Provider does not accept that there was, on its part, maladministration of the application for the **Executive Income Protection Plan**, but says it appears that the Complainant is attempting to find fault in the administrative process by creating scenarios where the Adviser was misleading her.

The Provider says the **Executive Income Protection Plan** was, with the full participation of the Complainant, established in the name of her employer for the benefit of the Complainant. The Provider says that the Complainant provided the Adviser with the details of an alternative GP to her regular doctor. The Provider says the Complainant knowingly withheld her medical history not only from the Adviser but also during the independent Nurse Medical, the sole purpose of which was to investigate and evaluate her medical history.

The Provider says that the Complainant was fully involved and aware of all requirements for disclosure at the application stage, and that she had a number of opportunities to provide full details of her medical history. The Provider notes from the Insurer's correspondence to the Complainant, that the level of nondisclosure in this matter goes beyond what could be considered absent mindedness. The Provider says it must not be held accountable for the Complainant's blatant attempt to omit obviously significant information in relation to her medical history.

The Provider notes that the Insurer's decision to void the **Executive Income Protection Plan** from inception also led to significant financial penalties for the Provider as it had to return any and all fees and commissions. The Provider says that while this may not be relevant in terms of the accusations levelled at it by the Complainant, it says it is important in the context that it is not in the Provider's interest to establish policies that at a later date would lead to penalties or refund requests.

<u>**The Complaint for Adjudication**</u>

The complaint is that in 2012, the Provider maladministered the Complainant's application for cover under an **Executive Income Protection Plan**, in that:

- the Adviser failed to complete the **Executive Income Protection Plan Application Form** with the Complainant present

/Cont'd…

- the Adviser completed the **Application Form** incorrectly, sourcing information gathered from earlier policies the Complainant had incepted through the Provider

- the Adviser incorrectly presumed that the Insurer's underwriters would request a PMA (GP Report) and therefore he ticked *"No"* to all the medical history questions contained in the **Application Form** which resulted in the Insurer declining the Complainant's income protection claim in **July 2018** and cancelling the **Executive Income Protection Plan** from inception, on the basis that she had failed to disclose her full medical history when applying for the cover

- the Adviser incorrectly inputted the **Application Form** online to the Insurer, insofar as it contained discrepancies in comparison to the information contained in the hardcopy **Application Form**; and

- the Provider failed to issue the Complainant a copy of the **Application Form** in early 2012, thereby denying her the opportunity to review the application and correct any errors or missing information.

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.

Since the preliminary decision of this office was issued, in June 2022, the Complainant made comments regarding this approach to the requirement or otherwise for an oral hearing, and has submitted that certain conflicts of fact arise, including:

> *"The Broker [name redacted] states in his submission of 4th June 2020, question 14, that No second Income protection application was submitted to [insurer 1] for [Complainant] in April 2013. This statement was proven by the Insurance company [insurer 2] to be incorrect.*

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A complete file was produced by [insurer 2] showing an online application plus several letters of communication between the Broker and [insurer 1] in April 2013 in relation to this application. All details are available to view on Item 4 of disclosure 1-16 by [insurer 2]."

[my underlining above, for emphasis]

I am conscious that the Provider, when responding to question 14, on 4 June 2020, as the Complainant has referred to, did not suggest that no income protection application was submitted in 2013. Rather, the Provider responded, confirming that such an application had been made, and advised, amongst other things, that:

> *"This accusation* is not accepted, as a full tele-interview was conducted by [this other insurer] with the complainant, as is standard practice with [this other insurer] for income protection. It would be difficult to accept that the client was unaware of said application but completed a tele interview with the proposed insurer.*
>
> *The reason for the new application in 2013 was that the complainant was unhappy with the current costs of the income protection policy and had requested research of an alternative more cost-effective plan. This application was declined by [this other insurer] on medical grounds to which we were not made aware of, due to data protection but the complainant was informed that she could request a copy of the medical report to be sent to her GP to which she did not avail."*

[* the accusation referred to is that the Complainant was unaware of this application]

The Complainant continued:

*"Most critical was that the online application was identical in every aspect of information and with all **No** answers to all medical questions to that of the Income protection Policy submitted in January 2012. This is critical evidence as it demonstrates that the broker submitted an application answering all questions himself and furthermore answering "No" to all medical questions on behalf of [Complainant], without [Complainant] being present, using the information that he had from his files. This is exactly what [Complainant] is claiming happened the previous year in January 2012 with her first income protection policy. The information needed was again taken from [Complainant] files of two previous life policies and pension policy."*

Section 12 of the ***Financial Services and Pensions Ombudsman Act 2017*** (the **2017 Act**) provides as follows:

> "*The principal function of the Ombudsman shall be to investigate complaints in an appropriate manner proportionate to the nature of the complaint by:*
>
> *(a) informal means,*
> *(b) mediation,*
> *(c) formal investigation (including oral hearings if required), or*
> *(d) a combination of the means referred to in paragraphs (a) to (c)*."

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No regulations have been made under ***Section 47(4)*** of the ***2017 Act*** and in that context, ***Section 47(5***) of the ***2017 Act*** provides as follows:

> *"Subject to any regulations made under section 4, the procedure for the making of complaints and the conduct of investigations shall be such as the Ombudsman considers appropriate in all the circumstances of the case, and he or she may, in particular, obtain information from such persons and in such manner, and make such enquiries, as he or she thinks fit."*

I further note that ***Section 56(1)*** of the ***2017 Act*** provides as follows:

> *"The conduct of investigations under this Part shall be undertaken as the Ombudsman considers appropriate in all the circumstances of the case and in a manner that is appropriate and proportionate to the nature of the complaint."*

It was open to this Office, when determining the most appropriate procedure for the conduct of the investigation of the present complaint, to consider holding an Oral Hearing to that end, bearing in mind what is appropriate and proportionate to the nature of the complaint. It has been the consistent practice of this Office to conduct oral hearings where there are conflicts of material fact arising in the dispute. This is in keeping with principles of natural justice.

In J*&E Davy v Financial Services Ombudsman* [2010] 3 IR 324 at para 135, the Supreme Court noted that:

> *"[c]onflicting evidence of fact . . . generally does not admit of resolution on written submissions and will generally require some form of oral hearing appropriate to the issues which arise*."

Within the same judgment, Finnegan J quoted from the judgment of Costello P, in Galvin v Chief Appeals Officer [1997] 3 IR 240, as follows:

> *"There are no hard and fast rules to guide the appeals officer, or on an application for judicial review, this Court, as to when the dictates of fairness require the holding of an oral hearing. This case (like others) must be decided on the circumstances pertaining, the nature of the inquiry being undertaken by the decision-maker, the rules under which the decision-maker is acting, and the subject matter with which he is dealing and account should also be taken as to whether an oral hearing was requested."*

It has further been held that an oral hearing is only necessary where the resolution of the dispute of fact will assist materially in resolving the dispute, or if the facts in issue cannot be

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resolved without such hearing; *Coleman v Financial Services Ombudsman* [2016] IEHC 169 at para 24.

Having examined the facts of the present complaint, I have determined that oral evidence is not required for the fair adjudication of this complaint. In addition, whilst the Complainant has referenced her interactions with the provider regarding a pension policy, such separate pension matters fall outside the investigation of this complaint, and are indeed understood to be the subject of pending litigation between the parties, such that any such issue falls squarely outside the jurisdiction of this Office.

A Preliminary Decision was issued to the parties on **8 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. Following the consideration of additional submissions from the parties, the final determination of this office is set out below.

I note that the Complainant was the life assured on an **Executive Income Protection Plan** that commenced on **6 March 2012** where the Policyholder was her employer. The application for the **Executive Income Protection Plan** was carried out with the Provider, an insurance intermediary.

In relation to the complaint that the Provider's Adviser failed to complete the **Executive Income Protection Plan Application Form** with the Complainant present, I note that the Adviser met with Complainant at her place of employment on **26 January 2012**.

The Complainant says that during this meeting the Adviser did not complete the hardcopy **Application Form** with her but instead handed her the Declaration and the direct debit mandate pages from the **Application Form** to sign. The Provider says that on the contrary, the Complainant was present and fully participated in the application process.

I note that the Complainant says, in different submissions, that information such as her date of birth, her PPS number, her date of entry into service with her employer and her weight were incorrectly recorded in the **Application Form**.

In addition, Section 6, 'Underwriting Details', at pg. 3 of this **Application Form** contained a number of medical history questions to be answered and instructed, as follows:

> *"Please answer carefully, giving full details and, if necessary, use a sperate sheet for additional information. If you need to alter an answer, please put a line through the incorrect part of the answer and initial the alteration.*
>
> *When completing this application form you must disclose all Material Facts. Failure to disclose all relevant facts, including full disclosure of your medical details and history, many delay or prevent the issue of your policy and/or invalidate future*

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claims. If you are in any doubt as to whether a fact is a Material Fact you should disclose it".

I note that all the medical history questions were answered *"No"*. I note that the Complainant signed Section 7, 'Declaration', at pgs. 6-7 of the **Application Form** on **26 January 2012**, declaring, amongst other things, that:

> *"I understand that this application, if partly completed online, shall consist of the declarations and consents made by me herein along with the details provided in my online application …*
>
> *I understand that terms and conditions, as provided to me, will apply.*
>
> *I have read over the replies to all questions in this application and declare that to the best of my knowledge and belief, all information given is true and includes all material facts and I understand that failure to disclose all relevant facts, including full disclosure of my medical details and history, may delay or prevent the issue of my policy and/or may invalidate future claims. If you are in aby doubt as to whether a fact is a material fact you should disclose it".*

This Declaration made it clear that the onus was on the Complainant to ensure that all of the information in the **Application Form** was correct and that she had also fully disclosed her medical history. In signing this Declaration, I am satisfied that the Complainant confirmed that all information provided in the **Application Form**, including the answers to the medical questions therein, were both true and complete, and that she understood the possible consequences of the failure to disclose her medical details and history in full.

As a result, I am of the opinion that it would have been prudent of the Complainant to have read back through the **Application Form** before signing the Declaration, to ensure that she was satisfied with the information recorded therein. If having done so she was dissatisfied with the accuracy of the information recorded in the **Application Form**, including the medical history answers, it would then have been open to the Complainant to have amended any such information accordingly.

If the Complainant did not participate in the filling out of the **Application Form** and/or did not have sight of the full hardcopy **Application Form** before signing the Declaration on **26 January 2012**, though I note that there is no evidence before me indicating that either was the case, then I am of the opinion that the Complainant was remiss in signing a declaration that stated otherwise.

In relation to the Complainant's comment in her complaint papers to this Office that:

> *"… My Broker enquired if I was taking any medications for any complaint, the names of my Doctor, I told him I was not taking any Medications, in great health and that the most recent doctor was* [GP 1] *in 2010 and* [GP 2] *previous to that …"*

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Question 8 of Section 6, ‘Underwriting Details’, of the hardcopy **Application Form** asks the applicant to *“Please indicate if you currently have a GP*” and if so, to insert the name and address of the GP.

In that regard, the details for GP 2 are entered, which I note was, by the Complainant’s own admission, her current GP at that time. If the Complainant had wanted to disclose details of a second GP that she had been attending in and around that time, it would have been prudent of her to have read back through the **Application Form** before signing the Declaration, to ensure that those GP details were also recorded therein.

In addition, I take the view that the Complainant’s recollection that the Adviser had asked her the details of her GP and if she was taking any medications for any complaints is somewhat at odds with her contention that the Adviser failed to complete these details in the **Executive Income Protection Plan Application Form** with her present.

Since the preliminary decision of this Office was issued to the parties in **June 2022**, I note that the Complainant has supplied an explanation for the above, that references a different meeting in **November 2011**, that she and her husband attended, and which perhaps caused confusion regarding the information made available.

In relation to the complaint that the Adviser completed the **Application Form** incorrectly, sourcing information gathered from earlier policies the Complainant had incepted through the Provider, I note the Provider says that as the Complainant was at that time a new client and as it had not yet established any protection policies for her, that it would not have held any of the information required to complete the **Application Form** to hand and therefore the Adviser would have had to have gathered such information directly from the Complainant.

The Complainant takes issue with this, and maintains that such a position is factually incorrect, given her attendance with her husband in **November 2011**, in the context of what appears to have been an application for pension cover. The pension application is a matter which falls outside the scope of this investigation and is something which I do not consider to be appropriate for examination in any manner by this Office, given the reference by the Complainant, to pending litigation.

Whatever the explanation, for these opposing views from the parties, I am satisfied that the Declaration the Complainant signed on **26 January 2012** made it clear that the onus was on her to ensure that all of the information in the **Application Form** was correct and in this regard, I take the view that it would have been prudent of the Complainant to have read back through the **Application Form** before signing the Declaration, to ensure that she was satisfied with the information recorded therein. Having done so, if she was dissatisfied with the accuracy of certain information recorded in the **Application Form**, such as, for example, her date of birth, her PPS number, her date of entry into service with her employer, her weight or her current GP details, it would then have been open to the Complainant to have amended any such information accordingly.

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In relation to the complaint that the Adviser incorrectly presumed that the Insurer's underwriters would request a PMA (GP Report) and therefore he ticked *"No"* to all the medical history questions contained in the **Application Form**, I am again cognisant of the fact that the Declaration the Complainant signed on **26 January 2012** made it clear that the onus was on her to ensure that all of the information provided in the **Application Form**, including the answers to the medical questions therein, were both true and complete, and that she understood the possible consequences of the failure to disclose her medical details and history in full.

In relation to the complaint that the Adviser inputted the **Application Form** online to the Insurer incorrectly, which contained discrepancies in the information contained in the hardcopy **Application Form**, the Complainant says in a number of her submissions that her name is inserted as the policyowner on the hardcopy **Application Form** but that the Provider entered her employer as the policyowner in the online **Application Form** and in doing so, the Provider directed the Insurer to establish the **Executive Income Protection Plan** with her employer as the Policyholder.

The hardcopy **Application Form** contains different sections, first for the employer and then the employee to complete, including different subsections under Section 7, 'Declaration'. I note that under Section 1, 'Employer's Details', the Complainant's name is inserted as the *"Name of employer"* in her capacity as *"M/D* [Managing Director]*"* for her employer, and her employer's address is inserted as the *"Business Address"*. I also note that under Section 8, 'Direct Debit Mandate', the name of the bank account from which the premiums are to be collected is a business bank account and that the business account holder is also confirmed to be the policyholder. I am therefore satisfied that Section 7 and Section 8 of this **Application Form**, both of which the Complainant signed on **26 January 2012**, indicate that the **Executive Income Protection Plan** was designed for a company to provide cover for an employee, as opposed to it being an individual plan, and this is what she applied for.

In addition, the Complainant says in several of her submissions that she did not sign the 'Declaration' section of the online **Application Form** and that she was not present when the Adviser inputted the application online. I take the view that it was not necessary for the Complainant to be present when the Adviser inputted the application or for her to e-sign the online 'Declaration' because she had already completed the hardcopy of the **Application Form** and signed the 'Declaration' in that, on **26 January 2012**. Indeed, this is the reason why the Insurer obtained from the Provider the original hardcopy of Section 7, 'Declaration', of the **Application Form** signed by the Complainant on **26 January 2012**, which clearly states:

> *"… **For Broker…online applications, please complete the following and forward only <u>this declarations section</u> to*** **[the Provider]** …".

In relation to the complaint that the Provider failed to issue the Complainant a copy of the **Application Form**, thereby denying her the opportunity to review the application and correct any errors or missing information, I take the view that the Complainant was afforded the opportunity to review the application when she signed the hardcopy **Application Form**. If, for some reason, the Complainant did not have sight of the full hardcopy **Application Form** before signing the Declaration on **26 January 2012** (though I note that there is no

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evidence before me indicating this) then I am of the opinion that she was remiss in signing a declaration that specifically stated otherwise.

The Complainant has raised a number of further points in her submissions to this Office.

In relation to her comments in her letter to this Office dated **13 August 2020** that:

> *"…* [the] *Broker never showed* [the Complainant] *the application questions for verification on the important letter of the 6th of March* [2018] *from* [the Insurer] *prior to start of policy, thus denying the claimant the opportunity to rectify any inaccuracies of information supplied to* [the Insurer] *…"*,

I note that the Insurer wrote to the Provider on **6 March 2012**, as follows:

> *"… I am pleased to enclose the following:*
>
> * *Original Policy Documents*
>
> *I trust you find the enclosures to be in order.*
>
> ***If the application was submitted online we have enclosed a copy of the health questions supplied to us. Please be advised that the answers to the questions formed the basis of our underwriting decision****".*

In my opinion, it would have been best practice for the Provider to have furnished the Complainant with a copy of the health questions that the Insurer had sent it on **6 March 2012**. I am cognisant of the fact that the online **Application Form** submitted by the Adviser to the Insurer contained the same answers to the medical history questions as those contained in the hardcopy **Application Form**, in that they were all answered *"No"*. In that regard, I am conscious that the Complainant had already been afforded the opportunity to review these answers prior to her signing the hardcopy **Application Form** on **26 January 2012**.

Similarly, I note that the Complainant was afforded the opportunity to review the disclosures she had made at the Nurse Medical prior to her signing the **Nurse Medical Form** on **7 February 2012**, which is included in the evidence.

In relation to the Complainant's comments in her letter to this Office dated **13 August 2020** that:

> *"…* [the] *Broker never prepared* [the Complainant] *for the Nurse Medical* [arranged by the Insurer] *in February 2012, failed to advise* [the Complainant] *to have available details of past visits to Doctors, or any information regarding injuries or examinations in preparation for Nurse Medical …"*,

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I am of the opinion that it was not the responsibility of the Provider "to prepare" the Complainant for the Nurse Medical. Rather it was a matter for the Complainant to answer the questions asked during that assessment truthfully and completely.

In relation to the Complainant's comments in her letter to this Office dated **13 August 2020** that:

> *"…* [the] *Broker failed to request that* [the Insurer] *contact my medical Doctor for information on receipt of letter on the 9th of February 2012 from* [the Insurer]*, requesting histology information, or to advise* [the Complainant] *to do so, instead choosing to allow a member of his staff deal with such medical questions …"*

I note that in relation to her disclosure at the Nurse Medical on **7 February 2012** that she had previously undergone a hysterectomy, the Insurer wrote to the Provider on **9 February 2012**, as follows:

> *"Following additional disclosure by* [the Complainant] *at her Nurse Medical please ask her to confirm **<u>in writing</u>** the reason for her hysterectomy, histology, treatment"*

I note that the Provider then arranged for the following handwritten note signed by the Complainant to be sent to the Insurer:

> *"*[The Complainant] *had a hysterectomy due to fibrosis, there was no follow-up treatment, histology was benign and no ongoing problem".*

I am satisfied that in asking the Complainant to sign a handwritten note regarding her hysterectomy, the Provider was simply complying with the Insurer's request of **9 February 2012** and that there was no obligation on the Provider to refer the Insurer or the Complainant to her GP for further details, though of course the Complainant could have chosen to do this if she had wished to.

In relation to the Complainant's comment in her complaint papers to this Office that:

> "… *My Broker was unfamiliar with the Application form in 2012 and never realised there was an option for a Tele medical until 2018 …* ",

I note that Section 5, 'Additional Details for Tele Underwriting Applications', at pg. 2 of the hardcopy **Application Form,** allowed for the Complainant to forgo answering the medical history questions contained in Section 6, 'Underwriting Details', in favour of partaking in a telephone interview with an experienced nurse at a later date. The Complainant, in her discussion with the Adviser, did not choose this option and instead the answer *"No"* was entered to all the medical history questions contained in Section 6, 'Underwriting Details', of the **Application Form**, with no medical history disclosed. In that regard, I am of the opinion that it was open to the Complainant, prior to signing the **Application Form** on **26 January 2012**, to have elected instead to avail of the option for a telephone interview at a later date, if this was her preference, rather than discussing these details with the Provider's advisor.

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I am conscious that the Complainant has maintained that when she eventually received a copy of the application for cover, she noticed immediately that certain details were wrong, including she says, her date of birth, which was incorrect.

I note however, that the Application Form contained details of a date of birth which is identical to the date of birth entered on the Nurse Medical which the Complainant subsequently completed, and which also matches the date of birth which the Complainant entered on the FSPO Complaint Form.

Since the preliminary decision of this office was issued to the parties on **8 June 2022**, the Complainant has since submitted:

> *"I must sincerely apologise this is my error, my date of birth was correct it was my pps number and start date, that was incorrect."*

It remains unclear how the Complainant could have believed that her date of birth was incorrect, but I note her acknowledgement of this error.

In submitting this complaint to this Office, the Complainant also explained that at the time when she met her broker, she responded to the enquiry as to whether she was taking any medications for any complaint and she told him "*I was not taking any medications, in great health*". It is clear to me however, from the details set out in the Insurer's letter to the Complainant dated **23 July 2018**, that at the time when she completed the Application for cover in early 2012, she had over the previous years encountered significant medical symptoms warranting numerous investigations, including MRIs, as follows:-

> *"The notes received have confirmed that you failed to advise us of the following significant medical history when you were completing your application for Income Protection:*
>
> *12.07.2004 - Mild depression short course of SSRI*
>
> *25.07.2008 - attended GP advised suffers night sweats swallowing Panadol, develops during the day, works 6/7, frontal and back of head, memory poor referred for MRI*
>
> *30.08.2008 - MRI of Brain*
>
> *03.11.2008 - attended A&E with severe lower back pain and left sciatica*
>
> *04.11.2008 - called to advised* (sic) *acute onset of low back pain brought to casualty by ambulance GP told to arrange MRI*
>
> *12.12.2008 - MRI of lumbar spine degenerative disc disease with prominent L4/5 disc bulging and further protrusion to the left causing L5 nerve root compression on the left*

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27.01.2009 - attended neurosurgeon following acute lower back pain that lasted 10 days around November

13.10.2009 - working hard and stressed out headache and ache down left arm pain in teeth

10.2009 - Chest X ray

21.05.2010 - still works v hard notices when walking one leg trips her mostly the left, more forgetful headless and not concentrating, concentration poorer, memory not as good, MMSE at next visit, bloods, MRI, peripheral nervous system exam

23.05.2010 - attended A&E with limb problems, noticed swelling and tenderness over right shoulder.

26.05.2010 - attended GP shoulder up and down a lot of pain sleep ok with it

26.05.2010 - MRI of chest and of shoulder

16.06.2010 - attended GP looks like shoulder feels well again movement has improved

19.07.2010 - attended GP referred for MRI brain

04.08.2010 - MRI cervical

04.08.2010 -MRI brain

29.08.2011 - attended GP 2 days passing blood in stool".

The Insurer also advised the Complainant in this letter of **23 July 2018**, that:-

"The significance of this failure to disclose full medical history is such that our Underwriters have confirmed that had we been aware of this information when considering your application for Executive Income Protection we would not have been in a position to accept your application.

Therefore in accordance with Condition 27 of your policy, outlined below, we regret that we must unfortunately decline your Income Protection claim and Void your policy since inception."

In examining this complaint, I am very conscious of the details which the Provider's Advisor set out to the Insurer in a communication on **13 August 2018**, referencing the fact that the Complainant, during a meeting which took almost 2 hours, had been called from the discussions on a few occasions in order to deal with workplace matters. Interestingly, the Provider's Advisor indicated the opinion that "*if the questions were put to her properly, she would have answered to the best of her ability and with 100% truthfulness*".

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In my opinion, this is indicative of a suggestion that the questions had not been put to the Complainant properly at the time of the completion of the application by the Provider. I note that the Provider's Advisor told the Insurer that this case

> "*has made me look at life assurance applications in a different manner. For instance, many questions asked on an application form may contain as many as 12 sub-questions within each question. This, in hindsight, is rather alarming as it is very easy to see why clients could say no to something when they might not hear every single part of the question posed. To use this case as an example, the amount of paperwork and topics that had to be covered on the day would necessitate meeting the client individually to discuss each particular piece of business in order for the client to be 100% au fait with what was going on, especially the way the questions are designed…*".

This information begs the question as to why the Provider, whose professional role it was to very clearly put the relevant questions to the Complainant, and secure accurate answers, might wonder as to whether she might not have heard every single part of every question it had posed.

It is also strange that the Provider's Advisor offered the opinion at the time that "*it defies logic that an individual in their 50s, or indeed any age, is 100% liable for the answers to questions asked on an Application Form*". This appears to be an unusual comment from a Broker which would be expected to fully understand the obligations arising from a proposer's duty of *uberrimae fides*.

In my opinion, the terms of the communication in question between the Provider's Advisor and the Insurer, suggest that inadequate attention was paid by the Provider's Advisor to how the questions were put to the Complainant, and that the Provider failed to communicate to the Complainant the importance of ensuring that the answers given to the medical questions were completely accurate.

In my opinion, the Provider has a case to answer to the Complainant in that regard and I take the view that the Provider's failure to ensure that the Complainant completely understood the questions being put to her and understood the necessity of giving accurate answers, was unreasonable within the meaning of ***Section 60(2)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017***.

Be that as it may, I am also conscious that whatever errors might have arisen from this potentially poor communication between the Provider and the Complainant, at the time of completing the Application Form, the Complainant had another opportunity to ensure that all relevant information was made available to the Insurer, when she underwent the Nurse Medical some weeks later on **7 February 2012**. I am conscious in that regard that in undertaking this separate Nurse Medical interview, the Complainant incorrectly answered "NO" to the following questions which were put to her at that time:-

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> *"3. Have you ever suffered from any mental or nervous disorder including anxiety, depression, psychosis or schizophrenia?*
>
> *8. Have you ever suffered from back problems or disorders of the muscles or joints including prolapsed/slipped disc, sciatica, gout, osteo or rheumatoid arthritis?"*

Since the preliminary decision of this Office was issued, in **June 2022**, I note that the Complainant maintains that contrary to the entry in the medical notes disclosing "*12.07.2004 - Mild depression",* she was not suffering from Depression in 2004, but rather she was suffering from bereavement, and that this was ultimately accepted by a different insurer in 2018.

I also note that Question 18 of the Nurse Medical interview, required the Complainant to answer the following question: -

> *"Have you been to see your GP in the past 6 months? If yes, for what reason?"*

I note that the Complainant also answered "NO" to this question although the details which are quoted above, from the Insurer's letter to her dated 23 July 2018, make clear that she had attended her GP on 29 August 2011, complaining of 2 days passing blood in stool.
I appreciate however, that the period in question was quite close to 6 months and I note that the Insurer ultimately took no issue in that regard.

Since the preliminary decision of this Office was issued to the parties in **June 2022**, the Complainant has submitted additional details and documents arising from certain interactions at a meeting with the Provider, which the Complainant attended with her husband in late 2011, including what she describes as "*details of company business information that was recorded on the 21/11/2011 by the provider in apply for a company pension for [Complainant]"*. I do not consider it appropriate to comment on such documents or details, as the pension issue arising appears to be the subject of pending litigation as between the parties.

Having considered all of the evidence available to me however, and on the basis of the Provider's letter to the Insurer dated **13 August 2018**, I take the view that the Provider has a case to answer to the Complainant in respect of its administration of her proposal for the Executive Income Plan. I am satisfied nevertheless that it is the Complainant herself who bears the lion's share of responsibility for the non-disclosure of information to the Insurer.

In my opinion, if adequate medical information had been made available to the Insurer, during the Nurse Medical interview, any items overlooked or forgotten whilst completing the Application Form with the Provider in January 2012, would have been corrected and this would have given the Insurer the opportunity to properly explore its assessment of the risk being proposed for by the Complainant, to enable suitable terms to be agreed.

Accordingly, taking account of the subsequent non-disclosure which occurred during the Nurse Medical interview in February 2012, I am satisfied that it is appropriate to partially

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uphold this complaint. To mark that decision, I consider it appropriate to direct the Provider to make a compensatory payment to the Complainant, as specified 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 to make a compensatory payment to the Complainant in the sum of **€7,500** (seven thousand, five hundred 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)

18 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

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(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.