An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0237
Sector:	Insurance
Product / Service:	Personal Accident
Conduct(s) complained of:	Mis-selling (insurance)
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The complaint concerns an accident and injury policy.

The Complainant's Case

The Complainant took out an accident and injury policy with the Provider in **1996** and maintained the policy "*for the next 20 plus years in good faith*".

In **July 2019**, the Complainant sustained an injury which required surgery and a period of convalescence. The Complainant had a [redacted] accident when he fell while repairing a roof. He suffered full tibial plateau fracture and underwent surgery for this on **21 July 2019**. He had no use of his leg at the time and was only mobile on crutches. He says he was totally disabled from the accident until the end of **August 2019** when his "*treating team advised*" that he could start physiotherapy. However, he explains that he continued to be partially disabled and required rehabilitation from his surgery for another number of weeks.

The Complainant's representative, who became his representative in this matter, states that a claim was submitted to the Provider on **17 September 2019**, and the Provider processed a total claim amount of **€228.54** (two hundred and twenty-eight euro and fifty-four cent).

She states that the statement of benefits, which the Complainant had received on a regular basis, had identified the accident convalescence amount on the policy to be **€38.09** (thirty-eight euro and nine cent) per day with no limit. As the Complainant's recovery occurred over a number of weeks, and he was unable to return to work until **mid-October 2019,** he expected the amount allowed under the claim to be greater.

The Complainant's representative notes that the Provider sets out that the accident convalescence claim amounts, are linked to the total period of stay within a hospital. The Complainant contends that this limitation was not communicated to him over the time when he was a policyholder.

The Complainant denies ever receiving a copy of the policy to which the Provider refers, and he says that there is no date on the policy document to indicate when this policy was created. His representative states that the policy is not viable when linked to hospital stays, as the average time spent within the hospital is low. She contends that the Provider has not made full and open disclosure of the limitations of the policy, by detailing the exceptions that apply, on the annual statements the Complainant receives, as is the case with other policies which the Complainant had.

The Complainant's representative also stated that the Provider initially told her that it was not possible to correspond by way of email, but then this changed overtime. She stated she had attempted to seek third party authority on two separate occasions, but the post was returned to her marked "*gone away*".

The Provider's Case

The Provider states that annual statements of cover were issued to the Complainant "*as far back as 2012*", which show a list of his policies and a summary of his benefits.

The Provider contends that, although these statements do not detail all limitations and exclusions, nor did they specify that the accident convalescence payments are limited to the number of nights spent in the hospital, the statements act as summaries and do not supersede the policy wording. The Provider states that "*each statement instructed* [the Complainant] *to read it with the Policy Wording and if he didn't have a copy, he could contact us to request this*". The Provider states that it has no record of the Complainant requesting a copy of the policy wording.

On **17 September 2019** the Provider wrote to the Complainant stating that he was entitled to €228.54 in respect of his claim. It stated that with this payment, it paid him benefits from, which reflected the two days as an inpatient and also the two days of convalescence at home.

The Provider notes that the Complainant's representative had sought to furnish a letter of authority to the Provider, at its request, on two occasions, but both had been returned to her undelivered. The Provider states that this is due to the letter being sent to the Provider's head office which does not normally accept mail there. The Provider's representative stated that it was "*sorry about this, you did what our claims department requested so this isn't your fault it's ours*".

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The Provider states that it accepts a scanned letter of authority, and that its representative set out that he "*agrees the service you are provided here fell short of what we would expect our customers to receive*". The Provider states that "*to apologise for the poor service, [it would] like to make a payment to* [the Complainant} *of €100*".

The Complaint for Adjudication

The complaint is that the Provider wrongfully failed to inform the Complainant of the limitations of his accident convalescence cover provided for in his policy, in its annual statements and failed to provide transparency in relation to the policy and its limitations. The Complainant also says that the Provider supplied poor customer service in the period since **September 2019**.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision, I have carefully considered the evidence and submissions put forward by the parties to the complaint. Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on **28 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.

The complaint was the subject of a jurisdictional review by this Office, and upon completion of this review it was determined that because this Office has no power to investigate the conduct of a financial service provider which occurred before **1 January 2002**, it is not possible for this Office to investigate any matters surrounding the sale of the of the policy to the Complainant in **1996**. The parties have agreed to proceed upon this basis, in respect of "The Complaint for Adjudication" which is outlined above.

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I note the wording of the policy dated **1996** which states at "Section B":

> "*CONVALESCENCE BENEFIT - ANY ACCIDENT*
> *If benefits are payable to the Insured under Section A and immediately following discharge from the Hospital the insured shall suffer Total Disability (not involving Hospital Confinement) then the Company would pay a benefit as shown in the Schedule of Benefits under B for each day of continuous Total Disability for a period up to but not exceeding the number of In-patient days.*

I note that the **1996** policy document was signed by the Complainant and therefore, I am satisfied that the Complainant was on notice of and thereby bound by the terms of the **1996** policy he agreed.

I note that **in 2018, 2019,** and **2020** the Provider sent a letter to the Complainant stating:

> "*To help you better understand the cover you hold with us, please find enclosed your annual statement of cover. This lists the policies you have with us and the benefits you may be entitled to. The full terms and conditions of the policy can be found in the Policy Provisions documents which you should have received when you first bought your policy. If you would like another copy of your Policy Provisions, please call us*.
>
> *If you have any questions about your cover, or if your circumstances change, please contact our Customer Services team*."

One such letter was sent on **16 July 2019**, shortly before the accident.

On **21 October 2019**, an agent of the Provider telephoned the Complainant stating that his representative had emailed the Provider, but the Provider could only contact him directly where there was no third-party authorisation yet. On the same day, the Complainant telephoned the Provider giving the details of his representative's mobile number to allow her to discuss the claim.

The Complainant stated he was "*disgusted with*" the offer of payment for the claim and the Provider's agent stated that the plan is the "*hospital indemnity plan*" and that, though the Complainant had three other plans, they were to do with sickness, and this was the only plan he had regarding accident cover.

The Provider explained that the convalescence cover under this plan only paid for the same number of days, as he had been in the hospital. Therefore, because he had two nights stay in hospital, he was only entitled to cover for two days of convalescence at home. The Provider's agent stated that the delay in sending him his policy wording was due to the delay in his representative sending the data protection form and third-party authorisation form, which meant the Provider could not speak with her directly or send her the documents.

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I note that the Provider's agent stated that she would send the documents to him directly. The Complainant sated that he had not been sent the **1996** policy document previously, to which the Provider's agent stated that he was required to request this before it would be sent out to him. The Complainant logged a complaint during the telephone conversation.

On **21 October 2019**, the same Provider's agent telephoned the Complainant's representative, and again explained the issue concerning sending the policy documentation directly to her pending receipt of the authorisation form and data protection form. She queried why the letter she sent had been returned marked "*gone away*" and she stated that the specific address and envelope for the authorisation form and data protection form, was not provided. The Provider's agent stated that she would send the policy wording to the Complainant directly, as she was awaiting the authorisation form and data protection form.

Analysis

I am satisfied that under the policy document dated **1996**, the Complainant is entitled to cover only for "*for each day of continuous Total Disability for a period up to but not exceeding the number of In-patient days*". For the Complainant, this amounted to two days in hospital and two days of convalescence at home.

Although I understand the Complainant's frustration about not having a copy of the **1996** policy document in his possession, I accept that it was open to him to contact the Provider to request a copy, at any stage before he had the accident. I am satisfied this was clearly set out in the annual statement letters which were sent to him, every year.

Accordingly, I do not accept the element of the complaint made by the Complainant that the Provider wrongfully failed to inform him of the limitations of his accident convalescence cover within his policy, within the Provider's annual statements, or that it failed to be transparent in that regard. In any event, annual statements are simply that – they are not designed to include every provision of the policy cover, and I note indeed that the statements issued by the Provider referred the Complainant to the policy document.

Regarding the failure to send the documentation to the Complainant at the time of his claim, I note that, despite corresponding by email with the Complainant's representative, the Provider stated in an email dated **24 September 2019** that it would send the relevant information by post to the Complainant. However, the Provider has since acknowledged to this Office, that this was not sent.

In addition, in the email exchange in **September 2019,** the Provider's agents failed to indicate the correct postal address for the authorisation form to be sent by the Complainant's representative. She had sent a scanned copy of same, but the Provider had sought for it to be posted instead. The Provider has also confirmed that, ordinarily, a scanned copy of the signed authorisation form should be sufficient.

I note that Provider has stated the following:

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> "*Our claims team should have made the process easier in order to try and assist with [the Complainant's] claim. The photo of the form …* [representative] *provided was poor, but she did say she could email a scanned copy which would have been clearer, but Claims requested that she post this which she did and the issues above occurred. In addition, they did not send the documentation they agreed to post [to the Complainant]; this should have been sent. I can find no evidence claims tried to call [the Complainant] back in September, other than the claims advisor confirming they did; there were no notes to confirm this. This complaint point was upheld*."

I note the Consumer Protection Code 2012 (CPC 2012) section 7.7 which states a regulated entity must have in place a written procedure for the effective and proper handling of claims. At a minimum, the procedure must provide that:

> "*d) the regulated entity must offer to assist in the process of making a claim, including, where relevant, alerting the claimant to policy terms and conditions that may be of benefit to the claimant*;"

I note that the Provider failed to send the policy documents to the Complainant directly, and it also failed to properly facilitate his representative becoming the authorised representative to engage with the Provider. This led to a delay of almost a month before the policy documents were ultimately sent to the Complainant and his representative. I am satisfied that this constituted poor customer service by the Provider and the delay was a breach of Provisions 2.2 and 7.7 of the CPC 2012, in addition to being unreasonable conduct, within the meaning of ***Section 60(2)(b***) of the ***Financial Services and Pensions Ombudsman Act 2017.***

The Provider states that "*to apologise for the poor service, [it] like to make a payment to* [the Complainant] *of €100*". The Provider has submitted that this payment was made by cheque to the Complainant on **8 November 2019**. However, I am of the view that this amount of compensation offered is insufficient, given the nature of the Provider's errors, including its failure to return calls. Accordingly, I intend to direct the Provider to make an additional compensatory payment to the Complainant, as directed below.

<u>Conclusion</u>

- 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 **€400** (four hundred euro) to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the Provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

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- 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)

20 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

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