Decision Ref: 2022-0313

Sector: Insurance

Product / Service: Income Protection and Permanent Health

Conduct(s) complained of: Dissatisfaction with customer service
Claim handling delays or issues
Delayed or inadequate communication

Outcome: Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant is a voluntary member of a **Group Salary Protection Scheme** since **1 November 1986**, which provides life, income protection and specified illness cover. The Grantees of this Scheme are a named Trade Union, the individual members of which can organise cover through the Respondent Provider which is a financial broker engaged by the Grantees to be the Scheme Administrator.

The Insurer is responsible for underwriting the applications for cover and assessing claims. This complaint concerns the suggested poor customer service the Provider demonstrated to the Complainant when she had cause to claim under the Scheme.

The Complainant's Case

The Complainant, a primary school teacher, was medically certified as unfit for work since **11 June 2014**. The Complainant says she had fallen severely ill due to numerous conditions that included post-surgery complications and that she suffered from nerve damage, resulting in her having difficulty thereafter, using one of her feet.

The Complainant says she telephoned the Provider on **20 February 2015** to query making an income protection claim under the Group Salary Protection Scheme. The Complainant subsequently on **25 February 2015,** completed an Income Protection Claim Notification Form to be sent to the Insurer.

The Complainant says that as part of the assessment of her income protection claim, she had a tele-interview with a specialist nurse on **13 March 2015** and, in that regard, in her letter of complaint to the Provider dated **29 July 2019**, she submits that:

> "[The] *interview by phone is too long (over 2½ hours) and it is unfair to someone who is ill, weak and recovering from serious illness and trauma to endure. Then the client has to edit the transcription which demands energy and concentration. A face to face meeting with a health professional would be much more appropriate and manageable in my case at least and I am curious why* [the Provider] *do not offer this to their clients?"*

Following its assessment, the Insurer admitted the Complainant's income protection claim from **2 May 2015** and the claim has remained in payment since.

The Complainant says the Provider wrote to her on **20 May 2015** to query if she had applied for or been granted ill-health early retirement, and in her letter of complaint to the Provider, she submits that:

> *"I was only a few months in receipt of* [Income] *Protection Benefit when* the Provider] *at the behest of* [the Insurer] *wrote asking me if I was considered Ill Health Retirement. This was inappropriate and an unfair imposition on me as I was struggling to overcome life-changing events and needed time to process and accept what had happened while at the same time, trying to recover medically and physically. I certainly did not need* [the Provider]*…niggling and troubling me with a possibility that I was not yet ready to countenance and could have plunged me into the depths of despair"*.

In her letter to this Office dated **18 November 2020**, the Complainant submits that the Insurer asking her about ill-health retirement was *"…a ploy to direct clients to consider or apply for Ill Health Retirement which would accordingly reduce* [the Insurer's] *pay out".*

The Complainant says her employer granted her early retirement, on ill-health grounds from **16 March 2016**.

The Complainant says she attended a retirement planning seminar in **February 2016**, where she first learned that given her medical diagnosis, she may also be eligible to claim a once-off specified illness benefit lump sum of 25% of her annual salary, under the Group Salary Protection Scheme and in her letter of complaint to the Provider, she submits that:

> *"I was not advised of* [Specified] *Illness Benefit when I made my request for salary protection benefit by phone* [to the Provider] *on 20/2/2015"*.

In that regard, the Complainant says that the Provider failed to properly advise her of her entitlements under the Scheme, during her telephone call to it on **20 February 2015**.

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The Complainant says she then telephoned the Provider on **3 March 2016** to request a specified illness claim form and in her letter of complaint to the Provider, she submits that:

> *"*[The Provider] *did not want to send a form to me but wanted to email* [the Insurer] *instead. He also asked me what was my medical condition (which was none of his business in any event) and then told me he was not a medical person. Why did he not want to send a* [specified illness claim] *form and why did he ask about my condition?"*

The Complainant completed a Specified Illness Claim Form to the Insurer on **26 April 2016** and following its assessment, the Insurer admitted the claim on **31 May 2016**.

The Complainant says that when the Insurer informed the Provider that it had arranged for her to attend for a medical examination with a Specialist in Occupational Health on **2 September 2016**, the Provider failed to furnish her with adequate location details and in that regard, in her letter of complaint to the Provider, she submits that:

> *"*[The Provider] *provided scant details as to the location of the* [medical examination] *venue – no map, no Eircode, not even a phone number. I had to make a number of phone calls on 2/9/2016".*

The Complainant says that following a later medical examination with this Specialist on **15 August 2017**, the Insurer informed the Provider that it had arranged for her to attend a Chronic Pain Abilities Determination (CPAD Assessment) at her home on 27 and 29 November 2017. The Complainant says she telephoned the Provider on **1 November 2017** to obtain a copy of the Specialist's Report and in her letter of complaint to the Provider, she submits that:

> *"I stated clearly* [to the Provider by telephone on 1 November 2017 that] *"I want to know what's in that report before* [the CPAD Assessor] *comes to me"".*

The Complainant says that the Provider then failed to promptly and properly advise the Insurer of her stipulation that she would not attend the CPAD Assessment without first having sight of the Specialist's Report, resulting in her having to cancel the CPAD Assessment, due to the delay in her GP receiving a copy of the Specialist's Report.

The Complainant says that during telephone calls that took place on **22 November 2017** and **15 December 2017** between the Provider and the Insurer, Provider Claims Administrator Mr D. failed to correct the Insurer when the Insurer made incorrect comments regarding her cancellation of the CPAD Assessment and in her letter of complaint to the Provider, the Complainant submits that:

> *"When my CPAD appointment for 27/11/2017 had to be cancelled on 20/11/2017 because of the delay* [in the Insurer sending the Specialist's Report to my GP], [the Insurer] *were annoyed. Phone calls between* [Provider Claims Administrator Mr D.] *and* [the Insurer] *on 22/11/2017 and 15/12/2017 reveal* [the Insurer] *making disparaging remarks about me in relation to the cancellation.*

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> [Mr D.] *failed to correct* [the Insurer] *and remind him that it was* [the Insurer's] *fault that they had to "take a hit" on the first CPAD cancellation as I had clearly stated to* [the Provider] *on 1/11/2017 that I would not see* [the CPAD Assessor] *without first reading the* [Specialist's] *report …*
>
> *The phone call on 15/12/2017 is quite offensive to me as a client of* [the Provider] *because* [the Provider] *did not support or defend me in any way when* [the Insurer] *referred to me as "that woman", said that I was unreasonable, and said that I would have to take a hit for cancelling the 2nd CPAD on 2nd and 4th January 2018 because the notice given by me on 15/12/2017 was inadequate.*
>
> *Again* [Mr D.] *should have quelled these derogatory remarks and supported my position as I had done nothing wrong while* [the Insurer] *and* [the Provider] *had failed to furnish me with a copy of the* [Specialist's Report] *in a timely fashion"*.

The Complainant also refers to a telephone call that took place on **22 July 2016** between the Provider and the Insurer and in her letter of complaint to the Provider, submits that:

> *"I listened with horror to the call on 22/7/2016 between* [Provider Claims Administrator Ms O.] *and* [the Provider] *when they laughed hilariously at missing the payment run and that I would not get my €662 payment until the following month and how they would have to "Apologise profusely". Then more hilarious laughter".*

In the **Complaint Form** she completed to this Office, the Complainant submitted that:

> *"*[The Provider] *failed to inform me of my entitlements …* [and] *failed to inform* [the Insurer] *of my instructions.* [The Provider] *caused me stress, anxiety and mental anguish. Due to* [the Provider's] *failures (admitted), I was made suffer, was threatened, disparaged and belittled"*.

The Complainant says the Provider did not treat her as a vulnerable consumer throughout her dealings with it and was in breach of is obligations under the Central Bank of Ireland ***Consumer Protection Code 2012 (as amended)***.

In her letter to this Office dated **18 December 2019**, the Complainant submits that:

> *"*[The Provider's] *"apology", if it could be called an apology, was insincere and conditional; it was my main reason for complaining about* [the Provider] *as I knew that I had been wronged in so many ways.*
>
> *In* [the Provider's] *dealing with me, they failed to represent me to* [the Insurer], *they failed to inform me of my entitlement to* [Specified] *Illness Benefit, they clearly did not want to send me a* [specified illness] *claim form …* [Provider] *staff feel free to laugh about mistakes made by them depriving me of my payments and tell me that they are "deeply sorry IF this conversation upset you in any way" and finally* [its] *offer of a tangible gesture* [a cheque in the amount of **€300.00 (three hundred Euro)**] *proves the lack of understanding they had of their failures to me"*.

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In that regard, the Complainant submits in the Complaint Form that in order to resolve this matter:

> *"I believe payment of an appropriate sum of money is in order. I would like a sincere and detailed apology and a recognition of the personal anguish I have suffered due to* [the Provider's] *failure".*

The Provider's Case

The Provider says that the Complainant telephoned the Provider on **20 February 2015** to advise that she had been on sick leave since **12 June 2014** and was due to come off her employer's payroll on **2 May 2015** and she provided details of her medical conditions.

The Provider says it sent an Income Protection Claim Notification Form to the Complainant on **23 February 2015**, which she completed on **25 February 2015**. The Provider notes that following its assessment, the Insurer advised on **15 May 2015** that it was admitting this claim from **2 May 2015** and that the claim has remained in payment, since that time.

The Provider acknowledges that due to an oversight, the Claims Administrator did not inform the Complainant during the telephone call on **20 February 2015** of the specified illness benefit available under the Scheme.

In that regard, the Provider says its Claims Administrators are not medical assessors and therefore the process is that where a Claims Administrator thinks a client may be able to claim specified illness benefit, they check with the Insurer before sending a claim form to the client. The Provider notes that this is to prevent a situation where it incorrectly sends a specified illness claim form and gives the client the expectation that they can claim this benefit, when in fact they cannot. The Provider also notes that the Insurer itself checks each income protection claim form received and when it identifies that the claimant can also make a specified illness claim, the Insurer advises the Provider of this, and the Provider will issue the Specified Illness Claim Form. The Provider says that, regrettably, in this case, neither of these steps occurred.

The Provider notes that its standard practice is to include a **Salary Protection Scheme Summary Booklet** with a claim form, however it is cognisant that the cover letter that accompanied the Income Protection Claim Notification Form it sent to the Complainant on 23 February 2015, did not specify that the Scheme Summary Booklet was included and as a result, the Provider says it has no proof that this was sent to the Complainant at that time, though it believes it is likely, as it has always been its standard practice to do this.

The Provider notes that details of the Specified Illness Benefit are set out at pg. 5 of the Booklet that was in circulation at the that time.

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The Provider notes that on **16 March 2016**, it sent an email to the Complainant as part of a general communication to all Scheme members which included a link to the Scheme Summary Booklet and details of the Specified Illness Benefit are set out at pg. 7 of this Booklet.

The Provider also notes that on **9 September 2014** it had sent an email to the Complainant as part of a general communication to all Scheme members which included a link to the Scheme Summary Booklet in circulation at that time, and details of the Specified Illness Benefit were set out at pg. 5 of this particular Booklet. The Provider says that while this email was sent before 2015, its records confirm that the Complainant opened this communication on **17 April 2015** and again on **14 August 2015**.

In relation to her income protection claim, the Provider notes that the maximum income protection benefit payable is 75% of the claimant's salary, less any other income, such as half-pay, temporary rehabilitation remuneration, State Illness Benefit or Ill-Health Early Retirement Pension. The Provider notes that on **15 May 2015**, the Insurer admitted the Complainant's income protection claim from 2 May 2015 and paid 75% of her salary, as she was not entitled to State illness Benefit, and she had not applied for ill-health early retirement at that time.

The Provider says it wrote to the Complainant on **20 May 2015** asking her to advise if she had applied for, or been granted an Ill-Health Early Retirement Pension and explained why it was asking for such information, as follows:

> *"In order for* [the Provider] *to ensure that your benefit is amended accordingly, and to ensure that no under or over payment of benefit occurs in respect of your claim, please can you confirm the following information for* [the Insurer] *at your earliest convenience:*
>
> - ***Have you applied for or been granted Ill Health Early Retirement Pension?***
>   - *If you have applied, please can you provide us with an update on your application.*
>   - *If your application has been granted, please can you confirm the date on which this was granted and the annual amount payable".*

The Provider says that it was asking this information so that it could pass it to the Insurer and that the Insurer in turn could ensure that the income protection benefit being paid was at the correct level. The Provider says it does not believe that this question put the Complainant under any undue pressure or that it was asked, as she asserts it was, as a ploy to reduce the Insurer's liability.

The Provider says that the relationship between it and the Complainant's employer is centred on the request and provision of information relating to the Complainant's claims with the Insurer. The Insurer requires such information to enable it to determine when its liability commences and the level of benefit to be paid.

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The Provider says that it forwards the information it receives from the employer to the Insurer, such that it acts as a conduit between the Insurer and the Complainant's employer, on the Complainant's behalf, so that she does not have to do this herself.

In that regard, the Complainant signed an **Employer Authorisation Form** on **26 February 2015** giving the Provider permission to request information from her employer, on her behalf, for the purposes of progressing claims.

The Provider says it wrote to the Complainant's employer on **4 March 2015** for confirmation as to whether or not the Complainant may have recently retired, or applied to retire, or, if she was entitled to, or had been granted, temporary rehabilitation remuneration. The Provider notes that this information is necessary for the Insurer to correctly calculate the level of income protection payable. The Provider notes that this letter also stated that:

> *"We note that this member may have recently retired or applied to retire on ill-health grounds".*

The Provider says that this wording is standard generic wording and uses the word *"may"* and therefore does not infer that the Complainant had retired.

The Provider notes that when the Complainant telephoned on **3 March 2016**, the Claims Administrator confirmed to her that she did have specified illness benefit cover on her policy and asked her the illness in question. The Complainant referred the Claims Administrator to the medical details on her income protection claim form and he advised her that he was not medically trained and would contact the Insurer with the details. In that regard, the Provider notes the following exchange during the call:

> Claims Administrator: *So basically, what I will have to do is because we are not medically trained here, so again just from looking at the claim form to see does it fall into one of the conditions that are listed, what I will do, I will send an email to* [the Insurer] *just with the details –*
>
> Complainant: *No, no, just send me the form …*

The Provider notes that the Claims Administrator never actually got the chance to finish his sentence which the Provider says was likely to have said that he was sending an email with the details to the Insurer to confirm if a specified illness claim could be made. The Provider says it actioned the Complainant's request by sending her a Specified Illness Claim Form the following day, on **4 March 2016**.

The Provider notes that the Complainant completed the Specified Illness Claim Form to the Insurer on **26 April 2016** and following its assessment, the Insurer advised on **31 May 2016** that it was admitting this claim, which is a once-off lump sum payment.

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The Provider says that on **2 April 2016**, the Complainant verbally confirmed to it that she had been granted an Ill-Health Early Retirement Pension from her employer from **16 March 2016** and that she would provide it with details once received from her employer.

The Provider notes that on **28 April 2016**, the Insurer requested details of the Complainant's pension and noted that there would be an overpayment on her income protection claim. The Provider says that on **17 May 2016**, it received from the Complainant's employer, details of her pension, which it forwarded to the Insurer on **24 May 2016**. The Provider says that it wrote to the Complainant on **20 May 2016** to advise her that the Insurer had paused her income protection as it wanted to minimise any overpayment that may occur while it was recalculating her benefit taking into account the pension information. The Provider notes that the Insurer recommenced paying the income protection claim from **14 June 2016** at the recalculated amount.

The Provider notes that all medical examinations are arranged by the Insurer and details of these are communicated by the Provider by email. In that regard, the Provider says it wrote to the Complainant on **15 August 2016** with the time, date and address for her first examination with the Specialist in Occupational Health and on **20 July 2017** with the time, date and address for her second examination with the Specialist. The Provider says it also wrote to the Complainant on **21 July 2017** with detailed directions for travelling to the examination location.

The Provider also notes that it wrote to the Complainant on **6 October 2017** to confirm that the two-day CPAD Assessment was scheduled to be carried out at her home at 14:00 on **27 November 2017** and 11:00 on **29 November 2017**. When this was rescheduled, the Provider wrote to the Complainant on **29 November 2017** to confirm that the Assessment was rescheduled for 14:00 on **2 January 2018** and 11:00 on **4 January 2018**, and again on **21 December 2017** to confirm that the Assessment had been rescheduled for 11:00 on **20 February 2018** and 11:00 on **22 February 2018**.

The Provider notes that after writing to the Complainant on 6 October 2017 to confirm that the CPAD Assessment was scheduled to be carried out on 27 and 29 November 2017, the Complainant telephoned on **1 November 2017** and spoke with Claims Administrator Mr D. to request that a copy of the Report from the Specialist in Occupational Health, be sent to her in advance of the CPAD Assessment. Mr D. informed the Complainant that the Provider does not have access to or control of the medical evidence held by the Insurer, and that a medical report can only be sent by the Insurer to a nominated medical practitioner.

The Provider emailed the Insurer on **1 November 2017** requesting that a copy of the Specialist's Report be sent to the Complainant's GP. The Provider accepts that it was an oversight on its part, that it did not make it clear to the Insurer at that time that the Complainant wanted to see this Report <u>before</u> the CPAD Assessment. The Provider submits that it was however reasonable for the Claims Administrator to assume that a 26-day period was sufficient for the Insurer to send the Report and for the GP to discuss it with the Complainant.

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The Provider notes that the Complainant telephoned on **14 November 2017** to advise that her GP had not yet received the Specialist's Report. As a result, the Provider telephoned the Insurer that same day, on 14 November 2017, asking for it to send the Report to the GP.

The Provider notes that the Insurer said during this call that it had previously sent the Report to the GP on 3 November 2017. The Provider says it now understands that this was not correct but submits that it had no reason not to accept the Insurer's word, at that time. The Provider notes that in any event, the Insurer confirmed by email on **15 November 2017** that it had sent the Report to the GP on that same day.

The Provider notes that the Complainant telephoned on **20 November 2017** to advise that her GP had still yet to receive the Specialist's Report and it suggested that it would ask the Insurer to fax a copy of the Report to the medical centre. During this call, the Complainant confirmed that her GP was on leave for a few days and that she would not attend the CPAD Assessment until she had reviewed the Report. The Provider says there were further calls that day during which the Complainant confirmed that her GP was not back until 27 November 2017 and that, as the Report was addressed to her GP, no other doctor in the medical centre could talk the Complainant through it and, as a result, the Complainant instructed that the CPAD Assessment had to be rescheduled.

The Provider says that the Complainant dealt with a number of Claims Administrators throughout, of which Mr D. was one of them. The Provider notes that it is unable to discuss the details of this matter with Mr D. as he is no longer an employee and consequently, it is reliant on file notes and telephone recordings for the purpose of any questions relating to him.

The Provider notes that the Complainant's viewpoint is that during her telephone call with Mr D. on 1 November 2015 (when she requested that a copy of the Specialist's Report be sent to her GP) Mr D. was aware of her stipulation that she would only attend the CPAD Assessment if this Report was first sent to her GP in advance, and the Complainant is therefore displeased that Mr D. did not advise the Insurer of this during his telephone calls with the Insurer, on 22 November 2017 and 15 December 2017.

In relation to the telephone call between Mr D. and the Insurer on **22 November 2017**, the Provider says there were no notes on the file at that time explicitly confirming that the Complainant would only attend the CPAD Assessment if the Specialist's Report was sent to her GP in advance. The Provider accepts that it did not make the Insurer aware of the Complainant's stipulation in its email of 1 November 2017 when it asked for the Insurer to send the Report to the GP. The Provider says that when the Insurer questioned during the call on 22 November 2017 why the Complainant had originally agreed to attend the CPAD Assessment and was now cancelling it, Mr D. did not explain that the Provider had previously failed to pass on the Complainant's stipulation to the Insurer, as Mr D. was most likely unaware of this stipulation also.

In relation to the telephone call between Mr D. and the Insurer on **15 December 2017**, the Provider notes that Mr D. informed the Insurer of the Complainant's request to cancel the CPAD appointment that had been rescheduled for 2 and 4 January 2018. The Provider

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acknowledges that the Insurer remarked on the cancellation notice for this and the previous cancellation notice, with the possibility of the Complainant incurring a cancellation fee.

The Provider says that it is satisfied that Mr D. did not make any disparaging remarks about the Complainant during this call and notes that in her letter to this Office of **18 November 2020** the Complainant confirms that Mr D. was *"always courteous and patient"*.

In relation to the telephone call between Provider Claims Administrator Ms O. and the Insurer on **22 July 2016**, the Provider notes that Ms O. is one of its most senior Claims Administrators with over 20 years' experience with Insurers and that her warmth and empathy with customers has been remarked upon on a number of occasions. The Provider notes that Ms O. had only been involved in the Complainant's case in a minor capacity and she outlined this in the opening segment of the telephone call with the Insurer, and as a result, the Insurer had to explain the circumstances of the Complainant's case to her.

The Provider says that it is of the opinion that what the Complainant refers to as *"laughed hilariously"* was more of a nervous laugh rather than a disparaging one, as Ms O. had the difficult task of explaining to the Complainant about the missed payment. The Provider says that the *"apologise profusely"* remark, is part of Ms O.'s mannerisms and again it does not believe that this was said, out of malice.

The Provider says that nonetheless, it acknowledges that this appears to be poor behaviour from its employee and it apologises for the upset this caused the Complainant. The Provider says it is regrettable that the Complainant does not accept its apology in this regard. The Provider confirms that Ms O. was informed of the Complainant's complaint and listened to the telephone call between herself and the Insurer and has apologised for how the call sounded and the upset caused to the Complainant, and Ms O. has identified her own need to continuously remain courteous and professional at all times.

The Provider notes the Complainant's comments regarding the tele-interview she had with a specialist nurse on 13 March 2015 and says that it is the Insurer that medically assesses claims and decides the method by which to collect medical information for each claim, which can vary for each claim case. The Provider acknowledges the Complainant's comments regarding the duration of the tele-interview and says it relayed these to the Insurer previously and the Insurer asked that the Complainant contact it directly about this, a direction the Provider passed on to the Complainant in its **Final Response Letter** of **19 September 2019**.

The Provider confirms that it considered the Complainant to be a vulnerable consumer as so defined in Chapter 3, 'General Requirements', of the Central Bank of Ireland ***Consumer Protection Code 2012 (as amended)***.

The Provider says its Claims Administrators are aware that all claimants should be treated as vulnerable and have had training from both internal and external bodies to provide them with practical tools and techniques on handling vulnerable consumers.

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The Provider says it assists each customer through the claims process by explaining the necessary documentation required to process a claim and the specific steps involved in making a claim, offering assistance to help complete the claim form, liaising with the Insurer and the claimant's employer so that the claimant does not have to do so, and where a claim is declined, it also assists the customer through the appeals process.

The Provider says it did fall down in its service in some respects, but it does not believe that it did anything untoward by asking the Complainant and her employer if she had applied for or been granted an Ill-Health Early Retirement Pension, or by taking the Insurer at its word when communicating with them.

The Provider says it received a complaint from the Complainant on **2 August 2019** and that it acknowledged this complaint five working days later, allowing for the August Bank Holiday, by letter on **12 August 2019**, and included the name and contact details of the complaint investigator. The Provider then emailed the Complainant on **2 September 2019** with an update, indicating that the complaint response was being drafted and would issue shortly. The Provider says it issued its **Final Response Letter** to the Complainant on **19 September 2019**, 33 working days later and within the timeframe of 40 working days allotted in the ***Consumer Protection Code 2012 (as amended)*** in which a regulated entity must seek to resolve a complaint.

The Provider says that given the number of telephone calls that it retrieved and listened to, the amount of claims documentation that was reviewed as well as the marketing material that was pulled and reviewed, it believes that it handled the Complainant's complaint promptly and efficiently. The Provider notes that the draft response to the complaint was reviewed by its Compliance Department and Senior Management in order to ensure that it had satisfied itself with the fairness of the complaint investigation and the outcome.

The Provider says it sought to resolve the complaint by offering the Complainant what it believed to be fair compensation for the oversights that had occurred. In that regard, the Provider says it included a cheque in the amount of **€300.00** (three hundred Euro) with its **Final Response Letter** of **19 September 2019**. The Provider notes that its records confirm that this cheque was neither returned nor cashed by the Complainant.

In its letter to this Office dated **5 May 2021**, the Provider, in an effort to resolve this matter, increased its compensatory offer to **€1,000.00** (one thousand Euro). This offer was declined by the Complainant.

The Complaint for Adjudication

The complaint is that the Provider, in its capacity as Administrator of the Group Salary Protection Scheme which she is a member of, provided the Complainant with poor customer service when she had cause to claim under the Scheme, in that:

1. the Provider failed to inform the Complainant of her entitlement to the specified illness benefit component of the Scheme;

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2. the Provider inappropriately wrote to the Complainant on 20 May 2015 to ask if she had applied for or was in receipt of an Ill-Health Early Retirement Pension from her employer;

3. the Provider failed to furnish the Complainant with full attendance details relating to medical examinations that the Insurer had arranged for her to attend with a Specialist in Occupational Health;

4. the Provider failed to communicate, on behalf of the Complainant, correct information to the Insurer relating to her attendance for a CPAD Assessment;

5. a Claims Administrator failed to correct the Insurer during telephone calls between the Provider and the Insurer on 22 November 2017 and 15 December 2017 by way of informing the Insurer of the Complainant's position in relation to her attendance for a CPAD Assessment;

6. a Claims Administrator was unprofessional towards the Complainant during a telephone call between the Provider and the Insurer on 22 July 2016; and

7. the Provider failed to recognise the Complainant as a vulnerable consumer and treat her accordingly.

Decision

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

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

A Preliminary Decision was issued to the parties on **17 August 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.

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In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

There are seven elements to the complaint which are addressed below separately.

Element 1:
The Provider failed to inform the Complainant of her entitlement to the specified illness benefit component of the Group Salary Protection Scheme

I note that the Complainant telephoned the Provider at **09:18** on **20 February 2015** as she had been medically certified as unfit for work since **12 June 2014** and was due to be removed from her employer's payroll from **2 May 2015**.

The Complainant furnished the Claims Administrator with details of her medical conditions and he proceeded to set up an income protection claim for her and the Provider sent her an Income Protection Claim Notification Form on **23 February 2015**.

The Complainant submits that the Claims Administrator ought to have also advised her during this telephone call of her entitlement to specified illness benefit under the Scheme.

The Provider has acknowledged and regrets that due to an oversight, the Claims Administrator did not inform the Complainant during the call on 20 February 2015 of the specified illness benefit available under the Scheme.

I note that the Provider has advised that its Claims Administrators are not medical assessors and therefore the process is that where a Claims Administrator considers that a client may be eligible to claim specified illness benefit, the Administrator will first check with the Insurer before sending a claim form to the client. The Provider has advised that this is to prevent a situation where it incorrectly sends a specified illness claim form and gives the client the incorrect expectation that they can claim this benefit, when in fact they cannot. I take the view that this is a reasonable process but subject to the proviso that the Provider's actions should never create a barrier to a claimant making a claim.

In that regard, I have listened to the recording of the telephone call the Complainant made to the Provider on 20 February 2015 and I accept that it would not have been readily clear to the Provider from the medical details that she provided, that she would qualify for specified illness benefit.

I note from the evidence before me that the Provider had previously emailed the Complainant on **9 September 2014** as part of a general communication to all Scheme members and that this email included a link to the Scheme Summary Booklet in circulation at that time. I note that pg. 5 of this **Salary Protection Scheme Summary Booklet [07/14]** set out details of the Specified Illness Benefit including the list of specified illnesses that qualify for the benefit. I take the view that this constituted an appropriate notification of the Complainant's entitlements under the Scheme.

/Cont'd…

I am of the opinion that it would have been prudent of the Complainant to have referred to the Salary Protection Scheme Summary Booklet in September 2014 in order to consider what her entitlements may be under the Scheme, particularly given that she was, at the time of the email, medically certified as unfit to work.

I note that the Complainant telephoned the Provider on **3 March 2016** to query her entitlement to specified illness benefit and that the Provider issued her with a Specified Illness Claim Form the following day, on **4 March 2016**. The Complainant completed this Claim Form on **26 April 2016** and following its assessment, the Insurer advised on **31 May 2016** that it was admitting the specified illness benefit claim, which is a once-off lump sum of 25% of the claimant's annual salary. In that regard, I am mindful that any delay in applying for this benefit did not financially disadvantage the Complainant insofar as the amount of benefit payable was a fixed calculation that was not altered by her not having applied for the benefit when she first met the qualifying criteria for it.

Having regard to the above, I am of the opinion that it would be unreasonable to uphold this element of the complaint.

Element 2:
The Provider inappropriately wrote to the Complainant on 20 May 2015 to ask if she had applied for or was in receipt of an Ill-Health Early Retirement Pension from her employer

The Provider wrote to the Complainant on **20 May 2015** regarding her income protection claim with the Insurer and in this letter it asked, among other things, that:

> *"In order for* [the Provider] *to ensure that your benefit is amended accordingly, and to ensure that no under or over payment of benefit occurs in respect of your claim, please can you confirm the following information for* [the Insurer] *at your earliest convenience:*
>
> - ***Have you applied for or been granted Ill Health Early Retirement Pension?***
>   - *If you have applied, please can you provide us with an update on your application.*
>   - *If your application has been granted, please can you confirm the date on which this was granted and the annual amount payable".*

The Complainant submits in her letter of complaint to the Provider dated **29 July 2019** that:

> *"I was only a few months in receipt of* [Income] *Protection Benefit when* the Provider]…*wrote asking me if I was considered Ill Health Retirement. This was inappropriate and an unfair imposition on me as I was struggling to overcome life-changing events and needed time to process and accept what had happened while at the same time trying to recover medically and physically. I certainly did not need* [the Provider]…*niggling and troubling me with a possibility that I was not yet ready to countenance and could have plunged me into the depths of despair"*.

/Cont'd…

I note that the maximum income protection benefit that the Insurer will pay is 75% of the claimant's salary less any other income, such as half-pay, temporary rehabilitation remuneration, State Illness Benefit or Ill-Health Early Retirement Pension.

I take the view that it was reasonable therefore for the Provider to write to the Complainant, on behalf of the Insurer, to ascertain whether she had applied for or been granted an Ill-Health Early Retirement Pension, particularly as she was at the time of the query almost a year absent from work. If she had been granted such a pension, this would then have necessitated a recalculation of her income protection benefit and it was in the interest of all parties involved – the Complainant, the Provider and the Insurer – to ensure that an overpayment of benefit did not occur. Having regard to the above, I am of the opinion that it would be unreasonable to uphold this element of the complaint.

Element 3:
The Provider failed to furnish the Complainant with full attendance details relating to medical examinations that the Insurer had arranged for her to attend with a Specialist in Occupational Health

The Complainant submits that when the Insurer informed the Provider that it had arranged for her to attend for a medical examination with a Specialist in Occupational Health on **2 September 2016**, the Provider failed to furnish her with adequate location details and in that regard, in her letter of complaint to the Provider dated **29 July 2019**, she submits that:

> "[The Provider] *provided scant details as to the location of the* [medical examination] *venue – no map, no Eircode, not even a phone number. I had to make a number of phone calls on 2/9/2016".*

I note that the Provider wrote to the Complainant on **15 August 2016** with the time, date and address for her examination with the Specialist in Occupational Health for 2 September 2016.

I note from the recordings of the telephone calls between the Complainant and the Provider on **2 September 2016** that the Complainant telephoned the Provider at **11:20** to say that she could not find the examination location and that no telephone number had been included with the original notification.

I note the following exchange when the Provider called the Complainant back five minutes later, at **11:25**:

> Complainant: *I think I know where I'm going so it's ok, I'm going to hang up now. You should put directions in with these appointments saying where it is –*
>
> Provider: *Ok*
>
> Complainant: *Really and truly, will you note that, I hope this is being recorded –*

/Cont'd…

Provider: *It is.*

Complainant: *It's ridiculous, yeah, there should be, there should be directions in with appointments like this –*

Provider: *Ok. I'll note that, note that for future reference.*

I note in that respect that within the five minutes it took the Provider to return the Complainant's call, she had established where she was required to be. I am also pleased to note that when the Provider wrote the Complainant on **20 July 2017** with the time, date and address for her second examination with the Specialist for 15 August 2017, that it also included the telephone number for the medical firm carrying out the examination.
In addition, I note that it also wrote to the Complainant the day after, on **21 July 2017**, enclosing detailed directions on how to travel to the examination location. This improved practice may well have come about because of the Provider's willingness to act on feedback from the Complainant.

Having regard to the above, I take the view that it would be unreasonable to uphold this element of the complaint.

Element 4:
The Provider failed to communicate, on behalf of the Complainant, correct information to the Insurer relating to her attendance for a CPAD Assessment

The Complainant telephoned the Provider on **1 November 2017** asking for a copy of the Specialist's Report from August 2017 to be sent to her GP.

Having listened to a recording of this telephone call, I note that the Complainant said to the Claims Administrator that:

> *The reason why I want the report is because there's a guy coming out the last week of November…and he wants to know what* [the Specialist] *put in the report from that point of view …*
>
> *I want to know what was in that report before he comes to me …*

I take the view that while the Complainant did explain that she wanted to know the contents of the Report before the CPAD Assessment, she did not clearly stipulate that she would not go through with the CPAD Assessment scheduled for 27 and 29 November 2017 until such time that the Specialist's Report had been received by her GP and she had time to go through the contents of that Report with the GP.

/Cont'd…

As a result, I am of the opinion that it is understandable that the Claims Administrator in question did not understand there to be any such stipulation or note it on the Complainant's file.

I note that the Provider nevertheless emailed the Insurer the same day, on **1 November 2017** as follows:

> *"*[The Complainant] *has asked for a copy of the IME report from 15/08/17 to be sent to her GP, can you confirm when same has been sent".*

Having regard to the above, I am of the opinion that it would be unreasonable to uphold this element of the complaint.

Element 5:
A Claims Administrator failed to correct the Insurer during telephone calls between the Provider and the Insurer on 22 November 2017 and 15 December 2017 by way of informing it of the Complainant's position in relation to her attendance for a CPAD Assessment

The Complainant submits that during the telephone call that took place at **11:46** on **22 November 2017** between the Provider and the Insurer, Provider Claims Administrator Mr D. failed to correct the Insurer when the Insurer made incorrect comments concerning the Complainant's cancellation of the CPAD Assessment and in that regard, in her letter of complaint to the Provider dated **29 July 2019**, the Complainant submits that:

> *"When my CPAD appointment for 27/11/2017 had to be cancelled on 20/11/2017 because of the delay* [in the Insurer sending the Specialist's Report to my GP], [the Insurer] *were annoyed. Phone calls between* [Provider Claims Administrator Mr D.] *and* [the Insurer] *on 22/11/2017 and 15/12/2017 reveal* [the Insurer] *making disparaging remarks about me in relation to the cancellation.* [Mr D.] *failed to correct* [the Insurer] *and remind him that it was* [the Insurer's] *fault that they had to "take a hit" on the first CPAD cancellation as I had clearly stated to* [the Provider] *on 1/11/2017 that I would not see* [the CPAD Assessor] *without first reading the* [Specialist's] *report".*

Having listened to the recording of the call that took place between the Insurer and the Provider on 22 November 2017, I note that the Insurer stated:

> *"…at no point was the IME, her reviewing the IME a stipulation – now it is".*

As I have already taken the view when examining Element 4 of this complaint above, that the Complainant did not clearly stipulate during her call to the Provider on **1 November 2017** that she would not go through with the CPAD Assessment until such time that she had sight of the Specialist's Report, I am of the opinion that it is understandable that Mr D. did not correct or clarify the position to the Insurer, when it was remarking on the lateness of the cancellation of the CPAD Assessment.

/Cont'd…

The Complainant's comment in her call to the Provider on 1 November 2017 – *"I want to know what was in that report before* [the CPAD Assessor] *comes to me"* – was not listed on file as a stipulation.

In addition, I note that in her letter of complaint to the Provider dated 29 July 2019, the Complainant also submits that:

> *"The phone call on 15/12/2017 is quite offensive to me as a client of* [the Provider] *because* [the Provider] *did not support or defend me in any way when* [the Insurer] *referred to me as "that woman", said that I was unreasonable, and said that I would have to take a hit for cancelling the 2nd CPAD on 2nd and 4th January 2018 because the notice given by me on 15/12/2017 was inadequate.*
>
> *…* [Mr D.] *should have quelled these derogatory remarks and supported my position as I had done nothing wrong while* [the Insurer] *and* [the Provider] *had failed to furnish me with a copy of the* [Specialist's Report] *in a timely fashion"*.

In terms of the Complainant's comments that Mr D. *"did not support or defend me in any way"* when the Insurer made *"derogatory remarks"*, I have listened to the recording of the telephone call that took place between the Provider and the Insurer at **14:30** on **15 December 2017** and I do not consider that the Insurer made any derogatory remarks about the Complainant. Therefore, I am satisfied that Mr D. had no cause to support or defend the Complainant in that regard.

Having regard to the above, I am of the opinion that it would be unreasonable to uphold this element of the complaint.

Element 6
A Claims Administrator was unprofessional towards the Complainant during a telephone call between the Provider and the Insurer on 22 July 2016.

The Complainant refers to a telephone call that took place on **22 July 2016** between the Provider and the Insurer and in that regard, in her letter of complaint to the Provider dated **29 July 2019**, she submits that:

> *"I listened with horror to the call on 22/7/2016 between* [Provider Claims Administrator Ms O.] *and* [the Provider] *when they laughed hilariously at missing the payment run and that I would not get my €662 payment until the following month and how they would have to "Apologise profusely". Then more hilarious laughter".*

I note that the Insurer telephoned the Provider on 22 July 2016 and explained to Ms O. that in order to recoup an overpayment on the Complainant's income protection claim, the Insurer had given her a *"no payment"* for July and she was meant to receive a *"reduced payment"* for August, before revised monthly payments would commence from September.

/Cont'd…

It seems that the Insurer had missed the special payment run for the reduced August payment of **€662.00** (six hundred and sixty-two Euro) and that it was now asking the Provider to contact the Complainant to see if she wished to get an advance of some of that payment now, or would she wait until September to get both the reduced August payment and the revised September payment together. I note that Ms O. then stated:

> *Ok, I'll ask her would she like to leave it until 1 September to get all of it* [some laughter] *or would she like a little bit of it now anyway, and I'll apologise profusely.*

Having listened to the recording of this call, I agree with the Provider's position that the brief laughter here was a nervous laugh rather than one which was disparaging, as Ms O. now had the difficult task of explaining to the Complainant that the Insurer had missed the special payment run for her August payment. In addition, while I note that Ms O. adopted a posh inflection in her tone when she said the term *"apologise profusely"*, I accept the Provider's position that this was not said out of any malice toward the Complainant.

I note that the Provider has acknowledged that this appears to be poor behaviour from its employee. I agree. The Provider apologises for the upset this caused the Complainant and says it is regrettable that she does not accept its apology in this regard. The Provider has also advised that this matter was brought to the attention of Ms O. and that she has apologised for how the call sounded and the upset caused.

I note that shortly after her call with the Insurer on 22 July 2016, Ms O. rang the Complainant and left a courteous voice message for her, clearly setting out the circumstances as the Insurer had presented them to her. This, in my opinion, was an important step for Ms O. to take, to recognise the impression which the telephone discussion had created. Courtesy and respect to customers is a fundamental of good service provision and I am pleased to note that Ms O. took the trouble to phone and leave a message for the Complainant to explain what had happened. Having regard to the above, I believe it is not appropriate to uphold this element of the complaint.

Element 7
The Provider failed to recognise the Complainant as a vulnerable consumer and treat her accordingly

The Complainant submits that the Provider did not treat her as a vulnerable consumer throughout her dealings with it and was in breach of is obligations under the Central Bank of Ireland ***Consumer Protection Code 2012*** *(as amended)*.

In that regard, Chapter 3, 'General Requirements', of the Central Bank of Ireland ***Consumer Protection Code 2012*** **(as amended)** states that:

> *"Where a regulated entity has identified that a personal consumer is a vulnerable consumer, the regulated entity must ensure that the vulnerable consumer is provided with such reasonable arrangements and/or assistance that may be necessary to facilitate him or her in his or her dealings with regulated entity".*

/Cont'd…

Having examined the evidence made available by the parties, I do not accept that the Provider failed on its part to recognise or treat the Complainant as a vulnerable consumer, as so defined by the ***Consumer Protection Code 2012*** *(as amended)*.

Having regard to all of the above, the evidence in my opinion, does not support the complaint that the Provider, in its capacity as Administrator of the Group Salary Protection Scheme which she is a member of, provided the Complainant with poor customer service when she had cause to claim under the Scheme. In its **Final Response** to the Complainant dated **19 September 2019**, the Provider, in acknowledgement of certain aspects of its service which were not up to its usual standard and as a tangible gesture of its apology, sent the Complainant a cheque in the amount of **€300.00**. The Provider has advised that this cheque was neither cashed nor returned by the Complainant. I note that the cheque in question is now, long-since, out of date.

In its letter to this Office dated **5 May 2021**, the Provider, in an effort to resolve this matter, increased its offer of a compensatory payment to the Complainant to **€1,000.00** (one thousand Euro). The Complainant confirmed in her email to this Office of **31 May 2021** that she declined this offer.

In light of the evidence before me, I consider the Provider's offer of a compensatory payment to the Complainant of **€1,000.00** to be a very reasonable offer. I note that this offer remains open to the Complainant, and I take the view that it is now a matter for the Complainant to advise the Provider if she wishes to accept this offer, as I do not consider it appropriate to make any direction in that regard.

Conclusion

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

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

MARYROSE MCGOVERN
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN (ACTING)

8 September 2022

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PUBLICATION

Complaints about the conduct of financial service providers

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will **publish legally binding decisions** in relation to complaints concerning financial service providers in such a manner that—

(a) ensures that—

  (i) a complainant shall not be identified by name, address or otherwise,

  (ii) a provider shall not be identified by name or address,

 and

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

Complaints about the conduct of pension providers

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

(a) ensures that—

  (i) a complainant shall not be identified by name, address or otherwise,

  (ii) a provider shall not be identified by name or address,

 and

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