An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0335
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Mis-selling (insurance) Delayed or inadequate communication Complaint handling (Consumer Protection Code) Failure to process instructions Premium rate increases
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The complaint concerns a Professional Body's group life insurance policy, which is underwritten by a named Insurer. The policyholder is the Professional Body, and the Complainant is a member of the group life insurance policy.

The Provider, an intermediary, sold the policy to the Complainant.

The policy provides for life cover in the sum of €500,000 up to the age of 50, reducing to €350,000 from the age of 51 to 65.

The Complainant's Case

The Complainant states that when the Provider sold him the life insurance policy in **October 2015**, the Provider advised him that because he was under the age of 40 when joining the group life policy, his monthly premium would remain fixed at €22.50 per month for the entire duration of his policy until his 65th birthday.

The Complainant states that the Provider supplied him with this information in emails dated **9 October 2015** and **21 October 2015.**

The Complainant states that when he became a member of the group policy on **18 November 2015,** he relied upon the express confirmations from the Provider that his premiums would remain at €22.50 per month until he was aged 65.

The Complainant states that, in a letter dated **19 October 2018**, the Provider informed him that his monthly premiums would be increasing, following a review by the Insurer. The Complainant submits that the Provider advised that the premium increase would be phased as follows:

- from 1 December 2018, premiums would be €33.75 per month; and
- from 1 December 2019, premiums would be €45 per month.

The Complainants states that he disputed this increase, in a letter to the Provider dated **14 November 2018**, to which the Insurer was cc'd, in which he stated that the premium increase was contrary to the contract he entered into, or that if the contract did not provide for a fixed premium, then he had been mis-sold the product. However, the Complainant states that the Insurer proceeded to increase his monthly direct debit to €33.75 in **January 2019**, before he had received any response to his complaint. The Complainant submits that he wrote to the Provider on **10 May 2019**, seeking an update, as he had not received a substantive response to his complaint, although six months had then passed.

The Complainant states that while he discussed a number of proposals with the Provider in **May and October 2019** to resolve this dispute, including an offer that the Provider refund all of the premiums paid to date, and a proposal for a new life insurance policy with guaranteed premiums of €52.76 per month for the duration of the policy, these proposals were unacceptable to the Complainant, because he would have had to enter into a new life insurance policy which would be subject to underwriting and which would have increased premiums.

The Complainant states that the Provider informed him that it was not willing to pay the difference in the increased premiums over the duration of the policy, as this "*would give rise to a tax liability on the part of the* [Provider] *and* [the Complainant]".

The Complainant contends that "*I relied upon* [the Provider's] *confirmations about the premiums to my detriment and I have been mis-sold the Policy".*

The Complainant is seeking compensation of €15,733, which is the financial loss he states that he will incur, due to the application of increased premiums over the duration of the Policy.

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

The Provider states it was engaged by a Professional Body to put a group life insurance policy in place with the Insurer, which was incepted in **June 2006**, and that the Complainant became a member of this Scheme in **November 2015**.

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The Provider states that it acted as an independent intermediary when advising the Professional Body, and that while it supplies information on the policy, to policy members such as the Complainant, it did not supply "*advisory services*".

The Provider however accepts that its representative incorrectly informed the Complainant, when he joined the group life insurance policy, that his premiums would not increase for the duration of the policy. The Provider states that this was a mistake made by its representative, and that in fact, the policy terms and conditions permit increases to the premiums charged.

However, the Provider states that it has "*taken significant steps to try and resolve this matter with the* [Complainant] *and we consider that we have been more than reasonable in our efforts".*

The Provider states that following the Complainant's initial complaint in **November 2018**, it made representations to the Insurer which were ultimately unsuccessful. It made an offer in **May 2019** to the Complainant to cancel the policy and pay the Complainant compensation equal to the cost of the premiums paid to that date.

The Provider states that

> "*we continued to make representations to the insurer, involving multiple meetings, to try and achieve a possible resolution with the member. This work was ongoing over the summer of 2019 with key stakeholders. During this period, we provided the member with regular updates and this culminated with the offer issued on 4th October 2019. In that letter, we offered the member a personal life assurance and income protection policy which* [the Provider] *would put in place for the complainant on a nil commission basis and not charge a fee. The Insurer also indicated to us that they would assist in providing a low quote circa 30% below market rates. We consider this offer to be a very reasonable in all the circumstances. The member has refused this offer too."*

The Provider further states that if its representative had not made a mistake when selling the policy, then either the Complainant would have joined the group life insurance policy and accepted the policy's terms, or the Complainant would have rejected the terms and not joined the policy.

Consequently, the Provider contends that "*an award to the complainant should therefore be no greater than the cost paid to date and that this would be a fair and equitable solution, or alternatively that the member takes up the offer within our letter of 4th October 2019 … which we would be prepared to reopen for a period of 6 months from the date of this response*".

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The Complaint for Adjudication

The complaint is that the Provider (i) mis-sold the policy to the Complainant in or around **October 2015** and (ii) proffered poor complaint handling from **November 2018** onwards.

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 **22 July 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 Provider, the final determination of this office is set out below.

1. **The Mis-Selling Complaint**

Documentation on File

The documentation on file includes:

- an email from the Provider to the Complainant dated **9 October 2015**, which states

> *"The life cover quotes are as follows:*
>
> *If you join the scheme before you turn 40, you will pay the rate for the members who are under 40 at the time of joining the scheme, which is €22.50 per month. The premium age brackets are only relevant to the age when you become a members (sic) of the scheme, so you will not move on to the over 40's premium when you turn 40 etc…."*.

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- a Brochure, which was sent by the Provider to the Complainant by email dated **9 October 2015**, which states, amongst other things:

"

7.1 How much will I be covered for and at what cost?

The level of benefit for which you will be covered is dependent on your age (and your Spouse's/Partner's age) at the date you join the plan.

Members who join up to age 50, will be covered for €500,000 if your Spouse/Partner joins up to age 50, he/she will be covered for €250,000.

If you join from age 51 onwards, you will be covered for €350,000 if your Spouse/Partner joins from the age of 51 onwards, he/she will be covered for €175,000.

AGE JOINING PLAN	MEMBER BENEFIT	MONTHLY COST	SPOUSE/PARTNER BENEFIT	MONTHLY COST
UNDER 40	€500,000	€22.50	€250,000	€11.25
40-50	€500,000	€67.00	€250,000	€33.50
51-65*	€350,000	€154.00	€175,000	€77.00

*Please note: All cover under the plan ceases at age 65

"

- an email from the Provider to the Complainant dated **21 October 2015**, which states amongst other things:

"[h]*ere are the figures in simplistic terms:*

[Name of Scheme Redacted] Scheme- ***Premium €22.50 per month x 25 years = Total premiums paid €6750***

Taking out equivalent cover now outside of the scheme- Premium €53.92 per month x 25 years = Total Premiums paid €16,176……."

[My Emphasis]

- a letter from the Provider to the Complainant dated **14 December 2015**, enclosing "*the relevant policy documentation*".

- a Policy Schedule which states, amongst other things:

"Life Assured [the Complainant] ...

Type of Premium: ***Guaranteed and reviewed in accordance with the Policy Conditions and Master Policy Schedule***

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Premium: *€22.50 per month payable by direct debit. The premium has been calculated in accordance with the rate set for the Master Policy*"

[My Emphasis]

- Policy Conditions dated **1 June 2006**, which state in section 2, paragraph 4, under the heading Rates and Guarantees:

  "*… Subject to the above the Premium Rate will remain unaltered up until the Premium Review Date as set out in the policy schedule.* ***On that Date and on any subsequent Premium Review Date*** **[the Insurer]** ***will have the right to charge a new Premium Rate for all Benefits insured under the Policy."***

  [My Emphasis]

- a Master Policy Schedule dated **1 June 2006** which states:

  *"…**Premium Details***

Premium Frequency	*Monthly in advance from the member.*
Premium Rate	***As determined from time to time by*** **[the Insurer].** *At the commencement date, the following Premium Rates apply:* *Age — Member Monthly Cost — Spouse Monthly Cost* *Under 40 — €22.50 — €11.25* *Age 40 – 50 — €67.00 — €33.50* *Age 51 – 65 — €154.00 — €77.00*
First Premium Review Date	*01/06/2009*

……"

[My Emphasis]

- a letter from the Provider to the Complainant dated **19 October 2018**, which states, amongst other things:

  "*…* [t]*he Plan was reviewed recently by the Insurer…in accordance with the policy conditions. The premium rates have been reviewed and the reviewed rates are outlined in the table below.*

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MEMBER BENEFIT - €500,000

Details	*Current Monthly Premium*	*New Monthly Premium*
Member under 40 years of age	*€22.50*	*€22.50*
Member 40-50 years of age	*€67.00*	*€45.00*
Member 51-65 years of age	*€154.00*	*€99.00*

…….

As you can see from the above tables, Members and Spouses/Partners move through the relevant age bands as they get older. At each rate review (usually every 3 years), member should be aligned to the correct premium bands based on the age of the Member or Spouse/Partner at the date of that review, and if members move into a different age band premiums paid will be adjusted accordingly. However due to an administrative error by the insurer, this had not happened to date at any previous rate review … all Plan members now need to move to the correct age appropriate band as per the table above…."

- An email from the Insurer to the Provider dated **18 December 2018**, which states, amongst other things:

  "*I've attached the policy conditions from 2006. The policy schedule states "The Sum Assured applicable will be determined by the age of the member at the date of joining". It further states that the Premium Rate is "determined from time to time by* [the Provider]*" and then goes on to list the premium rates at the commencement date. In Section 2.4 of the Conditions, it is stated that "Subject to the above the Premium Rate will remain unaltered up until the Premium Review Date as set out in the policy schedule. On that Date and on any subsequent Premium Review Date* [the Provider] *will have the right to charge a new Premium Rate for all Benefits insured under the Policy. ….**From a practical viewpoint, we move members through the age bands at each rate review, e.g. if a member is aged 38 at a rate review, we will charge €22.50 per month. At the next rate review, that member is aged 41 and his/her premium will increase to €67.00 per month.**"*

  [My Emphasis]

I note that in addition to the Policy Conditions dated **1 June 2006,** this Office has been supplied with versions of the Policy Conditions dated **4 February 2005** and **2018**. The Policy Conditions dated 4 February 2005 predate the inception of the group policy in 2006. It is unclear how this arose, and whether the 2005 version was an earlier draft of the 2006 Policy Conditions, however, I do not consider it necessary to make any finding on this point. I also

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note that the provisions of the Policy Conditions referenced above concerning premiums, are identical in both the 2005 and 2006 versions of the Policy Conditions.

As the policy was sold to the Complainant in or around **October 2015**, before the 2018 version of the Policy Conditions came into existence, I am satisfied that the 2006 Policy Conditions are the relevant version of the policy conditions, that must be considered for the purpose of this mis-selling complaint. Section 2, paragraph 4 of the 2006 Policy Conditions outlines that the Insurer has the right to charge a new policy premium rate at policy review dates. Similarly, the Master Policy Schedule dated 1 June 2006, sets out that the premium rate is "[a]*s determined from time to time by* [the Insurer]*.*"

However, it is clear from the emails from the Provider to the Complainant dated **9 October 2015** and **21 October 2015**, that the Provider's representative informed the Complainant that the policy premiums would remain at €22.50 for the duration of the policy. I am satisfied from the evidence that the Provider's representative failed to alert the Complainant to the fact that the Insurer can, in accordance with the policy conditions, charge a new policy premium rate at policy review dates, nor was this information highlighted in the brochure issued to the Complainant by the Provider, on **9 October 2015**.

Indeed, the Provider has acknowledged that its representative incorrectly informed the Complainant when he joined the group life insurance policy, that his premiums would not increase for the duration of the policy. I am satisfied that this was a serious failure on the part of the Provider, contrary to

- ***provision 2.2*** of the ***Consumer Protection Code 2012*** which states that a regulated entity must ensure that it

  "*acts with due skill, care and diligence in the best interests of its customers;*"

- ***provision 4.1*** of the ***Consumer Protection Code 2012*** which states

"[a] *regulated entity must ensure that all information it provides to a consumer is clear, accurate, up to date, and written in plain English. Key information must be brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information*"; and

- **provision 4.40** of the ***Consumer Protection Code 2012*** which states

"[p]*rior to offering, recommending, arranging or providing an insurance policy where the premium may be subject to review by the insurance undertaking during the term of the policy, a regulated entity must:*

a) explain clearly to the consumer the risk that the premium may increase; and

b) *provide the consumer with details of the period for which the initial premium is fixed*.

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The following warning statement must be included on the application form for the product:

Warning: The current premium [*'may' or 'will' – delete as appropriate*] increase after [*insert period of time for which the premium is fixed*].

This provision does not apply where the premium may be subject to review as a result of an alteration to the policy that is requested by the consumer."

In my Preliminary Decision I stated that

*"I also note that the policy Application Form sent to the Complainant by the Provider on **9 October 2015**, does not contain the warning necessitated by **provision 4.40** of the **Consumer Protection Code 2012**."*

The Provider has stated in its submissions following the Preliminary Decision that it is the responsibility of the Insurer to ensure that the Application Form includes the appropriate warning. The Provider has not explained whether the Application Forms were supplied to the Provider by the Insurer or why it is the Provider's position that it is the Insurer that is responsible for the Application Forms. There is insufficient evidence before this Office to make any finding in respect of whether the Provider or the Insurer, or both, are responsible for the content of the Application Form. However, regardless, this Office is satisfied from the evidence, that the Provider did not comply with provision ***4.40 of the Consumer Protection Code 2012***, because it failed to explain clearly to the Complainant the risk that the premium may increase, or provide the Complainant with details of the period for which the initial premium is fixed.

The letter from the Provider to the Complainant dated **14 December 2015**, states that "*policy documentation*" was sent to the Complainant by post around this time, and that the Complainant should "[r]*ead carefully through these documents*".

The policy documentation issued included a copy of the Policy Schedule, the Master Policy Schedule dated 1 June 2006 and the Policy Conditions dated 1 June 2006. I note that the Master Schedule does make clear that premium rates are "*as determined from time to time by* [the Insurer]." However, in my opinion, it is not readily apparent from the contents of the Complainant's Policy Schedule, that premium rates could be changed by the Insurer at policy review dates. The Policy Schedule, somewhat confusingly, described the premiums as "[g]*uaranteed and reviewed ...*" In my opinion, the use of the word "guaranteed" suggests that premiums of €22.50 were set for the duration of the policy, while the word "reviewed" suggests to the contrary.

I am satisfied that in order to fully understand the manner in which the premiums could be increased by the Insurer following reviews, it would have been necessary for the

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Complainant to have carefully reviewed the Policy Conditions, and in particular the final paragraph of section 2. 4 on pages 3 and 4 of the Policy Conditions.

While it appears that the Complainant either failed to carefully read the Policy Conditions, or having done so, failed to understand that the Insurer could increase policy premiums, I do not regard this as a significant oversight by him, particularly in circumstances where he had been informed by the Provider that policy premiums would remain at €22.50 for 25 years.

In this context, and given that neither the Brochure, nor the Application Form, nor indeed the Complainants' Policy Schedule, clearly outlined that policy premiums could be increased by the Insurer following reviews, in my opinion it is understandable that the Complainant failed to identify the significance of the final paragraph of section 2.4 of the policy documents, or the section of the Master Policy Schedule concerning premium rates. Furthermore, the Complainant could not have been aware, even if he read the Policy Conditions, that the practice of the Insurer would be to "*move members through the age bands at each rate review*".

Consequently, I am satisfied that the Provider (as opposed to the Complainant) is substantially at fault for the circumstances that arose, whereby the Complainant mistakenly believed when he purchased the policy in 2015, that premiums would remain at €22.50 for the duration of the policy.

I am of the view that the Provider's failure to explain the fact that policy premiums were likely to increase, compromised the Complainants' opportunity to make a properly informed decision as to whether the policy was suitable for his needs, and that the Provider's conduct in this regard was unreasonable and unjust within the meaning of ***section 60(2)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017***.

Furthermore, when this Office requested a copy of the 'Factfind' associated with the application for the policy, the Provider confirmed that "[n]*o fact-find was undertaken with the complainant and no fact-fact was gathered*…"

It is therefore clear that, when arranging the Complainant's membership of the policy in or around **October 2015**, the Provider failed to comply with the 'knowing your customer and suitability' requirements outlined in the ***Consumer Protection Code 2012***, including provisions ***5.1, 5.16, 5.17, 5.19, and 5.20***. In particular, I am satisfied from the evidence that the Provider failed to gather information about the Complainant's personal circumstances, so as to enable the Provider to understand the Complainant's needs and objectives when arranging the policy, nor did the Provider supply the Complainant with a statement of suitability. Similarly, the Provider failed to supply a copy of its terms of business to the Complainant in **October 2015**.

The Provider's explanation for this is that

> *"[t]he proposer of the policy was the* [Professional Body] *and not the complainant. The policy holder is also* [the Professional Body] *and not the complainant. Hence, we*

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do not consider that the [knowing your customer and suitability] *provisions outlined in the* ***Consumer Protection Code 2012*** *apply to the complainant, in this instance."*

In submissions following the Preliminary Decision, the Provider elaborated on this explanation stating that:

- "*…The complainant is a beneficiary of the client's policy, but not* [the Provider's] *client*….
    - *The ruling would suggest that this case should have been set up under either*
    - *Execution only (5.24 of the Consumer Protection Code – the CPC)*
    - *Advisory (Sections 5.16, 5.17, 5.19, 5.20, 5.21)*
    - *In this scheme where the member is not the policyholder, there is no requirement for* [the Provider] *to engage with the member. The member would have completed an application form and sent it to the insurer either directly, or through their representative body (i.e. the* [Professional Body]) *or* [the Provider].
    - *The requirement for factfinding/statements of suitability therefore do not apply to the member.*
- *We would also contend that a "sale" has not occurred here. But rather that in the incident in question that one individual was provided with inaccurate information on an existing scheme ...."*

The Provider further states that it did not supply terms of business to the Complainant because the Professional Body is the policyholder and because it "*provides information on the scheme to members but does not provide advisory services in relation to the scheme*".

The Complainant states that the Provider is attempting to hide behind a privity of contract argument to avoid its responsibility for mis-selling the policy. The Complainant submits that the Provider supplied incorrect information to him about the policy premiums and it did so as a regulated entity providing a service in the State, contrary to ***provision 2.2 and 2.3*** of the ***Consumer Protection Code 2012.*** The Complainant further states that the Provider's "... *negligence in this regard should be considered conduct otherwise improper in all the circumstances*" as per ***section 60(2)(g) of the Financial Services and Pensions Ombudsman Act 2017.***

It is clear that the Provider did in fact both supply information to the Complainant about the Policy, and it also arranged the Complainant's membership of the Policy, and that the Complainant is a beneficiary of this Policy**.** While the Provider asserts that the 'knowing your customer and suitability' provisions outlined in the ***Consumer Protection Code 2012*** did not apply in this instance, and that that a "*a "sale" has not occurred here",* the Provider has not explained this assertion by reference to the obligations contained in the ***Consumer Protection Code 2012***, or any provisions which may exempt it from these obligations.

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The 'Knowing the Consumer and Suitability' requirements apply where a regulated entity is arranging/offering a product or service for a consumer. I am satisfied that the Provider, which is a regulated entity, arranged the policy for the Complainant, who is a consumer.

I note that ***Provision 5.24(a)*** of the ***Consumer Protection Code 2012*** sets out an exemption from the 'Knowing the Consumer and Suitability' requirements, which do not apply where "*the consumer has specified both the product and the product producer by name and has not received any assistance from the regulated entity in the choice of that product and/or product producer; …."*

Provision 5.24 of the ***Consumer Protection Code 2012*** also specifies that:

> "*[i]n relation to 5.24 a) above, prior to providing an investment product to a consumer, a regulated entity must warn the consumer, on paper or on another durable medium, that the regulated entity does not have the information necessary to determine the suitability of that product for the consumer.*"

There is no evidence before me that the Provider warned the Complainant, on paper or on another durable medium, that it did not have the required information necessary to determine the suitability of the policy for him. However, I am of the view on the evidence, in any event, that the Provider did not satisfy the requirements for an exemption set out in ***provision 5.24(a)*** of the ***Consumer Protection Code 2012*** in this instance. I note that in an email to the Provider dated **20 October 2015**, the Complainant outlined that he wished to ascertain whether he would be "*better off to take out life assurance before I'm 40 with a non* [Professional Body] *scheme so that if I do leave the* [Professional Body]*, I won't have to pay the over 40/50 premiums when joining a new scheme*?", and he requested assistance from the Provider in comparing the cost of the policy premiums with other policies available in the market. The Provider supplied this assistance to the Complainant in an email dated **21 October 2015**, by supplying him with figures comparing the cost of the policy with equivalent cover "*outside the scheme*". Accordingly, I am satisfied that the Complainant received assistance from the Provider in his choice of the policy.

The Provider states in its submissions following the Preliminary Decision, that "[t]*he anomaly on this case is that the complainant did seek information from an* [Provider] *consultant and was provided quotations for similar cover where the complainant would be the policy holder. This we believe was an exception…."*

It is unclear whether a similar discussion regarding alternative products available, arose at other times when the Provider arranged for other members of the Professional Body to become members of the group life policy. I am however satisfied that, in this instance, information was sought and received from the Provider regarding alternative products available, which ultimately assisted the Complainant in choosing to join the group life policy, as distinct from selecting an alternative product.

Consequently, I am satisfied the Provider supplied a financial service to the Complainant, by arranging the Complainant's membership of the policy, irrespective of who paid for that service, and that the Provider unreasonably failed to comply with the 'knowing your

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customer and suitability' requirements outlined in the ***Consumer Protection Code 2012*** and failed to supply the Complainant with a copy of its terms of business, contrary to ***provision 4.12*** of the ***Consumer Protection Code 2012***.

The Complainant also contends that the Provider "*…was on notice from January 2016, that they had mis-sold the policy to members*" but that the Provider failed to communicate this error to him until **19 October 2018**, contrary to ***provision 2.8 of the Consumer Protection Code 2012***, which states

> "*A regulated entity must ensure that in all its dealings with customers and within the context of its authorisation it:*
> *…….*
> *corrects errors and handles complaints speedily, efficiently and fairly…."*

The documentation on file in this regard includes

- An email from the Insurer to the Provider dated **11 March 2016** which states

  *"… **Life Cover***

  Firstly, there has been some confusion about how this scheme works. I have attached the Brochure and the Policy Document including the schedule. This makes it clear that… premium rates … were never stated to remain static as members age over time. It is very clear from the Policy Schedule that from outset, these premiums were expected to increase where a member goes across an age threshold and also can be increased at policy review dates (please see section 4 of the policy) …

  … Letters should go out from [the Provider] *before the end of March* [2016] *announcing the premium increase that* [the Provider] *will be implementing…from 1st May".*

- An email from the Provider to the Insurer dated **22 November 2018**, which outlined that the Insurer first requested a premium increase in **January 2016**, which the Provider had disputed on the basis that "*the policy documents and members brochure ... do not mention anywhere that members will move through premium bands*".

  The email also states that in **April 2018**, after further engagement, the Provider received a request from the Insurer to:

  > *"….move members through the age bands" and that the Provider reluctantly agreed to communicate this to members "knowing that it wasn't likely to go down well when the scheme had been operated differently for 14 years and **members had been told that the scheme operated differently when they applied to join the scheme (ie- that they didn't move through the age bands, as for the [Complainant] example)** ….."*

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[My Emphasis]

While I note that there was an attempt by the Insurer to increase premiums in **2016**, the premium increase did not occur until **2018**. It is clear from the contents of the email from the Provider to the Insurer dated **22 November 2018,** that there was some dispute between the Insurer and the Provider during 2016, as to the interpretation of the policy conditions and the extent to which policy premium increases were permissible. However, it is also clear that in **March 2016**, the Insurer drew the Provider's attention to the fact that the Policy Conditions permitted premium increases on premium review dates.

Consequently, I am satisfied that the Provider should have been aware in **2016** that there was an error in the information made available to, not just the Complainant, but to potentially other members of the group policy, who according to the Provider's email dated 22 November 2018:

> "*... had been told that the scheme operated differently when they applied to join the scheme (ie- that they didn't move through the age bands...)*"

The Provider states that the reason it did not communicate the issue to the Complainant until **October 2018** is because it "*first received the details/data the affected members from* [the Provider] *on 11th September 2018. The premium changes then commenced on 1st December 2018*".

In my Preliminary Decision I stated that

> "[t]*he Provider also stated that it has never received another complaint in relation to this matter. However, it is difficult to understand the Provider's explanation that it required a list of affected members, in circumstances where it appears that all members of the life policy were potentially affected. Nor has the Provider offered any explanation for the delay in obtaining such information (if so required) from the Insurer*"

In submissions following the Preliminary Decision, the Provider sated that it did not seek the "*impacted list*" until the Insurer confirmed that it was proceeding with the increase and that:

> "[i]*n 2018, once* [the Provider] *was sure that* [the Insurer] *were going to implement increases for those members that had passed through an age band, and in advance of the application of those increases*, [the Provider] *wrote to all members setting out how the age bands and the unit rate reviews apply…..The complainant in this case, was the only member that made a complaint in response to the notification of an increase in premium. Again, we believe the case of the complainant is an isolated incident and not one of a systemic nature."*

As outlined above, it is clear that the policy conditions permit the Insurer to charge a new policy premium rate from policy review dates. The policy conditions do not specify that the Insurer would "*move members through the age bands at each rate review*". However, it is

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clear from the evidence that in **March 2016,** the Insurer alerted the Provider of its intention to do so.

While there was some dispute between the Provider and the Insurer in this regard, and ultimately the changes did not take effect till 2018, I am satisfied that in **March 2016**, the Insurer also drew the Provider's attention to the fact that the Policy Conditions permitted premium increases on premium review dates.

Consequently, and as stated above, I am satisfied that the Provider was on clear notice in **March 2016**, that there was an error in the information made available to the Complainant, and also to potentially all members of the group policy, regarding the fact that the Policy Conditions permitted premium increases on premium review dates.

While the Provider states that the Complainant was the only member to raise a complaint, I do not believe that this alone is sufficient to demonstrate that "*the case of the complainant is an isolated incident and not one of a systemic nature*", although in my opinion this is a matter for the Central Bank of Ireland to determine. I am conscious in this regard of the Provider's email dated **22 November 2018**, which states that "*members had been told that the scheme operated differently when they applied to join the scheme (ie- that they didn't move through the age bands, as for the* [Complainant] *example)".*

It is also clear that the Provider did not communicate the manner in which premiums would increase to the Complainant (and also it seems to other members) until **2018**. The Provider in its submissions following the Preliminary Decision, supplied an "*anonymised version of the letter*" issued to all members in **2018**. I note that the letter to the Complainant dated **19 October 2018**, does not reference any error by the Provider in the provision of information about the policy premiums, when the Complainant joined the policy, or that there was any failure on the Provider's part in this regard. Instead, the letter to the Complainant (and it seems, the letter sent to all members in 2018) states that

> "*[a]s you can see from the above tables, Members and Spouses/Partners move through the relevant age bands as they get older. At each rate review (usually every 3 years), members should be aligned to the correct premium bands based on the age of the Member or Spouse/Partner at the date of that review, and if members move into a different age band premiums paid will be adjusted accordingly. However due to an administrative error by the insurer, this has not happened to date at any previous rate review, resulting in most Plan members being under-charged for a number of years. While this administrative error has benefited members financially, all Plan members now need to move to the correct age appropriate band as per the table above. This is necessary to ensure the long term viability of the Plan, which is priced on the above basis."*

Consequently, I have a concern that the Provider may have failed to comply with ***provision 2.8 of the Consumer Protection Code 2012*** and with ***provision 10.2(d) of the Consumer Protection Code 2012,*** which states that

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> "[a]*regulated entity must resolve all errors speedily and no later than six months after the date the error was first discovered, including …*
>
> *(d)* ***notifying all affected consumers****, both current and former, in a timely manner,* ***of any error that has impacted or may impact negatively on the cost of the service, or the value of the product****, provided, where possible."*
>
> [My Emphasis]

Furthermore, I accept that the Complainant is correct insofar as he states in his submissions that:

> "*[i]f I had been informed about this issue sooner, I would have been of a younger age (I turned 40 in March 2016) and in a better position to investigate taking out a cheaper alternative policy and would have been subject to underwriting at a younger age. Essentially,* [the Provider] *sat on their hands hoping that the issue would go away to my detriment as I was only informed when I was aged 42 ½."*

The Complainant has sought compensation of **€15,733**, which is the financial loss he says that he will incur due to the application of increased premiums over the duration of the Policy. I take the view that if the Complainant had been informed correctly as to the policy premiums, when the policy was sold in **October 2015**, the Complainant would have had the option of:

- proceeding to become a member of the group life policy on the terms offered by the Insurer (i.e., that premiums could increase);
- seeking alternative life cover; or
- not obtaining life insurance cover.

I accept that it was never open to the Complainant to become a member of the group policy on the basis that his premiums were guaranteed to remain at €22.50 for the duration of the policy. Consequently, I take the view that the figure of €15,733 (which the Complainant has calculated to be his financial loss due to the application of increased premiums of more that €22.50 over the duration of the Policy) is of limited relevance in these circumstances and must be viewed in that context. Neither do I consider it appropriate at this remove, to speculate as to whether the Complainant, (if he had been properly informed as to the policy premiums) would have sought/been accepted for alternative cover, or whether he might have decided not to obtain life cover. That said, I do not accept that the proposals put forward by the Provider, constitute adequate compensation. The Provider's proposal in **May 2019**, to cancel the policy and pay the Complainant compensation equal to the cost of the premiums paid at that date (€990), would have left the Complainant with no insurance. Nor do I consider that €990 to be appropriate compensation in the circumstances.

While the Provider also proposed securing a new life insurance policy for the Complainant with guaranteed premiums of €52.76 per month for the duration of the policy, this new policy would be subject to underwriting. It is entirely understandable that the Complainant rejected this proposal, as this would have exposed the Complainant to the risk of medical underwriting at a time when the Complainant was older and may have developed further

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medical conditions since the cover was originally put in place, which could result in exclusions being applied on any new life insurance policy, or the application for cover being rejected.

The Provider's error with regard to the information it gave to the Complainant in 2015, about the cost of the premiums, was a very serious error, in my opinion. The cost of premiums for a life insurance policy is key information, and the figure of **€6,750** supplied by the Provider as representing the cost of the premiums for a 25-year period *"in simplistic terms",* was in fact entirely inaccurate, given that it has since transpired, that the total cost of the policy premiums is more likely, roughly speaking, to be more than **€20,000.**

Without accurate information in this regard, the Complainant was not in a position to make an informed choice as to whether the policy was suitable for him. Furthermore, the Complainant was deprived of an opportunity to accurately evaluate or compare alternative cover available to him from another insurer, at a time when the Complainant was younger and in a better position to secure a lower premium rate than may be available to the Complainant now (because premium rates for life insurance policies will generally be higher for older applicants as the cost to insure and risks associated with older applicant, will generally be higher).

I am satisfied that the Provider had a duty to supply the Complainants with accurate information in respect of the policy, and in particular the policy premiums, and that the Provider failed to do so, contrary to ***provision 4.1*** and ***4.40*** of the ***Consumer Protection Code 2012***. I am also satisfied, for the reasons outlined earlier in this Decision that the Provider failed to comply with ***provisions 2.2, 4.12, 5.1, 5.16, 5.17, 5.19, and 5.20*** of the ***Consumer Protection Code 2012***, and may also have failed to comply with provisions ***2.8*** *and* ***10.2(d)*** of the ***Consumer Protection Code 2012***. I am of the view that the Provider's failure to comply with certain provisions of the ***Consumer Protection Code 2012*** was contrary to its legal obligations, within the meaning of ***s60(2)(a)*** of the ***Financial Services and Pensions Ombudsman Act 2017*** and was also unreasonable and unjust to the Complainant within the meaning of ***s60(2)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017***.

On the basis of the evidence before me, I consider it appropriate to uphold this aspect of the complaint. I take the view that the manner in which the Provider arranged the policy was seriously flawed, for the reasons which I have identified, throughout this Decision.

Taking account of the Provider's failures in the manner in which this policy was arranged, including the denial of an opportunity to the Complainant in 2015, to consider in a properly informed manner, potential alternatives for cover, or to consider whether he wished to proceed with cover at all, I am satisfied that the Provider's conduct caused significant inconvenience to the Complainant.

Consequently, I take the view that a significant compensatory payment to the Complainants is warranted I, and I consider it appropriate to direct the Provider to make a compensatory payment to the Complainant, in the sum of **€8,000** in respect of this aspect of the complaint.

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2. Complaint Handling

The second aspect of the Complainant's complaint is that the Provider supplied a poor complaint handling service from **November 2018** onwards.

The documentation on file includes a letter of complaint from the Complainant to the Provider dated **14 November 2018**. The Provider responded on **21 November 2018** and confirmed that the Provider had raised the complaint with the Insurer and that the Insurer was investigating it.

The Provider subsequently emailed the Complainant on **13 December 2018** and **22 January 2019**, updating him that the complaint was being investigated and that the Provider was awaiting a response from the Insurer, and it enclosed a letter from the Insurer to the Provider dated **20 November 2018**, which stated that the Provider was investigating the complaint and that it envisaged "*that this is likely to take up to 20 working days to reply*".

The Complainant in a letter to the Provider dated **10 May 2019**, stated that:

> *"…It is now nearly 6 months since I first made my complaint ….it has still not been resolved and/or formally responded to. I have also not heard from you for a considerable period of time ..."*

The following correspondence between the Complainant and the Provider then ensued:

- an email from the Provider to the Complainant dated **10 May 2019**, apologising for the delay and informing the Complainant that it would be in touch with an update;
- a letter from the Provider to the Complainant dated **22 May 2019**, referring to a call with the Complainant on 16 May 2019, and stating that it "*will endeavour to come to a position on this within 20 working days from our phone call*";
- an email from the Provider to the Complainant dated **14 June 2019**, stating that it would contact the Complainant "…*within the next week*.";
- an email from the Provider to the Complainant dated **5 July 2019**, stating that "*a final position will be reached the week of the 29th July*";
- an email from the Provider to the Complainant dated **12 August 2019**, which states "[w]*e're hoping to be in a position to send you something in the next 2 weeks or so*";
- an email from the Provider to the Complainant dated **27 September 2019**, which states that a response "*will issue in the early part of next week*"; and
- a letter from the Provider to the Complainant dated **4 October 2019** outlining its final response to the complaint.

The Provider states in relation to its handling of the Complainant's complaint that:

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> "[t]*his complaint comes from a member rather than the entity we are engaged to provide services to. But we also take seriously complaints from members. This complaint has taken some time to take forward, mainly because the resolution sought by the member is not consistent with the terms of the Scheme or reasonable, in view of the circumstances. We do not dispute the timeline provided by the member.* ***We could have provided a final response sooner had we not taken gone to the considerable lengths we did, to try and resolve his complaint***"
>
> [My Emphasis]

At this point it is helpful to consider ***provision 10.9*** of the ***Consumer Protection Code 2012,*** which states

> *"[a] regulated entity must have in place a written procedure for the proper handling of complaints. ... At a minimum this procedure must provide that:*
>
> *a) …….*
> *b) the regulated entity must provide the complainant with the name of one or more individuals appointed by the regulated entity to be the complainant's point of contact in relation to the complaint until the complaint is resolved or cannot be progressed any further;*
> *c) the regulated entity must provide the complainant with a regular update, on paper or on another durable medium, on the progress of the investigation of the complaint at intervals of not greater than 20 business days, starting from the date on which the complaint was made;*
> *d) the regulated entity must attempt to investigate and resolve a complaint within 40 business days of having received the complaint; where the 40 business days have elapsed and the complaint is not resolved, the regulated entity must inform the complainant of the anticipated timeframe within which the regulated entity hopes to resolve the complaint and must inform the consumer that they can refer the matter to the relevant Ombudsman, and must provide the consumer with the contact details of such Ombudsman; and …."*

While it is clear from the documentation on file that the Provider informed the Complainant that he could contact its representative if he had any queries about his complaint, it does not appear that the Provider supplied the Complainant with the name of any individual appointed by the Provider to be the Complainant's point of contact in relation to the complaint contrary to ***provision 10.9(b)*** of the ***Consumer Protection Code 2012***.

Furthermore, contrary to provision ***10.9(d)*** of the ***Consumer Protection Code 2012,*** the Provider did not inform the Complainant that he could refer his complaint to the FSPO, after 40 business days had elapsed after the Provider received the complaint.

Nor do I consider it reasonable that the Provider failed to contact the Complainant, or to update him about his complaint after **20 November 2018** until **May 2019**. In my view the Provider demonstrated poor complaint handling in these respects.

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I note that the Provider's explanation for the delay in issuing its final response letter in **October 2019**, some 11 months after the complaint was made, is that it went to great lengths to resolve the matter. I am conscious however that no evidence has been submitted by the Provider to this Office demonstrating its attempts, either through its communications with the Insurer or otherwise, to progress its investigation of the complaint from **9 February 2019** until **24 April 2019**. Consequently, I do not accept that the delay in issuing the final response letter was solely attributable to the Provider's efforts to resolve the complaint, and I consider that there was some unreasonable delay in the Provider's response to the complaint. I welcome however the Provider's confirmation in its submissions following the Preliminary Decision that the Provider:

> "*will ensure that all policies and process are adhered to and that similar communications from members of such schemes are treated in accordance with provision 10.9 of the Consumer Protection [sic].*"

To mark the Provider's failures in respect of its complaint handling, which were unreasonable within the meaning of ***section 60(2)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, I consider it appropriate to direct the Provider to make a compensatory payment of **€750.00 (seven hundred and fifty euro).**

Accordingly, for the reasons outlined above, I consider it appropriate to direct the Provider to make a total compensatory payment to the Complainant of **€8,750.00 (eight thousand seven hundred and fifty euro)** for the mis-selling and complaint handling aspects of the complaint pursuant to ***section 60(4)(d) of the Financial Services and Pensions Ombudsman Act 2017***.

It is also my intention to bring my Decision in this complaint to the attention of the Central Bank of Ireland for any action it may deem necessary, because the evidence shows that incorrect information about the level of premium payable over the term of this policy cover, may have been supplied by the Provider to other members when they joined the group life policy, and the issues arising in this complaint may therefore be systemic in nature.

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is upheld on the grounds prescribed in ***Section 60(2)(a) and (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 **€8,750.00** (eight thousand seven hundred and fifty 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)

6 October 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.