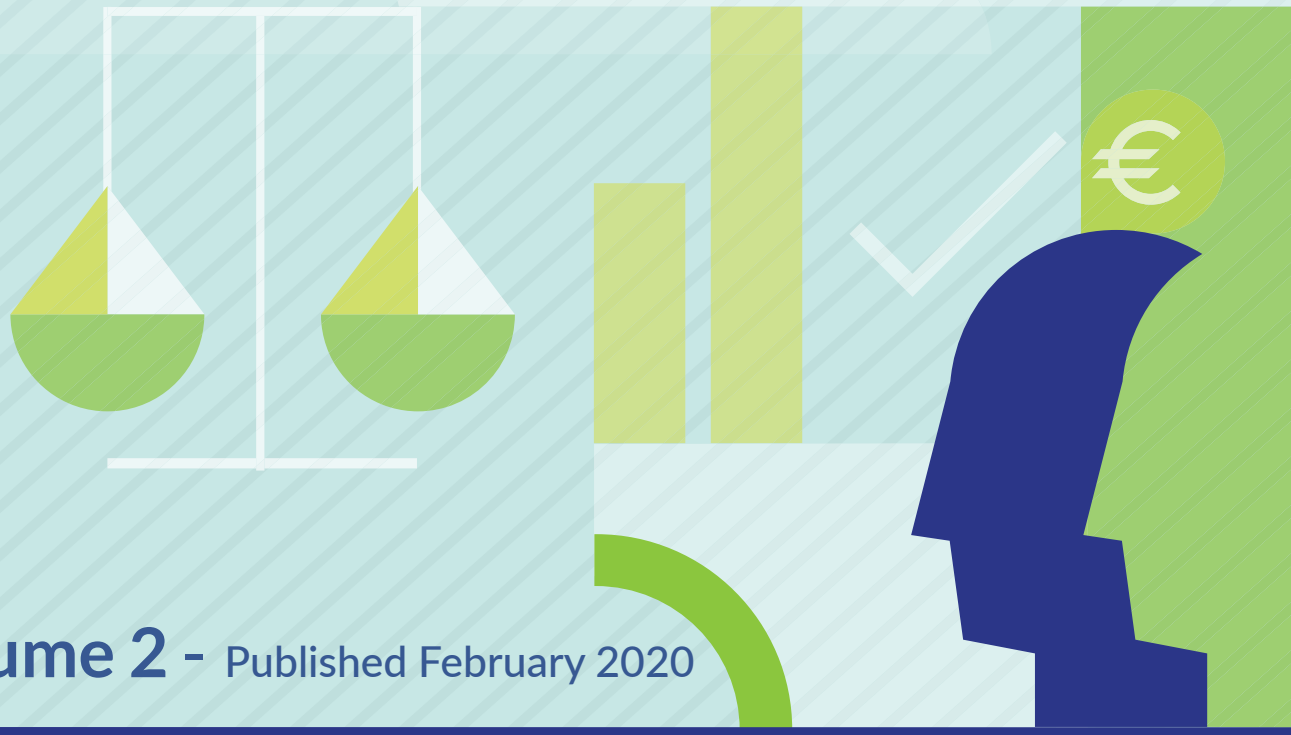
An tOmbudsman Seirbhísí Airgeadais agus Pinsean

Financial Services and Pensions Ombudsman

Ombudsman's Digest of Legally Binding Decisions



Volume 2 - Published February 2020

Contains summaries and case studies based on decisions issued between 1 January and 31 December 2019

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The Financial Services and Pensions Ombudsman (FSPO)

The FSPO was established in January 2018 by the **Financial Services and Pensions Ombudsman Act 2017.**

The role of the FSPO is to resolve complaints from consumers, including small businesses and other organisations, against financial service providers and pension providers.

We provide an independent, fair, impartial, confidential and free service to resolve complaints through either informal mediation, leading to a potential settlement agreed between the parties or formal investigation and adjudication, leading to a legally binding decision.

When any consumer, whether an individual, a small businesses or an organisation, is unable to resolve a complaint or dispute with a financial service provider or a pension provider, they can refer their complaint to the FSPO.

We deal with complaints informally at first, by listening to both parties and engaging with them to facilitate a resolution that is acceptable to both parties. Much of this informal engagement takes place by telephone. In 2019, we resolved approximately 2,160 complaints through the informal mediation process.

Where these early interventions do not resolve the dispute, the FSPO formally investigates the complaint and issues a decision that is legally binding on both parties, subject only to an appeal to the High Court. The FSPO issued 439 legally binding decisions in 2019 – 394 of which are being published in conjunction with this volume of the Ombudsman's Digest of Decisions.

The Ombudsman has wide-ranging powers to deal with complaints against financial service providers. He can direct that a provider rectify the conduct that is the subject of the complaint. There is no limit to the value of the rectification he can direct. He can also direct a provider to pay compensation to a complainant of up to €500,000. In addition, he can publish his decisions and he can also publish the names of any financial service provider that has had at least three complaints against it upheld, substantially upheld, or partially upheld in a year.

In terms of dealing with complaints against pension providers the Ombudsman's powers are more limited. While he can direct rectification, the legislation governing the FSPO sets out that such rectification shall not exceed any actual loss of benefit under the pension scheme concerned. Furthermore, he cannot direct a pension provider to pay compensation. He can only publish case studies in relation to pension decisions (not the full decision), nor can he publish the names of any pension provider irrespective of the number of complaints it may have had upheld, substantially upheld, or partially upheld against it in a year.

Formal investigation of a complaint by the FSPO is a detailed, fair and impartial process carried out in accordance with fair procedures. For this reason documentary and audio evidence, and other material, together with submissions from the parties, is gathered by the FSPO from those involved in the dispute, and exchanged between the parties.

A total of six of all 673 FSPO decisions issued to date have been appealed by the parties to the High Court. Of the 439 decisions issued in 2019, five were appealed by the parties to the High Court.

Unless a decision is appealed to the High Court, the financial service provider or pension provider must implement any direction given by the Ombudsman in his legally binding decision. Decisions appealed to the High Court are not published while they are the subject of legal proceedings.

Publication of FSPO decisions made during 2019

Section 62 of the **Financial Services and Pensions Ombudsman Act 2017,** provides the FSPO with the power to publish legally binding decisions in relation to complaints against financial service providers.

The legislation requires that decisions should be published in a manner that ensures that a complainant is not identified by name, address or otherwise and a provider is not identified by name or address. Publication must also comply with Data Protection legislation and regulations.

The legislation also provides the FSPO with the power to publish case studies of decisions relating to pension providers, but not the full decision.

In addition to publishing the full decision, the Ombudsman has also published this Digest which includes a short summary of a selection of 33 decisions in relation to complaints made against financial service providers and case studies of 3 decisions in relation to complaints made against pension providers. Some details within the summaries referenced in this Digest, such as names and locations, have been altered in order to protect the identity of the parties. It is important to keep in mind that these are only short summaries. You are encouraged to read the full text of the decisions. Each summary of a complaint against a financial service provider in this document includes a link, on the top of the page, to the full text of the decision, which was issued to the parties to that complaint.

To provide the maximum possible access to the Ombudsman's decisions we have created an online database of legally binding decisions. This can be accessed at www.fspo.ie/decisions. This database now holds the full text of more than 600 of the Ombudsman's decisions in relation to complaints against financial service providers, issued by the FSPO since January 2018. Decisions will continue to be added on an ongoing basis, including in the coming weeks.

Information on how to access decisions and search for areas or decisions of specific interest is included on Page 7 of this Digest.

In 2019, we resolved the majority of complaints, approximately 2,160, through mediation. However, a substantial number of complaints also required formal investigation and adjudication.

We issued 439 legally binding decisions, almost double the number of decisions issued in 2018. In the case of 201 decisions, the complaint was upheld to some extent, while 238 were not upheld. We will issue the 2019 Overview of Complaints in March 2020. The Overview will include a breakdown of all complaints closed in 2019, an analysis of complaint trends and will report on named financial service providers.

In February 2020, the FSPO published 394 decisions made during 2019. As the legislation does not provide the power to publish decisions relating to pension providers, three decisions relating to pension providers that were issued in 2019 are not published. Case studies of these three decisions are included in this Digest. A further five of the 2019 decisions were under appeal to the High Court at the time of publication in February 2020. These five decisions will be not be published pending the outcome of those appeal processes. In addition, there are 13 decisions where the content of the decision is so distinctive that, even when anonymised, it would risk identifying the complainants. For this reason these have not been published.

Considerable work was done by the Office in progressing the resolution of complaints relating to tracker mortgages in 2019. Complaints were resolved through both the informal dispute resolution process and the formal investigation and adjudication process. Given the breadth of tracker mortgage related complaints the Ombudsman decided to publish 25 tracker mortgage complaint decisions separately with a separate Digest of Decisions. These decisions and the Digest of Tracker Mortgage Complaints will be published separately.

Message from the Ombudsman

I believe it will be evident to anyone who reads either the summaries in this Digest or the full text of the decisions on our website, that the work of this Office can have a very profound impact on many of those who use our services. I also believe that decisions of this Office have a very important role in improving the conduct of financial service providers.

The powers available to me are extensive, particularly in relation to complaints against financial service providers. My decisions are legally binding on both parties, subject only to an appeal to the High Court. This means that a provider must implement any direction made in a decision.

This is the second occasion on which I have published decisions since the statutory power to do so, was given to me. Our database of decisions now contains over 600 legally binding decisions issued since the Office was established in January 2018. I will continue to publish my decisions on an ongoing basis. I will publish a third Digest containing summaries of decisions regarding complaints relating to tracker mortgages in February 2020 when I publish the decisions relating to those complaints.

Publication of decisions made by this Office is an important step in achieving one of the key objectives of our Strategic Plan 2018 – 2021, of improving communication and engagement with the public. I believe it also enhances the transparency and understanding of the work of the Office and assists in delivering our commitment to improving the quality and transparency of the service and enhancing the consumer framework within which providers operate.

I hope that having access to these decisions will assist consumers and their advocates and financial service providers both to avoid and resolve disputes.

The decisions published give a sense of the breadth and complexity of the issues we address and resolve. The case studies in this Digest alone, give a sense of the variety and complexity of complaints that our investigations and adjudications dealt with in 2019.

For example, in relation to banking, we adjudicated on matters such as the complexities surrounding joint mortgages where couples are separating, credit ratings, the appointment of receivers, transfer of funds outside the EU, disputes regarding interest rates and arrears and the closure of accounts.

In relation to insurance, we issued decisions regarding the voiding of policies, rejection of claims, disputes regarding the value of claims and quality of information made available by providers in relation to life, income protection, home, motor, health, business, travel and pet insurance.

We also issued decisions in relation to complex investment and pension disputes.

I am very grateful to all my colleagues for their hard work and commitment to providing a fair, impartial, independent and transparent service. I also want to thank all complainants and providers for their cooperation with our various processes.

We have reproduced a number of comments from people who used our investigation and adjudication service in 2019 on page 44. I believe this feedback demonstrates the importance of our service in the lives of our customers.

Ger Deering

Financial Services and Pensions Ombudsman

February 2020

How to search our decisions on **www.fspo.ie**

Accessing our database of decisions

Our database of legally binding decisions is available online at www.fspo.ie/decisions. To refine your search, you can apply one or a number of filters.

1 Applying **filters** to narrow your search

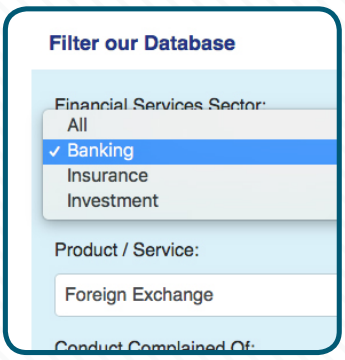
To filter our database of Decisions, you can firstly select the relevant sector:

2

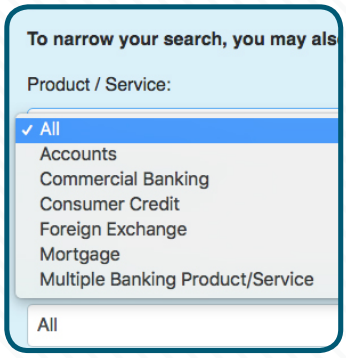
Having filtered by sector, the search tool with then help you to filter our **Decisions** further by categories relevant to that sector such as:

- product / service
- conduct complained of

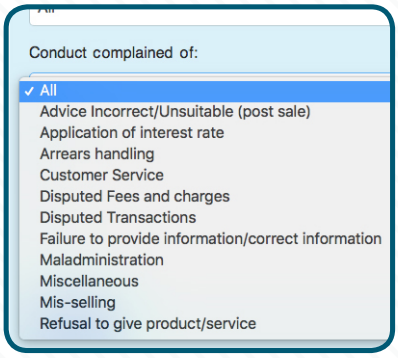
✓ Sector



✓ Product / Service



✓ Conduct complained of



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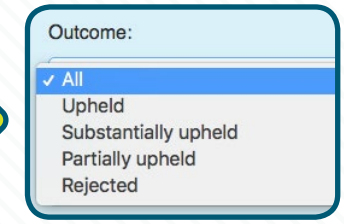
You can also filter our database of Decisions by year, and by the outcome of the complaint, i.e. whether the Ombudsman Upheld, Substantially Upheld, Partially Upheld or Rejected the complaint.



Once you have found the Decision you are looking for, click **View Document** to download the full text in PDF.

Sector:
Banking

READ THE FULL DECISION HERE

Decision Reference: 2019-0245

Dispute regarding mortgage repayment due date

Two sisters, Vivienne and Caitriona, held a mortgage with the bank since 2006. In 2015, the bank informed the Irish Credit Bureau (ICB) that the sisters had missed a mortgage repayment in February of that year. This missed payment was then recorded negatively on their ICB record.

This had serious consequences for both Vivienne and Caitriona. As Vivienne worked for another financial service provider, she was obliged to discuss her ICB record with her managers. This undermined her credibility and position in her place of work, an experience she described as 'embarrassing and upsetting.'

The two sisters disputed that they had missed a payment in February of 2015. The dispute centred around differing interpretations of the 'due date' for each monthly payment. The sisters contended that the due date was the 7th of every month. This was the date stipulated in the general conditions of the initial mortgage loan offer letter for the first monthly payment. They provided evidence that demonstrated they made payments for February on the 2nd and 3rd of March, both before the due date of the 7th of March.

The bank argued that the due date is the 1st of every month and that the 7th refers only to accounts for which a direct debit is in place. The sisters did not pay by direct debit. Therefore, as the payments for February of 2015 occurred after the 1st of March, the bank considered these to have been missed.

The Ombudsman, however, pointed out that the bank's interpretation of the due date was not specifically set out in any of its documentation. He found there was no way the sisters could have known this was supposed to be the due date, let alone be said to have agreed to it. The Ombudsman applied a common legal rule – where a contractual clause is ambiguous, it should be interpreted against the party who provided the wording.

This meant he accepted Vivienne and Caitriona's interpretation of the due date.

After the Ombudsman issued his preliminary decision, the bank made further submissions. It argued that the general conditions explicitly stated the date of the 7th was the due date for the first monthly payment only. The bank also argued that the conditions later go on to define a 'month' as a calendar month and state that the 'ordinary meaning of a calendar month should be taken.' It argued that it is clear what is meant by the term 'calendar month,' arguing there was no ambiguity. The bank also supplied recordings of two calls from 2014 and 2015 with its post-preliminary decision submission. It contended these calls demonstrated that the sisters had a 'full awareness' that payments had to be made before the end of a calendar month.

In considering these calls, the Ombudsman pointed out that recordings of these calls should have been submitted as part of the bank's earlier submissions. He found that these calls had given the bank the opportunity to explain explicitly to the customer when payments were due. However, it did not. Instead of supporting the bank's case, the Ombudsman found that it highlighted its lack of understanding of the need to provide clear information.

The Ombudsman also stated that the fact the bank relied on 'inferences from the definitions' of a calendar month clearly showed there is an element of ambiguity. He pointed out that if the bank required that all payments be paid by the 1st of the month, then it should have stated so in the conditions.

The Ombudsman substantially upheld the decision and directed the bank to pay €5,000 in compensation to Vivienne and Caitriona, furnish a letter outlining that the 'missed' payment in February of 2015 was incorrectly recorded and to ensure that the sisters' credit record was in no way negatively impacted by the matter.

Banking

READ THE FULL DECISION HERE

Decision Reference: 2019-0394

Request to amend credit rating

In 2016, Anna was issued with a credit card. When she later received a bill and contacted her bank to pay the bill, it suggested that a direct debit be set up to facilitate this. Several attempts to set up a direct debit failed. This situation was not resolved until January 2018.

In April 2018, Anna applied for a loan from a third-party financial service provider, in order to start a new business. She was informed that the loan could not be approved due to information on Anna received from the Irish Credit Bureau (ICB). Anna discovered that the bank had reported to the ICB that she had missed credit card payments. Anna complained to the bank on the 13th of April.

On the 25th April, the bank informed Anna it would contact the ICB to rectify the matter. Anna was told this would take four days. On the 17th of May, Anna got in touch with the ICB to check if the matter had been rectified. She was informed that the bank had not contacted the ICB.

In reviewing the evidence, the Ombudsman found that the bank had attempted to contact the ICB about Anna's account on two occasions. After trying to update Anna's record, the ICB responded to say that it had changed its processes, which meant that it would not accept the amendment to Anna's account in the format that the bank had sent it. On receiving this information, it appeared that the bank stopped trying to correct the record. Instead, the bank got in touch with Anna to inform her that updating the ICB credit record was now something that she needed to request herself directly. The Ombudsman stated that this was 'extremely unfair' towards Anna since it was the bank which had made the report to the ICB and only the bank could amend it.

In a post-preliminary decision submission, the bank questioned the Ombudsman's intended decision. It stated that the Ombudsman's preliminary decision read as if Anna sought the loan after making a complaint to the bank and that her credit rating had been negatively impacted after the complaint. In fact, Anna requested a loan before she made the complaint to the bank. It stated this was important as it showed that Anna's loan request was not adversely impacted by their failure to follow up on the complaint. It also disputed the level of compensation he proposed to direct.

The Ombudsman found that the bank's post-preliminary decision submission showed that it completely failed to 'understand the seriousness and impact of its conduct.' The most serious aspect of the complaint was the fact that the bank agreed to amend Anna's ICB record and then failed to do so after it was found to be administratively inconvenient. The timing of the complaint was irrelevant. He found the bank's offer of €100 in compensation to be wholly inadequate.

The Ombudsman substantially upheld Anna's complaint and directed the bank to pay €15,000 to Anna, as well as take the steps necessary to ensure that she does not have a negative credit rating with the ICB or the Central Credit Register in relation to the credit card.

Banking

READ THE FULL DECISION HERE

Decision Reference: 2019-0337

Appointment of a receiver

Joan and Pat were joint owners and mortgage holders of a buy-to-let property. From March 2010, the couple's mortgage account fell into arrears.

In August 2014, Joan and Pat were informed by their bank that a receiver had been appointed to manage the account. In response, the couple engaged a solicitor to try to come to an agreement with the bank to pay off the arrears.

The solicitor made a proposal to the bank's branch manager in September of 2014 regarding the repayment of arrears, which the branch manager relayed to the bank's Arrears Support Unit (ASU). The legal officer from the ASU stated that once the receiver has been appointed it was "game over" and that the couple needed to talk to the receiver.

Joan then became seriously ill and was hospitalised in early 2015. The solicitor made further efforts to reach agreement on the mortgage again at this time, but the bank would not engage. The solicitor sent multiple reminders over the next 12 months to the bank, with no response.

The couple assert that no effort was made to engage with them or their solicitor to come to an agreement on the mortgage. At the time of making the complaint, Joan and Pat did not know whether their property had been sold and what the balance was on their mortgage at that point. They believe that, had the bank engaged with them, the mortgage could have been salvaged.

In its response to the Ombudsman, the bank indicated that a staff member visited the couple's property in February of 2014 where he spoke to Pat about the mortgage. It stated that at this meeting it was agreed that the couple would provide an application for forbearance on the mortgage. This application was never made. This led to the bank referring the mortgage to the ASU and appointing the receiver.

The bank conceded that it did not respond to correspondence from the couple's solicitor during 2015 and 2016 and failed to deliver on customer service expectations. As a result, the bank offered a goodwill gesture payment of €1,000 to Joan and Pat.

The bank also confirmed the receiver had sold the property and lodged the proceeds of the sale to the couple's mortgage account.

In his preliminary decision the Ombudsman indicated his intention to uphold the complaint and direct the bank to pay €15,000 in compensation. In a post-preliminary decision submission, the couple argued that the ostensible meeting at their property, which played an important role in the appointment of the receiver, never happened. In response, the bank sought a further statement from the staff member who purportedly met Pat at the property. In this statement he said he could not recall if the conversation he had with Pat about the application for forbearance happened at a meeting at the property or over the phone.

In his decision, the Ombudsman stated that the bank's 'complete absence of communication' meant that it had not acted in the best interests of Joan and Pat. While he noted that the bank had advised that correspondence should be with the receiver, this did not justify the bank ignoring all correspondences.

The Ombudsman found it 'extraordinary' that the staff member could confirm specific contents of a conversation but could not recall whether that conversation happened at a meeting at the property or over the phone. Having received this statement, the Ombudsman accepted that, on the balance of probability, the meeting did not in fact take place. Considering that he now believed the meeting did not in fact take place, the Ombudsman upheld the complaint and directed the bank to pay the couple €30,000 in compensation.

Banking

READ THE FULL DECISION HERE

Decision Reference: 2019-0423

Transfer of funds outside the EU

On the 14th of August 2017, Ari instructed his bank to transfer the equivalent of €5,681.82 in dollars from his Irish bank account to an account in Pakistan, in order to pay an instalment for a plot of land. Ari said he was advised that the funds would reach the bank account within three working days. The funds did not reach the bank account in that timeframe.

Because of the delay, the intended recipient of the funds informed Ari he would not issue the plot to him. Ari immediately brought the issue to the attention of his local branch, but the issue was not resolved by the branch and was eventually escalated to the bank's complaints handling centre. Ari requested a refund of the funds from the bank to enable the funds to be transferred in a different manner. The funds eventually reached the intended bank account on 27th September 2017. Ari requested a refund of the amount transferred from the bank and compensation for his loss of the plot of land, which he calculated at between €50,000-€70,000.

The bank stated that any refund was a matter between Ari and the person to whom he had instructed the payment to be made.

The bank, in its submission to the Ombudsman, went into great detail to explain that Ari conducted the payment himself online and therefore could not have been advised by anyone in the bank that it would take an average of three working days. When this response was exchanged with the complainant, he provided evidence that he had in fact conducted the transaction in his local branch of the bank. The bank eventually accepted this and apologised for its error. The Ombudsman found it difficult to understand why the provider was querying the complainant's version of events and seeking to undermine his evidence.

The Ombudsman stated that he had no reason to doubt the complainant's version of events as supported by the evidence and accepted that he was in fact informed by the bank that it would take an average of three working days.

The bank also stated that a delay to the funds being paid was not due to any failure on its part.

The bank stated that any international transfer involving multiple currencies first goes through an 'originating bank,' Ari's bank in this case, then through a 'intermediary bank,' before arriving at the 'beneficiary bank,' the ultimate destination of the payment. Once the bank transfers payment to the intermediary bank, which it did, it states the situation is out of its hands. It was the intermediary bank that did not complete the transaction and his own bank suggested Ari should take up the complaint with that bank.

The Ombudsman accepted that the delay to Ari's payment was through no fault of the bank. He did find, however, that there were several aspects related to the bank's conduct and communication towards Ari that it must answer for. When the Ombudsman asked what queries were raised by the bank with the intermediary bank regarding the delay, the bank stated that it was 'not in the bank's remit to query or challenge' the intermediary bank's decision for the delay. The Ombudsman was surprised by this statement, as it implied that the bank felt it had no responsibility to ensure the funds reached their intended destination. This position was found by the Ombudsman to be 'not acceptable.' He found that the bank should have done its best to establish why the money had not reached the intended account.

The Ombudsman also found that it was 'not reasonable' for the bank to assert that Ari should take up the complaint with the intermediary bank. The other banks involved in the transaction had no relationship with Ari and were located in the United States. Instead, he believed the bank could have made greater attempts to provide information and an explanation as to where his money was.

The Ombudsman upheld the complaint. While he found no evidence to support Ari's claim that he had suffered losses of up to €70,000 and that any refund was a matter between Ari and the person he instructed the payment to be made to, he did direct the bank to pay a sum of €7,500 to Ari as compensation for the stress and inconvenience caused.

Banking

READ THE FULL DECISION HERE

Decision Reference: 2019-0213

Reporting of a customer's credit rating to the Irish Credit Bureau

In 2008, Farzad took out a loan for the purchase of a new computer. Shortly afterwards, Farzad separated from his wife and agreed that she could keep the computer provided she paid the outstanding loan.

The payments subsequently fell into arrears. By the time Farzad cleared the balance in February 2012, nine repayments in total had been missed. Once the payments had been made, the account provider closed the account on the 27th February 2012. When Farzad cleared the balance, the provider reported Farzad's accounts to the Irish Credit Bureau (ICB). It should have reported the accounts as '9' and 'C,' indicating that nine payments had been missed initially, then completed at a later stage. Instead, Farzad's records read as '9' and '9,' which indicated that his arrears had not been paid.

Between the years of 2015 and 2017, Farzad tried to secure credit facilities on several occasions, including a mortgage from various financial providers, but couldn't due to his poor credit rating. Farzad made enquiries and discovered that incorrect arrears codes had been reported on his credit file between February 2012 and late 2017. The error resulted in Farzad having a 5-year negative credit rating and the refusal of subsequent credit and mortgage applications.

When Farzad looked to resolve the issue with the provider, it stated that it was unable to locate his account details, as the loan had previously been taken out with the provider's predecessor and, therefore, was administered on a different system. The provider accepted that it had failed to inform the ICB that Farzad's balance had been cleared. It also acknowledged that Farzad's file should have read 'C' for complete instead of '9' for 9 months arrears and that this mistake was recorded for five years. While the provider stated that it had 'not been supplied with tangible evidence of a financial loss,' it offered Farzad €300 as compensation, which it later increased to €500.

The Ombudsman stated that it was 'extraordinary' that the provider was submitting information to the ICB on a loan which it was initially unable to find when Farzad first raised the issue. He noted that, if the provider reported the correct information, it would have still shown a series of missed repayments until it was cleared in full. However, he was in 'no doubt' that the provider's incorrect reporting impaired Farzad's credit rating unnecessarily from 2012 to 2017.

The Ombudsman believed that the sums of €300 or €500 were not at all sufficient for the inconveniences caused to Farzad and showed a serious lack of understanding on the part of the provider, of the implications of its conduct. The Ombudsman indicated his intention in the preliminary decision to direct the provider to pay the sum of €15,000 to Farzad for the inconvenience and distress caused.

Following the preliminary decision, the provider submitted that it thought the compensation was 'punitive' as they still had no tangible evidence of losses made by Farzad. This was despite the fact Farzad had submitted multiple letters to the Ombudsman confirming that numerous applications for credit had been refused by various institutions.

The Ombudsman upheld the complaint and found the provider's post-preliminary decision submission to be further evidence of its lack of understanding as to the effect of a negative credit rating and the inconvenience caused to Farzad.

He upheld the complaint and directed the provider to pay €15,000 in compensation to Farzad. In addition to the compensation, he directed the provider to ensure that no negative report in relation to the matter should be contained in Farzad's credit record, either on the ICB or the Central Bank's Credit Register.

Banking

READ THE FULL DECISION HERE

Decision Reference: 2019-0369

Complex issues relating to separation of joint mortgage holders

In 2005, Niamh and her now former partner took out a mortgage. Both parties moved out of the mortgaged home after separating in 2010, but Niamh's former partner moved back in a few months later. In November 2013, the mortgage began to accumulate arrears.

In October 2014, the mortgage provider agreed with Niamh's former partner to extend the term of the mortgage without consulting her. She contacted the provider to cancel the agreement, which it did. In April 2015, she was notified that an extension of 11 years had once again been agreed without her consent. This time, when she complained, she received a letter from the provider stating that a decision had been made to keep the arrangement in place. A subsequent letter explained that the provider applies a Single Party Voice Authority (SPVA) in circumstances where the parties to the account are separated and only one party is engaging.

Niamh did not accept that she was 'not engaging' and made two complaints, in July and September, that these actions were not in compliance with the Code of Conduct on Mortgage Arrears (CCMA). The provider responded to the first complaint stating the agreement would remain in place but offered a goodwill gesture of €500. It did not reply to the second complaint until February 2016, before agreeing at the end of August to reverse the term extension in an attempt to resolve the complaint. It increased its previous goodwill offer to €1,500 and subsequently apologised for the time it took to respond to the complaint.

The provider was unable to evidence any attempts to contact Niamh in relation to the second term extension but stated that it was satisfied that it acted within the parameters of its process, as it was obliged to assist any borrower who attempted to maintain mortgage repayments.

The Ombudsman noted this was a very challenging complaint, with both former partners doing their best to meet their financial and family commitments in a stressful situation and commended the support and sympathy displayed by representatives of the provider. The Ombudsman did not wish to discourage providers from attempting to agree Alternative Repayment Arrangements where only one party is cooperating and making payments on a joint mortgage.

However, the Ombudsman found that contrary to the provider's own policies, there was no evidence of any attempt to contact Niamh prior to agreeing either extension, despite the fact that she was a joint mortgage holder, the financial implications, and the fact the provider was aware that she would be opposed to such an arrangement. The Ombudsman found that, although it was appropriate that the provider engaged with her former partner in a solo capacity, since he was making the mortgage repayments and fully engaging, that did not mean the provider was entitled to deal only with him to the exclusion of Niamh.

The Ombudsman identified a number of customer service inadequacies and regulatory breaches.

The Ombudsman upheld the complaint and directed the provider to pay €4,000 in compensation to Niamh. A copy of the decision was furnished to the Central Bank of Ireland, for any action it considered to be appropriate.

Banking

READ THE FULL DECISION HERE

Decision Reference: 2019-0165

Dispute regarding loan calculations and quality of service

In 2006, Kevin took out a mortgage loan with a bank to assist with the purchase of business premises. In August 2014, Kevin contacted the bank to discuss extending the length of the term of his mortgage. An account manager responded in September with a range of repayment options and Kevin confirmed his wish to proceed with a twenty-year mortgage in October. Although Kevin followed up with the account manager for three months to get the bank to advance his application, it was never processed.

From December 2014, Kevin reduced his monthly mortgage repayments from €4,528.33 to €2,000, hoping that this would encourage the bank to discuss his application. He heard nothing until March 2015, when the account manager requested more information. When Kevin called the bank, he received no answer. He did not hear back until September 2015, when he was told that his account was to be taken over by a new manager.

A meeting was set up with the new account manager for November 2015 and attended by Kevin, his father and his accountant. The accountant presented a new fifteen-year plan for the mortgage on Kevin's behalf. The account manager responded that Kevin's mortgage was now in a 'distressed state' with arrears and the only option was to sell the asset.

Kevin requested to know how much he was in arrears. After multiple follow-ups, he received a response in February 2016, stating that the arrears were €8,477.46. In August 2016, Kevin informed the bank he was to issue a formal complaint. The bank did not respond.

In December 2016, Kevin instructed solicitors to write to the bank to request information on all payments made to the mortgage and a breakdown of the disputed arrears. Kevin never received the documents he requested.

During the investigation of the complaint a recalculation exercise on Kevin's interest rate payments by the bank uncovered that it incorrectly applied the interest rate to Kevin's initial repayments. In August 2017 it offered a refund of €5,233.46 to Kevin, which he did not accept. The bank also accepted that the account manager should have responded to Kevin when he sought to renegotiate the loan and accepted that there were delays in responding to him. It offered Kevin a total of €8,500 in compensation.

In his decision, the Ombudsman highlighted how the bank had failed to engage with both Kevin and his own Office. The bank only issued its final response letter to Kevin on the 1st August, after a significant number of letters from the Ombudsman. The Ombudsman stated that this was 'most unacceptable.'

The Ombudsman did not find the bank's offer of €8,500 at all sufficient for the 'appalling communication' and the 'considerable delay and inconvenience' that it had caused Kevin, especially considering that, minus the interest overpayment of €5,233.46, Kevin would be left with just over €3,000 in compensation.

The Ombudsman partially upheld the complaint and directed the bank to pay €20,000 in compensation to Kevin, in addition to the interest overpayment of €5,233.46.

Banking

READ THE FULL DECISION HERE

Decision Reference: 2019-0353

Application for forbearance on a mortgage loan

Jim and Mary had two properties and a mortgage on each: one mortgage for the house they lived in (private dwelling house) and one for a house, which they had previously lived in (buy-to-let property). A tracker mortgage interest rate applied to both mortgages. The couple intended to rent out the buy-to-let property, but it had been severely damaged by flooding in 2009, making it uninhabitable unless significant repairs were made.

Legal proceedings had been issued by the bank in relation to the complainants' private dwelling house prior to the complaint being brought to the Ombudsman. The Ombudsman cannot investigate or make a decision on a complaint where there are, or have been, proceedings before any court in respect of the matter that is the subject of the investigation.

However, a stay on the Court proceedings was granted by the High Court in accordance with Section 49 of the Financial Services and Pensions Ombudsman Act 2017 pending the resolution of the complaint by the Ombudsman.

The mortgage on the private dwelling had fallen into arrears. After a conversation with a Network Account Manager (NAM), assigned to them by the bank to help with their arrears, they requested an alternative repayment arrangement (ARA) on their private dwelling. They sought to just repay the interest for five years. The bank instead offered two different ARAs to pay off the arrears.

One was for their private dwelling, involving an over-payment plan for six months. The other was for the buy-to-let, where they would make interest-only payments for one year and agree to come off the tracker rate for this property only. The bank's plan was rejected by Jim and Mary, on the basis that they did not request the bank to offer any alternatives to the solution they had put forward and, even if they had, the bank's offer would substantially increase the amount of interest to be paid on the buy-to-let.

In their complaint to the Ombudsman, the couple stated that their request had been unfairly rejected and the bank's offer looked to exploit them through higher interest-rate charges. They also stated that they did not receive any written response to their initial ARA request.

The bank denied that there was anything wrong with its conduct. It stated that, when assisting customers with their arrears, it must consider their full circumstances, including their overall indebtedness and obligations, including mortgages on other properties. It stated that it is under no obligation to make any offer of an ARA or accept a specific proposal from a borrower. It stated that it offered the ARA after assessing a number of different options for the couple. It pointed out that Jim and Mary were under no obligation to accept either of the ARAs.

The Ombudsman accepted that the bank was not obliged to accept Jim and Mary's request and the ARAs offered by it were offered after assessing all possible options.

In the Ombudsman's preliminary decision, he stated that it was unclear why the bank had offered an ARA on the buy-to-let and expressed concern that this could be an attempt to entice them off their tracker mortgage. With this in mind, the Ombudsman indicated his intention to partially uphold Jim and Mary's complaint and request that the bank reassess the couple's initial request.

However, in a post-preliminary decision submission, the bank clarified that the two ARAs were offered independently of each other, and one or both could have been rejected by the couple. The bank argued that the ARA on the buy-to-let was designed to help the couple raise the funds for refurbishment, so it could be rented again, which in turn would help raise the funds to pay off the arrears.

The bank also submitted that it had made new ARA offers to Jim and Mary which allowed them to keep their tracker interest rates on both mortgages. The couple had accepted the new agreements and as a result, the Ombudsman did not uphold the complaint.

Banking

READ THE FULL DECISION HERE

Decision Reference: 2019-0129

Objection to the terms and conditions of a loan agreement

Paul applied online for a €10,000 loan from the bank on the 11th of July 2017. Within hours of his application, Paul was able to access the funds and they were transferred to his account.

A couple of days later, Paul received his loan pack, which included the terms and conditions of the loan. Upon reading these, Paul noticed a clause which stated that he had given the bank a power of attorney. Paul asked the bank why it needed this, but he did not receive an explanation. The only advice he was given was that he should contact a solicitor himself.

Later, Paul did receive a letter from the bank which stated that it had the right to assign the loan to a third party. The terms and conditions in question gave the bank permission to do so.

Paul was concerned that the bank had sold on his loan to a third party and it was profiting from his signature. He stated that until he received a proper explanation, he would suspend all repayments to the bank. He made a complaint to the Ombudsman, stating that his questions as to why a power of attorney was needed were wrongfully and unreasonably refused and demanded an explanation as to why this power was required.

In response, the bank stated that it had not sold on Paul's loan. It made the point that Paul had the opportunity to review the terms and conditions on the website before agreeing to the loan and would have ticked a box confirming that the terms and conditions had been read and accepted in order to have his loan application approved. The website through which Paul applied for his loan also had an option to 'set up later.' This meant that Paul had the option, after being accepted for the loan, to wait and query the terms and conditions with the bank before he took out the funds.

Not only that, but once receiving the loan, the terms and conditions stated that Paul had the right to withdraw from the credit agreement within a period of 14 days, without having to give a reason for doing so. Paul chose not to take any of these options before he suspended his repayments.

The bank, in recognition of Paul's confusion surrounding the terms and conditions, stated that it was willing to offer a goodwill gesture to clear the interest charged or accrued on the account and clear the records with the Irish Credit Bureau which noted Paul's missed repayments. It has also offered €500 in light of the misunderstanding that the terms and conditions caused.

Paul rejected this offer. He wanted the bank to write off the loan and the interest, as well as accept the offer of €500.

In his decision, the Ombudsman stated he was satisfied the loan application process provided Paul with the opportunity to review the credit agreement. The Ombudsman was also satisfied that the terms and conditions were readily available for him to consider before accepting the loan. He accepted that the bank had been reasonable in its attempts to resolve the matter, whereas Paul, who stopped repaying the loan rather than exercising his option to withdraw from the agreement after finding he did not like the terms and conditions, had not been reasonable. The Ombudsman did not uphold Paul's complaint.

Banking

READ THE FULL DECISION HERE

Decision Reference: 2019-0169

Redemption figures provided for a mortgage loan switch

Susan held a mortgage with the bank on a variable 4.5% interest rate. In March 2018, after seeing that a competitor was offering cashback if she switched mortgages, with a fixed interest rate of 3.2%, Susan contacted the bank by phone to see if it could offer any discounts. The bank responded that it could offer a fixed interest rate of 2.9% on her mortgage.

Still interested in the cashback offer, Susan requested the outstanding balance on the mortgage from her bank to start the process of moving to the competitor. The bank gave a figure of €202,667.36. This led to Susan applying to the competitor for a mortgage of €202,000.

After Susan's solicitors contacted the bank to confirm the figure, in April 2018, it transpired that over €204,000 was needed to clear the mortgage 'redemption figure'. This difference meant that Susan had to raise a shortfall of €1,651.08 at short notice.

Susan also calculated that she had made a further financial loss from the switch. Susan had decided to switch after calculating the savings from the original figure, considering solicitors' fees and the new interest rate of 3.2% over the next three years, along with the cashback offer. After receiving the new figure and paying her current 4.5% interest rate for the months until she switched, Susan realised she was left with no money from the cashback incentive offer and would have been better off accepting her original bank's offer of a lower rate of 2.9%.

In response to Susan, the bank offered to pay €250 in recognition that Susan may have been confused at the difference between the "outstanding balance" and the "redemption figure" and that it could have provided further clarity. Susan stated that the offer does not come close to the €1,651.08 that she had to gather together at short notice.

Susan made a complaint to the Ombudsman, on the grounds that the bank issued an incorrect figure for the redemption of her mortgage, causing financial loss and a great deal of stress.

The bank did not accept that there had been any failure on its part, nor that it had contributed to Susan's financial loss. On the first call in March, it stated that Susan requested the 'outstanding balance,' not the "redemption figure" on her mortgage account. This figure did not include accrued interest. When the solicitors requested the redemption figure, this was provided. This figure did include accrued interest. The bank argued the €250 offer was 'wholly appropriate for a minor slip in the level of customer service.'

In response, Susan stated that the difference between 'outstanding balance' and 'redemption figure' is nuanced and as she stated she was calling with the intention of switching mortgage banks, it should have been clear what she was looking for in the context of the conversation.

The Ombudsman did not accept that the bank's actions led to a financial loss. While noting Susan's assertion that the cashback received from the competitor was mostly spent on solicitor fees and the original interest rate of 4.5%, the Ombudsman could not see how either of these charges were related to the figure furnished by the bank. No matter what the figure provided, Susan would have had to pay the fees and the interest rate until she switched.

The Ombudsman did, however, accept Susan's argument that it should have been perfectly clear to the bank that she was looking for a redemption figure to give to the competitor when she originally called. The Ombudsman substantially upheld her complaint and directed the bank to pay €3,000 in compensation to reflect its communication failings.

Banking

READ THE FULL DECISION HERE

Decision Reference: 2019-0123

Access to shares in a credit union for a member who is a guarantor

Tony retired from work due to ill-health. Prior to this, he was the sole earner in his household with his wife not having been in employment since 1990. He held a loan account with a credit union and separately, was a guarantor on his wife's separate loan account with the same credit union.

Following the onset of his illness, Tony realised that he might be covered by a Loan Protection Policy with the credit union, which covered inability to work due to disability. He duly claimed on this policy and, following an initial rejection, his loan account was 'cleared in full' with the policy paying off his debt of €11,870.48 having accepted that he qualified as 'disabled'.

At this point, it was Tony's intention to also take his shares (around €6,000) out of the credit union account but he was prevented from doing so as these funds were required as security due to him being guarantor of his wife's borrowings.

Tony contended that both loans for which he was responsible should have been 'treated equally' and both cleared by the Loan Protection Policy and also complained that he was not advised that he could be prevented from liquidating his shares because he was guarantor of his wife's debt.

The credit union maintained that the Loan Protection Policy did not extend to the guarantor of loans, but is a product only available to the member taking out the loan. The credit union also maintained that Tony was made aware of the fact that his shares would be held as security for his wife's loans at the time he executed the guarantee.

In his decision, the Ombudsman noted that the guarantee Tony signed made it clear that the guarantor's shares will be held as security. He also noted that it was not correct that Tony was unable to access all of his funds as his wife's own share balance partially offset her loan. Only the amount not offset by this was ring-fenced and held as security.

In relation to the Loan Protection Policy, the Ombudsman noted that the terms did not provide for any benefit beyond that to an account holder on their own 'Insurable Balance', if they have become disabled. In this case, it was Tony and not his wife that had been deemed 'disabled' and that benefit had already been provided to him. This information was also specifically communicated to Tony in the course of his first discussion with the credit union about the Loan Protection Policy. The Ombudsman did not uphold his complaint.

Banking

READ THE FULL DECISION HERE

Decision Reference: 2019-0134

Request to change address not actioned

Ahmad requested a change of address to his current account in February 2016 and asserted that this request was not acted on for over three months and that correspondence was sent to him several months later at his previous address which was 'opened and interfered with'. Ahmad also contended that the bank's requirement that he submit a utility bill as proof of his current address was not necessary or common practice, given he was an existing customer.

Ahmad also complained of poor customer service and sought compensation in the amount of €17,500 and a letter of apology.

The bank stated that it received Ahmad's request to change his address through its online banking facility on 25th February 2016 and responded the same day to the email address provided by Ahmad, requesting that he submit proof of his new address. It received no response to this request. It followed up on 12th May 2016, with a letter, enclosing a postage-paid envelope for a response. It received a response from Ahmad on 9th June 2016 and the amendment request was actioned that same day.

The Ombudsman accepted that it was appropriate for the bank to engage with Ahmad on this issue by email and noted that Ahmad appeared to have been aware of the request for documentation made by the bank as he himself had noted it in correspondence. Ahmad had not disputed receiving the email correspondence. He did not provide any explanation why he did not respond to the emailed request for documentation.

It was clear that the sending of an account statement to the 'old' address occurred several weeks after the bank had issued a hard copy reminder to Ahmad by post. When the bank did receive the documentation first requested in February 2016 over three months later, it actioned the address change immediately.

The bank explained that proof of new address is required in order to ensure account security and to take measures in line with anti-money laundering guidelines issued by the Department of Finance. The Ombudsman was satisfied that this represented a reasonable justification. He also noted that although it can be difficult in certain circumstances to provide a utility bill, that the bank had submitted a list of different types of documents which would have been acceptable.

In respect of the suggestion of poor customer service, the Ombudsman stated that Ahmad appeared to have formed this view solely on the basis of the bank insisting on the provision of the proof of address document. As he had already concluded that the bank was entitled to require this, he found no evidence to support this aspect of the complaint. The Ombudsman did not uphold the complaint.

Banking

READ THE FULL DECISION HERE

Decision Reference: 2019-0424

Dispute regarding interest charges

Maitiú and Mary entered into a mortgage loan agreement with a bank in January 2001. The loan was paid off in December 2015. During the lifetime of the loan, the couple wished to evaluate the level of interest that they had paid. However, the bank often failed to provide bank statements or certificates of interest paid, only doing so after repeated requests made by the couple over several years. A letter from the bank from May 2016 also showed that it had removed the ability to order any financial statements related to the loan beyond seven years.

In 2015, the couple hired an audit firm to review the interest charged by the bank. The audit firm identified that they had been overcharged €23,751.37 worth of interest. The figures were based on the facility letter from the bank, dated December 2000, which stated that there would be an initial five-year fixed interest rate, after which the interest rate would be charged 'based upon the cost of funds and a margin of 1.5%, ruling day-by-day.' The audit firm believe the 'cost of funds' referred to is the Euribor interest rate, which is based on the average interest rates used by banks in the Eurozone. The audit firm came to this conclusion after investigating previous cases involving loans from the bank.

The bank responded that the audit firm's interpretation of the 'cost of funds' was incorrect, which meant that their calculations were inaccurate. It told Maitiú and Mary that, after performing its own recalculation on the account, that it had in fact undercharged the couple by €3,450.

The couple made a complaint to the Ombudsman, stating that the bank failed to issue them with financial statements on a regular basis and that it had overcharged interest. They wanted the bank to refund the amount of interest overcharged and pay compensation of €10,500 for charges and costs spent on identifying the overcharge.

The bank claimed that 'cost of funds' in this instance meant the three-month Euribor average, plus the 'reserve asset cost,' plus the bank's margin. Considering this, it recalculated the interest rate on the loan again and claimed it had in fact overcharged the couple by €4,829.44. It offered to refund this amount plus compensation of €4,000 for delays and confusing information. The bank also asserted that it was satisfied that it had issued Maitiú and Mary their financial statements as per its processes and regulatory obligations.

In his decision, the Ombudsman stated it was 'disappointing' that the bank did not make the couple's statements readily accessible to them. He pointed to the Consumer Protection Code, which states that all statements must be accessible throughout the duration of the loan. By removing the ability to order statements beyond seven years, the bank failed in this regard.

Regarding the overcharge of interest, the Ombudsman stated that the bank had made it 'entirely unclear what interest rate was applicable' to the couple's loan account. The bank continually referred to the 'cost of funds' and 'reserve asset cost' in its correspondence, yet there was no definition given as to what these were.

As the bank never made it clear what interest rate was applicable to the loan, the Ombudsman favoured the interpretation of Maitiú and Mary and the audit firm, on the basis that ambiguous contracts must be interpreted against the party that wrote them. The Ombudsman upheld the complaint and directed the bank to pay €35,000 in compensation for the totality of the complaint.

Banking

READ THE FULL DECISION HERE

Decision Reference: 2019-0300

Connected accounts and dispute as to whether a debt actually existed

In April 2016, Company Y received a letter from its bank's 'Problem Debt Management' unit advising that his company's 'outstanding debt' was due and that its loans would be sold to a third-party. Company Y e-mailed the bank, asking it to explain what this debt was, as the company had always been in credit.

In October of 2016, the bank sent a letter to Company Y informing it that the company's account was due to be closed on the 16th of December. Company Y e-mailed again, asking the bank to explain the letters, as the company had never taken out any loans with the bank.

After several more emails with no response, Company Y was forced to set up alternative banking arrangements at considerable expense. Then, on the day the accounts were due to be closed, Company Y received a letter from the bank confirming that the company had no debt with it and that the accounts would remain open and operational.

In this letter, the bank stated that the original notice of closure was issued because of a 'connection' which the company's account had with other accounts. This connection had been made in 2009 when the account was opened but had not been disclosed to the owner of the company. The bank apologised for the inconvenience and offered €2,000 compensation.

Company Y responded that this 'connectivity' was not part of the original terms of the accounts and the fact that the operation of the accounts was conditional on these so-called connections was intolerable.

During the investigation by the Ombudsman, more evidence came to light on the bank's behaviour. It was revealed that the company's account had been under the management of its Problem Debt Management unit since June of 2012, despite being in credit. The owner of the company was never made aware of this.

The bank denied that its conduct was improper. While it admitted that it had made an error in issuing the initial letter to the company, it pointed out that its terms and conditions allowed it to close accounts 'without giving a reason.' Defending its policy not to inform the company that the account was held by their Problem Debt Management unit, it stated that it does not provide details of its 'internal credit policies' as it is 'internal and market-sensitive information.'

In his decision, the Ombudsman found it unacceptable that the bank did not inform the company that its accounts were under the management of a unit tasked with handling problem debt. He also found it unacceptable that the bank never informed the company that it carried out assessments based on 'connected' bank accounts. This practice was not even listed in the bank's terms and conditions.

The Ombudsman stated that the bank's assertion that it had not identified any disruption showed 'a very serious lack of understanding on the part of the bank on the impact of its conduct' on the company.

The Ombudsman upheld the complaint and directed the bank to make a payment of €15,000 in compensation for its failings. He also brought the practice of connecting or aggregating accounts without informing the account holder to the attention of the Central Bank of Ireland, for any action it deems necessary.

Banking

READ THE FULL DECISION HERE

Decision Reference: 2019-0310

Dispute relating to arrears on a loan account

Jimmy and Clodagh had two mortgage arrangements in place since 1999. On the 25th of August 2014, a new provider, against which this complaint was made, began servicing their mortgages, taking over from a third party. This provider decided to split the mortgages into two accounts, something it was never instructed to do.

The provider claimed that on the date it started servicing the mortgages, they were in arrears of €1,035.91. Jimmy and Clodagh had never had any correspondence from previous financial service providers managing their accounts stating that they were in arrears. On the 30th of August, Jimmy and Clodagh made a payment to the provider to clear the arrears specified by the provider in full.

In February 2015, the provider wrote to Jimmy and Clodagh that they had arrears outstanding on their second mortgage account. They disputed this and provided evidence to show that this was incorrect.

In June, the provider notified them it had reviewed their accounts and found that the balance on the first mortgage had been incorrectly recorded, as some of it had been incorporated in the principal sum of the mortgage by mistake. This was rectified and now the arrears, according to the provider, stood at €672.18.

The couple continued to dispute the arrears. The provider responded in October, outlining all the mortgage repayments that had been made. Jimmy and Clodagh disputed the arrears again. In December, the provider sent a letter to the couple, which informed them that a review had found that two repayments made by them had not been recorded properly. It was also found that the €1,035.91 that had been paid in August to clear 'arrears' had instead been allocated to reduce the principal sum due to an 'administration oversight'.

Jimmy and Clodagh's mortgages were eventually sold on in June 2016 to a fifth party, and they continued to receive correspondence on the supposed arrears up to April 2018.

The provider acknowledged that administrative oversights were made which caused arrears to appear and offered to pay €100 as a gesture of goodwill.

The Ombudsman found multiple failures in the provider's handling of the situation. The provider appeared to allocate payment to either the accounts or the principal sum 'with no discernible pattern.' The Ombudsman stated that he found it 'exceptionally difficult to understand' the provider's explanation of what happened to the accounts and had 'no confidence in its calculation of the arrears figures.'

Following the issuing of the preliminary decision, in which the Ombudsman indicated his intention to uphold the complaint and direct €20,000 in compensation, the provider stated it felt that the level of compensation was excessive, as 'no detrimental or financial impact' had been found by the investigation. The Ombudsman felt this further indicated the provider's lack of understanding of the consequences of its actions and that its offer of €100 was derisory.

The Ombudsman upheld the complaint and directed the provider to pay €20,000 in compensation to Jimmy and Clodagh and amend their credit record with both the ICB and the Central Credit Registry.

Banking

READ THE FULL DECISION HERE

Decision Reference: 2019-0279

Disputed pre-authorisation on a credit card

On the 8th of April 2018, James put down a refundable deposit with a merchant of €87.80 for a rental car. A pre-authorisation for the deposit was placed on his credit card, authorised by his PIN. On the 11th of April, James returned the car to the rental company undamaged. James was advised by the merchant that the pre-authorisation of €87.80 would be removed in a couple of days.

Five days later, James contacted his credit card provider to check if the pre-authorisation of €87.80 was removed from his credit card. The provider informed James that not only had it not been removed, but that a second pre-authorisation of the same amount had been made against his credit card on the 11th, the same day that the car was returned.

James did not authorise this second transaction. He requested that the provider remove the pre-authorisations from his credit card urgently and that an explanation be provided as to how the merchant was allowed to put in place a pre-authorisation against his card without his consent.

Ultimately, the merchant never requested the funds from either pre-authorisation, so the money was never taken out of James' account. The pre-authorisations both expired by the 18th of April, five business days after being issued. The provider maintained, however, that James had in fact given consent for this second pre-authorisation, so had the merchant requested the funds, it would have honoured the payment.

The provider pointed to its terms and conditions, which James had agreed to, which lists the ways transactions can be authorised, including by "means of a card number." Because James had willingly given his card details to the merchant, the provider argued that this meant the provider was bound to honour the payment, even if it was ultimately an error on the part of the merchant.

James was not satisfied with the response. He maintained that the merchant had incorrectly allowed the second pre-authorisation.

In his decision, the Ombudsman pointed to the full paragraph of the terms and conditions that the provider had drawn upon to make their case, which states that transactions can be authorised by:

"1. …means of your Card used in conjunction with your PIN for point of sale transactions…

2. means of your Card number… for Transactions by mail, telephone, internet or using a Secure System; and;

3. …means of your Card and signature where the other options are not available."

While the provider maintained that the second pre-authorisation fell under the second criteria, the Ombudsman found this was incorrect. The original deposit was a point of sale transaction authorised by James' PIN. As it was not a transaction by mail, telephone, internet or secure system, the second criteria was not applicable in this scenario. James had not authorised the second pre-authorisation with his PIN, therefore it was not valid.

The Ombudsman was of the view that the provider was in breach of its terms and conditions, as well as EU regulations which state that consent must be given before placing a pre-authorisation hold on a credit card. However, James only told the provider that the pre-authorisation had not been authorised two days before it expired. Because of this, the steps that the provider ought to have taken when it received the information – investigate the transaction and then cancel it, once James' testimony confirmed this – were not possible in the short timeframe. As there was no action the provider could have taken on this, no compensation was directed on this basis.

However, the Ombudsman was also of the view that the provider did not seek adequately to resolve James' complaint. James' complaint was substantially upheld in this regard and the Ombudsman directed the provider to pay a sum of €500 to James in respect of its failings.

Sector:
Insurance

READ THE FULL DECISION HERE

Decision Reference: 2019 - 0102

Car insurance policy cancelled when company did not receive copy of no claims bonus

Kawa sought a quote for car insurance from an insurance broker, on the 27th of June 2017. When accepting the quote, the broker told him all he needed to do was send in a copy of his driving licence and it would take care of the rest. He supplied his driving licence on the 28th of June.

However, less than a week later, he was told in a phone call that he also needed to send in his original no claims bonus document from his previous insurer. It was pointed out to Kawa that the third party insurer would usually not start cover until this document was received. However, in his case it was decided to start the cover right away and allow Kawa to send everything in at a later stage. Kawa sent in a copy of his no claims bonus on the 4th of July.

Kawa was then told by letter that the no claims bonus document he sent was not in the format the broker wanted. The broker then requested that he forward the original email from the previous insurer, which contained the no claims bonus document. When Kawa informed the broker that he wasn't told that he needed to supply his original no claims bonus, let alone the original email, he was ignored by the agents he dealt with.

Also on the 31st of July, Kawa's wife called him, while he was abroad, to say that she had been informed by letter that the car insurance would be cancelled if they did not send the original email requested before the deadline of the 9th August. Kawa forwarded the email to the broker in the exact format and manner as instructed by the broker that very same day to the email address that he had been given by the broker.

On the 10th August, Kawa was informed by text message that his insurance had been cancelled. This was due, the broker claimed, to the fact that it had not received the requested documents in time. Subsequently, Kawa also discovered his account was still being charged for this cancelled policy as late as October.

Kawa called the broker and requested to speak with a supervisor, who insisted that the policy would remain cancelled because he had not emailed the original document in time. When Kawa tried to explain to the broker's agent that he had sent the email before the deadline and he had evidence to prove it, the supervisor did not accept this and tried instead to persuade him that he had not forwarded the email.

A subsequent investigation found that the broker had received the email on the date specified by Kawa, the 31st of July, but it had been blocked by its firewall, so it did not see the email until after the deadline.

The Ombudsman found that Kawa's policy was cancelled through no fault of his own, after he had complied with the broker's instructions. He pointed out that if any one of the broker's agents had listened to what Kawa was telling them and checked their e-mail system, they would have found that what they were being told was correct.

The broker initially offered €226.25 in compensation, including €126.25 to refund any charges that he incurred through this process, as well as €100 for inconvenience and stress.

The Ombudsman found this offer "derisory and completely inadequate." Because of the broker's negligence, Kawa was without car insurance for a significant period of time and eventually had to purchase a different, smaller car which he was only able to insure at a higher cost. When this was put to the broker, it stood by its initial compensation sum, stating that it was not in a position to comment on the other costs incurred by the complainant. The Ombudsman found this response inadequate. He upheld the complaint and directed the broker to pay €9,000 in compensation to Kawa and issue a letter to acknowledge that his policy had been cancelled due to an internal systems failure on its part, making it clear that Kawa was in no way responsible for the cancellation of his policy.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2019 - 0059

Car insurance policy cancelled because of incorrect date recorded for driver's licence

Ahmad was looking for car insurance for himself and his partner, Amy. He got in touch with an insurance broker which sourced an insurance policy with an insurer and filled in all the necessary paperwork. The policy commenced shortly after.

Within three months of the policy commencing, Ahmad made his first claim, following vandalism on his car. While processing the claim, the insurer pointed out discrepancies in the paperwork submitted by the broker. Most importantly, the paperwork had listed the incorrect date of issue on Amy's driving licence. The date of issue for the licence was listed as the 1st of January 2010, when in fact the driving licence was less than a year old.

Following an investigation, an employee of the broker wrote to the insurer to state that she had been responsible for the error with the licence date. At the time of setting up the policy Ahmad was not sure what date Amy had received her licence, so the employee entered it as the 1st of January 2010, with the intention of correcting it at a later date. However, having received the correct issue date, the broker did not update the file. The employee apologised to the insurer for the error.

The insurer responded to say that had the issue date of the licence been correct, it would have declined the policy immediately, as Amy had not held her licence for a suitable amount of time. Within days, the insurer confirmed to the broker that Ahmad and Amy's insurance was to be cancelled from inception. The insurance would, therefore, not cover the damage to the vandalised vehicle.

After the broker informed Ahmad of the situation, he asked via e-mail how the date of 1st of January 2010 could have come to be entered. A manager of the employee who had made the mistake responded to his email, claiming that Ahmad was responsible for the incorrect information as he had signed a Statement of Fact declaring the date to be correct. No reference was made to the error by the employee and no apology was issued to Ahmad or Amy.

Ahmad insisted that the broker was guilty of maladministration and took his complaint to the Ombudsman, seeking reimbursement for the cost of fixing the damaged vehicle and for public transport expenses accrued due to the lack of a vehicle.

The Ombudsman decided that, as the broker knew well in advance that the information was wrong, Ahmad and Amy could not be held responsible, regardless of the fact that they signed the Statement of Fact. It was known all along by the broker that the date included was a fabrication on its part. Had the broker provided the correct information, the insurer would simply have declined the policy and Ahmad would have been able to secure cover from another insurance provider.

The Ombudsman was satisfied that the broker was responsible for the losses suffered. Because of the broker's actions Ahmad and Amy's losses are ongoing, in that every time they apply for car insurance, they will have to disclose that they have had an insurance policy voided. This will affect the cost of all their cover in the future.

Accordingly, the Ombudsman upheld the complaint and directed the broker to pay €12,000 in compensation, for the damaged vehicle and public transport expenses, as well as any potential costs for insurance premiums in the future and the general inconvenience and upset caused by the broker's conduct.

The Ombudsman also directed the broker to write a letter to Ahmad and Amy, confirming that the broker complied with the Ombudsman's decision and that it is wholly responsible for the voiding of the insurance policy.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2019 - 0040

Car insurance policy cancelled because telematics device was not fitted

Donna took out motor insurance for herself and her daughter with an insurance provider. As part of its service, the insurer looked to install a telematics device in Donna's car, to record driver behaviour.

When Donna signed up for the insurance, the terms and conditions on the insurer's website stated that the insurer would arrange to have the device fitted to the car within 14 days of her taking out the policy . The website stated that the insurer would contact Donna to arrange a mutually convenient time and place to undertake the fitting.

Donna stated that she then never heard back from the insurers regarding this fitting until she received a letter several weeks later notifying her that, due to the non-installation of the device, the insurer was going to cancel her policy.

When Donna contacted the insurer, she was told to contact the installation company herself. Donna contacted the installation company before the specified cancellation date. However, the only date the installation company offered to Donna was after the cancellation date. Because of this, Donna's policy was cancelled regardless.

This meant that Donna was forced to take out insurance with another provider at double the cost of what she had originally planned to pay. This was particularly trying for Donna, as she is unemployed and her daughter is a student. The additional costs she had to pay meant she was under pressure to borrow money to pay for the new insurance.

In its response to the Ombudsman, the insurer pointed out that the terms and conditions clearly stated that if the telematics device was not fitted within 14 days, then the driver must contact the insurer, and, if the device is not fitted within 31 days, then the insurer has the right to cancel the policy.

The insurer also claimed that the installation partner made numerous attempts to contact Donna to make the appointment. According to the insurer, their partner called Donna multiple times and, when she failed to answer, it left voicemails.

However, the insurer's installation partner's own notes from the calls clearly state otherwise. They show that when the company called Donna, there was no answer and they did not leave a voicemail. Donna confirmed that her phone does not accept voicemails.

The Ombudsman stated that it was 'disappointing and completely unacceptable' that the insurer did not provide him with accurate information in this regard.

It was also discovered that Donna sent an "i-message" to the insurer, before the cancellation date, asking when the telematics device was to be installed and instructing the insurer to not ring her from a private number.

While the Ombudsman accepted that the terms and conditions of the policy meant the insurer was entitled to cancel the policy, he found the manner in which it did so was unreasonable and unacceptable. He concluded that the insurer ought to have made Donna aware of how the installation company was going to contact her, provided contact details for the installer well before it did and been more flexible with the cancellation date, as Donna did make arrangements with the installation company before the deadline.

The Ombudsman upheld the complaint and directed the insurer to make a compensatory payment of €5,000 for its lapses in service and to remove any reference to an imposed cancellation from its records. He also referred the decision to the Central Bank of Ireland for any action it might deem necessary.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2019 - 0350

Dispute regarding value of stolen property

In October 2017, Fergus' home was burgled, with many items of jewellery stolen. Fergus made a claim to the insurance company with which his home was insured in respect of 45 items of jewellery. Fergus stated that the value of the stolen items was in excess of €58,000. This includes 40 items of jewellery stolen with a value of €28,875 in addition to two watches both worth over €10,000 each, a third watch worth €3,950 and a fourth watch worth €3,500.

The insurance company asked Fergus to provide pre-loss proof of ownership or value of the items that were stolen. Fergus was unable to provide any documents which demonstrated that he owned any of the items that he was claiming for. Because he was unable to provide any proof of ownership or value for the items stolen, the insurance company applied entry level valuations to some of the items. In some cases, the valuations arrived at by the insurance company were much lower than what Fergus claimed the value of the items to be. The insurance company offered two options in respect to the claim, a re-instatement offer of €18,610 or a cash alternative of €14,880.

Fergus asserted that the provider did not say in the insurance policy that proof of ownership was a pre-requisite in the event of a loss. He said that many of the items of jewellery were either very old or gifts, so he had no receipts.

The insurance company pointed to a term in its policy document which stated that claimants would be required to produce 'all necessary documents and information to support any loss.' Fergus believed this sentence to be vague. The insurance company, in his view, ought to have explicitly stated in its policy that evidence of ownership was required and provided examples of the type of documents required.

Fergus made a complaint to the Ombudsman, stating that the insurance company had acted wrongly and/or unreasonably by seeking proof of ownership for the items stolen and attributing entry level values to certain items claimed.

In response, the insurance company submitted that while it did not expect claimants to provide pre-loss documentation for all the items claimed for, it would have expected Fergus to provide such documents for at least some of the items. Fergus did not provide any.

The insurance company also rejected Fergus' assertion that the insurance policy was vague. It stated that the phrase Fergus highlighted 'has an obvious meaning and is not open to more than one interpretation.'

In his decision, the Ombudsman stated that the insurance company was entitled to verify Fergus' claim, which in turn meant it was entitled to ask him to demonstrate that he owned or was legally responsible for the items being claimed for. The company would have accepted items such as purchase receipts, credit/debit card statements, guarantees/warranties, presentation boxes, photographs, pre-loss valuations, receipts for repairs/service, battery replacements receipts. Fergus said he and his wife were both innately camera shy and therefore had no photographs of the items and that documents and photos they had stored in an outside building were destroyed by mould and mildew.

The Ombudsman stated that it was 'not unusual' for people with high value items to have them valued and recorded for insurance purposes and it would have been 'prudent' for Fergus to have done the same.

The Ombudsman also rejected Fergus' claim that the insurance company's policy was vague, but he did believe that it would have been helpful if the insurance company had given more information of what was required to prove ownership.

As Fergus could not provide any documentation at all for any of the items claimed for, the Ombudsman found that it was not unreasonable for the insurance company to adjust the valuations of the items in the way it did. As he believed the insurance company had taken a reasonable approach to the claim, the Ombudsman did not uphold the complaint.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2019-0022

Threat to cancel car insurance after accusing driver of speeding

Sean, a professional driver, was looking to renew a car insurance policy for himself and his son Gerry. The policy that he bought was owned by the insurance company, but managed and administered by an intermediary on its behalf. As part of the policy Sean agreed to the fitting of a telematics device to his car which would record data on all driving, including the speed and distance travelled in the car. The device was fitted by a third-party telematics supplier.

On the 28th of June 2017, Sean was advised by the intermediary that the telematics device had recorded his car travelling at over 160 kilometres per hour on the 25th of June 2017. As this was a breach of the terms of the policy, Sean was informed that his insurance policy was going to be cancelled on the 11th of July 2017.

Sean made several calls to the intermediary, stating that neither he nor his son had travelled at that speed in the car at any point. Sean highlighted the fact that, as his car only had a one litre engine and was over a decade old, it was practically inconceivable that the vehicle could reach such a speed. Following these complaints from Sean, the intermediary went back to the telematics supplier to check the reading that it had provided.

On the 4th of July 2017, Sean was told that the cancellation was withdrawn and the telematics supplier eventually confirmed that the speed reading recorded was unreliable. Sean made a complaint to the Ombudsman that he was unfairly notified of the cancellation based on data that was found to be unreliable, which caused undue stress to himself and his son.

The company, in response, informed the Ombudsman that it was sorry to learn of this complaint and regretted the upset which the matter had caused. The company offered a customer service gesture of €300 in compensation to Sean and Gerry and an acknowledgement that they were still insured with them.

The company also stated that, as a direct result of the incident, the telematics supplier had been changed.

However, because the cancellation notice and all subsequent correspondence was between Sean and the intermediary, not the company itself, it refused to take any responsibility for any of the acts or omissions that caused the upset and stress.

The Ombudsman did not accept this. He found that, even though the company had outsourced the management and administration of the policy to the intermediary, it still had a responsibility to ensure all business arrangements it made delivered best practice, so that policy holders do not receive a service which falls short in quality. Because the company agreed that the intermediary could take certain actions on its behalf, including issuing cancellation notices, the Ombudsman found that the cancellation was sent on behalf of the company, thereby making it responsible.

The Ombudsman expressed his disappointment that it was never made clear to Sean or Gerry that their cover was held with the company and not with the intermediary.

The Ombudsman took the view that the intermediary ought to have sought a detailed analysis of the speeding event from the telematics supplier before issuing the notice of policy cancellation. To only do so following a complaint from Sean after the notice was sent out fell short of best practice.

Taking into account all the circumstances, the Ombudsman upheld the complaint and directed the company to make a payment to Sean of €1,500 in compensation for the distress caused. The Ombudsman also noted his concern that there could be other drivers who have had their policy cancelled due to unreliable telematics data and for this reason he brought the decision to the attention of the Central Bank of Ireland for any action it deemed necessary.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2019 - 0147

Car insurance cancelled due to non-disclosure of an accident

Before Trish's motor insurance was due to expire on the 8th of September 2017, she contacted a new insurance provider and accepted a quote to commence her new insurance policy on the date of expiry of her previous policy. She made a payment on the 22nd August 2017.

Trish was then involved in a single vehicle collision on the 7th of September 2017 in which her vehicle sustained some damage. As she was still insured under her previous policy, she registered a claim with that insurer. The claim was settled and paid on the 3rd of November 2017. She contacted her new provider on the 22nd of November 2017 to advise it of the claim.

At this point, her new provider voided her insurance from inception and told her she had 10 days to find another insurer. Trish stated that on this and subsequent calls with her new insurer that it remained unclear to her as why her policy had been voided, that she was treated as though she had 'committed a crime' and that she believed the voiding to be incorrect. Trish subsequently explained that this was because she thought the claim was 'protected' under her previous policy.

For its part, the provider stated that it would not have quoted for the policy of insurance she took out had it known of a previous accident and said that it was correctly voided on this basis. Whilst it acknowledged that she was claims free when she agreed the policy, it pointed out that because she was involved in an accident the day before her new policy commenced, she was not claims free at the time the new policy began.

Although the provider rejected the assertion that Trish was treated as if she had 'committed a crime', it offered to note the cancellation as voluntary and made an offer of €300, in accepting that they failed to communicate properly with her.

In her complaint to the Ombudsman, Trish requested that the provider apologise for the poor service she says she received, restore her previous driving history and pay compensation of €3,500 to cover the financial cost to her of obtaining a new insurance policy.

The Ombudsman found that the provider was entitled to void Trish's policy as she had bound herself to a contract on the basis of a certain period of no accidents and no claims. Although she provided correct information at the time of the quote, she failed to disclose an accident which altered this information until 10 weeks after the policy began. Regardless of her belief that the claim was 'protected', he was of the view that Trish should have made immediate contact with the provider, to inform it of the accident and check whether her understanding was correct.

The provider was therefore entitled to void the policy for non-disclosure of the accident and the Ombudsman did not uphold this element of the complaint.

The Ombudsman accepted that the provider did not adequately deal with the queries and issues raised by Trish and that the customer service in some of these instances was of a poor standard and that this further elevated her stress. Nevertheless, he took the view that the provider's offer of compensation in the sum of €300 was an appropriate remedy and did not uphold the complaint.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2019 - 0108

Rejection of a claim under an income protection policy

Brendan had been working with his employer since 1998. As part of his employment, his employer had provided an Income Protection Plan. The employer paid the premiums for the plan to the provider, who acted as the underwriter.

In 2007, Brendan made a claim under the plan, which the provider paid out on for the next few years. According to Brendan, the provider would often communicate with him directly about his situation and his payments, either by phone, e-mail or visiting his home.

On the 20th November 2012, the provider informed Brendan's employer that it now deemed Brendan fit for work and would be discontinuing his payments. It would be making one final payment to cover Brendan up until the 19th February 2013 and if Brendan wished to appeal the decision, he had until that date.

This information was not passed on to Brendan. Some months later he eventually found out about the decision and that he could appeal, and he wrote to the provider in July and August of 2013. The provider advised Brendan to speak with the employer.

His employer recommenced the payments that the provider had been making as it felt Brendan had been 'hard done by,' but these payments stopped in 2014. By this point, the provider would not consider an appeal, due to the lapse in time. Brendan made a complaint to the Ombudsman on the grounds that the provider incorrectly communicated its decision to cease benefit and what was required for an appeal.

The provider stated that it had met its obligations. While it did contact Brendan directly on several occasions to discuss his claim between 2007 and 2012, any communication relating to decisions on a claim must, it stated, be communicated to the plan owners. This was Brendan's employer. The provider also submitted that it is aware that current practice under Central Bank provisions dictates that claimants should also be written to regarding any claims decisions. This was, however, not in place when the decision on Brendan was made in 2012.

Brendan contested the provider's contentions. In particular, he stated that the Central Bank provisions to which the provider refers came into effect in 2012 and were preceded by a similar code in 2006, so were in place at the time.

In response, the provider stated that it had assumed the 'claimant' under the provisions meant the entity that paid the premiums, which was the employer. The Central Bank clarified the provider's understanding in 2015 and since then the provider has also written to the person affected.

In his decision, the Ombudsman noted that, because the provider had been in direct contact with Brendan on a number of occasions, both he and his employer would have reasonably expected the provider to contact Brendan personally on this issue. Even if this was not the case, no instruction was given to the employer to pass on the information. Furthermore, the Ombudsman believed that the provider should have clarified the Central Bank provisions well before 2015. It was not reasonable for Brendan to be penalised for the provider's lack of understanding.

The Ombudsman stated that there was a major breakdown in communication between the provider and Brendan in respect of the claim decision and the appeal process and upheld the complaint. He directed the provider to reinstate Brendan's benefit payments from when he was last paid in the most tax-efficient manner and pay €10,000 in compensation. The provider remains entitled to assess Brendan's eligibility for benefit and, if it were to find him ineligible at a later date, then it must inform him of the decision and the appeal process directly and properly.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2019 - 0332

Rejection of insurance claim for damage caused by burst pipes in a holiday home

In May 2011 Stephen took out an insurance policy on his holiday home, a policy which he renewed annually. In December 2017, Stephen's sister left the water mains turned on in the property and the central heating on its timed setting. In March 2018, the water in the pipes froze, causing a pipe to burst and the property to flood. He made a claim on the insurance policy.

In July 2018, his insurance provider wrote to him to inform him that it would not cover the losses incurred by the flood, on the basis that its policy conditions had not been complied with. In particular, the provider asserted that, if the property is vacant for more than 48 hours, then either the water supply must be turned off or it must have a 'thermostatically controlled central heating system that could maintain a constant temperature of five degrees Celsius.' If the holiday home had such a system, the provider claimed, the water in the pipes would not have frozen.

Stephen took issue with the way in which the provider applied this policy. While acknowledging that the property had no internal thermostat, Stephen argued that the boiler in the property did have a temperature gauge, which can be used to ensure the temperature does not drop below five degrees Celsius. Stephen's sister stated that she set the boiler temperature between '50 and stop,' which Stephen claimed represented an indoor temperature of eight degrees Celsius. This, Stephen argued, was sufficient.

Stephen also stated that, if an internal thermostat was required, then this should have been clearly stated in the policy document. The failure to do so amounted to the provider mis-selling the policy.

Stephen made a complaint to the Ombudsman, on the grounds that the provider incorrectly refused to admit the claim and that the provider mis-sold the product.

The provider stated that its policy was clear. The provider defined a 'thermostatically controlled heating system' as one that can 'regulate the ambient temperature' of a property. The heating system outlined by Stephen in the property only regulated the water temperature in the property, so was not compliant. This is confirmed by the admission that Stephen's sister left the heating on its timed setting. A thermostatically controlled heating system would have been activated automatically when the temperature fell below a certain point, not when the timer was on. The provider stated that the fact that the pipes froze showed that the temperature must have fallen below five degrees.

The provider also denied that it mis-sold the policy. It stated that the policy was made clear every time Stephen renewed the cover. It provided a phone call from April 2018 where Stephen demonstrated an awareness of the policy.

Following the preliminary decision, Stephen submitted that pipes can freeze at normal room temperature if the temperature suddenly changes. The Ombudsman stated that Stephen had not provided any evidence to support this argument. It also did not change the fact that he had not complied with the insurer's policy by having the correct heating system.

The Ombudsman accepted, after looking at photographs of Stephen's central heating system, that it only controlled the temperature of the water and not the ambient temperature of the property. The Ombudsman also accepted that the ambient temperature must have fallen below five degrees Celsius as the pipes had indeed frozen. The Ombudsman also found that the policy in question was made clear to Stephen and the phone call proved his awareness of the policy. For these reasons, the Ombudsman did not uphold the complaint.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2019 - 0011

Rejection of an insurance claim and voiding of a house insurance policy for non-disclosure

In September 2013, Paul took out a home insurance policy with an insurance provider on his former residence, which he had been letting out to tenants since November 2012 while he was out of the country. The policy was renewed in September 2014.

In 2014, Paul decided that he wanted to return to Ireland for health reasons and wished to live in his former residence. In January 2014, he served a notice of termination on the tenants. They refused to vacate. Subsequently, in March 2014, he made an application to the Private Residential Tenancies Board (PRTB) to terminate his tenants' lease. His application was successful, but the tenants still did not leave. Eventually, they were evicted in March 2015 with the help of the County Sheriff.

When Paul returned to the property, after the tenants had been evicted, he found that they had caused malicious damage to it, rendering the house uninhabitable. He made a claim to the provider to cover the damages, which amounted to €34,227.68.

The provider declined Paul's claim. It stated that Paul had not disclosed his ongoing dispute with the tenants and the eviction notice when he renewed his policy in September 2014. It argued that this amounted to Paul failing to disclose a material fact about a risk to his property, the provider also cancelled his home insurance policy.

Paul stated that he did not withhold information from the company as during his last visit to the property prior to renewal, in July 2014, he had found it in 'good order'. Paul made a complaint to the Ombudsman, stating that the provider had wrongly and unfairly declined his claim and cancelled his home insurance policy. Paul requested the company pay out the full claim, along with compensation.

The provider identified the provision in its terms and conditions which supported its decision to deny Paul's claim. The provision read that it will only make payments if customers 'tell us all facts or material changes affecting the risk since inception of the policy or last renewal date.' It stated that Paul failed to disclose the material change that the tenants had received an eviction notice when he renewed his policy. It stated that this was vital to its risk assessment and that it would not have renewed Paul's policy had it been informed of this.

In his decision, the Ombudsman stated that the eviction of tenants is a matter which one could reasonably associate with and expect from the renting of properties. If the provider felt that the eviction of tenants or other related matters was a material risk that needed to be disclosed, then it should have specifically stated so in the proposal form or the terms and conditions of the policy. If it had, this would have provided Paul with the opportunity to disclose this information or to seek insurance cover from an alternative provider.

The Ombudsman stated that there was no evidence that Paul believed that the risk attached to his property had changed or that the property would be subject to malicious damage by the tenants when he renewed his policy.

The Ombudsman upheld the complaint and directed the provider to reinstate the policy, consider the claim in the ordinary course and pay a sum of €7,500 in addition as compensation for the inconvenience caused.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2019 – 0160

Rejection of a claim under a pet insurance policy

In January 2017, John and Lucy took out an insurance policy with a provider for their pet dog, after their previous insurer ceased offering pet insurance. From the beginning of the policy, it was known by the couple and the provider that the dog was overweight.

After the policy was incepted, the dog developed lameness in its left paw. It was taken to be seen by a vet in April 2017. The couple made a claim to the provider to cover the cost of treatment, which was in excess of €700. The provider rejected the claim, stating that it would not 'cover any conditions associated with a pet being overweight.' This was laid out in its terms and conditions of the policy, which John and Lucy had signed up to.

The couple believed that their claim was improperly declined by the provider, as the provider was aware of the weight of the dog from the inception of the policy and, they maintain, the dog's weight was not the cause of its condition. Accordingly, they made a complaint to the Ombudsman on these grounds.

The provider identified the provision in its terms and conditions which support the decision to deny John and Lucy's claim. The provision read:

"What we will not pay: Costs for treatment of conditions arising from your pet being overweight, except for weight gain as a result of a diagnosed illness."

A letter from the provider to the couple stated that obesity was associated with joint problems 'such as the one you are claiming for,' which meant that it had to decline their claim.

However, during the Ombudsman's investigation, John and Lucy provided a letter from their vet. The letter stated that, while the dog's weight was certainly making the dog's condition worse, it was not the underlying cause.

In his decision, the Ombudsman separated the complaint into two issues: whether the provider was entitled to reject a claim because the dog was overweight and, if so, whether it in fact established the dog's symptoms arose from the dog being overweight.

Regarding the first issue, the provider's terms and conditions clearly stated that it is entitled to decline cover due to the dog's weight. John and Lucy's assertion that the provider knew about the dog's weight from the beginning was considered by the Ombudsman as not relevant, as it had no bearing on the wording of the provision.

Regarding the second issue, the letter from John and Lucy's vet provided a professional opinion that indicated obesity was not the underlying cause of the dog's lameness. The provider did not furnish any evidence to the contrary.

The provider's terms and conditions stated that it will not pay for any cost of treatment 'arising' from a pet being overweight, however in their letter to John and Lucy they stated that it will not cover treatments for conditions that are 'associated' with a dog being overweight. In his decision, the Ombudsman stated that it was 'not acceptable' for the provider to substitute the word 'arising' in its policy for the word 'associated' in its correspondence to suit its own needs.

As the provider could not establish that the dog's conditions arose from the dog's weight, the Ombudsman upheld the complaint. He directed the provider to pay the claim and a sum of €300 in compensation in addition for the inconvenience caused.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2019 - 0142

Rejection of a travel insurance claim

Rachel and her partner took out a travel insurance policy with an insurance provider in November 2017 to cover a trip planned for February 2018. Unfortunately, Rachel contracted a respiratory tract infection just days before they were due to take the trip. Under recommendation from Rachel's medical advisor, the trip was cancelled.

Rachel's partner, Michael, called the provider's claims line to make a claim under their policy. Michael was on the phone for 45 minutes on what he believed to be a premium rate number explaining the situation, before he was sent a blank claim form by email, to be completed on the same date. The couple submitted the claim form but the provider declined the claim, on the basis that Rachel had failed to disclose that she had suffered from asthma for several years before the policy was incepted.

While Rachel and Michael accepted that they should have disclosed that Rachel had asthma, they argued that this was not a sufficient reason to refuse the claim, as the asthma had nothing to do with contracting the respiratory tract infection. The couple made a complaint to the Ombudsman, on the grounds that the provider had wrongly refused the claim. They also disputed the cost of the telephone call, over £10 GBP, which they state was for 'the sole purpose of increasing revenue for the provider' as a claim form had to be filled out after the call regardless.

The provider submitted that the call made by Michael was longer, because a new, inexperienced employee was taking the call. While it attested that the call was charged at a local rate rather than premium, it offered to refund the cost of the call as a gesture of good will.

It also argued, however, that it was correct in rejecting Rachel's claim. Under the provider's terms and conditions, it was stated that claims will not be covered if they arise directly or indirectly from an existing medical condition, including a respiratory condition. The provider stated that the couple ticked the box which confirmed that they had read these terms and conditions. The provider was not aware of Rachel's asthma until the claim was made, which, it argued, meant it was not afforded the opportunity to properly assess the risk. The provider argued that it was entitled to cancel the contract, and that Rachel and Michael were aware what effect their non-disclosure would have.

As the provider offered to refund the cost of the telephone call, the Ombudsman made no finding on this issue in his decision.

In respect to the refusal of the claim, the Ombudsman noted that the terms and conditions of the policy state that claims will not be covered if they arise directly or indirectly from an existing medical condition unless previously agreed. Both parties agree that Rachel's asthma was not previously disclosed, the question instead was whether Rachel's infection directly or indirectly arose from Rachel's asthma.

No evidence was made available, from either party, that the infection arose from Rachel's asthma. Because of this, the Ombudsman stated that the provider should not have declined the claim.

The Ombudsman substantially upheld the complaint and directed the provider to pay the claim.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2019 - 0416

Information given in relation to dental benefit

Catherine had to undergo dental work related to crowns and bridges and had a health insurance policy in place, paid for by her employer, which provided coverage. Catherine phoned her provider on 26 January 2017 to seek information on the extent of her coverage.

During this call in January, the provider's representative informed Catherine that her insurance covered the cost of 70% of one bridge and 70% of the cost of crowns up to a maximum of €600. With this knowledge, Catherine underwent the dental work she needed which ultimately cost €7,000. Catherine expected the provider to pay out €3,000 but when she made her claim the provider only paid out €1,200.

Catherine queried why this was and was told that, as of 1 February 2017, five days after she had called to ask about her coverage, her policy had changed. The provider now only covered a maximum of €600 of the cost of a bridge (the same as crowns).

Catherine asserted that she was not made aware of the upcoming changes and had she known, would have managed her treatment differently. She also noted a delay in the handling and processing of both the claim and complaint, with her payment initially paid into the wrong bank account, due to the provider using incorrect bank details. The payment was only completed in January 2018, having made the claim in November 2017.

The provider took two months to deal with her subsequent complaint, a timeframe that Catherine considered inadequate. Catherine made a complaint to the Ombudsman, stating that the provider had acted improperly in providing advice on her coverage and failed in how it processed and handled both her claim and complaint.

The provider maintained that the advice given to Catherine was correct at the time of asking, as the policy had not changed at that point.

It also stated that Catherine indicated she was going to have the dental work done regardless, so any advice given could not have had a bearing on her decision.

The provider accepted the error in payment was their fault and stated that it reacted swiftly to rectify the situation, pro-actively calling Catherine to confirm that the payment went through. It also stated that its handling of the complaint complied with the Consumer Protection Code (CPC).

In his decision, the Ombudsman found that the provider had apologised at length for the incorrect payment and did handle the complaint within the time frames provided for in the CPC.

However, he found it was 'highly unfair and misleading' for Catherine not to be told about the imminent changes to her policy when she called the provider in January. The Ombudsman pointed to the CPC, which states that all information provided to a consumer must be 'clear, accurate, up to date and written in plain English' and that the provider must not 'disguise, diminish or obscure important information.' The provider had not met this standard. In his preliminary decision, the Ombudsman indicated his intention to direct the provider to pay €3,000 in compensation to Catherine.

In a post-preliminary decision submission, the provider argued that the CPC provision cited by the Ombudsman was taken out of context, suggesting the phrase 'written in plain English' shows that it only applies to written information. It also objected to the level of compensation proposed. The Ombudsman stated it was 'most disingenuous' for the provider to claim the CPC provision only applies to written communications thereby inferring that other communications are not required to be clear or accurate. He stated that it is clear that the CPC applies to all information provided. He upheld the complaint and directed the provider to pay €3,000 in compensation.

Insurance

The FSPO regularly deals with linked complaints where more than one provider is involved in the issue in dispute. Both these complaints were made to the FSPO by Sarah who took a complaint against the broker who sold her the insurance policy and also against the insurance company which underwrote the policy.

READ THE FULL DECISION HERE

Decision Reference: 2019-0075

Sale of a holiday home insurance policy by a broker

In 2007, Sarah obtained a mortgage loan through the broker, against which this complaint was made, to enable her to build a house. She also purchased a construction insurance policy through the broker to facilitate the building of the house.

Before the construction policy was up for renewal in November 2009, Sarah contacted the broker to inform it that she no longer required the construction policy. She informed the broker that the building work was complete, as confirmed by certifications from her engineer and her bank. She also informed the broker that she was living in the house on her days off work. The broker advised Sarah to get a holiday home insurance policy. Sarah agreed to this and requested additional accidental cover. The proposal form was sent through by the broker. Sarah checked it and confirmed that the accidental cover was included and signed the form.

In May 2010, burglars broke into Sarah's house and stole the copper water cylinder and all the copper piping in the property. Extensive water damage was caused to the property as a result. Sarah reported the incident to the underwriter of the policy in order to make a claim.

On 14 June 2010, Sarah received a letter from the insurance company stating that her claim had been declined and her policy was to be voided from inception for non-disclosure of a material fact. The insurance company stated that it had insured the property on the grounds that the construction was complete, but had now formed the opinion, that is was not.

Sarah complained to the broker about this decision, stating that it had recommended the policy to her when it should not have done so.

On 21 June 2010, the broker informed Sarah by email that her insurance policy was to be changed to a 'construction fire only' policy, yet the same premium from the previous policy would still be charged. Sarah stated that she had not given her consent to the broker to do this. Since then, Sarah had been unable to obtain cover for the property or repair the damage caused.

Sarah made a complaint to the Ombudsman, stating that the broker wrongfully sold an unsuitable insurance policy to her and then set up a new 'fire only' policy with her money without her consent.

The broker stated that it had no reason to believe the property was not complete from the information provided to it by Sarah. While the structure of the property may have been completed by November 2009, it was still without a kitchen. This meant, according to the broker, that the house was still under construction. Once the policy had been voided, the broker claimed it had no choice but to set up a new policy, due to the requirements of the mortgage lender.

In his decision, the Ombudsman stated it was clear that Sarah and the broker had different understandings of what 'completeness' means in the construction of a property, both of which are subjective. It is reasonable to expect the broker to have been clearer in its communications with Sarah on what requirements it needed in terms of insurance cover. It should have stated specifically what was needed for the property to be considered complete before it offered the insurance policy.

The Ombudsman also stated that the broker did not act correctly by setting up alternative cover without first consulting with Sarah. The Ombudsman upheld the complaint and directed the broker to pay Sarah €8,000 in compensation and assist in having any record of the cancelled policy for non-disclosure corrected.

Insurance

This summary should be read in conjunction with decision reference 2019-0075 on page 36.

READ THE FULL DECISION HERE

Decision Reference: 2019-0076

Holiday home insurance claim rejected and policy voided for non-disclosure

In 2007, Sarah obtained a mortgage loan from a broker, to enable her to build a house. This included a construction policy to facilitate the building of the house.

In November 2009, Sarah contacted the broker to inform it that she no longer required the construction policy. The building work was complete. This was confirmed by certifications from her engineer and her bank, and she was living in the house on her days off work. The broker sold Sarah a new insurance policy, provided by the insurance company against which this complaint is made.

In May 2010, burglars broke into Sarah's house and stole the copper water cylinder and all the copper piping in the property.

Sarah reported the incident to the insurance company in order to make a claim.

During the assessment of the case, the insurance company discovered the kitchen in the property was not finished completely, with other aspects of the property still in 'snagging stage,' the point where defects from construction are still being rectified. This led it to decide that the property in question was, in fact, still under construction. As a result on the 14th of June 2010, Sarah received a letter from the insurance company stating that her claim had been declined and her policy was to be voided from inception, for non-disclosure of a material fact.

Sarah rejected this, citing the certificates from the engineer and the bank which stated the property was complete, as well as the fact she was using the property herself. She made a complaint to the Ombudsman, stating that the insurance company had wrongfully cancelled an insurance policy and falsely accused her of concealing information.

The insurance company contested that a property shouldn't be defined as completely constructed unless the property had a fully functional bathroom and kitchen.

After inspection of the property while assessing the claim, the insurance company stated that it was clear that this was not the case. It asserts that if it had known that this was the case, it would have completely altered its consideration of the risk and would have declined to underwrite the policy.

In his decision, the Ombudsman stated that this was a dispute based on competing interpretations of what constitutes a 'complete property.' Given that the insurance company seemed to have a clear idea of what constituted completeness in relation to the construction of the property, he said he would expect that it should have been clearer in its communications with Sarah as to what those requirements were. He said the insurance company should have offered guidance and clarity on this issue.

This is especially true, the Ombudsman stated, given that the proposal form submitted by Sarah offered many clues about the supposed 'unfinished' nature of the house. In the section of the form that asked when the property was built, it read '2000-date.' Under the question 'What was the primary source of heating for the property' the answer recorded was 'not known.' Both answers should have been further queried by the insurance company before it agreed to insure the risk of the property. It did not.

The Ombudsman concluded that the policy should not have been voided for non-disclosure of a material fact and the claim following the theft should have been covered under the policy. He directed the insurance company to pay Sarah €8,000 in compensation, in addition to admitting the claim and paying the settlement amount. He also directed that any record of the cancelled policy for non-disclosure be corrected by the insurance company.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2019 - 0308

Failure by customer to declare previous claim

Colin took out a commercial insurance policy for his van in September of 2013. When the policy came up for renewal in 2016, his insurer had exited the Irish market. As a result, Colin transferred his insurance to a new provider, on the 12th of September 2016. The new provider later cancelled the policy from this date, due to what it called a 'non-disclosure of a material fact.'

When investigating a third party claim against Colin's insurance policy in March of 2017, the provider learnt that Colin had made two previous claims, in May and July of 2013 that he had failed to disclose to the initial insurer when he originally took out his commercial policy in September 2013. As a result of these two non-disclosures, the provider cancelled Colin's policy from the date of renewal.

Colin disputed the assertion that he had failed to disclose the two previous claims and complained to the Ombudsman, on the basis that his provider had unfairly cancelled his policy.

He argued that the two incidents had occurred on his private car policy, so he did not realise he had to disclose these for his commercial van policy. Furthermore, his solicitors noted that the provider had relied on the previous insurer's statement of fact to cancel the policy. They argued that the provider is 'not entitled to void a policy utilising a statement provided to a different insurer at the commencement of a different policy.'

The provider insisted that it was satisfied that it had acted in accordance with the terms and conditions of the policy. It argued that it took up the policy on the grounds of the information previously provided to it, which had now changed.

The provider believed that the wording in the original statement of fact was 'clear and unambiguous' in relation to what Colin needed to disclose. The statement of fact in question stated that Colin must 'give details of any previous or current accidents, claims or losses… in connection with every motor vehicle ever owned or driven'. It was also written in this statement that any false information provided could invalidate the insurance.

In his decision, the Ombudsman accepted that the wording in the statement of fact was clear and unambiguous, which meant Colin's failure to disclose his two previous claims on his personal car constituted a non-disclosure of a material fact, which gave the provider the right to cancel his cover.

In regard to the solicitor's claim that the provider cannot rely on an agreement with another insurer, the Ombudsman highlighted the renewal notice sent by the provider to Colin. These stated that the declarations previously signed by Colin with his previous insurer were to form the basis of the new contract. Colin agreed to these terms and paid the renewal premium before the renewal went ahead. Because of this, the Ombudsman accepted that Colin's contract of insurance was based on the information provided to the previous insurer.

Colin's solicitors called for an oral hearing to be conducted on this case, to cross examine the provider as to why it was initially prepared to accept Colin based on the information given but was now unable to do so. The Ombudsman did not accept that there was a need for an oral hearing as he had sufficient documentary evidence to decide the matter. The Ombudsman did not uphold the complaint.

Sector:
Investment

READ THE FULL DECISION HERE

Decision Reference: 2019-0077

Sale of a personal pension plan

In February 2016, Jim met with a sales advisor from a provider to set up a pension. As Jim worked as a self-employed contractor, he requested a product that allowed for his income to vary from year to year. Following this meeting Jim started a pension plan with the provider in March 2016. He stated that the only fee he was informed of was for €12.85 per month.

Around July/August 2016, Jim says he requested a breakdown of his pension from the provider, the response to which he says was delayed. In January 2017 he requested information on the charges applied to his pension. When he received the information, he was shocked to find that 50% of his contributions had gone to fees.

When Jim enquired about this, he was told that, under the terms agreed, 50% of his contributions would not be applied to his fund for the first two years of the plan but used to pay administration costs instead. The provider referred to this as a non-allocation period (NAP). Jim also found out that the NAP charges applied to any increases in income. This made it more difficult for Jim to save when his income was higher.

Once Jim discovered this, he immediately stopped his contributions. He said that if he had received the information he requested sooner, he would have stopped his contributions earlier. The fact that he did not have this information, he states, led to a financial loss on his part.

In Jim's complaint to the Ombudsman, he stated that the provider did not adequately explain the NAP charges to him. He also stated that the delay in correspondence from July/August meant he incurred a financial loss. In addition, Jim stated that the plan he was sold was not suitable for his situation.

The provider rejected the claims. It asserted that it emailed Jim details of the plan charges before their meeting in February and that at the meeting itself, all the charges associated with the plan were discussed with him before he signed the agreements.

A policy pack was then sent to Jim via email just days later, giving a detailed breakdown of the charges associated with the plan.

The provider stated it had no record of receiving the breakdown request in July/August 2016 or any subsequent correspondence until January 2017, when Jim requested information on the charges applied to the pension.

In his decision, the Ombudsman stated that there was no evidence that the provider had delayed in supplying information to Jim in July/August 2016, as there was no record of the request.

The Ombudsman also stated that, while it was unclear as to whether the provider's sales advisor had adequately explained the situation, Jim had to take some responsibility. If he had examined all the documents sent to him with care, he would have a better understanding of the charges.

The Ombudsman was not satisfied, however, that the pension plan offered to Jim was suitable for his situation. In the provider's statement of suitability, it stated that the pension plan was suitable for 'long term regular savings for retirement.' Jim had made it clear that his income was not regular and likely to fluctuate from year to year. The provider claimed that it discussed how the plan would work with someone on a fluctuating income, but the Ombudsman found that it had only discussed what would happen if Jim's income went down and did not consider that his income could rise.

The Ombudsman found that the executive pension plan recommended by the provider was not suitable for the complainant, given the volatile and inconsistent nature of the complainant's income. He substantially upheld the complaint and directed that the provider repay the contributions to the complainant.

Investment

READ THE FULL DECISION HERE

Decision Reference: 2019 – 0317

Dispute regarding the value and charges relating to an executive pension policy

In 1990 Declan took out an executive pension through his employer. It had three components to it; pension, life cover and disability cover. Declan's main correspondence with the provider of the pension was an annual statement, which, according to Declan, pointed out to him that if he increased his payments year on year, then it would boost his eventual retirement fund.

In 2012, Declan hired an accountant to obtain more information on his pension plan. The accountant found that many of his recent annual payments had not been boosting his eventual retirement fund but had instead been going to his life cover and disability cover, both of which had become significantly more expensive as the years had gone by. It had even reached a stage where the charges on the life and disability cover exceeded the payments that Declan was paying in, which meant the provider had been taking money from the pensions fund to facilitate the charges. Declan believed the provider did not have the right to take funds out of the pension fund and allocate them to other schemes without his permission. He also complained that it never informed him that the amount that he was paying in was not sufficient to cover the plans.

Declan made a complaint to the Ombudsman, accusing the provider of wrongfully allocating his monthly contributions to disability cover and life cover, wrongfully using some of his pension fund to pay for this cover and misrepresenting how it allocated his payments each year. Declan was looking for all premiums that were diverted from his pension to be reallocated back into the plans, with an injection of capital to reflect the amount the pension would be worth had the funds been invested properly.

In response, the provider stated that it was administering the pension plan in accordance with the terms and conditions as set out in 1990. These stated that it had the authority to allocate contributions to health insurance and life cover, as well as take funds out of the pension fund for these two schemes. It contended that if Declan had concerns with the way the policy was set up, then he needed to bring these up with the independent broker who originally set up the plan.

The provider stated that it sent out annual statements to Declan. While these statements are legally required to provide details of the life cover and disability cover, the provider claimed, they are not legally required to include how much these benefits cost. It also asserted that Declan was able to enjoy a 'high level of valuable life and disability cover' over the years. Had a claim arisen, then this would have been paid out under the plan. As a result, the provider stated it could not fulfil Declan's request to refund and reallocate the premiums allocated to the other schemes in the plan.

In his decision, the Ombudsman stated that the evidence provided to him showed that the provider was acting in line with the terms of the pension plan by reallocating parts of the pension fund to the other schemes and that Declan had been provided documents when the plan was taken out that confirmed how the plan works. Likewise, the Ombudsman agreed with the provider that the funds allocated out of the pension fund cannot be refunded, as Declan did enjoy the benefit of life and disability coverage over the years.

However, the Ombudsman also stated that the provider could have provided greater information over the years on the increasing costs under the plan. The fact that the life cover cost was increasing to such an extent that there was little or no contributions going towards the pension fund itself was important information that should have been communicated more fully and on a more frequent basis. For this lack of communication by the provider, the Ombudsman substantially upheld the complaint and directed the provider to pay €15,000 in compensation to Declan.

Sector: Pensions

Unlike the case studies published in other sections of this Digest, the full text of this decision is not available as the Financial Services and Pensions Ombudsman Act 2017 does not provide the power to publish the full text decision in relation to complaints against pension providers.

Delay in pension draw down

Cillian was a member of a defined contribution pension scheme, administered by the provider. On 19th November 2015, he informed the provider that he wanted to retire and asked it what documents were needed to access his pension. He was informed the provider required four documents, including a member decision form. Cillian indicated he wanted to invest his benefit into an Approved Retirement Fund (ARF) and provided all the documents by 20th November.

Because Cillian indicated that he wanted an ARF, the provider was obliged to obtain further documents before it could process Cillian's request. The provider received these on the 4th December.

On 5th January 2016, Cillian became aware that his benefit had not been disinvested by the provider. He contacted the provider, who acknowledged the delay and assured Cillian that it would cover any losses that had arisen. The provider accordingly made a payment of €2,533.31 to redress the loss.

Cillian was not satisfied that this payment covered his losses. Based on his monitoring of the fund, he expected a larger amount and after requesting information from the provider, he found that the total amount of his fund had been calculated from the value it was on the 14th December 2015, the date that the provider claimed it ought to have processed his retirement if there had not been a delay. This date happened to be one where his fund value was lower than it had previously been.

Cillian believed the fund would have been disinvested on the 30th November 2015 if there had not been a delay by the provider and that the fund should be based on its value on that date. Accordingly, Cillian made a complaint to the Ombudsman, requesting an additional €8,793.39 in redress and €3,184.50 in compensation for expenses that he incurred in calculating this redress.

In response, the provider stated that it needed the additional documents before it could begin disinvesting Cillian's fund. Cillian asserted that the provider should have told him that the additional documents would be needed when he submitted the original application. This would have meant he was able to submit all the documents at the same time and would have prevented any delay.

A delay also occurred due to an instruction Cillian gave to the provider in October 2015 to change the way his fund was invested. The provider only carried out his instruction on 26th November but insisted that there was no unnecessary delay and that it acted promptly and in accordance with its processes. Cillian asserted that the provider did not have to wait until this change in investment had been made, and therefore argued that there was no reason why the request could not have been processed earlier.

Regarding the redress, the Ombudsman accepted that the provider had acted in accordance with the terms of the pension scheme. The provider was obliged to make the change that Cillian requested before it disinvested his fund as it was made before Cillian indicated he wanted to retire. The Ombudsman also believed that the provider was not being insincere when it informed Cillian that the initial documents were the ones needed for retirement, as it was only known by the provider that further documents were needed when Cillian submitted his member decision form.

In his decision, the Ombudsman stated that there is no provision in the legislation governing the FSPO which allows him to direct compensation where a complaint is made against a pension provider. The Ombudsman can only direct pension providers to restore any financial loss suffered by a complainant. Consequently, the Ombudsman did not uphold Cillian's complaint.

Unlike the case studies published in other sections of this Digest, the full text of this decision is not available as the Financial Services and Pensions Ombudsman Act 2017 does not provide the power to publish the full text decision in relation to complaints against pension providers.

Early retirement request following unfair dismissal

Stephen, who suffers from a recognised disability, was employed from July 1997 until November 2010. He was dismissed by his employer for an alleged breach of the employer's 'Dignity at Work' policy. Stephen appealed but the employer upheld its original decision. Stephen's union then brought a case against the employer to the Labour Relations Commission (LRC). The LRC found that the employer did not give due consideration to his disability and that he was unfairly dismissed. The LRC recommended that Stephen be awarded a termination payment of €7,500.

Stephen's employer was the sponsor of a pension scheme, of which he was a member. He applied for a retrospective ill-health retirement following the decision from the LRC.

The provider of the scheme did not consider Stephen's application, stating that the rules of the scheme require members who wish to retire early to apply while they are still in active service. Stephen had not applied for ill-health retirement while he was at work and the matter only arose after he had left the employment of the company.

Stephen claimed that he was never afforded the opportunity to apply for ill-health retirement before he left the company. He believed that the provider did have the authority and discretion to award a retrospective ill-health pension, according to his reading of the rules. Stephen also asserted that, following the ruling from the LRC, the provider should not have considered his dismissal as valid, which means he should not be considered a 'leaver' of the company.

Stephen made a complaint to the Ombudsman, stating that he suffered financial loss as the provider refused to award him a retrospective ill-health pension.

Stephen claimed that the provider should award him an ill-health retirement benefit backdated to the date of his dismissal.

The provider stated that, according to the rules of the scheme, the award of ill-health retirement requires the member to suffer from a physical or mental deterioration which prevents them from following any paid employment. It pointed to medical evidence given by a GP in relation to Stephen after a bout of illness in September 2010. The GP had certified him fit to return to work. During Stephen's hearing in front of the LRC, a GP had given evidence that Stephen could return to work, on a limited basis. This showed that Stephen was not prevented from following paid employment.

The provider continued to maintain its position that the rules of the scheme only allow a member to claim early ill-health retirement while still in active service.

The Ombudsman disagreed with the provider on this point. He stated that there is nothing in the wording of the rules of the scheme that restricts the benefits to active members only. Therefore, it would have been possible for the provider to award a retrospective ill-health retirement benefit to Stephen.

However, he accepted that the provider could only award ill-health retirement benefits when the medical evidence to support such a decision existed. Such medical evidence did not exist at the time of his dismissal. In fact the medical evidence indicated that Stephen was in fact fit for work. As a result, the Ombudsman did not uphold Stephen's complaint.

Pensions

Unlike the case studies published in other sections of this Digest, the full text of this decision is not available as the Financial Services and Pensions Ombudsman Act 2017 does not provide the power to publish the full text decision in relation to complaints against pension providers.

Requirement for a pension payment declaration form

Emma retired in June 1995. She had received her occupational health pension for the past 23 years. In 2018 she submitted a signed copy of the payment declaration form to confirm that she was still eligible for the pension benefits. Her provider informed her that it required for her declaration to be signed and witnessed by a third party, something, Emma claimed, that they had never requested before. The provider informed her that it had no choice but to withhold her pension until she submitted a completed and witnessed form to the scheme administrators.

When Emma brought her complaint to the Ombudsman in October 2018, she stated that the provider had unfairly insisted that her declaration form be signed by a witnessing third party, despite the fact it had accepted unwitnessed declaration forms for the preceding 23 years.

Emma stated that her private health insurance fund had not been paid for a period of three months as her pension cheque was not lodged into the bank account as normal. She requested that a pension cheque be lodged to her bank account each month as it had been for the past 23 years, without the necessity for the declaration form to be witnessed and signed.

The provider stated that it was a legal requirement to have the form witnessed by a third party and that the administrator who previously accepted her forms was no longer an employee so it could not explain why it had accepted previously incomplete forms. It pointed out that Emma provided a form in 2004 that had been witnessed by a third party.

The provider claimed that it made numerous efforts to engage with Emma and had to suspend her pension benefits as a last resort on the 23rd of July 2018. It advised her that if she was unable to find someone to witness her signature, it would send a member of staff to meet her to witness her signature. Emma did not take up the offer or return the witnessed form. The provider stated that the payment would be available immediately once Emma complied with the rules. In addition, it claimed that it had processed the element of the pension necessary to maintain Emma's private health cover.

The Ombudsman stated that he was satisfied that this form being signed in front of a witness was a legal requirement which must be met. He was further satisfied that failure to submit an appropriately witnessed annual declaration form can result in the suspension of pension payments as it does not comply with the relevant declaration rules.

The Ombudsman did state it was unsatisfactory that the provider was unable to explain why the relevant pension payments were made in the absence of a witness declaration previously but was satisfied that the provider made several attempts to contact Emma prior to the suspension of her pension payments in order to explain the requirements.

The Ombudsman did not uphold Emma's complaint but encouraged her to contact the provider and to arrange for a representative to meet with her as soon as possible in order to have her pension payments restored.

Feedback on our service

We value feedback on our service. It helps us to consistently improve our service. In order to demonstrate the value of our service to our customers we have reproduced some comments received in 2019 from complainants who used our investigation and adjudication service.

"Thank you for your letter dated … and the legally binding decision in relation to the above referenced complaint.

I would just like to record my gratitude for all the hard work that the adjudication of the above complaint required. The painstaking investigation and analysis of the detail as evidenced in your letter is much appreciated and especially in the context of what I am sure is an extremely high demand for the Ombudsman service.

I am very grateful for the comprehensive and clear explanation of the decision".

"I am pleased with the decision reached in relation to my complaint and even more pleased that your office took the time and trouble to read into my claim in all of its tedious detail. I do feel exonerated and relieved.

I am also very impressed by the professionalism of your office and the high standard of your attention.

I have been paid the settlement amount and the additional compensatory payment directed and am happy that this matter is now a closed file.

With sincere thanks and kind regards."

"We would like to thank you and your staff for endeavouring to resolve both the above cases. We regret that having spent so much time on both that you have been prevented from completing your work due in the main to one of the parties initiating legal action especially at an advanced stage.

During the 3 years of engaging with the FSPO we have been treated with the utmost respect courtesy and patience and wish to express our appreciation for all your kind assistance."

"Sincerest thanks for your Trojan work in resolving our dispute, it entailed a lot of paper work. We received a cheque for €5,000 on 15/1/19. We are grateful for your commitment to the "little man" and the hope you give that we can "reshape the world".

Note: The reshape the world comment was a reference to the verse on the card which read: "Like water, be gentle and strong. Be gentle enough to follow the natural paths of the earth, and strong enough to rise up and reshape the world."

"I acknowledge receipt of the legally binding decision. I want to thank your Office for the professionalism in dealing with this complaint. The mediation was conducted with integrity and sensitivity. The adjudication process was seamless and communication excellent."

"My wife and I wish to thank you and all your colleagues at the FSPO for the way in which you have handled our complaint.

We are greatly relieved now that it is concluded. When we first contacted your office we had no idea just how much work would be entailed for you and we are grateful for all the time dedicated to us and for the courtesy afforded.

May I ask you please to pass on our thanks to [Investigation Officer] for his very detailed and thorough adjudication".

"Thank you so much. You have started to restore my faith in people again. I feel in really good hands. Not only are you prompt, but you are professional, polite, considerate and thoughtful. Qualities that are, unfortunately, in short supply these days. You should be really proud."

"Thank you again (and to all the staff at the Ombudsman's Office that I have dealt with in relation to my complaint over the past 26 months) for your patience and generosity of spirit in dealing with my complaint".

3 STEPS to making a complaint to the FSPO

1

Contact your provider

You should make your complaint with whoever provided the service or product to you, this could be your bank, insurance company, credit union, money lender etc.

You should speak or write to either the person you usually deal with, or ask for the complaints manager to make a complaint.

What information should you give them?

- ☑ **Make it very clear that you are making a complaint.**
- ☑ **Explain your complaint.**
- ☑ **Suggest how they should put it right.**

Provide detailed information, including:

- **Relevant dates, places and times**
- **Details of any phone conversations and meetings** (e.g. who was involved, when they took place and what was said)
- **Copies of relevant documents,** such as contracts, statements, emails, letters, invoices and receipts.

BEFORE MAKING A COMPLAINT TO THE FSPO, YOU MUST GIVE YOUR PROVIDER A CHANCE TO SORT OUT THE PROBLEM.

2

Be patient and persistent

The provider should deal with your complaint through its complaint handling process. The provider may take up to 40 working days to deal with your complaint.

When you complain to the provider be persistent. If nothing happens, call the provider to check on the progress of your complaint.

The provider should fully investigate your complaint.

Resolved
In the majority of cases the provider will resolve your complaint.

Not yet resolved
If they don't resolve it, they will issue a final response letter to you.

A final response
should set out what the provider has done to investigate your complaint through its complaint handling process. It should advise you to contact the FSPO as your next step, if you remain unhappy.

3

Contact the FSPO

If you remain unhappy after receiving your final response letter, you may contact the FSPO. To progress your complaint, we will need:

A **A completed complaint form**

&

B **A copy of your final response letter.**

If you are having difficulty getting the final response and 40 working days has passed or if your provider is not engaging with you please let us know and we will follow up on the complaint for you.

An tOmbudsman Seirbhísí
Airgeadais agus Pinsean

Financial Services and
Pensions Ombudsman

Lincoln House,
Lincoln Place,
Dublin 2,
D02 VH29

Phone: +353 1 567 7000
Email: info@fspo.ie