An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0160
Sector:	Insurance
Product / Service:	Mobile Phone
Conduct(s) complained of:	Claim handling delays or issues Dissatisfaction with customer service Failure to process instructions in a timely manner
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant incepted a mobile phone insurance policy with an Insurer on 1 November 2015. The policy, which ceased on 11 May 2017, was underwritten by the Company.

The Complainant's Case

The Complainant dropped her mobile phone on some stones on **18 September 2016**, shattering the screen. She submitted a claim online to the Insurer via its website the next day, on 19 September 2016. This website advises *"We will assess your returned claim form within 24 hours of receipt"*, however when the Complainant heard nothing she telephoned the Insurer on **23 September**, **26 September** and **27 September 2016** but on each occasion was placed on automated hold, with no answer, notwithstanding that she held the line for 40 minutes, 40 minutes and 15 minutes respectively.

The Complainant finally managed to talk to the Insurer by telephone on **28 September 2016**, when she was advised that she had not provided a proof of purchase with the online claim. In this regard, the Complainant notes *"I did not have my proof of purchase to hand on the 19th September, at which time I was concerned to provide prompt notification"*. The Complainant then emailed the Insurer this proof of purchase and it telephoned her within the hour to confirm that her claim was accepted. The Complainant then provided the Insurer with her credit card details to pay the policy excess of €75, however she later discovered that the amount of €77.18 had been charged.

In addition, the Insurer also advised during this telephone call on **28 September 2016** that the courier would collect her handset on **30 September 2016**, however the courier did not arrive. The Complainant tried telephoning the Insurer but again was placed on automated hold with no answer. She then telephoned the courier but it was unable to provide her with any information without a reference number, which the Insurer had not provided her with. The Complainant also emailed the Insurer's customer service address twice on **30 September 2016** to advise that the courier had not arrived. The Complainant subsequently learnt that the courier had tried to collect her handset from her previous address in Cork, the address that appeared on the proof of purchase she had emailed to the Insurer on 28 September 2016, as opposed to her current address in Dublin, which was the address she had supplied in her online claim form.

The Complainant next managed to make contact with the Insurer on **7 October 2016** and was advised that her handset would be collected by courier on 10 October 2016. When the courier had not arrived by late afternoon on **10 October 2016**, the Complainant telephoned the courier and provided them with the reference number she had been given by the Insurer on this occasion, however the courier advised that the only collection listed for that reference number was the earlier pick up at her previous address in Cork on 30 September 2016.

The Complainant telephoned the Insurer on **11 October 2016** to advise what the courier had told her, but whilst the Agent tried to blame the courier for having the wrong address, it was clear to the Complainant that no courier had in fact been booked. The Agent assured the Complainant that the courier would collect her handset the following day and that it would be repaired and returned to her within the next 3 to 5 working days. The courier collected the Complainant's handset on **12 October 2016** but when she had not heard anything about her handset being returned to her, the Complainant tried to contact the Insurer *"on numerous occasions by telephone and by email"*.

In this regard, the Complainant emailed the Insurer's customer service address on **20 October** and again on **21 October 2016** asking when she could expect her handset to be returned. She was subsequently told by telephone that the Insurer would check with the repair centre and email her but the Complainant then *"received an email which did not provide any information regarding the return of the phone"*. The Complainant telephoned the Insurer again on **24 October 2016** and was advised that it would request a further update from the repair centre and email her its response.

In her letter to the Insurer two days later, dated **26 October 2016**, the Complainant wrote, as follows:

> *"As of today, I have not been emailed and I have been given no information whatsoever as to when my phone will be returned to me. It is almost two weeks since my phone was taken by* [the Insurer].
>
> *I am hugely dissatisfied with the service with which I have been provided by* [the Insurer]*…I have been without my phone for more than five weeks now. Notwithstanding the fact that I have been without the use of my phone, I have been*

/Cont'd…

paying my bills and my insurance premium in this period. I have also spent a tremendous amount of time trying to communicate with your company, which has caused me considerable cost, inconvenience and upset…I am now calling on you to immediately do the following:

1. *Arrange for my phone to be transferred to me immediately (even if it has not yet been repaired);*

2. *Furnish me with the sum of €50 in respect of the calls I have made to your 1890 number to date;*

3. *Return the wrongly and unlawfully deducted sum of €77.18 to me;*

4. *Return the insurance premia I have paid to* [the Insurer] *since the start of my contract;*

5. *Cancel my contract with* [the Insurer] *with immediate effect and confirm that you have done so and that no further insurance premia will be deducted from my account; and*

6. *Furnish me with transcripts of all my calls with* [the Insurer] *in relation to this claim"*.

The Complainant received an email on **28 October 2016** from Hollie, an Agent with the Insurer, advising that *"the replacement unit for your handset is due into the repair centre today"*. The Complainant emailed Hollie back to ask whether this was a response to her letter of 26 October 2016 and that if it was, it was unsatisfactory and that she expected a proper response by 1 November 2016.

The Complainant next received an email on **2 November 2016** from Rachael, an Agent with the Insurer, informing her that the handset would be delivered that day. The Complainant replied to Rachael later that day confirming that the replacement handset had been delivered and advising that she was seeking a formal response to her letter of 26 October 2016 by 7 November 2016.

The Complainant next received an email on **9 November 2016** from Daniel, an Agent at the Insurer. In relation to the five outstanding actions the Complainant had requested in her correspondence of 26 October 2016 (one action was no longer relevant as she had received delivery of her replacement handset), this email advised that the Insurer would not provide the Complainant with the sum of €50 in respect of the calls she had made to its 1890 customer service number, that it had refunded to her credit card the sum of €2.18 it had overcharged when taking the policy excess of €75, that it would not refund the premiums previously paid as they were non-refundable and that she would have to pay an administration fee of €8.92 to obtain a transcript of her telephone calls with the Insurer. The Complainant notes that this email was silent in relation to her request to have her policy cancelled with immediate effect.

/Cont'd…

As a result, the Complainant replied by email to Daniel on **11 November 2016** pointing out the elements of her complaint that had not been addressed in his email and also advising that the replacement handset was now not functioning properly insofar that it was frequently freezing and had to be restarted.

The Complainant next received an email on **22 November 2016** from Katie, an Agent at the Insurer, which provided, as follows:

> *"Firstly I am sorry to hear of your dissatisfaction regarding the processing* [of] *your claim and the replacement device you have received as settlement. I have reviewed your file and can advise as follows:*
> *You submitted a claim via our online portal.*
>
> *28 September: We emailed you requesting a valid proof of purchase as you failed to supply this when submitting your claim. We received the required documentation. Your claim was re-assessed and accepted. You made payment of your policy excess.*
>
> *29 September: We logged your address details with our repair centre to arrange collection of your handset vis the courier …*
>
> *3 October: The courier failed to arrive at your address – (we had not been advised of this by you or the courier)*
>
> *7 October: You contacted us to advise the courier has failed to arrive at your address, it came to our attention that the courier had the incorrect address. We contacted the repair centre with the correct collection details and the courier was re-booked for Monday.*
>
> *20 October: You contacted us requesting an update on the repair of your device. We requested information from the repair centre – they confirmed that your device was with the technician, they had been unable to log it into the system prior due to an IT technician issue (the repair had since been marked as a priority).*
>
> *24 October: You contacted us for a further update as the device had now been with the repair centre for 6 working days (we do advise as a guideline the device will be with the repair centre for 3-5 working days – however we cannot guarantee this as the unit needs to be inspected by the technician so they can ascertain the damage that has been sustained).*
>
> *28 October: The repair centre advised us that your device was being replaced and they were expecting a delivery of stock…that day.*
>
> *2 November: The replacement device was out for delivery with the courier …*
>
> *I understand that the replacement device…is faulty – we will need to arrange collection of this: can you please confirm your preferred collection/delivery address and date so that we can arrange for the courier to come out. I will inform the repair*

/Cont'd…

centre that the handset is coming back in and they need to mark the inspection/repair as 'Urgent' due to previous delays. I hope this answers your concerns; should you wish to take this higher I can forward your file on to our underwriters [named]*".*

In her letter of reply addressed dated 24 November 2016, the Complainant wrote, as follows:

"I received your email Katie, which provides me with an incomplete and inaccurate chronology, which irks me considering the extent of time and expense I have been put to. It also fails to fully address my complaint letter [of 26 October 2016]*. For example, at no point has it been confirmed to me that my contract has been cancelled and in fact, on checking my bank statement, I can see that premia have been deducted since my formal request. Furthermore, I noticed on my bank statement that the sum of €2.00 was refunded, not €2.18. This is of course a trivial amount but in the context of your dealings with me to date, it is another source of frustration.*

Having spent further considerable time setting out a proper chronology, my lack of confidence in [the Insurer] *has been reinforced. I cannot countenance having you send a courier to pick up my phone and have it marked as "urgent". I have been told multiple things in the past, which have proved to be incorrect (e.g., a courier has been arranged) or utterly meaningless (e.g. my phone is a "priority"). Furthermore, I do not have any confidence in the repairs as having suffered 7 weeks with a non-functioning phone, I am now only in the marginally improved position of having a partially or occasionally functioning phone.*

I think in the circumstances you will have to forward my file to your underwriters"

The Complainant received an email on **28 November 2016** from Katie advising that her file would be passed to the Respondent Provider for an independent review of the matter.

The Complainant then received a letter from the Provider dated **29 November 2016** advising that her concerns would be investigated and a full response would issue by 17 January 2017.

In this regard, the Complainant subsequently received the Provider response by way of correspondence dated **10 January 2017**, wherein it advised that it had requested the Insurer to reimburse her the €75 policy excess along with the 18 cents that was previously missed. It also advised that the policy terms and conditions clearly state that premiums are non-refundable and it could not therefore agree to refund her the premiums she has paid. The Provider also noted that in her correspondence to the Insurer the Complainant had requested €50 to cover the cost of the calls that she made to the Insurer in relation to her claim and advised that it would reimburse the actual charges incurred and requested that she forward to the Insurer an itemised bill showing the charges incurred and it would refund this amount to her. The Provider also stated in this correspondence that it understood that the replacement handset that had issued to the Complainant has faults and that the Insurer had confirmed that it can arrange collection of this device and once its repairers have confirmed the faults it would either repair or replace the handset.

/Cont'd…

The Complainant then received an email on **13 January 2017** from Jenny, an Agent at the Insurer, advising that the sum of €76 had been refunded *"as advised by* [the Provider]*"* and that *"this settles your complaint"*. The Complainant replied to Jenny by email on **1 February 2017** advising that yet again an incorrect amount had been refunded and that on this occasion the sum of €71.68 had been refunded, and not the sum of €76, as advised in her email of 13 January 2017. The Complainant also advised in this email that she did not consider her complaint to be settled as there remained a number of outstanding issues. In this regard, the Complainant attached her mobile phone statements itemising her lengthy calls to the Insurer's 1890 customer service number, totalling a cost of €37.64. She also advised, as follows:

> *"*[The Provider] *has advised me that* [the Insurer] *has confirmed that they will arrange collection of my phone and either repair or replace the handset as appropriate. This was previously offered by* [the Insurer] *to me and I was not happy to do this as when I initially claimed it took almost two months to have my phone collected and returned to me by* [the Insurer]*. I have given this aspect of my complaint considerable thought and, having been assured that my phone will be treated as an urgent priority, I will allow it to be collected and repaired/replaced. Once it is returned to me safely and in a satisfactory condition, I will consider how to proceed with my existing complaint. You might note that my specific complaint in relation to the phone was that since it was returned to me it freezes regularly. The screen freezes but no buttons whatsoever work and I have to restart it to get it to work. This is not a rare occurrence; it happens extremely frequently and is very frustrating.*
>
> *I look forward to hearing from you shortly re the above"*.

The Complainant received a cheque in the amount of €37.64 on **7 February 2017** in respect of the calls she had made to the Insurer's 1890 customer service number, as detailed on the mobile phone statements she had provided.

The Complainant received an email on **1 February 2017** from Dan, an Agent at the Insurer, advising that he was forwarding her correspondence to his manager for review and would revert shortly. The Complainant then received an email from Dan on 7 February 2017 asking *"Can you let me know a preferred address so we can arrange collection for your handset?"* The Complainant responded by email confirming her Dublin address, which was the address she had supplied in her online claim form and asking Dan to let her know when to expect a collection so that she could arrange for her handset to be wiped. In this regard, in her correspondence to this Office dated 30 June 2017 the Complainant submits, as follows:

> *"I did not get any response to this email and this was the last communication that I had with* [the Insurer]*. No courier ever arrived to collect my phone and I received no follow up of any kind from* [the Insurer]
>
> *As I made clear to* [the Insurer] *in my email of the 1st February, I was incredibly reluctant to send my phone off to them again. In my previous dealing with them, it took 25 days from the submission of my claim form for my phone to be collected. It then took a further 21 days for my phone to be returned. In that time I suffered a*

/Cont'd…

huge amount of frustration in trying to engage with them and find out [what] *was happening regarding, initially, the processing of my claim, then the collection of my phone and, finally, the return of my phone. On top of that I was without the use of my phone for this lengthy period. I had no confidence whatsoever in* [the Insurer] *but, having received a degree of formal engagement from* [the Provider] *and having been assured that my phone would be treated as an urgent priority, I decided to give them a chance and allow it to be collected. It took 7 days from the date I advised* [the Insurer] *that I would give them this chance for Dan to contact me and then I got no response whatsoever to my email asking when the collection would take place. No courier ever arrived to collect my phone. It was then confirmed to me that my lack of confidence in* [the Insurer's] *treatment of my phone as any sort of priority, let alone an urgent priority, was correct and at this point I felt I had no option but to buy a new phone myself and make a complaint about my service provider"*.

The Complainant then made a formal complaint to this Office and the Provider furnished its response in its letter to this Office dated 21 June 2017 (which is set out in the next section).

In her correspondence to this Office dated 30 June 2017, the Complainant submits, as follows:

"[The Provider's] *letter dated the 21st June, 2017 provides an utterly incomplete timeline of events in relation to the issues raised in my complaint and is self-serving in the events that have been included …*

Given the factual background…I must say I find it quite offensive that it is being suggested [by the Provider] *that I "never returned the handset to* [the Insurer] *for the faults to be verified"*.

I am also offended by the [Provider] *suggestion that insurance payments were "missed" by me…One of the primary reasons that I made this complaint was that I had requested cancellation of my policy on numerous occasions and my requests were being absolutely ignored …*

At no point did [the Insurer or the Provider] *acknowledge my formal requests for my insurance to be cancelled. My requests were blatantly ignored and money continued to be deducted from my account. In both* [Provider] *letters to me dated the 10th January, 2017, and…the 21st June, 2017,* [the Provider] *makes no reference whatsoever to the issues of cancellation and wrongful deduction of money. It is perhaps one thing for a party to a dispute to respond ignoring an aspect of a complaint to which they may have no meaningful response but* [the Provider] *goes a step further than this and suggests that the contract was only cancelled because I "missed" two payments. In fact, notwithstanding that I had requested cancellation in accordance with the terms of my policy, I did not stop my direct debit. I was furiously trying to engage with* [the Insurer] *at this time …*

While I remain irked by numerous small matters, including the fact that it is again suggested that I gave the wrong delivery address notwithstanding that my claim

/Cont'd…

form shows otherwise and the fact that I was never refunded my full excess payment, my two principal outstanding issues are:

1. *I was given a faulty phone by* [the Insurer] *and when they failed to collect and repair/replace it, I had to purchase a new iPhone;*

2. *They ignored my request to cancel my insurance and wrongfully deducted money from my account for many months thereafter"*.

In this regard, the Complainant seeks *"either the cost of a replacement phone or a replacement phone itself (and once I have inspected it and am satisfied it functions properly, I will of course give* [the Insurer] *back its faulty phone. I also want all insurance premiums paid since I requested the cancellation of my contract to be returned to me"*. The monthly premium was €13.99.

The Complainant's complaint is that the Provider provided her with poor customer service throughout her mobile phone insurance claim and its handling of her subsequent complaint.

The Provider's Case

The Provider says that the Complainant incepted a mobile phone insurance policy with an Insurer on 1 November 2015, a policy underwritten by the Provider.

The Complainant submitted a claim to the Insurer on 21 September 2016, as she had dropped her mobile phone on some stones on 18 September 2016, shattering the screen. The relevant documents were requested to authorise her claim and the policy excess of €75 was taken. The claim was accepted and a collection was booked for the handset with the courier, but the wrong address had been supplied. The Complainant contacted the Insurer on 7 October 2016 and provided her correct details. A new collection was booked with the courier on 11 October 2016.

The Complainant contacted the Insurer on 20 October 2016 to enquire as to the delay in receiving the repaired handset back, and it confirmed that the handset was currently with a technician and that the repair centre was experiencing IT problems, which had caused a delay. The technician could not repair the Complainant's mobile phone and a replacement was due to be received by the Insurer for onwards transmission on 28 October 2016. As nothing had been received, the Complainant emailed the Insurer on 2 November 2016 demanding the immediate return of her handset. The Insurer confirmed that the replacement handset was being delivered that day by the courier and provided her with the tracking number of the parcel.

The complaint had still not been resolved and the Insurer sent an email to the Complainant outlining the terms and conditions in relation to the premiums being non-refundable, but the Insurer confirmed that it would refund the extra €2.18 that had been taken when the excess payment had been processed. The Complainant later advised that she had received a refund of €2 and that the 18 cents had not been included, and that the replacement handset she had received was also faulty. The Insurer apologised and confirmed that the

/Cont'd…

Complainant could return the replacement handset to the repairers, who would inspect the device on an urgent basis. The Provider notes that the Complainant has since retained the handset and not returned it to the repairer. As the Insurer could not resolve the Complainant's complaint, it forwarded the matter to the Provider as the underwriters for an independent review.

After reviewing the claim file, the Provider wrote to the Complainant on 10 January 2017 to apologise that the claim had taken longer to settle than it would expect and that it appreciated the frustration that this had caused her. To apologise for the length of time that her claim had been ongoing the Provider requested the Insurer to reimburse the Complainant the €75 policy excess and the 18 cents that was previously missed. In this regard, it appears that the Insurer had processed the policy excess transaction in Sterling, which would then take more in the Euro equivalent. The Provider noted that the policy terms and conditions clearly state that premiums are non-refundable and it could not therefore agree to refund the Complainant the premiums she has paid.

The Provider also noted in its correspondence to the Complainant dated 10 January 2017 that in her emails to the Insurer she had requested €50 to cover the cost of the calls that she made to the Insurer in relation to her claim. Whilst consequential losses are not covered by her policy, the Provider advised that it would be happy to reimburse the actual charges incurred and requested that the Complainant forward to the Insurer an itemised bill showing the charges that the Insurer's number had incurred and it would refund this amount to her. In this regard, a cheque in the amount of €37.64 was later sent to the Complainant on 7 February 2017 in respect of the calls she had made to the Insurer, as detailed on the itemised bill she provided. The Provider notes that the Insurer apologised for the time that the Complainant had spent on the telephone and confirmed that it has since taken on more staff to be able to deal with calls in a timely manner.
The Provider understands that the replacement mobile phone that issued to the Complainant has faults, and in its correspondence to the Complainant dated 10 January 2017 noted that the Insurer had confirmed that it could arrange collection of this device and once its repairers had confirmed the faults it would either repair or replace the handset. In this regard, replacement devices are supplied with a 90-day warranty but without the faults being confirmed, the Insurer cannot issue a further replacement device. The Provider noted in its correspondence to this Office dated 21 June 2017 that the Complainant had not returned the handset to the Insurer for the faults to be verified.

Finally, the Provider noted the Complainant's policy had been cancelled on 11 May 2017 as two payments had been missed and the direct debit mandate was no longer in place.

Decision

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

/Cont'd…

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

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

A Preliminary Decision was issued to the parties 7 November 2018, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

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

The complaint at hand is that the Company provided the Complainant with poor customer service throughout her mobile phone insurance claim and its handling of her subsequent complaint.

The Complainant incepted a mobile phone insurance policy with an Insurer on 1 November 2015. This policy was underwritten by the Provider. The Complainant dropped her handset on 18 September 2016, shattering the screen and she submitted a claim to the Insurer in respect of same. The history of the Complainant's claim has already been set out in great detail. In summary, the Complainant complains that there were delays and errors in having her claim assessed, in having her handset collected and replaced and of faults to the replacement handset, as well as incorrect monies firstly deducted and then refunded to her, in addition to the failure of the Insurer and the Provider to cancel her policy when requested. The Insurer forwarded the Complainant's complaint to the Provider, as the underwriters of her policy, for an independent review and the Complainant complains that the Provider itself failed to appropriately address her complaint.

Having considered the documentation before me, I note that there are errors contained in the Provider response to the Complainant's complaint and, in addition, that the Provider also failed to address specific elements of her complaint, despite this Office having provided it with the opportunity to do so.

For example, the Provider states in its correspondence to the Complainant dated 10 January 2017 that *"You made a claim on 28th September 2016"*, yet in its later correspondence to this Office dated 21 June 2017 the Provider states, *"On 21st September 2016, a completed claim form was received from the Complainant"*. However, I am satisfied from the documentation provided by the Provider itself that neither of these dates are correct as the

/Cont'd…

Complainant submitted a claim online to the Insurer via its website on 19 September 2016 at 5.03pm.

In addition, I note from the documentation supplied by the Provider itself that the Complainant provided a Dublin address when submitting her claim online. It was therefore incorrect for the Provider to advise the Complainant in its correspondence to her dated 10 January 2017 that *"the wrong address was supplied"*. Similarly, the Provider was incorrect when it advised this Office in its correspondence dated 21 June 2017 that *"the wrong address had been supplier* (sic)*"*.

Instead, it would appear to me that the Insurer booked the courier in the first instance to collect the handset at the address detailed on the proof of purchase dated 1 November 2015 that the Complainant emailed to the Insurer on 28 September 2016, that is, a previous address in Cork, when it should have booked the courier to call at the then current address that the Complainant had instead provided on the claim form she submitted to the Insurer on 19 September 2016. Whilst administrative errors of this nature can and do occur, I consider that the Provider has failed to acknowledge responsibility for this error or apologise for it.

It is also clear to me that the Provider failed to address or adequately address specific central elements of the Complainant's complaint. For example, in her letter to the Insurer dated 26 October 2016, the Complainant requested, *inter alia*, as follows:

> *"Cancel my contract with* [the Insurer] *with immediate effect and confirm that you have done so and that no further insurance premia will be deducted from my account"*.

In addition, in her letter to the Insurer dated 24 November 2016, the Complainant wrote, as follows:

> *"…at no point has it been confirmed to me that my contract has been cancelled and in fact, on checking my bank statement, I can see that premia have been deducted since my formal requested"*.

The Provider, however, advises in its correspondence dated 21 June 2017 that *"The decision not to refund the policy premiums was maintained as per the terms and conditions of the policy"*. In this regard, in its previous letter to the Complainant dated 10 January 2017, the Provider advised the Complainant that the 'Conditions' section of the applicable Policy Document provides, *inter alia*, as follows:

> *"4. Cover under this insurance policy is subject to the payment of the premium which must be up to date and are non-refundable after the insurance cover has commenced other than during the cooling off period"*.

However, I note that the 'Conditions' section of the applicable Policy Document also provides, *inter alia*, as follows:

/Cont'd…

> *"6. Monthly Policies: Each party is entitled to cancel the insurance at any time giving not less than 30 days notice to the other in writing"*.

In this regard, I am satisfied that in her correspondence dated 26 October 2016 the Complainant gave clear written instruction that she wanted her policy cancelled with immediate effect, as follows:

> *"Cancel my contract with* [the Insurer] *with immediate effect and confirm that you have done so and that no further insurance premia will be deducted from my account"*.

The Provider has failed to address this element of the Complainant's complaint and instead advised in its correspondence to this Office dated 21 June 2017 that the Complainant's policy *"was cancelled on 11th May 2017 as two payments has been missed and the direct debit mandate was no longer in place"*. One can well appreciate the Complainant's frustration in that regard

Furthermore, the Provider also advised in its correspondence to this Office dated 21 June 2017 that *"the €75.00 excess was refunded, and the 18 cents that had been missed off the previous refund"*. I note from the documentary evidence before me that the Insurer had previously emailed the Complainant on 13 January 2017 to advise that the sum of €76 had been refunded. The Complainant, however, emailed the Insurer on 1 February 2017 advising that the sum of €71.68 had been refunded, and not the sum of €76. In this regard, the Provider has also failed to address this element of the Complainant's complaint. I also consider that this indicates that in preparing its correspondence to this Office dated 21 June 2017, that the Provider did not verify that the actions which it had directed the Insurer to carry out in January 2017 (to remedy the Complainant's complaint) had been carried out in full or correctly.

Having examined the documentary evidence before me in full, I am satisfied that by providing incorrect information and in failing to address central elements of her complaint, that the Provider did not assess the Complainant's complaint thoroughly and appropriately when the Insurer forwarded the file to the Provider and that this, in and of itself, constitutes poor customer service, as a result of which it failed to fully appreciate the correct history of the Complainant's claim. In this regard, a policyholder should expect that a complaint made to a Provider will be investigated thoroughly, with any errors and omissions made, identified, apologised for and appropriately redressed.

As a result of this poor customer service, I direct that the Provider pay the Complainant a compensatory payment in the amount of €900 to an account of her choosing. I also direct that the Provider ensure that all records relating to the termination of the Complainant's policy are corrected, to reflect the fact that the Complainant requested a voluntary cancellation of the policy.

It is my Preliminary Decision therefore, on the evidence before me, that this complaint is upheld.

/Cont'd…

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is upheld on the grounds prescribed in ***Section 60(2)(g)***

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainant in the sum of €900, to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the Provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

- The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

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

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION
AND LEGAL SERVICES

3 December 2018

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

(a) ensures that—
(i) a complainant shall not be identified by name, address or otherwise,
(ii) a provider shall not be identified by name or address,
and
(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.