An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0187
Sector:	Insurance
Product / Service:	Other
Conduct(s) complained of:	Premium rate increases
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant Company is a small business which operates a visitor centre which includes a children's playground, a café and indoor play area.

In May 2016, the Complainant Company purchased a Business Insurance Policy underwritten by the Provider, for an annual premium of €4,708.02 for the insurance period 11 May 2016 to 10 May 2017.

Following an incident at the Complainant Company's premises in June 2016, the Provider was notified of a third party claim against the Complainant Company's public liability insurance in August 2016.

In March 2017, the Complainant Company notified the Provider of an incident at its business premises involving alleged injuries to a minor.

At renewal of the policy in May 2017, the Provider increased the policy premium to €11,762.17.

The complaint is that the Provider wrongly and unfairly applied a significant increase to the Complainant Company's annual insurance premium at renewal of the policy in May 2017, in circumstances where the Complainant Company contends that the two incidents which had been notified under the policy had not proceeded and remained "open".

The Complainant Company states that the Provider's actions in this regard have affected its small business "*exceedingly negatively*".
The Complainant Company wants its premium to be restored to its previous 2016 level, and to be refunded the difference charged at renewal in 2017.

The Complainant Company's Case

The Complainant Company submits that, on the basis of a competitive insurance premium of €4,708.02, it made the decision in May 2016 to take out a Business Insurance Policy underwritten by the Provider.

The Complainant Company states that, at renewal of the policy in May 2017, the Provider increased the policy premium from €4,708.02 to €11,762.17 (an increase of €7,054.15).

The Complainant Company disputes the Provider's actions in this regard stating that, at the date of renewal of the policy, neither of the public liability incidents notified to the Provider during the previous 12 month period had proceeded and that, accordingly, neither incident should have been recorded as a "claim" against the policy, impacting on the policy premium at renewal.

In respect of the first incident, in June 2016, which led to a third party claim against the policy and involved an alleged accident on a slide, the Complainant Company submits that "*engineers from claimant and* [the Provider] *assessed the claim and deemed it invalid with no negligence*" and found that the Complainant Company's "*safety standards and procedures were watertight*". The Complainant Company contends that there was no need for the Provider to keep a reserve in place in respect of this claim, and submits that this claim should have been removed from the Complainant Company's records.

In respect of the second incident, in March 2017, the Complainant Company submits that this incident was reported to the Provider as it involved a child who was taken to hospital from the Complainant Company's business premises in an ambulance, following an accident in which he allegedly received a bump to the head. The Complainant Company states that the child was discharged from hospital soon afterwards, "*in full health*", and has been a return visitor to the business since. The Complainant Company states that no claim against the policy ensued in this instance.

The Complainant Company submits that its circumstances have not changed, despite these incidents, and that its insurance premium should remain unchanged. It is the Complainant Company's position that any issues faced by the Provider in "*tackling issues due to high claim costs should not be unfairly reflected in the price of our premium. Our standards are extremely high. Our risk has not increased in any way.*"

The Complainant Company requests that its premium be reviewed by the Provider and restored to the level quoted in May 2016, €4,708.02, with an appropriate refund of the difference paid.

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The Provider's Case

The Provider states that the Complainant Company's Business Insurance Policy was incepted and put in place on 11 May 2016, for a premium based on the Complainant Company's insurance requirements and 3 year claims free insurance history at that time.

The Provider states that it subsequently received notification of two possible public liability claims arising during the insurance period 11 May 2016 to 10 May 2017.

The Provider states that one incident is reported as having occurred at the Complainant Company's premises on 2 June 2016. The Provider submits that it received a letter dated 18 July 2016 from the solicitor appointed to represent the third party claimant in respect of this incident.

The Provider submits that the second incident is reported as having occurred at the Complainant Company's premises on 26 March 2017, involving a minor who was ten years of age at the time.

The Provider states that both claims remained "*open*" at date of policy renewal in May 2017, with no settlements paid, and estimated reserves in place. The Provider states that, in respect of the first incident, it remained open to the third party claimant to pursue the claim up to two years post incident. In respect of the second incident, the Provider states that the minor concerned has up to two years after becoming an adult within which to submit a claim. The Provider states that, for these reasons, both incidents remained potential claims at renewal in May 2017 which required to be noted on the policy claim history.

The Provider submits that the premium of €11,762.17, applied to the Complainant Company's invitation to renew in May 2017, is justifiable. The Provider states that "*a combination of the current rates applicable for the various risks contained within the policy and the level of public liability exposure has resulted in the increased premium".*

The Provider states that, in recognition of the Complainant Company's custom with the Provider, a discretionary discount of €1,062.17 was offered to the Complainant Company, bringing the premium payable to €10,700, and that the policy was renewed on this basis.

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 Company was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

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

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

A Preliminary Decision was issued to the parties on 11 September 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.

This complaint arises from a premium increase applied by the Provider to the Complainant Company's Business Insurance Policy, at renewal in May 2017.

The complaint is that the Provider wrongly and unfairly increased the Complainant Company's annual insurance premium from €4,708.02 to €11,762.17 (an increase of €7,054.15) at renewal of the policy in May 2017, in circumstances where two incidents of alleged third party injury occurring at the Complainant Company's premises during the previous insurance year, and notified as potential claims to the Provider, had not proceeded and remained "open" at date of renewal.

The Complainant Company disputes the Provider's position that two potential claims, which had not proceeded against the policy when it was renewed in May 2017, should continue to be recorded on its claims history, and have such a significant impact on the renewal premium.

The Complainant Company requests that its premium be reviewed by the Provider and restored to the level quoted in May 2016, €4,708.02, with an appropriate refund of the difference paid.

From a review of the Complainant Company's policy documentation, I note that it is a condition of the Complainant Company's Business Insurance Policy (at page 5), in respect of claims, that:

> "*on the discovery of any circumstance or event which may give rise to a claim under this policy, the insured shall do the following: (i) Notify the Company immediately, either in writing or by telephone*".

The insured is required to notify the Provider, and the Provider is entitled to be notified by the insured, of ANY incident that MAY give rise to a claim.

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The submissions show that the Provider was notified of two such incidents occurring at the Complainant Company's premises during the insurance period 11 May 2016 to 10 May 2017. Thereafter it is evident that the Provider carried out an investigation into indemnity and liability in respect of each separate incident, and determined how best to progress each notification. In this context, the Provider has submitted a copy of its full claims file in respect of each notification, including all correspondence and communications in this regard, and copies of all liability investigation and engineering reports.

I note that, in the case of the incident occurring on 2 June 2016, the Provider received a letter dated 18 July 2016 from a solicitor appointed to represent the third party claimant. The Provider has indicated that it placed an initial estimated reserve on this claim of a certain sum, plus costs. Although no settlement had been paid in respect of this claim at renewal in May 2017, and indeed it was the stated belief of the Complainant Company that this claim would not proceed, it was recorded by the Provider as an "open" claim on the policy.

In circumstances where the statutory time limits for a claim of this nature did not expire until June 2018, and there continued to be a possibility that the third party would pursue a claim against the policy for injuries sustained, I accept that this incident remained a potential claim at renewal in May 2017 which required to be noted on the policy claims history, and which the Provider was entitled to take into account in offering renewal terms.

Indeed, I note that the third party in this instance did subsequently pursue the claim against the Complainant Company's policy. Correspondence submitted by the Provider indicates that the Provider wrote to the Complainant Company on 16 November 2017, to advise that it had not heard from the claimant's solicitors in almost a year and that it was closing its file of papers on the matter. The Provider warned the Complainant Company, in that letter, that "*there is however still a risk that the third party could pursue a claim and she has up to 2 June 2018 to do so*". Some three months later, on 14 February 2018, the Provider wrote to the Complainant Company again to advise that the third party claimant had applied to the Personal Injuries Assessment Board seeking compensation for personal injuries allegedly suffered as a result of the incident at the Complainant Company's premises on 2 June 2016. The Provider informed the Complainant Company that "*in the circumstances, it has therefore been necessary for us to re-open the claim"* and advised that it continued "*to be of the view that this claim should be fully defended".*

In a letter to this office dated 8 March 2018, the Provider advised that, based on the information it had received at that date, the estimated reserve for the claim had been increased.

In the case of the second incident, occurring at the Complainant Company's premises on 26 March 2017, I note that the Complainant Company itself notified the Provider on 27 March 2017 of alleged injuries sustained by a child while on a visit to its business premises.

The Provider has advised that, while no formal claim had been made against the policy in respect of this incident at date of policy renewal in May 2017, the incident was still recent

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and needed to remain open for monitoring for a period of time. The Provider advised the Complainant Company, in a letter dated 23 June 2017, that the third party claimant was a 10 year old minor, and that the minor had a period of up to two years after becoming an adult within which to make a formal claim.

The Provider states that it placed an estimated reserve on this potential claim, plus costs, and advised the Complainant Company, in its letter dated 23 June 2017, that it would continue to review the incident on an ongoing basis, and determine with the passage of time whether to keep the claim open, and/or to reduce the reserve.

In circumstances where this incident involved alleged injuries to a minor, a relatively short period of time before the renewal of the policy, and in circumstances where the minor had a period of up to two years after reaching 18 years of age within which to make a formal claim, I accept that this incident remained a potential claim at renewal in May 2017 which required to be noted on the policy claims history. I also accept that the Provider was entitled to take this potential claim into account in offering renewal terms.
There is no doubt that the two incidents, occurring in June 2016 and March 2017 respectively, had an impact on the Complainant Company's premium quotation at renewal in May 2017. In this context, the Provider has submitted as follows:

> *"Insurance rates change on an ongoing basis…The various changes in rates is again as a result of a number of factors including, but not limited to, rising claims costs, contributed to by excessive and inconsistent legal awards and very high legal costs associated with injury claims in Ireland. Premiums offered are based on projected costs of future claims for each risk category. The premium issued to a customer reflects the premium that* [the Provider] *considers appropriate to that risk at that time".*

It is the Provider's position that the premium of €11,762.17, applied to the Complainant Company's invitation to renew in May 2017, was justifiable. The Provider states that "*a combination of the current rates applicable for the various risks contained within the policy and the level of public liability exposure has resulted in the increased premium".*

Insurance premiums are priced based on a number of factors including, but not limited to, the prevailing rates applicable for the various risks contained within the policy, the level of cover the policy offers, the overall claim history of the risk type, including both the market and the individual policy, and the level of public liability exposure.

Insurance companies and underwriters are entitled to set their own level of premium based on their assessment of the risk they have agreed to accept as part of an insurance contract. Further, there is no obligation on a financial service provider to disclose the specific evaluations/calculations they use in making their commercial decision in this regard. These practices are in line with Council Directive 92/49/EEC which safeguards a free, competitive market for insurance premiums.

It is ultimately up to the customer to decide if the premium level is acceptable, in return for the cover offered. It is of course also open to the customer, if unhappy with the level

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of premium offered, to shop around for more acceptable terms. However, I acknowledge that pending claims may have a bearing on any alternative premium offered.

Having considered the circumstances of this complaint, I accept that the two open claims recorded on the Complainant Company's claims history at the end of the insurance period 11 May 2016 to 10 May 2017 caused considerable aggravation to the Complainant Company, as a small business. I also accept that these open claims had a considerable impact on the renewal premium offered to the Complainant Company at renewal in May 2017.

However, I consider that the Provider was entitled to record the two incidents as "open" claims on the Complainant Company's claims history at renewal in May 2017, in circumstances where both incidents remained unsettled potential claims against the policy at the end of the period of insurance. I also accept that the Provider was entitled to take into account at renewal the level of potential public liability exposure consequential on two open claims against the policy, in its assessment of the risk and the pricing of the renewal premium offered. An insurance company is entitled to set the level of premium for any risk or risks it has agreed to accept. It is not the role of this office to interfere with the exercise by the Provider of its commercial discretion in this regard.
For these reasons, I do not uphold this complaint.

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Conclusion

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

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

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

10 October 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.