Decision Ref:	2018-0211
Sector:	Insurance
Product / Service:	Household Contents
Conduct(s) complained of:	Dissatisfaction with customer service Delayed or inadequate communication
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants' complaint relates to the automatic renewal of their household insurance.

The Complainants' Case

The Complainants purchased household insurance in June 2015 "*for 1 year*". The Complainants state that they had no intention of renewing the policy but that, on the 1st of July 2016, the Complainants received notification that the policy had been renewed. The First-named Complainant states that subsequently he found an email from the Provider dated the 3rd of June 2016 in his spam folder which referred to an automatic renewal in the absence of instructions to the contrary being given to the Provider prior to the 30th of June 2016.

The First-named Complainant states that he immediately contacted the Provider on the 1st of July 2016 and was advised that the Provider "*had only started the automatic roll-over process in the last few months*" and that, because of this, the procedure "*would not have been mentioned on previous documents from 2015*". The First-named Complainant states that he made a formal complaint in response to which he was promised the return of his premium, however he states that, as of the date of his original complaint to this office he had yet to receive the refund. The First-named Complainant states that the Provider also claimed to have sent him an sms (in addition to the email) notifying him of the automatic renewal but he disputes receiving this. The First-named Complainant also contends that the Provider has not been "*polite*" in dealing with him.

The complaint is that the Provider has inappropriately renewed the Complainants' insurance policy.

The Complainants seek that the Provider reimburse the First-named Complainant in respect of the premium taken from his bank account in the amount of €51.94. The Complainant also seeks various apologies and acknowledgements on the part of the Provider as well as compensation for "*time spent and ill-treatment*" in the amount of €250.00.

The Provider's Case

The Provider accepts that the policy was automatically renewed. The Provider states that it emailed the Complainant on 03/06/2016 to advise that this would take place unless the Complainant directed otherwise. The Provider also states that it sent an sms on 20/06/2016 to the same effect but that, on subsequent enquiries made with the telephone service Provider on 26/06/2016, it was discovered that the sms had not in fact delivered.

The Provider states that it made a full refund to the Complainant on 25/07/2016 and confirmed the reference for the credit transfer to the Complainant on the following day. In relation to the sms matter, the Provider offered €25 "*by way of apology*" however the Provider has stated that "*during investigating this matter, we discovered that, im* (sic) *error, the €25.00 gesture was in fact not issued to the client*".

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

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

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

A Preliminary Decision was issued to the parties on 21 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

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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, I set out below my final determination.

Analysis

This complaint relates to the process of renewing an insurance policy automatically in the absence of an express instruction to that effect. In this case, the Complainant immediately took issue with the process and contacted the Provider. On the day that the complaint was first made, the Provider offered to cancel the policy. Thereafter, two days following an instruction was provided by the Complainant to cancel the policy, the Provider cancelled the policy and committed to return any premium that may have been paid.

The Provider responded to the First-named Complainant's initial communication on 01/07/2016 by way of email of the same date setting out the following:

> *If you do not wish to renew your policy with us please let me know by return email and it* (sic) *can arrange to lapse it from 30/06/2016?*
>
> *I await your response.*

The Complainant provided a response formally cancelling the renewal of the policy by email of 16/07/2016 advising of his intention to make a complaint which was interpreted (correctly in my view) as a request to cancel the policy. In this email he communicated (indirectly) his request to cancel the policy by seeking the return of his premium on and this was actioned on 18/07/2016 effective from 30/06/2016. A commitment was also given to return any premium charged once confirmation was secured that the money had indeed been debited from the Complainant's account. Thereafter, the Provider issued a full refund to the Complainant on 25/07/2016 and provided the reference for the credit transfer to the Complainant on the following day. It would seem that the Complainant may have made his complaint to this office before the funds had reappeared in his account.

As the Provider had already refunded the premium before the Complainants made their complaint to this office albeit, that the funds may not have been received by the Complainants for a further short period, I do not intend to make any direction in relation to this aspect of the complaint.

The Complainants make repeated reference to 'legal notice' as being 'postal notice'. In this regard, they appear to be conflating the default rules for serving court proceedings with notices in general. There is no legal notice requirement stipulating any specific manner of service of insurance documents. The Consumer Protection Code, for example, makes repeated reference to the provision of documentation by way of "*durable medium*" which is defined in such a way as to include email and indeed email notification satisfies Statutory Instrument 74/2007 Non-Life Insurance (Provision of Information) (Renewal of Policy of Insurance) Regulations 2007. In most cases, the fact of receipt of material will

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satisfy notice requirements and, in this case, the Complainants concede that they received the email of 03/06/2016 albeit that same went unread in a spam folder. The fact that the Provider and the Complainant communicated for several years, including in relation to this complaint, by the particular email address is also relevant.

The second part of the complaint addresses the manner in which the Provider engaged with the Complainants throughout the process. The Complainants argue that the Provider has been rude, contemptuous and underhand. I have reviewed all the written correspondence on file in addition to which I have listened to recordings of a phone call. I do not agree that these communications demonstrate the objectionable behaviour alleged by the Complainants.

The First-named Complainant, in the third of his emails of the 26th of July seems to identify a particular letter which upset him:

> *"I was prepared to let my grievance pass upon receiving my refund. However, your letter sent by post to me aggrieved me.*
>
> *The tone of the letter, inaccuracies i.e. sms message being received and general contempt for my right to form an opinion on what I deem to be a failing in your processes.*
>
> *This is not how to treat a customer who has been with you for so many years".*

This is reference to the Provider's letter of the 21st of July 2016. I have reproduced the content of this letter below:

> *"Dear [Complainant],*
>
> *I refer to the above policy and to your recent complaint, which we received by email on 15 July 2016. Customer service is a priority in our business and we welcome all feedback and comments.*
>
> *I have now had the opportunity to investigate the matters raised in your complaint.*
>
> *On 03 June 2016 we sent a renewal invitation to you by email [Complainant's email address] confirming a renewal date of 30 June 2016 and a renewal price of €234.25 inclusive of a €35.00 non-refundable renewal fee. On the first page of the renewal invitation we clearly stated:*
>
>> *'If you wish to renew your insurance and pay by instalments you don't need to do anything. We'll take care of it for you' AND 'if you do not wish to renew, you must contact us before 30 June 2016 to stop the first payment'.*
>
> *We sent an SMS text message to you to [Complainant's mobile number] on 20 June 2016 confirming that we sent a renewal invitation to you and again confirmation that you do not need to do anything to renew your policy and pay by direct debit.*

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We confirmed that if you had any queries you should contact us by telephone [Provider phone number].

As we did not hear from you, your policy automatically renewed and we sent a renewed pack to you by email to [Complainant's email] on 01 July 2016.

We received a number of emails from you between 01 July 2016 and 15 July 2016 in relation to the renewal of your policy and on 15 July 2016 you expressed your dissatisfaction with your policy automatically renewing.

On 18 July 2016 we received an email from you in which you asked that we cancel your policy with effect from 30 June 2016 and issue a full refund to you.

We regret to hear that you are dissatisfied with your policy automatically renewing. However, we issued a renewal invitation and SMS text message to you to advise you that this was our process and we did not hear back from you. I can confirm that your policy has been cancelled with effect from 30 June 2016 and you will receive a full refund in the next 3-5 working days.

We do hope this resolves the matter satisfactorily for you, however if you are not satisfied with our response, you may refer this matter to the Financial Services Ombudsman's Bureau [contact details of FSOB provided].

While I would not take issue with the "*tone*" of this letter as the Complainant has done, I do believe the Provider should have more properly investigated the Complainants' complaint before issuing this response.

In particular, it is most disappointing that the Provider did not investigate the Complainant's complaint that he did not in fact receive the sms that the Provider claims to have sent him. Rather, the Provider continued to rely on the sending of this sms as a basis for automatically renewing the policy.

Furthermore, I note in the Schedule of Evidence supplied by the Provider to this Office, at Item 3 – a timeline of events in relation to the specific issues raised in the complaint, the Provider includes the sending of the sms without identifying that the sms did not in fact deliver to the Complainant.

Notwithstanding that the Provider returned the premium promptly when the policy was cancelled by the Complainant, I believe the manner in which the policy was renewed could have been handled and communicated better.

While there can be significant benefits to automatic renewal of insurance policies, it is my view that there should be no surprises in relation to such matters.

Therefore, I believe a consumer should either be informed clearly when taking a policy that automatic renewal is a feature and be given the opportunity to either accept or not accept such a feature.

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Where it is intended to introduce automatic renewal within an existing contract of insurance, I believe greater and clearer communication than was evident in relation to the Complainants is required.

The Provider relied on an email that appears to have gone into the Complainant's spam and an sms that did not deliver. I believe it would have been prudent for the Provider to have sought some form of confirmation that the Complainant had received the correspondence and wished to have the policy automatically renewed.

I note that the Provider has previously offered €25 as a 'gesture' in light of its mistake as to the delivery of the sms message. The Provider has however identified that, by reason of oversight, this payment was not made.

For the reasons set out above, including the poor communication in relation to the renewal of the Complainants' insurance policy and the further failings in relation to the investigation of this complaint, I uphold this complaint and direct the Provider to pay a sum of €250 to the Complainants for the inconvenience caused. For the avoidance of doubt, the payment of €250 includes the €25 which the Provider has previously offered to the Complainants.

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) (b) and (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 Complainants in the sum of €250 (to include the €25 already offered by the Provider to the Complainants), to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants 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.***

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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

14 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.