An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0102
Sector:	Insurance
Product / Service:	Car
Conduct(s) complained of:	Lapse/cancellation of policy Delayed or inadequate communication Dissatisfaction with customer service Maladministration
Outcome:	Upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint relates to the conduct of the Provider (a broker) which resulted in the Complainant's car insurance policy being cancelled.

The Complainant's Case

The Complainant held a motor insurance policy with a third party insurance company (the underwriter). The Complainant maintains that the underwriter cancelled this policy owing to his alleged failure to submit requested documentation to the Provider prior to a deadline. The Complainant disputes that he failed to furnish the required material. In particular, the Complainant refers to an email which he states he sent on the 31st of July 2017 'forwarding' an email from the Complainant's previous insurance company confirming the Complainant's 'no claims bonus' position. In support of this, the Complainant has provided a screen-grab picture of his email account which shows a record of an email sent via android from his account on the 31st of July 2017 to the Provider's email address attaching a .pdf file.

The Complainant stated as follows:

"[Underwriter] cancelled my Insurance policy for an unacceptable reason and vain excuse that I did not submit the documents they requested before the deadline which was not true. I had called [Provider] for a quote and followed through until my policy was set up and first Installment was made.

Subsequently, I was asked to produce my no claim bonus from [third party] which I immediately requested from [third party] who furnished me with the document by email which was forwarded to [Provider's] Office by email along with other scanned documents. This was acknowledged by the [Provider's] agent. After this, I received another letter stating that the original no claim bonus from [third party] is required and that they needed a signed copy of the original initially sent by email to be sent by post which I did along with copies of the documents from [other country] available in addition to the declaration of none [sic] insurance since the last policy expired. These, I supposed were all received by [Provider]. I thought all was well until I traveled out of the Country to [other Country]. My wife also told me of the letter sent to her and her calls to [Provider's] representative in respect of her driver's licence and the no claim bonus which she attended to directly. My wife called me on 31st of July, 2017 while in [other Country] to inform that our policy with [Underwriter] would be cancelled if the original email from [third party] was not forwarded as [Provider] requires that the email be forwarded directly as received. I had already printed and sent a copy to [Provider] before I traveled out of the Country as well as the declaration which my wife was aware of. She insisted that [Provider] wanted the original email of no claim bonus from [third party] to be forwarded as originally received otherwise the policy will be cancelled. She also texted me the email she had received over the phone from the [Provider] representative who spoke with her and that I was supposed to forward the original email to the [email] address given. I quickly forwarded the email to the [Provider] email address stated above from my [other] email address from which I originally received it from [third party].

A copy of this email is still in my sent items as evidence dated 31st July, 2017. I returned from [other Country] on the 10th of August to receive a text message that my policy was already cancelled. I thought it wise to resend the scanned documents to the initial email I had corresponded with [Provider] just to check if they would respond but no response. Then we started calling time and again and waiting in line to get to speak with a representative which is usually on hold. After many days of trying, we were able to get through to a representative (S.) who could not satisfy us with his vague explanations. We requested to speak with a supervisor who said and insisted that nothing could do about it and that it will remain cancelled for the fact the we did [not] email the Original document as required. We tried to explain to him that we had sent the email and have our evidence but he insisted that it will remain so. So, we decided to lay a formal complaint which did not produce the expected result. So we decided to take it up [with the FSPO] as advised in the letter from [Provider] dated 29th September, 2017.

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> Furthermore, we would like to inform that after the claim to have cancelled my policy on 9th of August, I noticed that my direct debit was still being charged and as of 2nd of October, 2017 my statement reflects that [Provider] still debits my account".

When asked what he wants the Provider to do to put things right, the Complainant states:

> "We want thorough investigations to be carried out to reveal the truth on this matter and if they did not receive the email send on 31st July, 2017 to [e-mail address] as instructed and to investigate all the evidences involved. I shall demand a monetary compensation for the psychological distress and the representation damage caused in addition to a formal apology should [Provider] be found at fault which is most likely".

The Provider's Case

The Provider's initial response was as follows.

The Provider maintained that the Complainant sought a quote for motor insurance on the 26th of June 2017. The Provider states that during this call the Complainant was advised that he would need to send his EU driving licence to the Provider by registered post and this was duly received on the 28th of June 2017. The Provider did not inform the Complainant on this call that the original no claims bonus and gap in cover letter were required. In a follow-up call, the Provider advised the Complainant that it would also need an original 'no claims bonus' document. The Complainant duly provided certain documentation by email on the 4th of July 2017. The Provider maintains that, though it would normally require an original 'no claims bonus' document before cover can begin, it agreed in this case to commence cover and the Complainant was allowed to furnish the original 'no claims bonus' document, together with a 'gap in cover' letter, at a later point.

The Complainant e-mailed a copy of his no claims bonus and gap in cover letter to the Provider on 4 July 2017. However, this e-mail did not contain the original e-mail from the Complainant's previous insurer so the Provider contacted the Complainant and asked that the original e-mail from the previous insurer be furnished.

The Provider states that it sent reminders on the 11th and 18th of July 2017 and, in the absence of any reply, the underwriter sent a registered cancellation letter on the 27th of July 2017 threatening that if the original no claims bonus discount was not received "*your cover under this policy will end at midnight on the 9th of August 2017".* The Provider states that it received the documentation via email on the 11th of August.

Subsequent to investigations required by this office, the Provider discovered that the Complainant's email of the 31st of July 2017 was blocked by the Provider's firewall and not released until the 11th of August 2017.

The Provider states as follows regarding this:

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> This is deeply regrettable and I am disappointed that this was not identified at the time of the original investigation.
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> [The Provider] strive to provide a quality service to all our customers and clearly, we have fallen short of our own high standards on this occasion.

The Provider states that it has made representation to the underwriter of the policy who have agreed to amend the cancellation on the from an [sic] Provider led cancellation to an insured led cancellation". (It is stated that this will "remove the duty of disclosure from the insured".)

In addition, the Provider has offered to "*refund the charges incurred*" by the Complainant and to offer an additional amount of €100 as compensation for "*inconvenience and stress*" resulting in total compensation of €226.25. The Provider has also indicated that it will issue a formal letter of apology to the Complainant.

Decision

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

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

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

A Preliminary Decision was issued to the parties 11 March 2019, 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, I set out below my final determination.

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Analysis

Since this Office initially received this complaint, the Provider has acknowledged significant shortcomings on its behalf. Importantly, the Provider acknowledges that the Complainant did indeed email the required documentation to the Provider on the 31st of July 2017 but that this email was blocked by the Provider's firewall and not released until the 11th of August 2017. It is most unacceptable that this fact was not uncovered as part of the original investigations as acknowledged by the Provider.

The efficiency with which the underwriter cancelled the policy, with all of the serious implications this causes, is in stark contrast to the Provider's management of the complaints communications and the investigation of the complaint.

In the circumstances, I am satisfied that the Complainant's policy was cancelled by the underwriter through no fault of the Complainant who had complied with the Provider's instructions. Accordingly, the complaint is well-founded, and is essentially accepted by the Provider. I am also satisfied that the Provider demonstrated very poor communication insofar as there was a failure initially to communicate to the Complainant the need to submit the no-claims bonus documentation and the policy was cancelled with great haste and absolutely no justification.

Recordings of the numerous telephone calls between the Complainants and the Provider have been provided in evidence.

I have listened to these calls. It is clear from these calls that in the first instance the Provider was not at all clear in relation to its requirements in order to put the insurance policy in place. In fact, on the initial call the Complainant was told "*you just have to send us in your licence".* Each time either of the Complainants made this point in their various subsequent calls they were simply ignored or deflected to some other issue by the various agents who dealt with them.

It is abundantly clear from the phone calls that if any one of the Provider's agents had actually listened to what the Complainants were telling them and checked their e-mail system (as they later did) they would have found that what they were being told by the Complainants was perfectly correct.

I find both Complainants to be perfectly clear and credible in what they told this Office and what they told the Provider.

Despite this, the various agents argued with them. In particular, two agents, including team leader, tried to persuade the Complainants that they had not sent the e-mail despite the Complainants telling them repeatedly that they done exactly what they were told to do by forwarding the e-mail they had received from the previous insurance company to a designated Provider e-mail address.

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On the phone call of 31 July 2017, the Complainant was told that the policy would not be cancelled "*once we receive it [the no claims bonus] by the cancellation date on the letter [9 August 2017].*

On a lengthy phone call on 5 September 2017, after the policy had been cancelled, the Complainant offered to send in a copy of the no claims bonus again. The agent responded that "*no point in sending it to me".* Though he did go on to state "*if it's a mistake on our part we could see about getting it reinstated*".

During this call, the Provider's agent conceded that he had found the e-mail and alleged that as it didn't have a policy number the Provider had sent an e-mail back to the Complainant seeking further details.

The Complainant made the point that the name was on the no claims bonus and asked could the Provider not have accepted it or at least checked if it matched a customer on that basis.

The agent was quite argumentative when the Complainant outlined that she had been given very specific instructions by the Provider's other agent as to what to do that she had done exactly as she was instructed.

When she outlined what she said she had been told to do, the agent condescendingly suggested "*What she [the agent] probably said.*

Having listened to the calls, I note that the Complainant was correct in stating what she had been instructed to do whereas the agent who speculated what the other agent "*probably said"* and was more "*likely to have said"* was in fact wrong.

Furthermore, I have not been provided with any evidence that such an e-mail was ever sent to the Complainants. I am very concerned about the statement by the Provider's agent. The Complainants later queried this and did not receive a satisfactory response.

During the telephone call on 5 September, the Complainant asked to speak to a supervisor. None was available at that time but a team leader from the Customer Experience Team called her back later that day.

The Complainant informed the team leader that they had since "*searched through all his [the Complainant's] messages and I did not see any response from you*. *He did not receive an e-mail from you seeking the policy number. Is there any evidence that they [Provider] sent the e-mail?"*

The Complainant was rightly querying what she had been told by the previous agent earlier that day that a response had issued to their e-mail [forwarding] the no claims bonus.

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I note once again that this question was ignored and the team leader deflected the issue by informing the Complainant that the Provider had received the document on "11 August and that it was past the cancellation date".

The Complainant protested that it had been sent well before the cancellation date. The team leader reiterated that the Complainants had been sent a cancellation notice and "*nothing is going to change that*".

The argument went on with the Complainant pointing out that the e-mail was sent on 31 July 2017 at 22:24 and the team leader stating "*we did not get that e-mail on 31 July, we got it on 11 August so there is nothing I can do*".

The Complainant asked for a letter confirming that and was informed to make a formal complaint.

The Complainants followed the instructions of the Provider at every step of the process. In fact, it was precisely because the Complainants followed the exact instructions that the difficulties arose.

The Provider's agent insisted that the Complainant forward the e-mail he received directly to a designated address in the Provider. Exactly as he had received it from the previous insurance company.

The Complainant did exactly as requested by forwarding the e-mail received from the previous insurer. However, the e-mail address which the e-mail was forwarded from was different from that which the Complainant had given to the Provider in his insurance proposal.

If anyone in the Provider had made an effort to listen to either of the Complainants on the various calls, this problem would have been resolved very quickly and the policy would not have been cancelled or at worst, should have been reinstated very quickly.

I find the Provider's conduct to have been most unreasonable and totally unsympathetic and unhelpful.

It is clear to me that the Complainants have suffered very significant inconvenience, stress and hardship because of the conduct of the Provider.

My function now it to consider the question of compensation. The Provider has confirmed that the total payments made by the Complainant amounted to €413.38 and that a refund was made in the amount of €237.13. The difference is accounted for by reference to a €126.25 charge for "*time on cover*" and a €50 "*cancellation charge*". The Provider has offered to "*refund the charges incurred*" by the Complainant but it calculates this figure as €126.25 rather than €176.25. The Provider has also offered an additional €100 as compensation for "*inconvenience and stress"* resulting in total compensation of €226.25.

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I note the Provider has stated it is "*sympathetic to the situation that the complaint (sic) found himself in, following the incorrect cancellation of his motor insurance policy"*.

However, it stood by its initial offer of €226.25 and said it was not in a position to comment on the costs incurred by the Complainant. It did indicate it was willing to "*review and consider the difference in premium between the insurance offered by [it] and the new business insurance policy taken out by the Complainant from [third party insurer]*". The Provider offered to liaise with the FSPO about making a contribution towards this cost.

The cancellation of an insurance policy is a very serious matter with grave and lasting implications for a consumer. I therefore find this offer of compensation derisory and completely inadequate.

From the manner in which the Complainant's insurance policy was cancelled, the manner in which the Provider investigated the Complainants' complaint and the compensation offered, it appears to me that the Provider is unaware or indifferent to the inconvenience and hardship that the cancellation of the Complainant's insurance policy caused.

I am satisfied that the Complainant is entitled to the return of the entire €176.25. In addition, I am satisfied that the Complainant is entitled to compensation well over and above that offered by the Provider. The Complainant refers to a prolonged period during which he was unable to insure his vehicle, and which ultimately forced him to purchase a smaller car which he was able to insure at "*a higher cost*" than might have been the case but for the cancellation of the policy.

In the circumstances, I am satisfied that the Complainant is entitled to compensation that would reflect the seriousness of the situation. Accordingly, I direct the Provider to pay the Complainant the total amount of €9,000 in compensation. I note that the Provider has offered an apology letter. While I welcome this, I fail to understand why it has not yet issued. In addition to any apology the Provider may issue, I direct that a letter should issue from the Provider to the Complainant, containing an acknowledgement that the policy was cancelled owing to an internal systems failure on the part of the Provider and it should make clear that the Complainant was not responsible for the cancellation. This is directed as I am not entirely convinced that the Provider's actions in having the records of the cancellation amended from "*a Provider led cancellation to an insured led cancellation"* will obviate all future difficulties for the Complainant. In any event, such wording does not reflect what actually occurred, the Complainant did not cancel the policy.

Lastly, I note that the Provider has indicated that it has undertaken a review of its security settings and systems as a result of the failing identified in this complaint so as to avoid "*recurrence of this error*".

Accordingly, I do not make any direction pursuant to Section 60(4)(a) of the Financial Services and Pensions Ombudsman Act 2017.

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In light of the entirety of the foregoing, I uphold the complaint.

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 (e).***

Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to rectify the conduct complained of by (i) issuing a letter to the Complainant, containing an acknowledgement that the policy was cancelled owing to an internal systems failure on the part of the Provider and it should make clear that the Complainant was not responsible for the cancellation and (ii) making a compensatory payment to the Complainant in the sum of €9,000 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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

3 April 2019

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.**