An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0127
Sector:	Insurance
Product / Service:	Household Buildings
Conduct(s) complained of:	Failure to process instructions
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint relates to an allegation of mis-selling of a home insurance policy.

The Complainants' Case

The first Complainant submits that he purchased what he thought was holiday home insurance from the Provider on 09 March 2016, renewing it on 06 March 2017. The first Complainant states that when he applied for the insurance for the property, he "*stated it was for weekend and holiday use".* The first Complainant submits that he received a phone call from his main home insurance provider (a different entity to the Provider against which this complaint is made) on 21 March 2018 during which he was made aware that the policy he had for his holiday home was not a holiday home policy and was therefore "*invalid*". This was apprehended on the basis of the excess payable on the policy which was equivalent to a standard home policy (€275) and not equivalent to the excess applicable in respect of the Provider's holiday home policy (€715).

On contacting the Provider, the first Complainant states that he "*was told that a mistake was made and the agent had not rated the property correctly - what I had was a standard home insurance policy".*

The complaint is that the Provider incorrectly mis-sold home insurance instead of holiday home insurance to the Complainants for a period of two years. The Complainants want to be reimbursed in respect of the premiums paid for the insurance policy which the Complainants calculate in the total amount of €480.48.

The Provider's Case

The Provider, in its Final Response Letter, acknowledged that it had made a clerical error on 09 March 2016 and apologised to the first Complainant. However, the Provider maintains that its agent "*did enter the correct property information but he did not change the total excess payable*". The Provider thus maintains that effective cover was in place at all relevant times and that its clerical error meant simply that the policy was subject to a lower excess and to lower premiums than should have been the case. The Provider stated as follows in bold in its Final Response Letter:

> *I can confirm as this was a clerical issue on our part we would have provided full cover should any incident have arisen (covered under the policy) which would have resulted in a claim.*

With regard to the premiums paid, the Provider confirmed as follows:

> *Our records did show the property was a holiday home, but we had not applied the correct excess. As a result, the property was rated the same as if it had been your main residence. A property home* [this should presumably have read a 'holiday home'] *is rated differently to a main residence due to the property not being occupied fulltime. In our experience the longer a home remains empty, the higher the risk. As a result the premiums you paid in 2016 and 2017 would have been lower than if we had rated the property correctly.*

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

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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 29 April 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.

Analysis

The Provider acknowledges that it made a clerical or administrative error in terms of the entry of information into its system regarding the policy at the point of inception in March 2016. The Provider has given what in my view is a full and reasonable explanation for this error and has apologised to the Complainants.

In its response to this office, the Provider amplified upon matters previously addressed in its Final Response Letter to the Complainants with regard to the cost of premiums. Specifically, the Provider has calculated that the Complainants were charged a total of €240.23 less over the relevant two-year period than they would have been charged had the Provider not committed the administrative error. The Provider does not seek to recoup this amount.

The Provider also notes that, had a valid claim been made on the policy, the Provider would have stood over the policy. Additionally, the Complainants would have been subject to the stated excess of €275 rather than the excess that should have been applicable of €715. In the event, no claims were made.

I note that the Provider has confirmed that it would have stood over the policy. I accept this as I cannot see how had a claim been made, and the Provider could have sought to avoid liability by reference to its administrative error. As such, my view is that the Complainants are incorrect when they state that the property was "*without insurance*" for two years. Additionally, I consider it appropriate for the Provider to have confirmed that the lower excess, as recorded on the policy documentation, would have been employed. Again, I cannot see how it could have been otherwise.

The Complainants had the benefit of full cover for the relevant period on better terms than would have been available to them had no administrative error been made. The Provider issued a prompt response to the Complainants' complaint and apologised for its error whilst confirming that the policy would have been honoured. In the circumstances, I do not see that the Complainants have suffered any loss that warrants the provision of any compensation. I accept that the Provider's Final Response Letter, which included a frank apology, represented a fair and appropriate response to the Complainants' complaint.

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In light of the entirety of the foregoing, I do not uphold this complaint.

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

27 May 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.