An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0263
Sector:	Insurance
Product / Service:	Travel
Conduct(s) complained of:	Rejection of claim - definition of valuables
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

On **6 October 2015**, the First Complainant purchased a travel insurance policy online, via the Provider. The policy was with a named Insurer. The policy commenced the next day, 7 October 2015, and was renewed on **7 October 2016**. The Provider is a tied agent of the Insurer only for the purpose of selling travel insurance and it does not have the authority to admit or decline claims on behalf of the Insurer.

The Complainants' Case

The First Complainant sets out the Complainants' complaint, as follows:

> *"In May 2016 we had to cancel a trip to Montenegro on medical grounds. We knew there was an excess of €150 on the policy, but* [the Insurer] *deducted €150 x 2 on our refund. We think this is totally wrong.*
>
> *On 17th Nov* [2016] *my wife and I travelled to London on a belated shopping trip for her 60th birthday. My wife's wallet was stolen containing £1,900 sterling and €150. When we made a claim, after waiting two weeks for a call back, we were told the cash was not insured.*

> *When we purchased this policy we understood all our possessions including our cash was insured, as was our baggage"*

In addition, in his correspondence to this Office dated 17 February 2017, the First Complainant submits, as follows:

> *"… the policy booklet and schedule of insurance referred to* [by the Provider]*, neither of which were received by us. We have never seen in writing anything stating that our cash was not insured. As far as we were concerned when we purchased this policy everything medical and all our cash and belongings were covered. We believe that it was only when we divulged the amount of money involved, that then they decided to claim our cash was not insured"*.

In this regard, the Complainants *"want payment of the second excess of €150. We also want payment of €2,423.19, which is the cost of the £1,900 sterling along with €150, the total in my wife's wallet"*.

The Complaint for Adjudication

The Complainants' complaint is that the Provider mis-sold the Complainants their travel insurance policy.

The Provider's Case

The First Complainant purchased the travel insurance policy online on 6 October 2015. The policy commenced the next day, 7 October 2015 and was renewed on 7 October 2016. The Provider is a tied agent of the Insurer for the purposes of selling travel insurance; it does not have the authority to admit or decline claims on behalf of the Insurer.

Following the sale of this travel insurance policy on 6 October 2015, the Provider emailed the Policy Booklet, which details all of the policy terms and conditions, to the email address supplied by the First Complainant. In addition, the Provider also wrote to the First Complainant on 6 October 2015 advising that it had emailed the Policy Booklet to [identified email address].

The Provider notes that the Complainants submitted a claim to the insurer, on **16 May 2016** for the cost of two flights, as they were unable to travel due to medical reasons. The Complainants had been scheduled to fly to Dubrovnik on 22 May 2016. This claim was assessed by the Insurer and a total excess of €300 was applied and deducted in the calculation of the benefit payable. In this regard, the Provider notes that the applicable policy excess was €150 per person, as detailed in the Schedule of Benefits that the Provider had previously emailed to the Complainants.

In advance of the policy renewal date of 6 October 2016, the Provider wrote to the First Complainant on 10 September 2016 advising that it would renew the travel insurance policy and that it had emailed the Policy Booklet to [identified email address]. Provider records

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indicate that the First Complainant telephoned the Provider on 9 November 2016, to pay the sum of €12.60 to add the excess waiver to the policy, which was added with immediate effect.

The Provider notes that the Complainants submitted a second claim on **22 November 2016** as the Second Complainant's wallet, which contained GBP £1,900 and €150 cash, was stolen during a trip to London on 17 November 2016. In this regard, the Provider notes that the Insurer declined the claim, as the policy does not provide cover for the loss of personal money, as detailed in the Policy Booklet that the Provider had previously emailed to the Complainants.

The Provider is satisfied that it provided the applicable Travel Insurance Policy Booklet to the First Complainant both when he purchased the Complainants' travel insurance policy in October 2015 and again when it was renewed in October 2016 and that this Policy Booklet detailed all of the policy terms and conditions, including those relied upon by the Insurer when it assessed the Complainants' claims in May and November 2016, respectively.

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 8 July 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, within the period permitted, the final determination of this office is set out below.

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The complaint at hand is that the Provider mis-sold the Complainants their travel insurance policy which the First Complainant purchased online on 6 October 2015, via the Provider. The policy commenced the next day, 7 October 2015, and was renewed on 7 October 2016. The Provider is a tied agent of the Insurer for the purposes of selling travel insurance but it does not have the authority to admit or decline claims on behalf of the Insurer.

The Complainants had cause to make two travel insurance claims in 2016.

In **May 2016**, the Complainants cancelled a trip to Montenegro for medical reasons and submitted a claim to the Insurer in respect of their flights. The Insurer, in settling this claim, applied the policy excess of €150 in respect of each flight. In this regard, the First Complainant submits, *"We knew there was an excess of €150 on the policy, but* [the Insurer] *deducted €150 x 2 on our refund. We think this is totally wrong"*.

In **November 2016**, whilst in London, the Second Complainant's wallet, which contained £1,900 sterling and €150 cash, was stolen. The Insurer declined this claim as the Complainants' travel insurance policy does not provide cover for the loss of personal money. In this regard, the First Complainant submits, *"When we purchased this policy we understood all our possessions including our cash was insured, as was our baggage"*.

In his correspondence to this Office dated 17 February 2017, I note that the First Complainant submits, as follows:

> *"… the policy booklet and schedule of insurance referred to* [by the Provider]*, neither of which were received by us. We have never seen in writing anything stating that our cash was not insured. As far as we were concerned when we purchased this policy everything medical and all our cash and belongings were covered. We believe that it was only when we divulged the amount of money involved, that then they decided to claim our cash was not insured"*.

I note, however, that the documentary evidence before me does not bear out the First Complainant's recollection of events, in that regard. Rather having purchased the travel insurance policy on line, I note that the Provider wrote to the First Complainant on 6 October 2015, as follows:

> *"Thank you for choosing* [Provider] *Travel Insurance.*
> *We've enclosed your documents. These form part of your policy, please read and keep them safe. We've emailed your Policy Booklet and our Terms of Business to* [identified email address].

It would have been prudent of the First Complainant to have contacted the Provider if he had not received the email referenced in this correspondence. In this regard, the onus is on the policyholder to familiarise themselves with the policy terms and conditions to ensure that the policy suits their needs.

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In addition, I note that the '**Important Notice – Statement of Suitability**' document enclosed with the Provider correspondence of 6 October 2015 advised, as follows:

> *"This is a summary of the policy and does not contain the full terms and conditions of the cover. For full details please see the policy booklet. Policy booklets are available for inspection online at www.xxxXX.ie"*.

I also note that the Travel Insurance Certificate enclosed with this correspondence provided, *inter alia*, as follows:

> *"**Cooling Off Period***
>
> *This policy includes a cooling off period. What this means is that if, within 14 days of receipt of your annual documents, you decide for any reason to withdraw from the contract, you may cancel the policy by notifying* [the Provider] *in writing.*
> *Where no claim or adjustment has been effected on the policy of insurance, you are entitled to a refund for the period of cover that has not been used"*.

As a result, if having read the policy booklet the Complainants had decided that the travel insurance policy was not suitable to their needs, it was open to them to cancel their policy and receive a full refund.

I also note from the documentary evidence before me that the Provider wrote to the First Complainant on 10 September 2016, as follows:

> *"We'll automatically renew your annual policy …*
>
> *We've enclosed your documents, and have also emailed your Policy Booklet and our Terms of Business to* [identified email address].

The Complainants' travel insurance policy, like all insurance policies, does not provide cover for every eventuality; rather the cover with be subject to the terms, conditions, endorsements and exclusions set out in the policy documentation. In this regard, the 'Schedule of Benefits, Limits and Excess' section of the applicable Travel Insurance Policy Booklet, provides*, inter alia,* at pg. 1:

Section	Description	Value Cover Limit	Excess per Insured person
G	**Holiday Abandonment**	Up to €1,000 (after 24 hours)	€150

I am satisfied that this clearly indicates that a policy excess of €150 will apply to each insured person if they have to abandon their holiday, as in the circumstances when the Complainants cancelled their trip in May 2016, due to medical reasons.

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In addition, Section D, 'Baggage and Passport', of this Policy Booklet provides, *inter alia*, at pgs. 20-21, as follows:

> ***"What is NOT Covered*** *….*
>
> *14. Claims arising from* ***personal money"–***

I am satisfied that this clearly indicated that the policy does not provide cover for the loss of cash, which was the loss suffered when the Second Complainant's wallet was stolen whilst in London in November 2016.

I am satisfied from the documentary evidence before me that the Provider furnished the Complainants with the Policy Booklet which detailed all the policy terms and conditions of their travel insurance, and that this Policy Booklet contained the conditions that the Insurer later relied upon when assessing the Complainants' subsequent travel insurance claims.

What remains unclear however, is the extent of the information which was made available to the Complainants, at the time when they incepted their policy online. I sought to establish, through enquiries with the Provider, as to precisely what information was made available to the Complainants regarding the terms and conditions of cover they were purchasing, at the time when they were proposing for cover online.

In that context, I wrote to the Provider on **2 April 2019** pointing out the Complainants' contention that "*when we purchased this policy we understood all our possessions including our cash was insured, as was our baggage*". I advised the Provider that given the nature of the contentions made, I sought to examine a copy of each and every individual screenshot which was displayed to the Complainants on 6 October 2015, at the time when they purchased the online policy.

Although this communication was sent to the Provider by way of email and also by surface post, no response was forthcoming from the Provider. For that reason, I sent a reminder again by email and post on **17 May 2019** expressing disappointment that the office had received no response whatsoever, notwithstanding the elapse of 5 weeks. I advised the Provider in those circumstances that if we did not hear within an additional period of 10 working days, the FSPO would take it that the Provider was unwilling to make the evidence in question available, and the adjudication of the complaint would continue on that basis.

It is very disappointing that, for the purpose of this investigation, the Provider has failed to furnish evidence of the precise information made available to the Complainants at the time when they purchased their policy online. The terms which have limited/excluded the benefit sought by the Complainants on foot of the two claims which they made, are clearly set out within the policy document, which was made available to the Complainants after the policy had been purchased. It remains entirely unclear to me however, how the Provider established that the policy was suitable for the Complainants at the time when the policy was sold, in the absence of the screenshots, or equivalent evidence, regarding the information made available to the Complainants online, at the time when they elected to purchase the policy.

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In those circumstances, I believe that the Provider has a case to answer to the Complainants, in that regard. The limitations and exclusions of cover are not details which a policyholder should discover after purchasing a policy, and rather that purchase should proceed on the basis of an informed consent. In this instance however, there is no evidence available to me upon which I can be satisfied that the Complainants made such an informed decision to purchase the policy.

In those circumstances, I consider it appropriate to partially 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 partially upheld, on the grounds prescribed in ***Section 60(2) (f) 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 €500, 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.***

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

1 August 2019

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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.