An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0276
Sector:	Insurance
Product / Service:	Mobile Phone
Conduct(s) complained of:	Claim handling delays or issues Complaint handling (Consumer Protection Code) Failure to process instructions in a timely manner
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant incepted a mobile phone insurance policy with a named Insurer on **28 December 2012**, in order to provide cover in respect of his mobile phone handset. The policy, which was cancelled on **25 November 2016**, was underwritten by the Provider.

The Complainant's Case

The Complainant lost his mobile phone handset on **28 September 2016** and submitted a claim to the Insurer the following day, 29 September 2016. In this regard, the Complainant sets out his complaint, as follows:

> *"On the* [Insurer] *website they claim they would replace my handset or if not available, it would be replaced with the closest functional model "in a speedy and efficient fashion" or "as quickly as possible". I submitted my claim online. I had to follow up 5 days after submitted my claim, as I had no correspondence/acknowledgement from* [the Insurer]. *I then had to make 4 circa 40 mins calls to have my claim processed. I was then informed it would be 3 weeks (not 2 days) from the point at which I submitted my claim before I received a handset. Confusing emails ensued, forcing me to once again contact this cumbersome firm by phone – in which I found out that there was no clear status of my claim. After much*

following up, I was informed my claim had been processed and I would need to pay an excess. I paid this [€75] *excess based on the fact I was getting a replacement model:*

> [Email from the Insurer 7 October 2016] *"I am writing to let you know that following the success of your claim the particular handset is currently out of stock although our Suppliers have indicated that such will be available to us in the next 7 working days. As soon as this is received at our offices we will immediately send the handset to you via 1-2 day delivery"*.

No handset was delivered. I followed up again with three emails which went unanswered and then phone calls.

> [Email from the Insurer 13 October 2016] *"Thank you for your recent excess payment in relation to the acceptance of your claim. At this time we do not have your required handset available within our stock:* [Brand] *and we would be prepared to consider a 'cash settlement' by way of a cheque to the value of €165.89. You will receive your cheque within the next 5-7 working days. It should also be noted that the cash settlement figure is based on refurbished (as new) stock allowing of course for age and condition at the time of the claim being made"*.

I appealed this decision based on the following:

1. *The advertised replacement policy on* [the Insurer's] *website. I made my decision to purchase this insurance policy based on these claims* [that is, *"on the* [Insurer] *website they claim they would replace my handset or if not available, it would be replaced with the closest functional model "in a speedy and efficient fashion" or "as quickly as possible"*]

2. *After* [€75] *excess had been deducted I would be receiving €90, this does not allow me to replace my handset. On the majority of sites I visited the avg. cost of my handset used is €240.*

[The Insurer] *availed of the full 8 weeks to deal with my claim, eventually responding with the same offer of compensation (they did offer a €20 goodwill gesture or something).* [The Insurer] *did not detail how they felt this €90 would allow me to recoup my loss "with the same make and model". I feel I was punished for questioning* [the Insurer's] *valuation, in the form of a greatly extended claim processing time.*

Additionally, I feel [the Insurer] *dealt with my claim in a very unprofessional manner from the outset"*.

In this regard, the Complainant submits that *"I do not feel the compensation offer allows me to replace my handset as* [the Insurer] *have claimed it will"*.

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The Provider's Case

Provider records indicate that the Complainant incepted a mobile phone insurance policy with a named Insurer on 28 December 2012, in order to provide cover in respect of his mobile phone handset. The policy, which was cancelled on 25 November 2016, was underwritten by the Provider.

The Complainant submitted a claim for the loss of his mobile phone to the Insurer on 29 September 2016. In this regard, he had visited a cinema the previous day after work and later noticed that the device was no longer in his pocket. This claim was validated and the policy excess of €75 was collected from the Complainant on 7 October 2016. The Provider notes that unfortunately at this time the particular model was out of stock but it was expected to be available within the next 7 working days. The Insurer emailed the Complainant on 7 October 2016 to advise him of this.

The Complainant contacted the Insurer on 12 October 2016 to ask if the handset had been dispatched. The Provider notes that as the particular handset was still out of stock, and in order not to delay settlement of the claim any further, the Insurer notified the Complainant by email on 13 October 2016 that the claim would now be cash settled by way of a cheque for €165.89, which he would receive within 5–7 working days.

The Complainant then emailed the Insurer later on 13 October 2016 to advise *"no – send me a phone"*, to which the Insurer advised that it was unable to source a [Brand] handset from any of its suppliers, therefore the claim would be cash settled on this occasion. The Complainant raised further concerns on 19 October 2016 advising that he had not received any confirmation as to when he would receive a handset and it was once again reiterated that his claim was being cash settled. The Complainant was not satisfied with this and lodged a complaint, which the Insurer forwarded to the Provider on 20 October 2016.

Following its assessment of this complaint, the Provider wrote to the Complainant on 5 December 2016 to advise that it was satisfied that his claim had been handled correctly insofar as the terms and conditions of his policy allow for the Provider to settle his claim by way of, *inter alia*, cash settlement. However, in recognition of the fact that as the [Brand] handset had been out of stock, a small delay did occur in settling his claim, the Provider directed the Insurer, as a gesture of goodwill, to reimburse the Complainant the sum of €20 from the policy excess payment, it had previously collected from him.

Accordingly, the Provider is satisfied that the Complainant's mobile phone insurance claim was settled in accordance with the terms and conditions of his policy and that his claim was handled correctly throughout.

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The Complaint for Adjudication

The Complainant's complaint is that the Provider wrongly or unfairly assessed his mobile phone insurance claim and that it also provided him with poor customer service throughout its handling of this claim and his subsequent complaint.

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 on 7 June 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.

The complaint at hand is that the Provider wrongly or unfairly assessed the Complainant's mobile phone insurance claim and that it also provided him with poor customer service throughout its handling of this claim and his subsequent complaint. In this regard, the Complainant incepted a mobile phone insurance policy with the Insurer on 28 December 2012, in order to provide cover in respect of his [Brand] handset. This policy was underwritten by the Provider.

The Complainant lost his mobile phone on 28 September 2016 and submitted a claim in respect of this loss to the Insurer on 29 September 2016. This claim was validated and the policy excess of €75 was collected from the Complainant on 7 October 2016. In this regard,

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I note from the documentary evidence before me that the Insurer emailed the Complainant on 7 October 2016, as follows:

> *"Good afternoon. I am writing to let you know that following the success of your claim the particular handset is currently out of stock although our Suppliers have indicated that such will be available to us in the next 7 working days. As soon as this is received at our offices we will immediately send the handset to you via 1-2 day delivery. An automated email will be sent to you via email from* [named] *couriers confirming the date and time the handset will be delivered. Than you in advance for your patience"*.

I note that the Complainant contacted the Insurer on 12 October 2016 to check if the handset had been dispatched. In this regard, I note that the Insurer then emailed the Complainant on 13 October 2016, as follows:

> *"Thank you for your recent excess payment in relation to the acceptance of your claim. At this time we do not have your required handset available within our stock:* [Brand] *and we would be prepared to consider a 'cash settlement' by way of a cheque to the value of €165.89. You will receive your cheque within the next 5-7 working days. It should also be noted that the cash settlement figure is based on refurbished (as new) stock allowing of course for age and condition at the time of the claim being made. Thank you"*.

I note from the documentary evidence before me that the Complainant then emailed the Insurer later on 13 October 2016 stating *"no – send me a phone"*. In this regard, the Insurer emailed the Complainant the following day, 14 October 2016, as follows:

> *"Good morning. Thank you for your email. Unfortunately we are unable to get hold of this phone from any of our suppliers. We would only send a cash settlement if we are unable to get a handset for you. Best wishes"*.

The Complainant's mobile phone 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, I note that 'The Cover' section of the applicable Policy Document provides, *inter alia*, as follows:

> *"The Company will, subject to the exclusions and conditions, indemnify You by payment or at its option by replacement (with identical Equipment or Equipment of comparable specification up to a maximum retail value of €1000) or repair in respect of accidental damage, liquid damage, theft & loss including Airtime Abuse (following a successful claim for theft or loss) of the Equipment occurring the period of insurance. A replacement phone may be from refurbished (as new) stock that has been tested and is fully functional"*.

As a result, I am satisfied that the terms and conditions of the Complainant's policy allow for the Provider to settle a claim by way of, *inter alia*, payment. Given that in this instance the Provider was unable to readily obtain a replacement handset for the Complainant, I am

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satisfied that it was reasonable for it to settle his claim by way of payment, in accordance with his policy terms and conditions.

The Complainant did not want his claim to be settled by way of payment but instead wanted a replacement handset and he made a complaint to the Insurer on 19 October 2016, which I note it then forwarded to the Provider on 20 October 2016. Following its assessment of this complaint, I note that the Provider wrote to the Complainant on 5 December 2016, as follows:

> *"You contacted* [the Insurer] *to notify them of a claim, as you had lost your* [Brand] *on 28 September 2016.*
>
> *Once all the required documentation had been received, your claim was validated and the policy excess payment of €75 was collected on 7 October 2016.*
>
> *Unfortunately,* [the Insurer] *had to notify you that they were currently out of stock of the* [Brand]*, but were expecting a supply to arrive in the next 7 working days. As the supply was not received,* [the Insurer] *wrote to you advising they were making a cash settlement of €165.89 in lieu of the replacement handset.*
>
> *You expressed your dissatisfaction at receiving a cash settlement as you would prefer the handset to be replaced and following the complaint procedure as detailed in your terms and conditions, your complaint was forwarded to* [the Provider]*, the underwriters of the policy, for review.*
>
> *<u>Policy Wording</u>*
>
> *The cover*
> *The company will, subject to the exclusions and conditions, indemnify you by payment or at its option by replacement (with identical equipment or equipment of comparable specification up to a maximum retail value of €1000) or repair in respect of accidental damage, liquid damage, theft & loss including airtime abuse (following a successful claim for theft or loss) of the equipment occurring the period of insurance. A replacement phone may be from refurbished (as new) stock that has been tested and is fully functional.*
>
> *<u>Conclusions</u>*
>
> *Having now carried out a full review of this case, I must unfortunately advise that your claim has been handled correctly, and in accordance with the cover provided within the terms and conditions of your policy.*
>
> *As confirmed in the above policy wording, the claim may be settled by payment or by replacement. Unfortunately the handset was out of stock at the time of the claim and to prevent the claim settlement being delayed any further, a cash settlement of €165.89 was offered. Having researched on line the value of a refurbished* [Brand]*,*

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taking into consideration the age of your original handset, I believe this to be a fair and reasonable settlement of your claim.

There will always be an element of inconvenience in relation to pursuing an insurance claim and from my review it is apparent that due to the handset being out of stock, a small delay did occur in your claim being settled. This is not the standard of service normally provided by [the Insurer]*, but I completely appreciate that the delay in this instance will have been frustrating for you, and I must offer my sincere apologies for any unnecessary inconvenience caused.*

By way of an apology, I have requested that [the Insurer] *reimburse €20 from the policy excess payment you made as a gesture of goodwill. You should receive this credit shortly"*.

An element of the Complainant's complaint is that the Provider provided him with poor customer service during its handling of the complaint he made to the Insurer on 19 October 2016 and which it forwarded to the Provider the following day, on 20 October 2016. In this regard, the Complainant submits that the Provider *"availed of the full 8 weeks to deal with my claim, eventually responding with the same offer of compensation (they did offer a €20 goodwill gesture or something)"*.

Whilst the terms and conditions of the Complainant's policy allow for the Provider to settle a claim by way of payment and thus its correspondence to the Complainant dated 5 December 2016 was correct, I am not satisfied from the documentary evidence before me that the Provider dealt with the Complainant's complaint in accordance with the provisions of the Consumer Protection Code 2012. In this regard, Chapter 10, '**Errors and Complaints Resolution**' of the Consumer Protection Code 2012 provides, *inter alia*, at pg. 67, as follows:

"***COMPLAINTS RESOLUTION*** *…*

10.7 A regulated entity must seek to resolve any complaints with consumers.

10.8 When a regulated entity receives an oral complaint, it must offer the consumer the opportunity to have this handled in accordance with the regulated entity's complaints process.

10.9 A regulated entity must have in place a written procedure for the proper handling of complaints. This procedure need not apply where the complaint has been resolved to the complainant's satisfaction within five business days, provided however that a record of this fact is maintained. At a minimum this procedure must provide that:

a) the regulated entity must acknowledge each complaint on paper or on another durable medium within five business days of the complaint being received;

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b) the regulated entity must provide the complainant with the name of one or more individuals appointed by the regulated entity to be the complainant's point of contact in relation to the complaint until the complaint is resolved or cannot be progressed any further;

c) the regulated entity must provide the complainant with a regular update, on paper or on another durable medium, on the progress of the investigation of the complaint at intervals of not greater than 20 business days, starting from the date on which the complaint was made;

d) the regulated entity must attempt to investigate and resolve a complaint within 40 business days of having received the complaint; where the 40 business days have elapsed and the complaint is not resolved, the regulated entity must inform the complainant of the anticipated timeframe within which the regulated entity hopes to resolve the complaint and must inform the consumer that they can refer the matter to the relevant Ombudsman, and must provide the consumer with the contact details of such Ombudsman; and within 40 business days of having received the complaint; where the 40 business days have elapsed and the complaint is not resolved, the regulated entity must inform the complainant of the anticipated timeframe within which the regulated entity hopes to resolve the complaint and must inform the consumer that they can refer the matter to the relevant Ombudsman, and must provide the consumer with the contact details of such Ombudsman; and

e) within five business days of the completion of the investigation, the regulated entity must advise the consumer on paper or on another durable medium of:

i) the outcome of the investigation;
ii) where applicable, the terms of any offer or settlement being made;
iii) that the consumer can refer the matter to the relevant Ombudsman,
and
iv) the contact details of such Ombudsman".

As part of its investigation into the Complainant's complaint, this Office wrote to the Provider on 18 October 2017 asking it, *inter alia*, to furnish it with *"Evidence of compliance by the Provider with the provisions of the applicable Consumer Protection Code, relevant to/pertaining to the complaint. (Please highlight all provisions relevant/pertaining to the dispute and provide evidence of compliance with each provision)"*. In this regard, I note that the evidence that the Provider then submitted to this Office does not contain evidence of its compliance with the above-cited provisions of the Consumer Protection Code 2012.

For example, whilst the Complainant made his complaint to the Insurer on 19 October 2016, which was then forwarded to the Provider on 20 October 2016, I note that there is no record on the Provider's file or its timeline of events contained therein, of an acknowledgement letter issuing to the Complainant within 5 days of his making his complaint, or indeed of an

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acknowledgement letter issuing at all. In addition, there is also no record of the Provider having furnished the Complainant within 20 days of his having made his complaint, with an update on the progress of its investigations into the matter, or indeed of any such update issuing at all. Instead, it would appear from the evidence submitted to this Office by the Provider that it did not make any contact with the Complainant after he submitted his complaint on 19 October 2016 until it wrote to him on 7 December 2016 with its final response.

Although I am satisfied that the Provider acted in accordance with its entitlements, in assessing the Complainant's claim for the loss of his mobile phone, and was entitled to offer a cash settlement to the Complainant, rather than a handset itself, nevertheless, I take the view that in investigating the Complainant's subsequent complaint, the Provider did not meets its regulatory obligations. I am satisfied that the Provider's failure to comply with the above-cited provisions of the Consumer Protection Code 2012 constitutes a poor level of customer service to the Complainant and it is therefore my intention to uphold this element of his complaint. Having considered the circumstances of the complaint at hand and having regard to the nature and extent of the noncompliance in this instance, I direct that the Provider make a compensatory payment to the Complainant in the amount of €150, to an account of his choosing.

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(2g.***

- 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 Complainant in the sum of €150, 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 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.

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION AND LEGAL SERVICES

2 July 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.