An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0417
Sector:	Insurance
Product / Service:	Travel
Conduct(s) complained of:	Failure to provide product/service information Failure to process instructions Maladministration
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint relates to a Complainant's attempts to renew a travel policy.

The Complainant's Case

On **28 March 2017**, the Complainant attempted to renew his travel insurance for himself and his family with the Provider through a phone call. The Complainant was quoted a price of €133.00 and agreed to it. The Complainant provided his card details and was issued a policy certificate that purported to cover the period from **1 April 2017** to **31 March 2018.**

Due to an administrative error on the part of the Provider, the Complainant was not covered by the policy of insurance and the sum of €133.00 was not debited from his account. On **22 March 2018**, the Complainant called the Provider to renew his travel insurance policy, but was informed that he did not have one.

On **27 March 2018**, the Complainant lodged his complaint with the Provider. This was not successfully resolved and on **19 April 2018** the Provider delivered its final response letter which resulted in the complaint being made to this Office on **17 July 2018**.

The Complainant says that he has been a long-term customer of [the Provider] for over 32 years and that he attempted to take out the policy in good faith. The Complainant notes that he did nothing wrong and that his details were provided and he was issued with the insurance certificate, which led him to believe that he had insurance cover.

This gave the false sense of security to the Complainant that he and his family were covered during their trips during the relevant time period. The Complainant sets out that this involved trips abroad to the United Kingdom, the USA and India. In respect of the latter two locations, the Complainant says that the coverage could have been particularly important. The Complainant notes that he did not have to claim on the purported policy during the time period. The Complainant had a particular concern that flights that had been booked during the relevant period but had not yet occurred might not be covered by the purported policy.

The Complainant asserts that the Provider's handling of the complaint was not done properly and was not done in accordance with the Provider's own complaint handling procedure. In particular, the Complainant states that the initial response of the Provider was dated **4 April 2018**, but was actually received on **9 April 2018** which the Complainant asserts was outside the 5 day limit. The Complainant states that he initially complained on **22 March 2018** and received the final phonecall on **18 April 2018**, which was too long a delay. The Complainant was unhappy with the approach taken by Provider's representatives in various respects. For example, the Complainant states that the representative attempted to figure out whether any claims had arisen during the relevant period before making a goodwill gesture of €133.00 to the Complainant. Also the Complainant has concerns with the manner in which the Provider's representative asked security questions.

The Complainant seeks compensation over and above the goodwill gesture of €133.00 that was made by the Provider.

The Provider's Case

First, in respect of the policy coverage not coming into existence, the Provider notes that it erroneously sent a policy certificate to the Complainant and did not debit his account. The Provider accepts that it is responsible for this and that it was due to an internal administrative error. The Provider apologised for this failure to meet proper standards. The Provider states that it would have covered any claim had one occurred during the relevant period. The Provider notes that the Complainant's separate healthcare policy would have covered a limited sum in respect of certain medical expenses had they been incurred. The Provider states that it did not reinstate cover once the error was discovered as there was no reason to due to no claims being in existence.

In respect of the complaint handling, the Provider asserts that it complied with its complaint handling procedure. The Provider states that a complaint was lodged on **27 March 2018** by phone call and that a response was sent on **4 April 2018**. The Provider states that the office was closed for the Easter break from **30 March 2018** to **2 April 2018** and that, therefore, the response was sent within 5 business days as per 10.9 of the Consumer Protection Code (CPC) and also the Provider's own complaint handling procedure. The Provider states that it

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complied with 10.8 of the CPC in that it gave the Complainant the opportunity to lodge the complaint once it was clear that he had a grievance. The Provider notes that it had a final phone call on **18 April 2018** setting out the Provider's findings and that the final response letter issued on **19 April 2018**, which was within the 40 day limit.

The Provider made the goodwill gesture of €133.00 but notes that it has not been cashed by the Complainant.

The Complaints for Adjudication

The complaints for adjudication are that the Provider acted inappropriately or unfairly in dealing with the Complainant's travel insurance renewal for the relevant period of 1 April 2017 to 31 March 2018 and that the Provider handled the Complainant's complaint improperly and not in accordance with the CPC and its own procedures.

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 23 October 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.

Following the issue of my Preliminary Decision, the Complainant made a further submission under cover of his letter to this Office dated 10 November 2019, a copy of which was transmitted to the Provider for its consideration.

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The Provider has not made any further submission.

The Complainant, in his post Preliminary Decision of 10 November 2019, raises his dissatisfaction with the Provider's original offer of compensation. He has also raised issues in relation to a call he states he made to the Provider. Neither of these matters would serve to change my Decision.

I note that in that same submission the Complainant states that I have incorrectly interpreted the CPC 2012. I believe I have correctly interpreted the CPC as it applies to this complaint.

In his post Preliminary Decision submission the Complainant raises issues more appropriate for the Data Protection Commission.

Following consideration of the Complainant's additional submission, and all of the submissions and evidence furnished to this Office, I set out below my final determination.

It is clear that the Provider acted inappropriately in dealing with the Complainant's insurance renewal: the Provider indicated to the Complainant that it would provide insurance and furnished a quote which the Complainant accepted. The Provider then issued a certificate of insurance confirming that the Complainant had insurance coverage. Entirely due to the Provider's administrative error, this was a misrepresentation which has understandably caused the Complainant concern and frustration. It is equally clear, however, that there are no actual or intended claims that have arisen during the relevant period of 1 April 2017 and 31 March 2018. As such, while the Complainant has been misled, most fortunately, it has not resulted in any financial consequence at all. That said, there is no doubt that the Provider acted incorrectly, but that the Complainant has suffered no financial loss of any form as a result.

I note the Provider has stated that it would have honoured any claims that would have arisen when the policy was supposed to be in place. In my view, it is most fortunate that this was not tested and that there were no incidents giving rise to a claim while the cover was not in place.

The evidence before me indicates that the complaint was properly lodged on **27 March 2018** by phone call which was noted by the Provider's representative. I find that the letter dated **4 April 2018** was the formal acknowledgement of the complaint by the Provider. Taking account the non-business days due to the Easter break, I find that the Provider has established compliance with 10.9 of the CPC in furnishing a response within 5 business days. I note that the Complainant states that he did not receive this letter until **9 April 2018**, but I find that it is sufficient for the purposes of 10.9 that the complaint be acknowledged within 5 business days, which I find the letter of 4 April 2018 to be sufficient evidence of. The final response letter was sent on **19 April 2018**, which is within the time limit of 40 days provided for by the CPC and the Provider's own complaints handling process. In my view this was not an excessive delay on the part of the Provider.

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With respect to the phone calls between the Complainant and Provider, I find that the representatives did not act inappropriately. First, it is understandable that a representative would try and figure out if any claims were outstanding for the relevant uninsured period in order to ascertain whether the issue of providing retrospective cover might arise. Second, while the security questions were asked perhaps in a perfunctory manner, I cannot find that this amounted to a breach of the CPC or unreasonable or inappropriate conduct.

In all of the circumstances, I find that the Complainant was inadvertently misled by the insurance certificate being issued but that he has suffered no financial loss and that the Provider handled the complaint appropriately.

It is important to note that the intended premium of €133 was not taken from the Complainant's account and that in addition a sum of €133 was offered to the Complainant as a goodwill gesture. Given that the Provider made this offer at an early stage in the process and that it was reasonable in the circumstances where the Complainant had not suffered any loss and had not been charged the premium, 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

9 December 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.