An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0159
Sector:	Insurance
Product / Service:	Car
Conduct(s) complained of:	Dissatisfaction with customer service
Outcome:	Substantially Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint arises out of a motor insurance policy and it concerns suggested maladministration, poor practice and poor customer service.

The Complainant's Case

The Complainant held a motor insurance policy with the Provider, incepted in **July 2015**. The Complainant submits that the Provider automatically renewed her policy without her permission at a price that she states was three times the market rate and "*multiples beyond the highest available premium [she] could find at the time*". The Complainant submits that the Provider failed to tell her about the auto renewal during phone calls and that it relied on other communication methods to do so.

The Complainant states that the Provider failed to get the best price available for motor insurance and she says that the Provider's pricing is a "*rip-off*". The Complainant also complains of poor customer service, communication and complaints handling and she says that she was "*hung up on*" several times during phone calls and that she does not believe that the Provider fully appreciated or was aware of what the complaint was, by the end of the process.

The complaint is that the Provider was guilty of maladministration, insofar as it:

(i) wrongfully renewed the Complainant's policy automatically without her express permission,

(ii) failed to obtain the best price and charged her a premium that was "*3 times the market rate*"

(iii) provided below par customer service, communication and complaints handling throughout.

The Complainant wants the Provider to refund the cost of her motor insurance policy and to review its auto renewals policy.

The Provider's Case

The Provider submits that the Complainant returned a signed credit agreement which agreed to the automatic renewal of the policy. The Provider denies inflating the cost of the car insurance and it also submits that it acted appropriately in seeking or endeavouring to provide the best policy and the best rate to her.

The Provider states that it did not inflate the cost of the Complainant's car insurance. It makes the point that it is an intermediary that does not set insurance rates or acceptance criteria for insurance policies. The Provider makes the point that this is carried out by the underwriter and the Provider merely offers the policy to the consumer. It states that it acts as an intermediary and in that capacity, it endeavours to provide the best policy and the best rate to customers. The Provider states that in this case, as in all cases, renewal quotes are checked with all insurers that the Provider holds agency agreements with and no alternative quotes were returned in 2016 or 2017.

The policy is noted to have lapsed from the renewal date in 2018.

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.

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A Preliminary Decision was issued to the parties on **28 February 2020**, 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 consideration of additional submissions from the parties, the final determination of this office is set out below.

The Complainant says that the Provider automatically renewed the policy without the Complainant's permission. The Complainant incepted this policy on **29 July 2015**. The audio recording of a phone call between the Complainant and the Provider on that date, makes it clear that, as the Provider has now conceded, the Complainant was not notified or advised during this call that the policy would automatically renew. The Provider has also conceded that it is part of the agent scripting that the agreement of the customer will be obtained in order to set up the policy on an automatic renewal basis. Therefore, there was no possible way that the Complainant could have been aware that her policy was going to automatically renew on the basis of that phone call, though the Provider advises the customer to read the terms and conditions and to return the direct debit mandate.

Importantly, during this phone call the Complainant expressly asked the Provider when her policy would expire and she was expressly told that her policy would expire on 29 July the following year.

The terms and conditions of the policy have been furnished to this office. In particular the "Terms of Business" which were issued at the inception of the policy in 2015, contain a section on page 4 entitled "*Renewals/Premium Payments/Insurance Premium Direct Debit Default Policy".* There is no mention of an automatic renewal in this part of the Terms of Business.

However, in the Credit Agreement Terms and Conditions contained within the Terms of Business, it is stated, *inter alia*, that "*Instalment payments will be continued in future years (Roll Over). Provided you continue to pay by instalments there will be no need to complete a new instalment plan each year. [The Provider] will notify you each year what your annual premium is and with your consent will continue to apply to your bank monthly. No deposit is payable in year 2, with your first instalment due on your renewal date. The remaining 11 instalments will be paid at monthly intervals*."

It is also stated that "*You have the right to withdraw from our Direct Debit plan without penalty if written notice to this effect is forwarded to [the Provider] within 14 calendar days from the inception/renewal date of your policy."*

It does not appear to be disputed that these documents were signed by the Complainant. I am conscious however, that the rollover of a direct debit is a matter separate from any agreement regarding the automatic renewal of cover.

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All of the audio recordings provided to this office have been listened to and the following calls are considered material, in addition to the call of 29 July 2015 already referred to above.

On **4 January 2017**, the Complainant informed the Provider that she had sent an email to the Provider on 25 July 2016 querying why her policy had been automatically renewed. A recording of an internal discussion within the Provider demonstrates that notwithstanding that the Complainant's email was sent to a "non-reply" email address, the email was still received and the Complainant was to be contacted but it appears that she was not. During this call, the Complainant was told that the email was sent to a non-reply email and that she would not have got a response from that email. Whether or not this is the case, the internal discussion clearly records that her email was received and it was planned or intended that the Complainant would be contacted by the Provider.

During this call, the Complainant enquired about cancelling her insurance and she was told that she would have to formally request the cancellation of the policy and that there was a €50 cancellation fee. It appears that the Complainant did not ultimately choose to cancel her policy at this time.

On **11 August 2017** the Complainant again queried the automatic renewal of the insurance policy and she was told that the automatic renewal occurred if she was paying her insurance by direct debit. The Complainant stated during this call that she had informed the Provider previously that she did not want her policy to be automatically renewed. The Complainant then stated that she wanted to cancel her policy and she was expressly told that in order to cancel the policy she must send back policy documents with formal notification that she wanted her policy to be cancelled.

When the Complainant was told that she would have received her renewal documents on 4 July 2017 by post and by email, the Complainant stated that she would never have opened that email and even if it had been received, she would have assumed it was spam and if it came in the post she would have assumed it was promotional material as she was not expecting any documents regarding the automatic renewal of her policy. The Complainant did not cancel her policy at this time, but I note that the policy lapsed at renewal time in 2018.

It seems that the Provider relies on the terms of business and the credit agreement with the Complainant (which provides for a rolling direct debit arrangement) as an agreement that the policy would automatically renew. Any such arrangement however, was or should have been, dependent upon the customer's informed consent that the policy would renew automatically, and such evidence is absent in this instance. It was a clear failing on the part of the Provider not to bring this to the attention of the Complainant when she initially incepted the policy and seek her consent. While the Complainant was sent the terms of business and the terms and conditions, I am satisfied that it was not readily identifiable from the wording of those documents that the policy would automatically renew. Therefore, notwithstanding the documentation, I am satisfied that the conduct of the Provider in its failure to inform the Complainant at the inception of the policy of the automatic renewal provisions, was unreasonable and was a culpable omission on its part.

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I also note the Provider's advice that although all documentation is scanned, upon receipt, its extensive searches have not in fact located the signed credit agreement returned by the Complainant in this instance. Indeed since the Preliminary Decision was issued by this office, the Provider advised by letter dated 16 March 2020, that:-

> "*Despite previous searches having being carried out we were unable to locate a copy of the signed credit agreement returned by the Complainant and this is referred to in the Preliminary Decision. This documentation has since been located by* [the Provider] *and is now attached as additional material for the FSPO's consideration along with the Complainant's direct debit mandate.*"

I note in that regard, that although the Provider submitted additional details including a copy "[Provider] *Credit Agreement Application*", it remains the position that the *Credit Agreement* itself, as distinct from the Application for that agreement, has not been made available to this office and continues to be absent from the evidence, notwithstanding that it was referred to within that application form, which the Complainant signed.

The Complainant was written to by the Provider regarding the renewals prior to the commencement of each policy and on each of those occasions the document set out that the policy was being automatically renewed and what the cost of insurance was going to be. She says that she would not have opened any emails enclosing her policy documentation and she also maintains that if she had received such renewal documentation by post, she would have considered it to be promotional material and would not have opened those communications. It is entirely unclear in such circumstances how the Complainant would have been in a position to display the required motor insurance disc.

I am also cognisant that notwithstanding the fact that she had twice enquired about cancelling her policy during 2017, and was told how to go about cancelling the policies on those two occasions, she clearly chose not to cancel the policies. Moreover, it is not suggested that the Complainant incepted motor insurance with another provider, or acted in a manner which would suggest that she was unaware of the cover which she held during those periods, with the Provider. In addition, she had the benefit of motor insurance cover during the lifetime of these policies which she says she didn't receive. In those circumstances, I do not consider it appropriate for the Complainant to recover a refund of the cost of the policies that she had the benefit of and chose not to cancel.

The Complainant incepted this policy on **29 July 2015**. The premium for this policy was €427. In July 2016, the policy was automatically renewed and on **25 July 2016**, the Provider wrote to the Complainant advising that the policy was being renewed and that the annual premium for this year was going to be €532.44.

The policy was again automatically renewed in **July 2017** and on 25 July 2017, the Provider wrote to the Complainant setting out that the policy was being renewed and that the annual premium for this year was going to be €1,089.47.

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There was therefore a significant increase in the annual premium for the policy period commencing in July 2017. At the time when the Preliminary Decision was issued to the parties, in February 2020, no evidence had been made available which demonstrated that the Provider had canvassed the insurers with which it held agency agreements, for quotes for the Complainant.

The additional evidence since made available by the Provider now shows that a number of quotes were recorded by the Provider regarding cover from the insurers with which it holds agency agreements. The Provider has advised that the premium quotation from the Complainant's existing insurer in the amount of €1,089.47:

> "*… was the cheapest quote received from any of the insurers approached to quote for the business…the quote obtained for the Complainant was the most financially advantageous to her in the market at that time for the level of cover provided to her. Alternative value quotes (no bonus protection) were also obtained from the various providers. Some of those quotes were lower than the premium for renewal of the Complainant's policy however, these quotes, being value quotes, did not provide comparable insurance cover for the Complainant to that which she had under her policy…."*

I note in that regard that the quotations now listed in the evidence, in fact include a number of "*value*" quotes, one of which was with the Complainant's existing insurer in the sum of €766.92 being approximately €322 less than the premium on foot of which the Complainant's policy was auto-renewed. It seems that this differential of €322, based on the Provider's recent submission, represented the cost of bonus protection.

It is surprising that, in such circumstances, the Provider proceeded with an "*auto renewal*" on the basis of a premium which was effectively double what it had been the previous year, without engaging in any communication with the Complainant. Not only would a discussion regarding policy options have been appropriate, arguably even if the Complainant had clearly instructed an auto-renewal, in this instance, the evidence before me is insufficient to draw a conclusion that the Complainant made an informed consent to agree to an auto-renewal arrangement of her policy via the broker when she incepted the policy in 2015. Hence, a discussion regarding policy options, would have been all the more appropriate.

I accept that it is not the Provider which decides on the cost of the insurance but rather the underwriter or the insurance provider. The Provider submits that it checks its renewal quotes with all insurers that it holds agency agreements with, and that no alternative quotes were returned in 2016 or 2017. It is disappointing that when I wrote to the Provider on 5 November 2019 calling for details of any renewal quotes received by the Provider from certain identified insurers, together with confirmation of the dates of any such renewal quotes, no response was received, even by way of identifying which insurers had been asked for quotes at the relevant time. It seems however that this evidence was in fact available from the Provider, and the relevant details were located after the Preliminary Decision had been issued to the parties.

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In November 2019, I also queried with the Provider as to the manner in which the Complainant had agreed to enter into the Provider's credit agreement, and where and in what manner the Complainant had agreed to accept a fee for the renewal of her policy each year. I requested a copy of the Complainant's written acceptance of the fee. My queries to the Provider also requested its observations in particular regarding the number of references in the response to this office to the effect that the Complainant "*did not say*" that she didn't want auto renewal on the policy. I asked the Provider to confirm whether it had formed the opinion that the Complainant positively indicated that "*she did want*" auto renewal and I requested details of the evidence available in that regard which the Provider relied upon.

On 9 January 2020 I wrote to the Provider again, by email and also by surface post, as I had received no response whatsoever to my queries of 5 November 2019. I advised the Provider at that time that if no response was received from the Provider within an additional period of 10 working days from that date, with a substantive reply to the queries raised in the correspondence of 5 November 2019, the FSPO would proceed with the adjudication of the complaint on the basis that the Provider had failed, refused and/or neglected to furnish the information and evidence sought by this office.

It is disappointing to note that the Provider failed to revert with any response to the queries raised or indeed with details of any evidence available, of the nature requested, until after the Preliminary Decision had been issued. In those circumstances, not only was there no evidence whatsoever available up to that point, to confirm that the Provider had canvassed its various insurers with whom it holds agency agreements for quotes in respect of the Complainant, at the relevant times of renewal, in addition, there was no evidence whatsoever of the Complainant's agreement to incurring an annual cost in order to have her policy auto renewed, even after she was advised by the Provider that auto renewal was a feature of the arrangement she had put in place with it, at the time when she originally incepted the policy in July 2015.

Since that time, additional evidence has been made available by the Provider which maintains the position that the SEPA direct debit mandate signed by the Complainant in September 2015 and the "*[Provider] Credit Agreement Application*" signed on the same date "*supplements the material previously provided to the FSPO*", being the Terms of Business and the relevant Terms and Conditions. Ultimately however, the missing document, the Credit Agreement, which is sought to be relied upon by the Provider, has not been made available as part of the evidence in this investigation, and there is simply no adequate evidence before this office to confirm that the Complainant consented to automatically renewing her car insurance each year, via the Provider, or indeed that she agreed to incur an annual fee for any such auto-renewal of cover.

It is disappointing that in seeking to formally investigate the issues raised by the complaint, this office met with silence over a number of months, in response to its request for evidence of the Provider's actions. The FSPO has since received evidence from the Provider of the measures taken to "*shop around*" for the best premium for her renewal, but in the absence of adequate evidence that the Complaint made an informed decision to agree to auto-renew her cover, I consider it appropriate to uphold this aspect of the complaint.

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Related to the foregoing is the complaint regarding poor customer service and poor complaints handling on the part of the Provider. I note that the Provider accepts that there was poor customer service with issues identified during the complaint handling process. While the Complainant was clearly unhappy with the outcome of the decision of the Provider following the complaint handling process, I am satisfied having reviewed the documentation that the complaint was handled in a manner that was compliant with the Consumer Protection Code. I am equally satisfied however, that there was, as a whole, very poor customer service offered to the Complainant by the Provider.

Whilst I note that the Provider has offered the Complainant a compensatory figure of €350, in recognition of its conduct, I do not consider the figure in question to be adequate compensation for the nature of the issues which have been raised. Accordingly, I consider it appropriate to substantially uphold this complaint and to direct the Provider to make a compensatory payment to the Complainant in the sum of €1,000, to conclude.

Bearing in mind the absence of any evidence of the Provider having secured the Complainant's informed consent to automatically renew her car insurance cover, or her agreement to the costs thereby incurred, I am referring this matter to the Central Bank of Ireland for any action considered to be appropriate.

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is substantially 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 Complainant in the sum of €1,000, 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.***

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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 April 2020

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.