An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0200
Sector:	Insurance
Product / Service:	Car
Conduct(s) complained of:	Lapse/cancellation of policy Rejection of claim
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The complaint concerns the Provider's cancellation of a Motor Insurance Policy because of the Complainant's alleged non payment of premium instalments. The Complainant was involved in a car accident in June 2016. The Complainant advised the Provider of the accident, but the Provider refused to cover the claim on the basis that the policy had lapsed due to non payment of premiums. The Provider states that it had issued correspondence to the Complainant in May 2016, advising him to pay the outstanding premium amount. The Complainant advises he received no such correspondence.

The complaint is that the Provider incorrectly cancelled the insurance policy and incorrectly refused to deal with the claim resulting from the Complainant's accident with a third party.

The Complainant's Case

It is the Complainant's position that he took out car insurance with the Provider in 2016. He paid a €300 deposit on 13 April 2016, with the remainder to be paid by Direct Debit. The Complainant states that no documentation was received from the Provider to set up the Direct Debit.

The Complainant states that he informed the Provider of a Road Traffic Accident that he was involved in, on 22 June 2016, and states that he was only then advised that his policy had been cancelled.

The Complainant submits that at no stage in advance of this was he informed of any issue with his insurance policy.

The Complainant says that he never received a reminder letter, nor a cancellation letter as referred to by the Provider. The Complainant states that on the date the registered letter was allegedly signed for, he was at work. The Complainant states that there was no one at the house to accept the post.

The Complainant submits that he received conflicting letters from the Provider after the cancellation, and received a refund of €112.00. The Complainant considers that the €112.00 payment would have covered the May 2016 premium.

The Complainant states that the mode of payment was not well explained to him at the time he took the policy out. The Complainant says that he was expecting the Provider to send him the Authorisation Letter of Direct Debit to his bank as it had done previously when he took out an insurance policy with the Provider some years earlier, before changing to another Provider. The Complainant submits that he thought the same method of payment would apply and he was awaiting the Provider's instruction.

The Complainant states that he wants his car insurance cover to be re-instated and he wants the Provider to cover the claim arising from the road traffic accident that occurred on 22 June 2016.

The Provider's Case

A Summary of the Complaint and a Schedule of Questions was issued to the Provider by this office. The following are the Provider's responses:

In response to whether the Provider accepts that the Complainant agreed to pay the premium for the period of insurance, the Provider states:

> *"No. In circumstances where [the Provider] sent the insured Bank Giro credit forms and followed its procedures in writing to the address they had on record for the insured to include a registered post letter on this matter [the Provider] is entitled to conclude that the insured was not agreeing to pay the premium for the period of insurance as he took no positive steps to do so himself from the date of inception of the policy. [The Provider] is satisfied that it's process in dealing with non-payments goes beyond what is required legally as set out below and for an insured to benefit from the indemnity of a contract they must accept primary responsibility for payment of the insurance premium on the agreed terms. To find otherwise would expose insurers to risks in all such policies where payment has lapsed for whatever reason and impose an obligation on insurers that the Irish High Court would not impose on them.*
>
> *If the FSPO accepts that the insured for whatever reason did not receive any of the correspondence that [the Provider] states it sent to the address for the insured he*

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still is obliged to proactively take steps to pay his premium and cannot simply say that the payment of my insurance is a matter for [the Provider] to organise and if they do not so organise then I am entitled to benefit from my contract of insurance notwithstanding such failure on my part to take any steps.
In this regard [the Provider] relies on the Irish High Court decision Wildgust v Governor and Co of the Bank of Ireland and the Norwich Union Life Assurance Society 2001 ILRM 214.

In that case the insured alleged that their insurer was obliged to notify the insured if a breakdown in the direct debit system through which their monthly premium was paid as an implied term of the contract but the Irish High Court held they could see no circumstance in which such an obligation fell on an insurer.

The relevant policy document in this claim is very clear in General Conditions paragraph 2 that you must keep your payments up to date and further states that failure to do so could result in the cancellation of your policy.

[The Provider] submits that its practice and procedures go beyond what is expected of them legally in terms of writing to the insured to advise of non-payment of instalments and the procedures followed in this case are in line with industry norms in relation to direct debits".

In response to a request by this office for information on what cover letter accompanied the lodgement / Bank Giro Credit Transfer forms, the Provider states that:

"The Giro forms were posted to the address the policyholder supplied on the 14 June 2014. There was no covering letter with them.
We issued a Certificate of Insurance to him at that address on 13 June 2014 and we believe that he received this document.

The Complainant had provided an email address [.....] and he had registered for the [the Provider's] self service online facility in April 2015. He used this facility on I June 2015 and again on 29 October 2015 to print Certificates of Insurance. As a result of him having a [self service online facility] account when he contacted the Provider] on 13 April 2016 (when he paid the €300), the confirmation letter was issued to his [..] self service account.

I enclose a reprint of the two page confirmation letter, which advised the monthly instalment amounts of €116.61 and the total due of €583.08 with the first instalment due on 1 May 2016 with the last instalment due on 1 September 2016.

The confirmation letter also advises him to call us at 1890 …. with his bank details, if he choose to pay by direct debit.

> *'If you choose to pay by direct debit please call us at 1890 …. with your bank details'.*

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The confirmation letter further advises

> *'If you miss a payment*
>
> *If you miss a payment, we will send you a letter telling you how you must bring your account up to date. This letter will also tell you that if you do not bring your account up to date as we have asked, we will ask you to pay the amount you owe plus the balance of the premium due to your renewal date. If you do not pay this amount, we will cancel your policy as explained in the letter'."*

In the Complainant's submission dated 8th September 2017, he states that the Provider sent him a cheque after his complaint about the policy cancellation. The Provider clarifies the circumstances around the refund of premiums, as follows:

> *"As the refund cheque of €112.11 (number 983***) issued on 17 June 2016 was not cashed, a new replacement cheque (number 245** was issued on 30 January 2017.*
>
> *..*
> *The refund of €112.11 was issued by cheque (number 983***) on 17 June 2016.*
> *....*
> *The refund was for €112.11.*
> *.....*
> *The single page perforated letter dated 17 June 2016 had the refund cheque (number 983***) on the bottom.*
>
> *The letter was addressed to the Complainant and the cheque was made payable to him.*
>
> *The letter had the following single paragraph of text:*
>
> *"We enclose a cheque in your favour for €112.11 being the refund due.*
> *We cannot do a reprint of the letter as it included the actual cheque".*

The Provider was asked by this office to provide a copy of the premium payment agreement / arrangement, that was in place with the Complainant for the period March 2016 to March 2017. The Provider was also questioned as to whether the Provider informed the Complainant in writing from the outset of the amount of premium that it was going to charge him, and how this premium was to be paid by him / collected by the Provider. The Provider's response was:

> *"See attached reprint of the confirmation letter done on 13 April 2016 on the complainant's [..] self service facility, which advised the monthly instalment amounts of €116.61 and the total due of €583.08, with the first instalment due on I May 2016 with the last instalment due on 1 September 2016.*

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This letter advised the Complainant:

> *'If you choose to pay by direct debit please call us at 1890 …. with your bank details'.*

The confirmation letter further advises

> *'If you miss a payment*
>
> *If you miss a payment, we will send you a letter telling you how you must bring your account up to date. This letter will also tell you that if you do not bring your account up to date as we have asked, we will ask you to pay the amount you owe plus the balance of the premium due to your renewal date. If you do not pay this amount, we will cancel your policy as explained in the letter'.*

The Provider was asked by this office to explain how the payment notifications differed for the 2015 to 2016 cover period, to that of the cover period for 2016 to 2017. The Provider was also asked whether the Provider prompted the Complainant when payments were due for the period March 2015 to March 2016, or whether the Complainant automatically contact the Provider to make payment over the telephone with his credit card details. The Provider's response was as follows:

> *"In 2015 / 2016 the Complainant had opted to pay over nine monthly payments of €46.24. The first instalment due on 1 May 2015 and the last instalment were due on 1 January 2016. He actually paid a deposit of €400 by card over the phone on 3 April 2015 and three payments by card over the phone of €150 on 4 June 2015, 7 September 2015 and €110.34 on 7 December 2015.*
>
> *Reminder letters were issued to him on 11 May 2015, 22 May 2015, 10 August 2015, 24 August 2015, 10 November 2015 and 23 November 2015".*

The following question was put to the Provider by this office: *"It appears that the Complainant's contacts with the Provider were mainly by telephone and he paid his premiums by credit card over the telephone. In that respect, was any contact made by the Provider with the Complainant by telephone with regard to the outstanding premiums? If not why not?".*

The Provider's response was:

> *"No contact was made to the Complainant by [the Provider]. It is not the practice of [the Provider] to do this".*

The Provider was asked whether the Complainant's premium payment arrangement went outside what normally would be agreed to by the Provider, for example it appeared that a deposit was paid at 2016 renewal and 5 instalments were then to be made.

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The Provider's response was:

> *"No, it was a normal renewal and if the Complainant had responded to our letters and paid his payments on the due dates or paid extra this would have kept his policy in order".*

The Provider was asked (a) whether the Provider ever contacts an Insured by telephone to establish receipt by the Insured of cancellation correspondences or (b) whether the Provider ever communicates with the Insured in writing to advise that the policy had actually been cancelled and that he/she should then return the insurance certificate and disc.

The Provider's response was:

> *"No contact is made by telephone to policyholders by [the Provider], to establish receipt of cancellation correspondence. It is not the practice of [the Provider] to do this.*
>
> *After cancellation a refund cheque is issued or alternatively a letter may be issued looking for payment of any outstanding arrears.*
>
> *We advised the policyholder to return his cert and disc, in the initial cancellation notification registered letter, issued on 23 May 2016".*

Evidence

Further submissions from the parties

The Complainant's response to the Provider's submission of 30 April 2018:

> *"[The Provider's] Customer care manager, […], was wrong to write that I didn't agree to pay the premium for the period of insurance in question.*
>
> *I did agree with [the Provider] staff on phone during the course of our conversation for my car insurance renewal in April 2016.*
>
> *The [the Provider] staff made me to understand that I can renew & pay for my policy on phone as I did with them the previous year. I paid a deposit of €300 on that same day on phone and she agreed with me that I can pay the remaining over the phone again either once or twice within the instalment period.*
>
> *…. it's my recollection that [the Provider] sent the 2016 certificate of insurance including the car disc to me through my contact address when I made them to understand on phone that I cannot print out the disc as specified in 2016.*
>
> *The 2 pages letter [the Provider]] referred to was not included in the certificate of insurance rather they issue it to [my] self service account.*

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The advice needed with regard direct debit for instalment payments was not given to me on phone on that day when I renewed the contract".

The Provider's submission dated 15 July 2019

The Provider states that the Complainant logged onto his online Provider account on the following occasions:

- The Complainant registered for his account on 2 April 2015.
- The Complainant logged onto the account on 29 October 2015 and printed or at least viewed his Certificate of Insurance.
- The Complainant logged onto his account on 19 July 2016.

The Provider advised that all documents and correspondence were not posted to the Complainant's account. The Provider also advised that it would not specifically alert a customer once something was posted to the account, as it was not part of its functionality in 2015 or 2016. The Provider states that the Premium reminder letter was not posted online, as it was not part of the functionality of the account in 2015 or 2016. The Provider advised that 23 May 2016 letter was not posted to the online account, as it was not part of the functionality of the account in 2015 or 2016.

The Provider states that the terms and conditions attaching to the account do not differentiate as to what will or will not be posted to the online account, as it was not part of the account functionality in 2015 or 2016.

As regards whether it should have been made clear by the Provider that some communications would be sent by ordinary post and that there would be no alerts posted online for those items of post, the Provider's response was:

"No we do not accept this, as the normal policy terms apply, whether a customer uses their .. account or not.

Cancellation letters are posted and the actual letter cancelling the policy is sent by registered post".

The Complainant's submission of 8 August 2019

"[The Provider] failed to provide a formal letter setting out the terms and conditions of the motor insurance policy. The Provider also failed to forward a direct debit mandate to the complainant following the complainant's expressed agreement to pay by monthly instalment when the policy was arranged over the telephone. [The Provider] also failed to give notice in writing of the particular dates when monthly instalments are due. Insurance policies, particular motor insurance policies are to be properly arranged and all terms and condition including payment and payment plans, direct debit mandate are to be evidenced in writing, formally communicated and signed by the parties concerned. [The Provider] failed woefully in this regard.

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We note that [the Complainant's] policy was cancelled on the 8th of June 2016 because [the Provider] could not collect the sum of €116.61 being monthly instalment for May 2016. This suggests that a payment by direct debit was agreed".

The Provider's timeline of events

29 March 2015 – The Complainant arranged the previous year's policy with the Insurance Provider. The Complainant paid a deposit of €400 on 3 April 2015 and agreed to pay the remaining premium by five instalments. The instalments of €46.24 were due on 1 May 2015, 1 June 2015, 1 July 2015, 1 August 2015, 1 September 2015 and 1 October 2015.

The Provider states that these payments were received irregularly as follows:

04	02/04/2015	Deposit	400.00	Cr	29/03/2015	Visa
05	04/06/2015	Payment	150.00	Cr	04/06/2015	Visa
06	07/09/2015	Payment	150.00	Cr	07/09/2015	Visa
07	07/12/2015	Payment	110.34	Cr	07/12/2015	Visa

29 March 2016 (Renewal 2016) - The Complainant contacted the Provider to query his 'No Claims Bonus'.

13 April 2016 - The Complainant contacted the Provider and agreed renewal terms. The Complainant reduced cover to Third Party Fire & Theft, the premium was agreed at €863.08. The Complainant paid the instalment deposit of €300 by Visa Card. The remaining five instalments of €116.81 were due on 1 May 2016, I June 2016, 1 July 2016, 1 August 2016, 1 September 2016 and 1 October 2016.

13th April 2016 – letter from the Provider to the Complainant:

"Thank you for your payment of €300.00.

We will collect your remaining 5 monthly instalments of €116.61 by direct debit from your account on the first working day of each month. We will start on 18/04/2016 and we will collect your last instalment on 01/09/2016.

It is important that you read and understand the attached confirmation letter"

10 May 2016 - Reminder letter (sent by ordinary post) was issued to the Complainant. The Provider's position is that the May 2016 payment was not received.

"We have been unable to collect the next instalment of €116.61 due under your payment plan. …. If you have not paid, then please pay this amount within the next 10 days. You can pay by credit or laser card over the phone at the number below, or post a cheque / postal order to [the Provider]"

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In a submission dated 12 December 2017, the Provider states that the above letter should have read that no payment was received, and that no Direct Debit was in place.

23 May 2016 – The Provider states that as no payment was still received a notification of cancellation letter was issued to the Complainant by registered post, advising that the policy would cancel on 8 June 2016, if full payment of the outstanding amount was not received.

> *"If you have not paid the outstanding premium instalment(s) then, in accordance with the terms of your instalment agreement, you must now pay the full remaining amount of your annual premium by 08/06/2016 for your insurance to continue".*
>
> *"If you do not pay the full remaining amount of your annual premium your policy will be cancelled from 08/06/2016 and you will not be insured to drive your vehicle. You may also find it difficult to arrange insurance of this type in the future. If we cancel your policy, by law you must return your insurance certificate and disc to us. We will let the Department of Transport know that we have cancelled your policy".*

27 May 2016 - The above Registered letter of 23 May 2016 was delivered to the Complainant's address and signed for.

The Provider states that an Post has confirmed this. A copy of the signed confirmation was submitted to this office by the Provider

8 June 2016 - Policy Cancelled by the Provider

13 June 2016 – letter to Department of Transport from the Provider.

> *"In accordance with article 9(4) of the Road Traffic (Compulsory Insurance) Regulations, 1962 you are hereby notified that the undernoted policy ceased to be effective.*
> *..*
> *Date Policy Ceased to be Effective: 08/06/2016*
>
> *Date of Issue of Notice to Insured: 23/05/2016"*

17 June 2016 – A refund cheque issued to the Complainant for €112.11.

22 June 2016 – The Complainant contacted the Provider to report an accident and was advised his policy was cancelled since 8 June 2016

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The Complaint for Adjudication

The complaint is that the Provider incorrectly cancelled the insurance policy and incorrectly refused to deal with the claim resulting from an accident.

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.

A Preliminary Decision was issued to the parties on **30 March 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.

The Provider made a post Preliminary Decision submission on **22 April 2020**. The Provider's post Preliminary Decision submission was exchanged with the Complainant for his consideration. There was no additional submissions received from the parties.

In arriving at my Legally Binding Decision I have carefully considered post Preliminary Decision submission of and all of the evidence and submissions put forward by the parties to the complaint.

In its post Preliminary Decision submission the Provider advised that on reviewing this case it wished to correct two points made in its 2017 submission to this office. The Provider now states that the 2015 policy was arranged on a nine-month instalment plan and not on a five month as stated. The Provider submits that the correct monthly instalment amounts in 2015 were €65.97 and the last payment was due on the 1 January 2016. The Provider also states that, the 2016 final payment was due on 1 September 2016 and not on the 1 October 2016 as stated.

In its submission of 22 April 2020, the Provider argues that because of the numerous inconsistencies in the position taken by the Complainant, it is submitted that this is a case where an oral hearing is necessarily required, if any causation is to be inferred.

Referring to my Preliminary Decision, the Provider submits that the conclusion of loss fundamentally disregards the admitted facts and, without an oral hearing, seeks to make sense of the various inconsistent positions taken by the Complainant. It is submitted by the Provider that if I wish to interpret the various versions of events offered by the

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Complainant, this could only be sensibly done having heard his explanation, to see whether all or any of them were either consistent or credible. The Provider acknowledges that it was not in a position to call a witness to rebut the Complainant's assertions, but states that where different explanations are offered, it submits that it is inappropriate to accept any of them without some underlying basis.

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. This is particularly so, as the evidence shows that the Provider has not been able to give a consistent account of the Complainant's dealings with the Provider in relation to his premium payments. The Provider's corrections or change of position on what it advised over the course of this complaint has continued right up to its last submission of **22 April 2020**.

Analysis

The following matters are of particular note:

- The Complainant was aware from his previous insurance dealings with the Provider that instalments were required to be paid in addition to the initial deposit.

- If, it is the positon that the detail of how the additional premium instalments were to be paid, was not advised to the Complainant in the telephone call of 13 April 2016, it would be reasonable to expect that the Complainant would have made an enquiry about this from the Provider. There is no evidence of such an enquiry being made by the Complainant, prior to the policy cancelling.

- The policy cover was arranged on 13 April 2016 and two months passed from when the Complainant took out the policy, before the Complainant made contact with the Company. That contact was in relation to the accident that occurred on 22 June 2016, some two weeks after the policy was cancelled.

- It is the Complainant's positon that he did not receive the Registered letter of 23 May 2016 as he was working and his family were not at that address at that time. I accept that the Provider was not aware that there was no one home to accept a letter, and the Provider cannot be held responsible for any non receipt of post which it had correctly addressed and sent through the postal system. The Provider had received confirmation of receipt from the postal service.

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- Under the relevant legislation (Section 62.1 (d) of the Road Traffic Act 1961 as amended) the Provider was only required to give 7 days notice in writing of its decision to cancel the motor policy. Section 62.1 (d) of the Act states that:

  "(d) the period of cover is not capable of being terminated before its expiration by effluxion of time by the insurer save either with the consent of the insured or after seven days' notice in writing to the insured".

  The Policy Provisions state that:

  "We, or our authorised agent, may cancel this policy by giving you 10 days notice in writing. We will send any notice to your last known address and we must tell the Department of Transport. You must then send us the insurance disc and certificate of insurance".

I accept that the Provider went further than the statutory requirements in that its policy terms allow for 10 days notice and it is noted that the cancellation letter issued on 23 May 2016 and was delivered on 27 May 2016. This letter advised of a cancellation date of 8 June 2016. Therefore, I accept that the Provider fulfilled its contractual and statutory requirements for the notification of a cancellation of the policy.

The fact that the Provider also sent the Complainant the cancellation letter by Registered post must also be noted. This was also over and above what was required by the policy document and the relevant legislation. Any issue the Complainant may have with how the Registered post operated in this situation is a matter for him and the Postal service.

I accept that as with any other type of insurance, it is the Policyholder's responsibility to make the premium payments for motor insurance.

That said there are particular matters to consider in the circumstances of this complaint. I will outline these below.

The Complainant renewed his insurance cover over the telephone on 13 April 2016. It was the Complainant's recall that he paid a deposit of €300 by way of a credit card and says that the Provider's representative agreed with him that he could pay the remaining premium over the telephone again either once or twice within the instalment period. In this regard it is noted that the payment plan did allow for payment of the outstanding instalments at any time: *"You may settle the account in full at any time".*

In its post Preliminary Decision submission he Provider states that:

"It is matter of straightforward interpretation by allowing the party to "settle the account in full at any time". It does not mean that payment can be made at any time that suits the insured but rather, that if he wishes to pay in full he can do so at

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any time. We do not believe that there is any room for dispute as to its interpretation because, as with any payment plan, the party is entitled to discharge it in full earlier than it is required to be paid.

It therefore provides no support and could not reasonably be interpreted as allowing the insured to have a free rein as to when he decided to make payment".

With regard to the above submission, I would point out that it was on the basis that the Complainant had an irregular payment history with the Provider (which was facilitated by the Provider) that the above advice from the policy documentation was considered to have relevance.

It is the Complainant's positon that: *"The [the Provider's] staff made me to understand that I can renew & pay for my policy on phone as I did with them the previous year.*

In this regard, the Provider has advised this office that the Complainant had agreed in the previous year to pay the 2015 premium over nine monthly payments of €46.24, but that he actually paid a deposit of €400 by card over the telephone and three payments of €150 in June 2015, September 2015, and December 2015.

I remain of the position that this supports both the Complainant's positon that he thought he could pay the 2016 premium in the same manner as in 2015, and also accords with what the payment plan states: *"You may settle the account in full at any time".* I have been provided with no evidence that the Complainant was informed that he could no longer pay his premium in the manner in which he had done previously.

The Direct Debit Instalment Plan said to have been sent to the Complainant had not been activated. The Complainant would have had to first call the Provider with his bank details. Which did not happen in respect of the policy in question. The Complainant also argues that the Provider did have his bank account details from a previous insurance period and that there were monies in his account for payment of premiums. The Provider states that no arrangement was ever put in place for the Complainant to pay his instalments by Direct Debit and no instalments were ever received by Direct Debit on this policy. The Provider also stated that it never received the Complainant's Bank account details and it has no record of them on the policy, in question. The Provider's position is that bank giro forms were issued for the instalment payments. The Provider submitted a screen shot of its records showing: *"14/04/2016 PBI: CT BOOKLET PRINTED".*

In the above regard the Complainant states that his account details were provided in the telephone call of 13 April 2016 and the Provider's letter evidences that this was the position. As regards the Payment by Instalment Booklet (PBI Booklet) being printed by the Provider on 14 April 2016, the Complainant points out that this information is

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contradictory, as the letter advising of the said instalments is dated 13 April 2016 (one day earlier).

The Complainant advises that he did not receive the payment plan details by ordinary post. However, he does state that the certificate of insurance that is said to have accompanied those details was supplied to him by post as he was unable to print the certificate from the online facility.

All of the Provider's written communications with the Complainant are based upon the incorrect premise that a direct debit instalment plan was to be in place. The Provider accepts that it should not have referred to direct debits as no direct debit was in place. It is of particular note that the Provider never corrected this contradictory positon with the Complainant regarding a requirement for direct debit payments.

There was no prompt or reminder from the Provider for the Complainant to send in his bank account details.

The acknowledgement of receipt of the deposit letter of 13 April 2016 refers to the Provider starting to deduct the 5 monthly instalment as follows:

> *"We will start on 18/04/2016 and we will collect your last instalment on 01/09/2016".* The letter goes on to state: "*It is important that you read and understand the attached confirmation letter".*

It is noted that the attached confirmation letter states that the first instalment was to be collected on 01/05/2016. This is at variance with the cover letter which stated that the first instalment would be collected on 18/04/2016 (again it must be noted that this incorrectly relates to collection of premiums by way of direct debits).

The Provider only submitted a partial telephone recording involving the renewal of the policy in 2016. The most important part of the telephone call – that is where the payment details were agreed / explained / discussed, and how payments were going to be made – is missing. The reason given by the Provider for the incomplete telephone recording, is that once the staff member goes into the payment system that the recording shuts down, so as not to record Credit Card or Bank account details. I note that the recording ends before any discussion took place as to card details or how the payment was going to be made. This is most unfortunate, as this call is key to understanding what the Complainant was told in relation to how he could pay for his insurance policy.

When the Provider was asked to provide a written signed statement from the staff member who spoke with the Complainant in 2016, the Provider advised that the staff

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member has retired. The Provider also stated that as the staff member had 30 years' experience the Provider would be surprised if she had agreed, as stated by the Complainant: *"I can pay the remaining .. either once or twice within the instalment period".*

The Provider stated in its response to the complaint (dated 30 April 2018) that on the same day the policy was put in place (13 April 2016), the Provider had posted a letter on the online platform outlining the Direct Debit Instalment Arrangement.

However, in a subsequent submission from the Provider (letter of 17 January 2020) the Provider states:

> *"No communications were issued in 2015 or 2016 through [online] accounts. It was never intimated to Customers that communications would be done through their [online] accounts. All communications to all customers in 2016 were made by Post"*

The Provider was asked to submit the terms and conditions that applied to the online facility. In its response of 18 July 2019, the Provider initially submitted the terms and conditions that applied from 1 March 2017 and advised that the version applicable to 2015 / 2016 were not readily available. The 2017 terms and conditions that were supplied were comprehensive as to the use of the on-line facility.

In October 2019 the Provider submitted a document called ***"Our conditions and data protection details"*** which the Provider stated were the *"Conditions and Data Protection Details attaching to the [on-line] account for 2015 / 2016".* However, this document primarily related to Data Protection issues and did not go into any detail as to the operation of the online account.

This office sought clarification as to whether this document was the complete document that was issued in 2015 / 2016 and was advised by the Provider that: *"The document submitted on 11 November 2019 "Our conditions and data protection details" is the entirety of the document".*

I consider that without the fullest information on how the online account was to operate, it would have been difficult for the Complainant to know how it was to operate or to know what was or was not going to be posted there by the Provider.

The Provider submitted that it does not alert the Policyholder by way of telephone call or text message, that the there was a posting on the online platform. The Provider also advised that its records show that the Complainant only logged on to the account once in 2016 (19 July 2016) which was after the policy had cancelled.

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The Provider states that it sent two letters to the correspondence address that the Complainant had previously provided. The first letter was sent on 10 May 2016 advising of the premium payment that was required. The second letter was sent on 23 May 2016 and was sent by Registered Post. This Registered Letter notified the Complainant that his policy would be cancelled from 8 June 2016 should the outstanding premiums not be received. This Registered letter was signed as having been received on 27 May 2016. The Complainant disputes that he received this letter (as he was at work some distance away from his home) and that the signature on the Proof of Delivery was not his.

There was a pro-rata refund of premium which the Provider states reflected time on cover. The Complainant argues that this refunded premium would have covered him for the accident period. The deposit that was paid is said by the Provider to have represented a % of the overall premium in addition to a handling charge.

The Provider accepts that the Complainant paid for a greater period of cover than provided.

The cancellation letter refers to the position that by law the Complainant must return his insurance certificate and disc. The Policy was to cancel on 8 June 2016. I note that 14 days passed beyond this date before further contact was made with the Complainant (when he reported the motor accident). In the intervening period the Complainant was not contacted by the Provider regarding a return of the insurance certificate and disc.

The Complainant's method of dealing with the Provider was primarily by way of telephone. The Provider also had the Complainant's e-mail details, but did not at any time contact the Complainant by e-mail or telephone to advise him of missed payments or that his policy was going to be cancelled.

On the balance of the evidence I must conclude that the Complainant did not receive the premium payment details in writing from the Provider for the 2016 policy cover. Even if the Complainant had received the written payment details, I consider that the payment details recorded on the communications are contradictory and not as clear as would reasonably be expected for such important information.

The consequences for the Complainant of the cancellation of cover by the Provider are many and serious. He no longer had insurance cover. A claim under the policy by either the Complainant himself or a third party would be affected by the cancellation. An insurance cancellation is something he would have to declare with every request for insurance from any provider. Finding an insurer may also prove difficult and additional costs may arise.

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On the evidence submitted I accept that the Complainant reasonably thought that he could arrange his motor insurance cover and pay for that cover (in 2016) in the same manner that he had done previously (in 2015) with the Provider. I have been provided with no evidence that he was informed otherwise by the Provider. The way that he had previously arranged his insurance was by paying his deposit upfront and paying the balance in lump sum payments over the remaining period of cover. The Complainant's positon is also that he expected some contact from the Provider seeking direct debit instructions, as per the Provider's correspondence that was to issue to him. It would appear, for whatever reason, that the Complainant did not personally receive the registered cancellation letter that was sent to his home and was unaware he was driving uninsured for a time.

The Provider's evidence was incomplete and I consider that its record of dealing with the Complainant was not clear and was at times contradictory and confusing. I particularly would have expected to be able to receive a greater part of the crucial telephone call of 13 April 2016 in evidence, as the payment details had not begun to be discussed to cause the call to stop recording, as suggested by the Provider.

In its post Preliminary Decision submission the Provider suggests that the reasoning in my Preliminary Decision is inconsistent and that my proposed upholding of the complaint and directing of compensation are both inappropriate.

It is because of the various inconstancies and issues set out above in the Provider's communications with the Complainant and submissions, that I consider that the complaint must be upheld, on the evidence presented.

The certainty that is required from a Provider as to what a policyholder must do regarding the payment of motor insurance premiums, was not demonstrated by the Provider.

Having regard to all of the above, it is my decision that this complaint is upheld and I direct the Provider to (i) reinstate the Complainant's policy (ii) deal with any claim that has arisen in the normal way (iii) correct its records as regards the cancellation to show that the policy was not cancelled (iv) inform the relevant authorities of the reversal of the cancellation, and (v) pay the Complainant the compensatory payment of €8,000 (eight thousand euro) for the stress and inconvenience caused to him by the cancellation.

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is upheld, on the grounds prescribed in ***Section 60(2)(g).***

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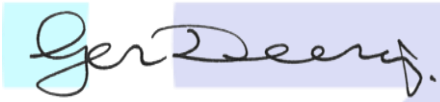
- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to (i) reinstate the Complainant's policy (ii) deal with any claim that has arisen (iii) correct its records as regards the cancellation to show that the policy was not cancelled (iv) inform the relevant authorities and (v) pay the Complainant the compensatory payment of €8,000 (eight thousand euro) for the stress and inconvenience caused to him by the cancellation.

- The Provider is to make to make the compensatory payment to the Complainant in the sum of €8,000, 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.***

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

18 May 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.