An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0267
Sector:	Insurance
Product / Service:	Car
Conduct(s) complained of:	Premium rate increases
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant held a policy of motor insurance with the Provider, against which this complaint is made. In June 2016, the Complainant was involved in a road traffic collision with an uninsured driver. The Provider raised the Complainant's premium from €467.22 in 2015 to €1,179.26 in October 2016 and to €986.72 in October 2017. The Provider indicated that this was due to the Complainant losing her no claims bonus.

The Provider stated that it would reimburse the Complainant for any overpayment in premiums once a Garda Abstract Report was received setting out the outcome of criminal proceedings brought against the uninsured driver.

The Complainant received a refund of €298.70 from the Provider in addition to a €50.00 payment for inconvenience caused. The Complainant believed that she should receive a refund of €830.00. The Complainant also complained regarding various customer service failings by the Provider.

The Complainant's Case

The Complainant states that she has not been refunded sufficiently by the Provider. She asserts that her premium increased from €467.22 in 2015 to €1179.26 in October 2016 and to €986.72 in October 2017. The Complainant states that the slight reduction in 2017 was due to obtaining a new no claims bonus. The Complainant accepts that there would have been a slight rise in her premium as insurance premiums generally increased that year. The Complainant states that the Provider has failed to set out any proper explanation of how it arrived at its figures.

The Complainant says that she should be entitled to a refund of €520.00 for 2016 and €310.00 for 2017. The Complainant seeks a refund of the difference between what she was paid and what she says she ought to have been paid.

The Complainant also raises issues concerning the customer service provided by the Provider. After the uninsured driver was found guilty in April 2018, the Complainant states that she made numerous phone calls to the Provider in an attempt to obtain her refund. The Complainant states that these were ignored or not actioned, which amounts to an unreasonable delay. The Complainant also notes that two letters were sent to her at her old address. The Complainant states that these letters were ultimately delivered to her new address, but that this represented a lack of care on behalf of the Provider and potentially amounted to a data breach. The Complainant states that she received inaccurate information concerning how and when the refund would be paid to her, albeit this information was given to her by her broker and not the Provider.

The Provider's Case

The Provider explains the premium increases as follows. In 2016 and after the accident with the uninsured driver, the Provider states that the Complainant's no claims bonus was effectively suspended until such time as she was deemed not liable for the accident. This resulted in the Complainant's no claims discount being reduced from 56% to 45%. Similarly the Complainant changed two details (her address and removed a named driver) which increased her risk profile. The Provider states that the overall performance of its business resulted in a general increase in premiums, which was not unique to the Complainant's policy. In 2017, the Provider notes that the Complainant benefitted from a limited no claims bonus and also a reduction in vehicle value which drove the Complainant's premium downwards. The Complainant's no claims discount moved from 45% to a 55%. In 2018, the Provider notes that the Complainant benefitted from an increased no claims discount which moved from 55% to 59%. The Provider states that there were no customer adjustment in 2018, which resulted in a lower or higher premium.

In explaining how it came to assess the refund that the Complainant was entitled to receive, the Provider states that the no claims discount that a customer is entitled to increases in smaller percentage increments as each year passes. Furthermore, the Provider explains that changes in premiums offered by reference to the change in risk factors that occurred. The Provider says that it is also entitled to take account of general market risk factors. It asserts that all the foregoing set out how the refund was calculated.

With respect to the two letters that were incorrectly addressed, the Provider states that it has two systems in which it keeps its customers' addresses. While the Complainant's details were updated in one system, the other system was not updated. The Provider notes that the details have been updated in both systems as of September 2018.

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In respect of the customer service complaints, the Provider acknowledges that it was slow in paying the refund. The Provider states that this was not solely precipitated by the lodging of the complaint, but that it was influenced by it.

The Provider states that it was told on **4 July 2018** that the uninsured driver was, in fact, uninsured. This allowed it to manage the claim pursuant to a protocol associated with uninsured drivers. On **6 September 2018** and **17 September 2018**, the Provider made the refund. It accepts that this was not acceptable.

The Provider paid the Complainant €50 for the inconvenience caused.

The Complaint for Adjudication

The complaint for adjudication is that the Provider did not act appropriately in how it assessed the refund that the Complainant was entitled to and that the Provider failed to provide proper customer service to the Complainant.

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 6 May 2020, outlining my preliminary determination 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.

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Following the issue of my Preliminary Decision, the parties made the following submissions:

1. E-mail from the Complainant to this Office dated 6 May 2020.

2. E-mail from the Provider to this Office, together with attachment, dated 25 May 2020.

The above submissions were exchanged between the parties.

Having considered the above submissions, together with all of the submissions and evidence furnished by the parties to this Office, I set out below my final determination.

In relation to the assessment of the Complainant's refund I note the following. The Complainant was understandably aggrieved by the significant rise in her premium between 2015 and 2016, as it increased by €712.04. The question to be decided as part of this Decision is whether or not the Provider acted unreasonably or unfairly or unlawfully in how it measured the refund that it provided to the Complainant. In that regard, the Provider has set out objective information that it used to calculate the recalibrated premiums. First, the Provider notes that in general there were increases in premiums across its client base for the relevant years.

In my Preliminary Decision, I stated:

> *"… the Provider specifically notes that there were changes in the specific risk profile of the Complainant during the relevant years, including the purchase of a new vehicle which resulted in a pro rata return payment."*

The Complainant, in a post Preliminary Decision submission dated **6 May 2020,** comments on this as follows:

> *"The court case for accident was on 27 April 2018. I purchased a new car AFTER the court case. The car which was involved in the accident was a 2 litre [details of car redacted] and my new car is a 1.6 litre [details of car redacted]. My argument here would be that the pro rata return was because I now had a car with a smaller engine size. Also, this car was not in my possession when the insurance company charged me my premiums in Oct 2016 and 2017(the dates that this complaint are about) so that argument should not be used as part of their defence. I do, however, acknowledge that I changed address and removed a party from my policy".*

The Provider made a post Preliminary Decision submission on **25 May 2020.** The Provider wishes it to be noted that in the "*the opening section 'Background'"* I refer to the premiums charged by the Provider.

The Provider also wishes it to be noted that "*for the periods in 2015 through to 2017…the premiums referenced also include a brokerage fee which does not form part of the premium charged by the Provider".*

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The Provider states that the nature of the no claims discount in question is that the increase in the no claims bonus reduces incrementally as the customer in question has a longer period of no claims.

This can give a misleading impression to a customer that the benefit that they will receive is linear. Similarly, the Provider notes that the Complainant may have been under the impression that she was receiving none of her no claims bonus for the relevant years, when in fact she was receiving a reduced a no claims bonus. The Provider asserts that this may have resulted in the Complainant perceiving that she would be entitled to a bigger refund than she received.

The Provider, in its post Preliminary Decision submission, seeks to highlight that while I state in my Preliminary Decision that:

> *"The Provider states that the Complainant's no claims bonus was effectively suspended until such time as she was deemed not liable for the accident".*

It points out that:

> *"The No Claims Bonus was not suspended for the period of cover following the incident, but rather it was stepped back. The No Claims Bonus was impacted at renewal 2016, following the incident in 2016, at which point it was reduced from 6 years to 4 years. Each year thereafter, the complainant continued to earn a No Claims Bonus with 2017 seeing an increase from 4 years to 5 years. 2018 would have increased to 6 years, had the policy remained claims free, only that it was increased to 9 years following full reinstatement".*

The Provider has, also, in its post Preliminary Decision submission, argued that my comments in the Preliminary Decision *"may be interpreted as the Provider providing or being aware of misleading information being provided to the Complainant throughout the period, which is not the case".*

The Provider submits that:

> *"The 'Preliminary Decision' section refers to how the No Claims Bonus 'reduces incrementally as the customer in question has a longer period of no claims.' It then continues stating that 'this can give a misleading impression to a customer that the benefit that they will receive is linear'. In keeping with this point, reference is made to how the Complainant may have 'similarly' been under the impression that she was receiving none of her no claims bonus for the relevant years'. This, combined with reference to a view on how the No Claims Bonus value should be calculated, may be interpreted as the Provider providing or being aware of misleading information being provided to the Complainant throughout the period, which is not the case. As stated within, the calculation of premiums and by extension No Claims Bonus, 'is fundamentally a commercial decision by the Provider'."*

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I do not believe that my comments infer that the Provider was "*providing or being aware of misleading information being provided to the Complainant throughout the period".* This is reflected in the level of compensation directed.

The Provider has stated in its post Preliminary Decision submission, that while I state in my Preliminary Decision that:

> *"The Provider states that there were no customer adjustment in 2018, which resulted in a lower or higher premium".*

It points out that:

> *"Whilst there were no customer adjustments at renewal in 2018, we had however acknowledged that there was a change made on the 1st May 2018 which resulted in a return premium of €163.80".*

The Provider states that the above was detailed in its "*initial submission* [which] *included full detail of changes made throughout the policy for the relevant years. Reference to the change of vehicle in the 2018 period, and associated pro-rata premium, demonstrates that the risk information, which the premium was based on for that period, was not on a like for like basis when compared to previous periods".*

The setting of insurance premiums is a matter that falls within the commercial discretion of a provider. I will not interfere with this discretion unless the Provider's conduct was in some way unreasonable or unlawful. While the Complainant has queried the premium that she was charged, the Provider has explained the reasons behind the change in premium and has set out an objective basis as to how the premiums were calculated. The Provider is entitled to underwrite its own risk and to calculate the relevant premium for the particular risk of a particular individual taking account of changes to risk factors relating to that particular individual. I have been provided with no evidence that the Provider acted unreasonably or unlawfully in how it set the premium and calculated the relevant refund. This is fundamentally a commercial decision by the Provider.

In relation to the customer service complaints, I note the following. First, the phone calls, (recordings of which have been provided in evidence), primarily relate to the issue of the Garda Abstract Report being provided. It is clear that the Provider was informed by the Gardaí on **4 July 2018** that the other driver was uninsured. I note that the Provider states that it had made 15 calls to the Gardaí to establish this prior to **6 July 2018.**

On **6 July 2018**, the Complainant spoke to the Provider and raised issue with the amount that she received. The Provider explained that this was the repayment of the policy excess. The Provider's agent indicated that she had instructed the underwriting department to contact the Complainant's broker to deal with the payment of the refund. On **14 August 2018**, the Provider received a phone call from the Complainant's broker concerning the repayment of her refund. The Provider said that it would have to check with the underwriting department. There are no further phone calls submitted.

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The phone calls illustrate that there was a delay in how the Provider dealt with the payment of the refund. The Provider acknowledges in its formal response that there were excessive delays in dealing with the Complainant's queries. The Provider acknowledges that it should have contacted the Complainant sooner and arranged for her refund to be provided. It does not seem that there is any dispute in this regard.

In respect of the contact details being incorrect, the Provider has acknowledged that it did not have the proper details of the Complainant in one of its systems. The Provider is obliged to have proper contact details of the Complainant pursuant to 11.5 of the CPC.

The Provider was not in compliance with this requirement. In relation to the alleged breach of data protection, this is outside my jurisdiction and is more appropriately a matter for the Data Protection Commissioner. All things considered, I find that the customer service provided by the Provider fell below the standard to be reasonably expected.

It should be noted that the Complainant states that she was incorrectly told that she would only be paid her refund once the losses were recovered from the uninsured driver. The Complainant was told this by her broker. The Provider accepts that this was incorrect. The refund was paid once the court case concluded. The Provider cannot be held responsible for this incorrect information.

While I accept that the changes that occurred in the Complainant's cost of premiums were a matter for the commercial discretion of the Provider, I believe that the communication with the Complainant could have been better. It is understandable how the Complainant believed she had "*lost*" her no claims bonus and that she should have been entitled to a greater refund.

In particular, I believe the Provider could have furnished the Complainant with a more detailed explanation of the charges she incurred and how they were arrived at by the Provider. In this regard, a more fulsome explanation was given to this Office. I believe this more detailed explanation should have been given to the Complainant on foot of her enquiries or, at the very least, in the Final Response Letter she received.

I note the Provider has given the Complainant a goodwill gesture of €50. However, given the delay in making the refund and the shortcomings in communication, I believe a more appropriate amount for the inconvenience caused would have been €250. Therefore, I partially uphold this complaint and direct the Provider to pay the Complainant the sum of €200 for the inconvenience caused.

Conclusion

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

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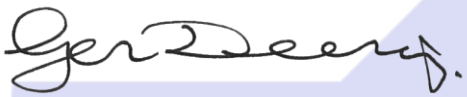
Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainant in the sum of €200, to an account of the Complainant's choosing, within a period of 35 days of the nomination 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

10 August 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.

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