An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0340
Sector:	Insurance
Product / Service:	Car
Conduct(s) complained of:	Maladministration Premium rate increases No claim bonus issues
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns the Complainant's motor insurance policy and a claim submitted to the Provider.

The Complainant's Case

The Complainant alleges that the Provider has shown poor customer service and maladministration in dealing with his motor insurance policy, following a *"very minor bump"* motoring accident. The Complainant submits that on **5 October 2015** he had a minor traffic accident with a third party. The Complainant states that he admitted liability for the accident after having hit the third party's vehicle from behind. He goes on to say that, having called the Gardaí, he was then advised to exchange insurance details with the third party, which he did and he also contacted his insurance broker, who advised him that *"the* [Provider] *would now deal with it".* The Complainant says he had already accepted liability for the accident and informed his broker of this.

The Complainant submits that he received an initial letter from the Provider dated **7 October 2015**. This correspondence acknowledged his accident and also contained the statement *"The settlement of this claim may affect future motor insurance premiums"*. Shortly afterwards, the Complainant received a further letter from the Provider dated **16 October 2015** informing him that a *"thorough investigation had been completed"* and that the Provider had settled with the third party noting that a settlement amount of €1,525.07 had been paid to the third-party.

The Complainant states that *"this all was done without* [the Provider] *directly contacting me or sending me out any 'car accident report' forms or anything else of the sort*". The Complainant says that *"although he was surprised at the speed and the extent of the compensation awarded…* [he] *was just happy to have it all behind him".*

In **February 2016**, the Complainant submits that he was *"shocked"* to learn that his policy renewal premium had significantly increased. *"This figure is €224.88 more than what they had just paid out for the damage to the third party's car".* He further states that *"Almost 4 months had elapsed since* [his] *contact with* [the Provider] *and it was now only 2 weeks' notice prior to* [his] *insurance renewal being due".* The Complainant contacted his broker, who informed him that the Provider was responsible for the premium increase and that the previous insurance claim still *'Remained Open'*. No further information was forthcoming from the Provider. The Complainant further submits that he could not believe this and as far as he was concerned the claim was closed. The Complainant contends that the Provider *"withheld all detailed information from* [him] *up until the point approaching* [his] *premium renewal."* The Complainant also submits that the increased premium rate he has been levied is a reflection of the Provider's "*insurance incompetency*".

The Complainant argues that the Provider should have formally contacted him within *"5 working days"* to acknowledge receipt of letters sent by the Complainant. The Complainant also submits that he did not receive an *'Accident Report Form'* from the Provider at the time of the accident. The Complainant also alleges that an *'Accident Report Form'* was not sent to him until **March 2016.** The Complainant asserts that that when he contacted the Provider, in or around early March 2016, he was told by the Provider that it *"was now going to send out"* a formal 'Accident Report Form' and that he should *" fill it up and that it might help* [his] *case".*

The complaint is that the Provider has shown poor customer service and maladministration in dealing with his motor insurance policy. The Complainant seeks that his "*status as a safe driver with 33 years of claims free experience to be reflected in my insurance premium going forward*". The Complainant wants the "*designation of 'Claims Open' to be closed off immediately*." The Complainant also seeks compensation.

<u>The Provider's Case</u>

The Provider maintains that it made it clear to the Complainant at all times that any claim on his policy could result in an increase of premium. The provider relies on the letters of 7 and 16 October 2015 in this regard. Further correspondence from the Provider dated **2 August 2016** and **4 August 2016,** advises the Complainant that *"once a claim is made and /or is open on* [his] *policy* [his] *premium is effected".*

With regard to the Accident Report Form, a letter dated **8 June 2016** is submitted from the Provider which states that an 'Accident Report Form' was issued to the Complainant on 7 October 2015 and which asks *"can you please return to* [the Provider]*. On receipt of same we will review the file in full again".*

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The Provider states that an investigator was appointed following the communication by the Complainant of his concerns regarding the authenticity of the third party's personal injuries claim. The Provider concedes that this investigator "*should have been appointed earlier in the complaint process*" and, notwithstanding that the Provider considers that the outcome with regard to the third party would have remained the same, the Provider has offered compensation in the amount of €500.00 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 15 September 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.

In the absence of additional submissions from the parties, within the period permitted, I set out below my final determination.

Prior to considering the substance of the complaint, it will be useful to set out the relevant terms and conditions of the policy and to reproduce certain relevant provision of the Consumer Protection Code.

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Policy Terms and Conditions

The motor insurance policy includes the following on page 23:

> ***3. Claims Procedure***
>
> *…*
>
> *(d) we have full discretion in conducting any defence or in the settlement of any claim and in prosecuting in your name any claim for indemnity or damages*
>
> *(e) You are required to provide us with all information and assistance, including if we request it, the completion of an accident report form.*

Consumer Protection Code 2012

The following provisions are drawn from the Consumer Protection Code to which the Provider was subject at the relevant time.

> Provision 7.6
>
> *A regulated entity must endeavour to verify the validity of a claim received from a claimant prior to making a decision on its outcome.*
>
> Provision 7.7
>
> *A regulated entity must have in place a written procedure for the effective and proper handling of claims. At a minimum, the procedure must provide that:*
>
> *a) where an accident has occurred and a personal injury has been suffered, a copy of the Personal Injuries Assessment Board Claimant Information Leaflet is issued to the claimant as soon as the regulated entity is notified of the claim;*
>
> *b) where the potential claimant has been involved in a motor accident with an uninsured or unidentified vehicle or with a foreign registered vehicle, the regulated entity must advise the potential claimant to contact the Motor Insurance Bureau of Ireland (MIBI);*
>
> *c) where a claim form is required to be completed, it is issued to the claimant within five business days of receiving notice of a claim;*
>
> *d) the regulated entity must offer to assist in the process of making a claim, including, where relevant, alerting the claimant to policy terms and conditions that may be of benefit to the claimant;*

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e) a record must be maintained of all conversations with the claimant in relation to the claim; and

f) the regulated entity must, while the claim is ongoing, provide the claimant with updates of any developments affecting the outcome of the claim within ten business days of the development. When additional documentation or clarification is required from the claimant, the claimant must be advised of this as soon as required and, if necessary, issued with a reminder on paper or on another durable medium.

Provision 7.21

Where the policyholder who is a consumer is not the beneficiary of the settlement the policyholder must be advised, on paper or on another durable medium, by the regulated entity, at the time that settlement is made, of the final outcome of the claim including the details of the settlement.

Where applicable, the policyholder must be informed that the settlement of the claim will affect future insurance contracts of that type.

Analysis

The Complainant takes issue with the standard process of subrogation and the means by which motor insurance companies can resolve claims against their customers without necessarily securing the consent or approval of the policy holder to such resolutions. The right of the Provider in this instance to operate in this fashion is set out in Clause 3(d) of the policy as reproduced above.

This Office will not interfere with the Provider's right to resolve the claim as provided for in the policy of insurance unless the conduct of the Provider is unreasonable, unjust, oppressive or improperly discriminatory in its application to the Complainant.

The Complainant has been informed of this by this Office on a number of occasions.

I have been provided with no evidence that the conduct of the Provider was unreasonable, unjust, oppressive or improperly discriminatory in its application to the Complainant.

The Complainant has made certain allegations about the third party involved in the road traffic accident however, insofar as these allegations do not relate to the conduct of the Provider, I cannot investigate them and they are not relevant to this decision. This Office has written to the Complainant on numerous occasions outlining this.

The remaining element of the Complainant's complaint relates to the service given by the Provider.

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The Complainant acknowledges that he admitted liability at the scene of the accident on 5 October 2015 and further acknowledges that he communicated this to his insurance broker which in turn passed the information to the Provider. Within less than two weeks, the Provider settled the third party's material damage claim for the damage to the third party's car in the amount of €1,525.07. This was communicated to the Complainant in a letter of 16 October 2015.

I am satisfied that the Provider complied with provision 7.6 of the Consumer Protection Code 2012 insofar as it was able to verify the validly of the claim by reference to the Complainant's admission of liability. With regard to the issue of an 'Accident Report Form' ['ARF'], and notwithstanding that the Provider maintains that an ARF was sent to the Complainant on 7 October 2015 (the letter itself makes no reference to any such enclosure raising a serious doubt regarding this claim), I do not see that there was any obligation on the Provider to issue an ARF to the Complainant in circumstances where the Complainant had conceded liability for the accident.

It is apparent from the Clause 3(e) of the policy reproduced above that an insured is obliged to complete an ARF if requested to do so by the Provider, but there is no obligation on the Provider to issue the ARF in the first place; it is a matter that falls within the discretion of the Provider. In any event, the Complainant's grievance largely relates to the extent of injuries claimed by the third party to have been suffered, rather than to the circumstances.

I am further satisfied that the provisions of Chapter 7 of the Consumer Protection Code 2012 generally were complied with by the Provider up to the point at which the material damage claim was settled with the third party including, in particular, provision 7.7 (relating largely to obligations owed to a claimant) and provision 7.21 (relating to advising a policyholder about the final outcome of a claim including the details of settlement) which was satisfied by the letter of 16 October 2015. This letter clearly set out the outcome of the material damage claim and the amount of the settlement. This letter also included the following sentence at the end (a sentence which had also appeared in the letter of 7 October 2015):

> *The Settlement of this claim may affect your future Motor Insurance Premiums. This will depend on the extent, if any, of your No Claims Discount Protection.*

What followed thereafter was that the Complainant's policy fell due for renewal in March 2016, prior to which, in February 2016, the Complainant was advised that his new premium would be €1,674.95. This figure represented an increase of €1,254.57 from the previous year's premium which had been €420.38. (The figure of €1,749.95 quoted by the Complainant includes his broker's premium and an additional charge arranged by his brokerage.)

The figure of €1,674.95 was stated to include a 20% reduction (amounting to €406.09) on the basis of a 2-year no claims discount in circumstances where the Complainant's previous full no claims discount (earned following a minimum of 5-years without a claim) had been reduced to 2 years in light of the October 2015 claim, and given that the Complainant had the benefit of 'Step-Back' no claims discount protection. The renewal figure with 0% no claims discount would have been €2,081.04, based on the Provider's undated renewal letter.

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The Policy Schedule from the previous year's insurance (in the amount of €420.38) notes that there were 9 years of no claims discount. This was stated to equate to a 63% reduction (amounting to €613.43). The renewal figure for the previous year with 0% no claims discount would have been €1,033.81, based on the Provider's undated renewal letter.

It is not at all clear why the gross premium (i.e. net of any no claims discount) appears to have more than doubled from 2015 to 2016. There is a premium increase referable to the October 2015 accident which is built into the loss of the full no claims discount, however the doubling of the gross premium is separate to this and certainly does not seem to me to be explicable by reference to standard annual inflation. The Complainant refers to being orally advised that the premium hike was related to the outstanding personal injuries claim. As already noted, the renewal letter from the Provider is (unsatisfactorily) undated. There is however a letter dated the 9th of February 2016 which documents that the Complainant's no claims discount stood, at that date, at 20% in circumstances where the Complainant was deemed to stand at "*2 on a 5 year scale".* The 9 February 2016 also appears to be the date that the Provider received the letter from the third party's solicitor notifying it of the third party's personal injury claim (in this regard, the Provider's substantive response to this office refers to an incorrect date). It is therefore possible that the notification gave rise to the increase in the gross premium.

However, as has previously been advised to the Complainant by this Office, a motor insurance company has a broad discretion (subject to the provisions of the code of conduct) over a commercial decision such as the price to quote for a motor insurance policy, which will reflect the level of risk it has agreed to accept as part of the insurance contract. There is no obligation on a financial services provider to disclose the specific evaluations/calculations it uses in making its commercial decision. These practices are in line with Directive 2009/138/EC- Insurance and Reinsurance Directive (recast) (Solvency II) which safeguards a free, competitive market for insurance premiums. It is important to remember that an insured is free reject any offer advanced by an insurer.

As noted above, in or around the same time as the renewal time of the policy, the third party communicated his intent to bring a personal injuries claim arising from the accident of 5 October 2015. This caused the Provider to reopen the claim file which had previously been closed following the settlement of the material damage claim. I accept this was appropriate and reasonable.

Thereafter, there was an extended process of engagement between the Provider and the third party resulting in the third party's claim being settled, in March 2018, for €38,000 in general damages plus various amounts in costs and fees. The detail of this settlement was communicated to the Complainant in a letter of 5 March 2018. This meets the requirements of provision 7.21 of the Consumer Protection Code 2012.

The Complainant is of the view that the third party's claim was exaggerated and, indeed, fraudulent. The Complainant made his views known to the Provider. The Provider maintains that it took the Complainant's views on board and appointed a claims investigator to consider the matter, albeit belatedly. The Provider further maintains that, having "*extensively investigated*" the matter, and notwithstanding the Complainant's views, it considered it appropriate to advance the compensation which it offered to the third party.

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The Provider notes that liability for the accident itself was "*in no way disputed*" by the Complainant and it further comments that "*there was absolutely no evidence to support there being any issues with the injury claim*". The Provider concludes that "*the settlement reached was considered to be a very satisfactory outcome in all the circumstances*".

The subrogation clause in the Complainant's policy means the Provider is entitled to settle claims made against the policy holder even in circumstances where a policy holder may object. A complaint could only be upheld against an insurer if a complainant was in a position to substantiate some allegation of improper conduct on the part of the insurer in carrying out this function. I am not satisfied that the Complainant has substantiated any such conduct.

In this regard, it is clear that the Provider took the Complainant's view into account albeit that it subsequently did not accept this view. I make no comment whatsoever as to whether the Complainant is correct or incorrect in his suspicions about the third party; as regards the proper conduct of the Provider, I accept that the extent of its obligation was to consider the Complainant's submission which it appears to have done.

The Provider was furnished with medical evidence by the third party which supported the proposition that the claimant had suffered an injury. In such circumstances, it was within the Provider's right to settle the claim, notwithstanding the Complainant's views.

Insofar as the Complainant seeks this office to ensure that his "*status as a safe driver with 33 years of claims free experience* [is] *reflected in* [his] *insurance premium going forward*", there is no basis in law for this office to give effect to this request. The Complainant is of course entitled to be provided with an accurate summary of his claims history and he ought to be furnished with this by the Provider upon request being made. As already noted however, if forms no part of the function of this office to dictate the amount of any premium proposed by an insurer. This office is restricted to the analysis of the conduct of insurers as regards their interaction with customers and, in terms of the Provider's interaction with the Complainant, I have been provided with no evidence of inappropriate conduct by the Provider.

Insofar as the Complainant seeks that the Provider's system reflect that the claim relating to the October 2015 is closed, this is now a moot request in circumstances where the claim was closed following the settlement of the third party's personal injury claim in March 2018. In any event, it was appropriate for the Provider to re-open the claim in February 2016 upon receipt of notification of the third party's intention to seek compensation for personal injuries. It was equally proper and normal for the Provider's system to reflect that the claim remained open up until the point in time that the claim was resolved in 2018.

Finally, the Provider has acknowledged a delay in appointing an investigator and has offered compensation in the amount of €500 in respect of this delay.

I believe the €500 in compensation offered by the Provider in appointing an investigator is reasonable in the circumstances and for this reason I do not uphold this complaint.

It will be a matter for the Complainant if he wishes to accept this offer.

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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

6 October 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.