An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0387
Sector:	Insurance
Product / Service:	Household Buildings
Conduct(s) complained of:	Mis-selling
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainants incepted a home insurance policy with a financial services provider (the **Insurer**) in **April 2015** through their insurance broker, the Provider, against which this complaint is made. The First Complainant instructed the Provider to cancel the policy by telephone on **12 April 2017**. The Provider failed to advise the Insurer of the cancellation of the policy causing the Insurer to debit the First Complainant's bank account with two premium payments totalling approximately €185.00.

The Complainants' Case

The First Complainant explains that he cancelled a home insurance policy at the time it was due for renewal in **March 2017**. The Provider, unknown to the Complainants, did not cancel the policy and continued to deduct monthly premiums from the First Complainant's bank account. When the First Complainant noticed the Insurer's reference on his bank account statements some months later, he tried to contact the Insurer by email and telephone. The First Complainant states that no response was received and when he made further enquiries, he was told *"… the company could not find any policy or know why I was being charged."*

The First Complainant advises that the Provider became involved when he discovered the deductions being made by the Insurer were in respect of the home insurance policy: *"They could not find why my clear instruction to cancel policy was not implemented."* The First Complainant submits that he was refused a refund of the premiums as the original policy was in the names of both Complainants.

When the First Complainant *"… explained that the deduction and policy was invalid and could not be classed as any policy – it took multiple attempts for a refund to be issued."*

The First Complainant states that the Insurer did not follow up or provide a reason why *"… their customer service could not trace the payment or respond to my contacts over an extended period."* The First Complainant also remarks that *"[t]he broker was particularly unapologetic and arrogant throughout. This was similar to behaviour at time of renewal."* The First Complainant expresses the view that *"I expect the policy was intentionally not cancelled as the broker sought to keep commission and charges."* The First Complainant explains the Provider eventually agreed to provide him with a refund *"… after much unnecessary argument on my part."*

In resolution of this complaint, the Complainants are seeking *"… a full explanation from both the broker and insurer. Also an ex gratia payment in the amount of 1000 euro for the distress and inconvenience caused."* The First Complainant also advises that the Provider refused to provide copies of *"… all records and wish to force me to make a formal data protection act request."*

The Provider's Case

The Provider explains the Complainants' policy was incepted as a home insurance policy on **13 April 2015** and was due for renewal on **13 April 2017**.

The Provider advises that an instruction to cancel the policy was received on **12 April 2017** by telephone. The Provider states the instruction was acknowledged but it was not communicated to the Insurer. The Provider explains that its agent did not realise the Complainants' policy was on direct debit payments with the Insurer and did not advise the Insurer to stop deductions. The Complainants' policy lapsed on **23 June 2017** with effect from the renewal date of **13 April 2017** and the Provider's agent advised the First Complainant of this by telephone.

The Provider states that it did not receive any commission, fees or charges in relation to the Complainants' policy. The Provider states that it will only receive commission on a policy once it renews a policy and the Insurer forwards a commission statement. The Provider explains this did not happen in this instance as it had lapsed the policy from their end.

The Provider states the Complainants' policy was renewed by the Insurer because it is the Insurer's process to renew policies automatically unless advised otherwise.

The Provider states that on **11 July 2017** an Insurer cheque in the sum of €184.50 was issued to the First Complainant and on **31 July 2017**, the Provider issued a cheque in the same amount to the First Complainant. The Provider does not dispute the First Complainant's submission that it took multiple attempts for a refund to issue. However, the Provider explains that the First Complainant wanted the cheques to issue in his sole name.

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The Insurer could not do this without the written authorisation of the Second Complainant. The First Complainant was unable to provide this authorisation which delayed the refund cheques being issued.

The Provider advises that it has reviewed all calls, emails and letters in relation to this complaint and cannot find any instances where its agents were unapologetic or arrogant.

The Complaints for Adjudication

The complaints are that the Provider:

1. Failed to carry out an instruction to cancel the Complainants' home insurance policy;

2. Wrongfully continued to charge monthly premiums;

3. Failed to acknowledge the Complainants' distress and inconvenience when investigating their complaint; and

4. Was *unapologetic and arrogant* during its interactions with the Complainants.

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 Complainants were 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 9 October 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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In the absence of additional submissions from the parties, within the period permitted, I set out below my final determination.

At the outset, I would comment that auto renewal of an insurance policy can be a very useful feature and facility. However, it is essential that a customer is clearly aware that they have agreed to or accepted that their policy will auto renew and that the customer is made aware of the arrangements and charges that will apply both at renewal and post renewal of the policy.

It appears from the evidence submitted that the insurer did notify the Complainant that the policy would auto renew and how to cancel the policy.

The Complainant appears to have been furnished with a document titled "[Insurer plan name] *instalments Application Form"* which details on page one that:

> *"Do I have to re-apply every year?*
>
> ***No.*** *Once you are a participant and have paid all due instalments, we will write to you or your Broker each year before renewal telling you of any changes. We will continue to apply to your bank for the monthly amount due.*
>
> *Should you wish to cancel your instalments you will need to notify us in writing Otherwise we will continue to apply to your bank for the monthly amount due."*
>
> [Emphasis from document]

While the policy contained the warning detailed above from the insurer's *Instalments Application Form,* I have not been presented with any further information that was furnished to the Complainants regarding the auto renewal of the policy. I believe the greatest possible communication is required in relation to auto renewal.

<u>The First and Second Complaints</u>

The Complainants incepted a home insurance policy with the Insurer through the Provider in **April 2015**. The policy was due for renewal on **13 April 2017**. The Provider states in its Schedule of Evidence that the First Complainant contacted it by telephone on **12 April 2017** and instructed one of its agents to cancel the Complainants' policy.

I note that a copy of this recording has not been furnished by the Provider. However, it is not disputed that such an instruction was given during this call.

The Provider has acknowledged that while the Complainants' policy was cancelled at its end, its agent did not inform the Insurer of the cancellation of the policy. This appears to have resulted in two premium payments being debited to the First Complainant's bank account by the Insurer. The first on **20 April 2017** in the amount of €92.33 and the second on **20 May 2017** in the amount of €92.21.

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The Insurer issued the Provider with a refund cheque payable to the Complainants in the amount of €184.50 under cover of letter dated **6 July 2017**. This cheque was forwarded by the Provider to the First Complainant on **11 July 2017**. As this cheque was marked *A/C payee only*, the First Complainant was required to lodge it to an account held in the names of both Complainants, however, the Complainants did not have a joint account. A further cheque was issued to the First Complainant by the Provider on **31 July 2017**.

I am satisfied the Provider failed to notify the Insurer of the cancellation of the Complainants' policy. I accept the Provider's explanation that this was caused by one of its agents not realising the Complainants' policy was subject to direct debit payments with the Insurer. I have been provided with no evidence that the Provider's conduct was motivated by the commission or fees it would receive from the renewal of the policy.

The Provider's failure to notify the Insurer of the cancellation of the policy resulted in premium payments being debited to the First Complainant's bank account by the Insurer after the cancellation of the policy. I am satisfied that had the Provider informed the Insurer of the cancellation of the policy this would not have occurred.

As the Provider was not the entity collecting the direct debit payments, I do not accept that it wrongfully collected premium payments from the Complainants. However, I am satisfied that the Provider's conduct caused and/or contributed to the collection of premium payments by the Insurer after the cancellation of the Complainants' policy.

The Third and Fourth Complaints

The Provider apologised to the First Complainant in its Final Response letter dated **20 July 2017**, as follows:

> *"… we would like to take this opportunity to express our sincere apologies for any difficulties or problems which you have experienced during your custom with [the Provider]."*

In an email to the First Complainant dated **25 July 2017**, the Provider states:

> *"… the policy stayed in place as [the Insurer] were not notified by [the Provider] of your instruction to lapse the policy …*
>
> *The letter issued on 20/07 states this and also confirms that the fault is on our part for failing to notify [the Insurer]. We are deeply apologetic for this oversight.*
>
> *…*
>
> *In respect of correspondence issued by [the Insurer] regarding the payments for the above policy, we regret to hear you felt threatened by the wording [of] this letter. The wording contained is standard for any letters issued where payments fail and [the Insurer] were unaware of your instruction to end the policy at renewal. …"*

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By letter dated **2 August 2017**, the Provider wrote to the First Complainant as follows:

> *"… we regret that no further resolution to your grievances can be provided, other than arranging for the refund of erroneous payments and offering our sincere apologies for this inconvenience and difficulties caused to you. …"*

Having considered the documentary evidence in this complaint and having considered the content of the call recordings furnished by the Provider, I am not satisfied the Provider failed to acknowledge the distress and inconvenience caused by its mistake. Furthermore, the Complainants have not identified any specific incident or occasions when the Provider or its agents were *unapologetic* or *arrogant* towards them.

Goodwill Gesture

In response to this complaint, the Provider states that:

> *"As there was no material loss for the insured other than the inconvenience caused, we would like to propose as a gesture of goodwill, a €75.00 donation to a charity of his choice."*

The Provider has acknowledged its error in failing to properly execute the First Complainant's instruction to cancel the insurance policy and has offered compensation in the sum of €75.00 by way of a donation to a charity to be chosen by the First Complainant. However, in light of the foregoing, I do not consider the Provider's offer to be a reasonable sum of compensation for its conduct. In these circumstances, I partially uphold this complaint and direct that a sum of €500 be paid by the Provider to the Complainants in compensation.

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) (b), (e) 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 Complainants in the sum of €500, to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants 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.

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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

2 November 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.