An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0388
Sector:	Insurance
Product / Service:	Household Buildings
Conduct(s) complained of:	Failure to process instructions
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

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

The Complainants' Case

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

The First Complainant advises the Broker became involved when he discovered that the deductions being made by the Provider 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 he was refused a refund of the premiums as the original policy was in the names of both Complainants.

When the First Complainant explains that *"[w]hen I 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 the Provider did not follow up or give a reason why *"… their customer service could not trace the payment or respond to my contacts over an extended period."*

In a letter to this Office dated **28 August 2017**, the First Complainant explains he queried the payments from his bank account with the Provider by email and telephone but the Provider did not respond or follow-up with him. The First Complainant then instructed his bank to cancel the payments. Following this, the Provider wrote to the Complainants threatening to cancel their home insurance policy. The First Complainant contacted the Provider by phone but the Provider refused to discuss anything with him and directed him to the Broker.

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 incepted a home insurance policy on **13 April 2015** which was renewed in **2016**. The Provider states the policy auto renewed on **13 April 2017** and its renewal documentation advised that the Provider should be notified if the Complainants wished to discontinue their policy. The Provider states that no instruction was received to discontinue the policy.

The Provider submits it was not notified until **23 June 2017** that the policy was not being renewed and therefore, disputes that premium payments were taken without authorisation. The Provider states the instalment scheme continues at renewal unless a customer advises it that they are not renewing their policy. This ensures an easier process for customers whereby they do not have to complete new direct debit mandates at each renewal.

The Provider was first advised by the Broker on **23 June 2017** that the policy should have lapsed. The Provider states a refund was requested by the First Complainant on **23 June 2017** when he advised the Provider he did not renew his policy. The Provider advises that when this instruction was received the policy had already auto renewed and the direct debit arrangement had rolled over. The Broker confirmed it did not pass the First Complainant's instruction to the Provider therefore, the policy was renewed in good faith. The Provider advises that two instalments had been collected: 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 Provider explains that as soon as it was made aware the policy was to lapse from renewal, it agreed to backdate the lapse to the renewal date and issued a refund to the Complainants. As the policy was in the joint names of the Complainants, the Provider was obliged to issue payments in the joint names of the policyholders unless requested and confirmed by all policyholders. The Provider states that it advised on what was required to re-issue a refund cheque in one name only however, confirmation from the second policyholder was not received. In an effort to resolve matters, the Provider states it issued a cheque to the Broker to give to the Complainants.

The first instalment default occurred on **20 June 2017**. This meant that an automatic standard default letter issued on **20 June 2017** and was received by the Complainants on **23 June 2017**. This letter advised the Complainants that a direct debit payment had been retuned unpaid and that full payment was required within 21 days to avoid cancellation of the policy.

A telephone call was received from the First Complainant who spoke to the Provider's Finance Department. However, the First Complainant did not want to proceed with answering identification and verification questions. The Provider explains that as the caller could not be identified, it could not proceed with discussing the policy and the caller was advised to contact their broker. The Provider states that in order to protect customer data it has a process in place to identify and verify a caller before it can discuss a policy. The Provider advises that it asks between 4 and 5 questions to verify the identity of a caller.

The Provider states that the First Complainant provided his name and address but declined to provide his date of birth, therefore, the Provider could not verify that it was speaking to a policyholder. The First Complainant did discuss the letter he received and it was agreed the Provider would contact the Broker as the First Complainant advised that he had not renewed the policy.

A refund cheque was issued by the Provider's Finance Department on **6 July 2017** in the joint names of the policyholders. On **20 July 2017** the First Complainant telephoned the Provider and advised that he wanted the cheque issued in his name only. The Provider's agent advised the First Complainant that it required a letter signed by the Second Complainant to confirm the cheque was to be issued in one name only. The Broker contacted the Provider on the same day and was also advised of this. The Provider states that it did not receive a letter to confirm that the cheque was to issue in the sole name of the First Complainant.

Addressing the complaint regarding unanswered emails, the Provider has set out a list of email correspondence with the Complainants detailing when the relevant email was received and responded to. The Provider also points out that a number of emails were sent to an email address that does not exist. In respect of these emails, the Provider submits that the Complainants would have received an undelivered email notification. The Provider refers to an email dated **22 June 2017** and states that *"… we have not been able to trace receipt of same and apologised to the policyholder for this and that he didn't receive a response."*

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The Provider states that it wrote to the First Complainant on **21 July 2017** advising that it had no record of receiving a request for a final response letter and that to enable it to issue one could he forward details of his complaint. The Provider states that the First Complainant responded advising *'The broker is investigating the matter and I trust all will be addressed by them.'* The Provider explains that no details of the complaint were provided to it.

The Complaints for Adjudication

The complaints are that the Provider:

1. Failed to respond to communications from the First Complainant in a timely manner;
2. Issued a threatening letter to the Complainants;
3. Failed and/or refused to engage with the First Complainant;
4. Failed and/or refused to issue a refund to the Complainants;
5. Failed and/or refused to provide relevant records; and
6. Failed to adequately advise of the eligibility requirements of this Office.

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.

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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.

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

Background

The Complainants incepted a home insurance policy in **April 2015**. The First Complainant informed the Broker during a telephone call on **12 April 2015** that he did not wish to renew the policy. Due to an error on the part of the Broker, the Provider was not notified of the First Complainant's instruction to cancel the policy.

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 Provider did notify the Complainants that the policy would auto renew and how to cancel the policy.

A document submitted by the Provider, in its submission, titled "[Provider plan name] *instalments Application Form"* 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]

The Provider states that it issued the:

> *"Renewal papers to the broker in March 2017 and when we did not get an instruction to lapse the policy our system automatically renewed the policy and applied for a direct debit of €92.21 on the 20th of April and again on the 20th of May.*

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> *The direct debit that we applied for on the 20th of June was uncollected as we got a message back to say the account was 'blocked by debtor' and an automatic letter was issued to the Complainant advising that they were in breach of their credit agreement. At this point we got calls from the broker and the insured to advise that the policy was lapsed and no further attempts were made to collect direct debits".*

While the policy contained the warning detailed above from the *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.

The First and Third Complaints

The First Complainant contacted the Provider's customer service section by email dated **1 May 2017** querying a direct debit payment in the amount of €92.33. The Provider responded on **3 May 2017**. The customer care section was unable to assist the First Complainant and on **5 May 2017** provided the First Complainant with a telephone number and email address for its customer help section.

The First Complainant emailed an incorrect email address on **5 May 2017**. The email address used was consumerhelp@ rather than customerhelp@. The First Complainant sent an email to the incorrect email address again on **22 May 2017**. It appears the First Complainant sent an email to the correct email address on **22 June 2017** seeking a reply to his previous correspondence. However, as acknowledged by the Provider, this email does not appear to have been replied to. The First Complainant emailed the incorrect address again on **23 June 2017** but Cc'd the Provider's customer service section, in respect of a letter he had received from the Provider regarding a missed payment on his policy. This email does not appear to have been responded to by the Provider. The Provider advises that it has not been able to trace a copy of this email and has apologised that a response was not received.

A number of the emails not responded to, was not the fault of the Provider. Rather this arose as a result of the First Complainant using an incorrect email address. However, it is clear, and the Provider has acknowledged, that two emails sent to the correct address were not responded to. Accordingly, I am satisfied the Provider failed to respond to the First Complainant's correspondence.

Notwithstanding this, looking at the correspondence between the Provider and the First Complainant as a whole, I accept that the Provider attempted to engage with and address the issues raised by the First Complainant.

The Second Complaint

The Provider wrote to the Complainants by letter dated **20 June 2017** as follows:

> *"The last direct debit has been returned unpaid by your bank and you are now in breach of your Credit Agreement with us.*

/Cont'd…

The instalment facility is now withdrawn and we require payment of the full outstanding balance of €689.44 within twenty one days i.e. 11/07/2017.

Failure to pay this balance ***will result in cancellation of the policy.***

There is no need to contact us if you have already sent a payment directly to us.

If you have any queries regarding your policy or method of payment do not hesitate to contact our office at …"

The Provider was not aware of the cancellation of the policy in **April 2017** and therefore, assumed the policy was renewed. As a result of this, the Provider sought to collect premium payments from the Complainants in respect of the policy. The **June 2017** direct debit was returned unpaid and the above letter issued to the Complainants.

I accept the letter was a standard, pro forma letter issued by the Provider when direct debit payments are not received. Having considered the letter and the circumstances in which it was issued, I am not satisfied that it could be considered a *threatening* letter. As noted above, the Provider believed the policy was renewed by the Complainants as it had not received any contrary instruction. If this were the case, the Provider would have been entitled to charge and collect premium payments. There is no evidence to suggest the Provider was aware the policy had been cancelled at the time the letter issued.

The Fourth Complaint

The Provider does not appear to have been made aware of the cancellation of the policy until **23 June 2017**. By this time, two premium payments had been collected by the Provider in respect of the cancelled policy.

The Provider issued a cheque payable to both Complainants under cover of letter to the broker on **6 July 2017**. However, during a telephone call on **20 July 2017**, the First Complainant advised the Provider's agent that he wished for the refund cheque to be made payable to him only. While I have not been furnished with a recording of this telephone conversation, this aspect of the conversation does not appear to have been disputed.

In the Provider's submissions outlined above, it is stated the Provider's agent advised the First Complainant that it required a letter signed by the Second Complainant to confirm the cheque was to be issued in one name only. The evidence demonstrates that the First Complainant was unable to provide any such consent or authorisation. To overcome these issues, the Broker issued the Complainants with a refund on **31 July 2017**.

The Provider issued a refund to the Complainants within approximately two weeks of being made aware of the cancellation error. In or around two weeks after this, the First Complainant indicated that he wanted the refund cheque made payable to him alone. To do this, the Provider required the consent or authorisation of the Second Complainant.

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This was a reasonable requirement. However, the First Complainant was unable to comply with this.

That said, the most logical approach would have been to credit the bank account that had been incorrectly debited.

Taking the foregoing into consideration, I am not satisfied the Provider failed or refused to issue a refund to the Complainants.

The Fifth Complaint

In an email to the Provider dated **18 January 2018**, the First Complainant states in the penultimate paragraph as follows:

> *"When I ask for records to be provided – I expected all records relating to the matter to be provided. I did not envisage you would continue to deny me access. I expect this may be related to your multiple errors."*

The Provider replied to this email on **25 January 2018**. In response to the above statement, the Provider advised the First Complainant that it had no record of any request for documentation. The Provider indicated that if the First Complainant identified what records he was looking for and when the request was made, the Provider would investigate the matter. The First Complainant responded the same day stating: *"I note that you remain unwilling to provide relevant records."*

It is not clear when the First Complainant made a request to the Provider for *relevant records*. The email correspondence also shows a lack of co-operation on the part of the First Complainant when the Provider sought to assist him with obtaining the records he was looking for. Subsequent to this, the First Complainant made an enquiry to the Provider on **30 July 2018** regarding its data subject access request procedure.

The First Complainant has not identified in his Complaint Form or in any additional submissions to this Office in support of this complaint, when he made a request for documentation to the Provider nor has he provided any evidence of any such request being made. In any event, this is a matter more appropriate for the Data Protection Commissioner.

The Sixth Complaint

By email dated **21 July 2017**, the Provider refers to an email from the First Complainant dated **20 July 2017**. A copy of this email does not appear to have been furnished by either party to this complaint. Notwithstanding this, the Provider's email states:

> *"We have no record of receiving a request from you for a final response letter. To enable us issue a final response letter could you please forward details of your complaint and we will investigate same. …"*

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The First Complainant responded on the same day in the following terms:

> *"… The broker is investigating the matter and I trust all will be addressed by them."*

Following this, the First Complainant wrote to the Provider by email dated **5 December 2017** requesting a final response letter in respect of a number of matters outlined in the email. The Provider responded on **7 December 2017** advising the First Complainant that it would be reviewing the First Complainant's complaint.

The Provider issued a Final Response letter dated **12 January 2018**. The final paragraph of this letter states:

> *"Should you remain unhappy with the outcome of this matter and would like to refer it further you may avail of your right to refer the matter to the Financial Services and Pensions Ombudsman. You may treat this correspondence as our final response for that purpose. The Ombudsman can be contacted at:*
>
> *Financial Services and Pensions Ombudsman*
> *Lincoln House, Lincoln Place, Dublin 2, D02 VH29*
> *Tel: (01) 567 7000*
> *Email: info@fspo.ie*
> *Website: www.fspo.ie"*

There is no evidence to suggest that a formal complaint was made to the Provider prior to **5 December 2017**. The Provider issued a Final Response letter on **12 January 2018**. I am satisfied, having reviewed this letter, that the First Complainant was made adequately aware of his right to refer a complaint to this Office and all of the means by which this Office can be contacted.

For the reasons outlined in this Decision, I partially uphold this complaint and direct the Provider to pay a sum of €200 in compensation to the Complainants.

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) 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 €200, 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.

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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

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.