An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0473
Sector:	Insurance
Product / Service:	Van
Conduct(s) complained of:	Premium rate increases Delayed or inadequate communication Dissatisfaction with customer service Failure to provide correct information
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint arises from a motor insurance policy and the suggested poor customer care, communication and complaint handling of the Provider, which is a motor insurance broker.

The Complainant's Case

The Complainant purchased a motor insurance policy that was incepted on **19 April 2018** through the Provider, an insurance intermediary.

The Complainant states that he contacted the Provider on 17 April 2018 to obtain information and a premium quote for insuring a second-hand van that he was looking to purchase. The Complainant states that he purchased the van on 19 April 2018 and the policy came into force that day. He submits that he was initially given a premium cost of €729.72 at inception, but this was shortly afterward increased to €1,513.88.

In addition, the Complainant submits that when he contacted the Provider on 17 April 2018, he informed the Provider of his plans to drive in Europe and he agreed to pay a surcharge of 7.5% onto his premium for this. He states that he was assured that the Provider had all the necessary documentation and that a full policy document would be issued to him.

The Complainant says that he also had a discussion with the Provider regarding his ability to "mirror" his current no claims bonus which existed on another vehicle which was also driven by his daughter. The Complainant states that the Provider agreed that this would be done. The Complainant states however that on **25 April 2018**, he was contacted by the Provider and he became aware that the insurer was looking to remove his daughter from the existing insurance policy applied to the shared car. In the alternative, he was being asked to pay an additional sum onto the insurance premium in relation to the new van.

The Complainant states that he was travelling in Europe from 25 April 2018 and was alarmed when he was informed by the Provider that the surcharge he had paid to cover his travel outside of Ireland, only covered him from the start of his trip for a period of two weeks. He says that he continued to receive inconsistent information in respect of how long he was actually insured to drive outside Ireland and in addition, he had yet to receive the policy document booklet.

The Complainant states that he subsequently received a registered letter from the insurer on **22 May 2018** informing him that cover on his van would be cancelled with effect from 29 May 2018, on the basis that there had been a failure to produce documentation.

The Complaint for Adjudication

The complaint is that the Provider was guilty of maladministration, insofar as it:-

1. Incorrectly quoted for cover which was accepted but then sought an increased the premium payment, due to its own errors;
2. Failed to provide clarity to the Complainant regarding what European travel was covered on the insurance policy, in return for the surcharge he had paid;
3. Failed to send relevant documentation to the Complainant;
4. Failed to deal with the Complainant's grievances within the provisions of the Consumer Protection Code 2012.

The Provider's Case

The Provider does not accept wrongdoing in respect of numbers 1 to 3 above, as it relied on the information made available to it by the insurer.

The Provider now acknowledges that the manner in which the Complainant's complaint was dealt with, did not meet the requirements or timelines set out in its complaint procedure.

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.

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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 **17 November 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. Following the consideration of additional submissions from the parties, the final determination of this office is set out below.

On **10 April 2018**, the Complainant called the Provider and requested a quotation for a van he was looking to purchase. The Complainant has explained that he already had insurance (arranged through the Provider) on a car and he was going to keep this car. It was explained to the Complainant that if he wanted to mirror the no claims bonus and the van, he could continue to use his car, but he would not have open insurance on the van.

On **17 April 2018**, the Complainant called the Provider again to inform the Provider of the purchase price of the vehicle. When the Complainant queried about foreign travel, he enquired as to how many days of travel "*on the continent*" the policy provided for. The Provider's representative stated that she thought it was 30 days and in response the Complainant stated that he would not be gone for longer than that, in any event.

I note that the Provider then paused the call in order to contact the insurer and then came back to the Complainant to inform him that she was informed by the insurer that there was no limit on the dates of travel but that there was a 7.5% surcharge and the overall cost was therefore €729.72 including travel surcharge. This was accepted by the Complainant and the Complainant proceeded to pay in full for the policy.

In respect of this aspect of the complaint, it is apparent from all of the documentation that the Provider correctly quoted the cost of the policy to the Complainant. What happened thereafter was that the insurer contacted the Provider stating that the named driver on the motor vehicle policy would have to be removed, in order for a live no claims discount to issue, and otherwise the policy would be re-rated. The Provider had appropriately mirrored the no claims bonus on this policy which was in accordance with the insurer's terms and conditions. (The insurer has since accepted that it incorrectly challenged this.) The Provider then challenged the insurer over this issue and requested the insurer to review its decision and following this, the insurer confirmed that the policy would continue as originally arranged and there would be no additional premium applied.

The Complainant has complained that this all arose out of errors on the part of the Provider. However, the documentation submitted to this office bears out that the Provider, a broker, in respect of this aspect of the complaint, did not misquote for cover in the first place, and thereafter, it was obliged to relay the mistaken attempts by the insurer to re-rate the premium.

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Following that, the Provider successfully challenged this decision by the insurer, which ultimately resulted in no increased premium to the Complainant. Therefore I take the view that the evidence discloses no wrongdoing by the Provider regarding this aspect of the complaint.

In relation to the complaint that the Provider failed to provide clarity to the Complainant regarding what European travel was covered on the insurance policy, given the surcharge he had paid, I note that the Provider initially expressed the view that it thought the restriction on travel period was thirty days, but in order to confirm that, the Provider telephoned the insurer which in turn spoke to the underwriter and then informed the Provider that there was no limit on the number of days of permissible travel, but that a 7.5% surcharge would apply. In fact, this turned out to be incorrect and the insurer confirmed subsequently that the cover to travel in Europe is free of charge for up to 31 days, with a 7.5% surcharge for any travel thereafter.

It is also evident from the documentation submitted, that apart from the documents sent to the Complainant when he incepted the policy, there is no additional documentation available in relation to foreign travel or foreign use of the vehicle. Therefore, I am satisfied that the Provider did take steps to confirm the position with the insurer orally, regarding travel in Europe.

The Provider also makes the point that the insurer's policy booklet does not confirm the maximum number of days that the European travel cover provides for. I accept that the Provider did not provide the requisite clarity to the Complainant regarding what European travel was covered but I note that this was because it was misinformed by the insurer. For that reason, it applied a 7.5% surcharge notwithstanding the fact that the Complainant had indicated that he would not be travelling for a period in excess of thirty days. I note that the refund secured from the insurer was not made available to the broker to be refunded to the Complainant until **July 2018**. I do not accept however that the Provider's failure in this regard was a culpable failure given the fact that the insurer had provided the erroneous information in the first place.

In relation to the complaint that the Provider failed to send relevant documentation to the Complainant, it appears from a review of the documentation submitted, that the Complainant's primary complaints in this regard relate to the lack of documentation issued in relation to the foreign travel terms and conditions. However, as is stated above there does not appear to be any further documentation from the insurer dealing with this, other than what is contained in the policy booklet. This was forwarded to the Complainant and confirmed by him in his call to the Provider on 20 April 2018.

I am satisfied accordingly, that there is no evidence to suggest that the Provider failed or omitted to send any documentation to the Complainant.

In relation to the complaint that the Provider failed to deal with the Complainant's grievances within the provisions of the Consumer Protection Code 2012, I note that Provisions 10.1 and 10.9 of the Consumer Protection Code 2012 state:

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10.1 *A **regulated entity** must have written procedures in place for the effective handling of errors which affect **consumers.** At a minimum, these procedures must provide for the following:*

a) *the identification of the cause of the error;*
b) *the identification of all affected **consumers;***
c) *the appropriate analysis of the patterns of the errors, including investigation as to whether or not it was an isolated error;*
d) *proper control of the correction process; and*
e) *escalation of errors to compliance/risk functions and senior management.*

10.9

*A **regulated entity** must have in place a written procedure for the proper* handling of ***complaints.*** This procedure need not apply where the ***complaint*** has been resolved to the Complainant's satisfaction within five ***business days,*** *provided however that a **record** of this fact is maintained.*

At a minimum this procedure must provide that:

a) *the **regulated entity** must acknowledge each **complaint** on paper or on another **durable medium** within five **business days** of the **complaint** being received;*
b) *the **regulated entity** must provide the Complainant with the name of one or more individuals appointed by the **regulated entity** to be the Complainant's point of contact in relation to the **complaint** until the **complaint** is resolved or cannot be progressed any further;*
c) *the **regulated entity** must provide the Complainant with a regular update, on paper or on another **durable medium,** on the progress of the investigation of the **complaint** at intervals of not greater than 20 **business days,** starting from the date on which the **complaint** was made;*

The Provider has accepted that the Complainant's complaint was not dealt with in a timely manner and it was not adequately escalated and dealt with in an adequate time. While there are shortcomings in relation to the efficiency and the timeliness of the process, I note that the complaint was objectively investigated and ultimately responded to. However, this aspect of the complaint is one in respect of which the Provider has a case to answer to the Provider, owing to the poor timelines and effectiveness with which the complaint was met.

Accordingly, having considered all of the evidence before me, I am satisfied that this complaint should be partially upheld and I consider it appropriate to direct the Provider to make a compensatory payment to the Complainant in the sum of €200.

I note that since the Preliminary Decision of this Office was issued, the Complainant has indicated that he wishes for the payment to be made by cheque, sent to him, but made payable to the Simon Community. The Provider has also reverted indicating that it would like to double that amount, and will issue the payment by cheque to the Complainant's nominated address. If the parties wish to agree those arrangements this will be a matter for themselves.

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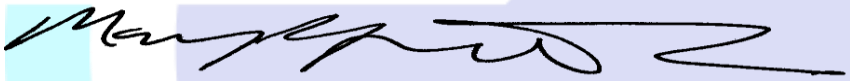
Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially upheld on the grounds prescribed in ***Section 60(2)(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 Complainant in the sum of €200 by cheque (though it may of course pay a larger figure by cheque if it wishes to do so, as it has indicated) within a period of 60 days from today. I also direct that interest is to be paid by the Provider on the said compensatory payment of €200, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid by cheque, 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.



MARYROSE MCGOVERN
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

18 December 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.