An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0018
Sector:	Insurance
Product / Service:	Car
Conduct(s) complained of:	Disagreement regarding Pre-accident value provided Claim handling delays or issues
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The complaint relates to a claim made on the Complainant's motor insurance policy, which was first reported to the Provider on 2 July 2018.

The Complainant's Case

The Complainant's complaint is that the Provider mishandled his motor insurance claim in the following ways:

1. The Provider wrongfully misled and/or misinformed him and/or furnished him with confusing and inconsistent information in regard to the assessment of the vehicle damage.

2. The Provider gave poor customer service.

3. The Provider wrongfully failed to refund him the outstanding balance paid on his insurance policy from 2 July to 13 August 2018.

The Complainant queries why his car was sent to K Motors and not W Motors which was nearby. He contends that the claims handler informed him that K Motors would assess the damage and the cost of repairs but ultimately that this was not what transpired. Ultimately, it was determined that the car was a write-off and that it would have been uneconomical to repair the vehicle.

The Complainant disputes the method and outcome of an evaluation carried out on his car by K Motors. The Complainant contends that there is no reference to the actual damage or itemisation carried out of projected costs for repairs and he submits that it appears as though only a visual assessment was carried out and that the Provider "*had no intention to repair vehicle but instead took a convenient route for them by saying vehicle was unrepairable*".

The Complainant contends that the Provider misled and/or misinformed him and/or furnished him with confusing and inconsistent information in respect of the assessment. He states: -

> "[t]*his confirms what I stated earlier*… […] …*I was told lie after lie by them*."

The Complainant contends that if the Provider's representative had informed him that the car was being written off then he could have arranged an independent assessment with another garage. He contends that the Provider denied him this alternative option.

The Complainant submits that the Provider sent him an "*offer letter on Tuesday which was backdated to Friday 6th giving 10 days to accept or decline*". The Complainant believes that the Provider effectively denied him the opportunity to arrange an independent assessment and that by declaring the car as a write-off, it made the car uninsurable which he says left him with no alternative but to accept the offer.

The Complainant disputes the determination of the Provider, along with K Motors, that the car was a write-off and that it would have been uneconomical to repair it. The Complainant states the Provider determined that the "*car was old and valued accordingly*". However, the Complainant argues that it "*did not take into account was that car was properly maintained and in excellent running condition all of which would have increased value for resale, but* [the Provider] *only offered* [an] *average value opposed to a valuation from a car salesman*".

The Complainant believes the Provider's determination in respect of his claim has been unfair for many reasons. In addition to the above outlined, he says that the total value of €1,600 "*did not reflect the true market value of car based on its excellent condition or the price it could have sold for at auction".*

The Complainant says the Provider gave him poor customer service. The Complainant is unhappy with the time and delay it took for the Provider to confirm that the car was uninsured. He contends that the Provider's claim handling was poor and inefficient. He submits that the Provider rang him in December 2018 to say that his no claims bonus had been reinstated as the claim had been finalised. During the phone call the Provider's representative queried with him why he did not renew his insurance policy and that he had to inform her that he has no car to insure.

Further, the Complainant submits that the Provider wrongfully failed to refund him the outstanding balance paid on his insurance policy from 2 July to 13 August 2018.

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The Complainant, in seeking a remedy for the above outlined, is seeking: -

> "*Replacement car or compensation for correct value of car* [the Provider] *scrapped and losses*."

The Provider's Case

The Provider maintains that it processed the claim in a fair manner and in accordance with the terms and conditions of the policy. Specifically, the Provider states that its engineers determined that the vehicle was a write-off on the basis that it was "*uneconomical to repair*" and, in those circumstances, and by reference to the terms and conditions of the policy, the Provider maintains that it was entitled to compensate the Complainant by paying him the market value of the vehicle. The Provider maintains that it did precisely that, by paying the Complainant, within 16 days of the loss having occurred, the market value of the vehicle (€1,600) minus the excess applicable on the policy (€500). The Provider has supplied evidence in support of its valuation of the vehicle in the form of three comparators; three cars of the same make, model and year as that of the Complainant's which were on the market for sale at the time the valuation of the Complainant's vehicle was conducted.

With regard to the decision to deem the Complainant's vehicle a write-off, the Provider contends that the cost of repairing the vehicle would have far exceeded the market value of the vehicle. The Provider refers to repair costs in the amount of €4,378.32.

The Provider maintains that the terms of the policy provide for no refund of premia in the event that the cancellation of a policy is requested in respect of a policy that is less than a year old, but which has less than three months left to run, as was the case with regard to the Complainant's policy.

The Provider maintains that the delay in providing confirmation to the Complainant that his 'no claims bonus' would not be affected was due to a delay on the part of the Motor Insurers' Bureau of Ireland providing formal confirmation that the third-party individual that caused the crash was, in fact, uninsured at time.

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.

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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 18 June 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.

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

1. E-mail from the Complainant to this Office dated 24 June 2020.

2. E-mail from the Complainant to this Office dated 6 July 2020.

3. E-mail from the Provider to this Office dated 20 July 2020.

4. E-mail from the Complainant to this Office dated 29 July 2020.

5. Letter from the Provider to this Office dated 23 November 2020, in response to the Ombudsman's letter to it dated 2 November 2020.

Copies of the above submissions were exchanged between the parties.

Having reviewed these additional submissions and all of the submissions and evidence furnished by both parties to this Office, I set out below my final determination.

Prior to considering the substance of the complaint, it will be useful to set the relevant terms and conditions of the policy.

Policy Terms and Conditions

The following appears in Section 1 of the policy relating to "*damage to your car*":

> ***What is covered?***
>
> *We will pay for:*
>
> - *loss of or damage to your car, and its accessories while in your car, up to the market value of your car;*

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'Market Value' is defined as:

> *The amount you would have got for your car if you offered it for sale.*

Later in Section 1, the following is set out:

> ***Our uninsured driver promise***
>
> *If you make a claim for an accident that is not your fault and the driver of the car that hits you is not insured, you will not lose your no claims discount.*
>
> *Your excess will have to be paid.*
>
> *…*
>
> *Also, if/when you renewal is due investigations are still ongoing, you may lose your no claims discount temporarily.*
>
> *However, once we confirm that the accident was the fault of the uninsured driver, we will restore your no claims discount and refund any extra premium you may have paid.*

The 'General Conditions' Section of the policy includes the following:

> ***1 Cancelling the Policy***
>
> *To cancel the policy, return your certificate of insurance and insurance disk with a written request to:* [address redacted]*, or your local branch.*
>
> *When we receive your certificate, disc and written request, your policy will be deemed cancelled immediately. If you have not claimed or there is no incident that is likely to result in a claim during the current period of insurance, we will work out a refund on the following basis:*
>
> - *If you have had continuance cover for more than 12 months, we will work out the percentage of premium for the period you have been insured and refund any balance after an administration fee has been taken away.*
>
> - *If you cancel within the first 14 days after receiving the policy documents within the first year of insurance, we will refund your full premium, providing no claims have been made on your policy.*
>
> - *If you cancel after the first 14 days after receiving the policy documents and within the first year of insurance, we will refund your premium based on the figures in the table.*

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Period which your policy is in force	*Percentage of premium returned*
Up to 1 month	*80%*
2 months	*70%*
3 months	*60%*
4 months	*50%*
5 months	*45%*
6 months	*35%*
7 months	*25%*
8 months	*20%*
9 months	*10%*
Over 9 months	*nil*

Analysis

The Complainant in this case suffered damage to his vehicle (a 1.2 litre 2003 hatchback with circa 121,000 miles recorded on the odometer) on Monday 2 July 2018 when an uninsured third-party driver collided with the Complainant's vehicle which was parked at the time. The Complainant contacted his insurer, the Provider, by phone the same day and, in the course of the phone call, the Complainant provided certain details regarding the nature of the damage suffered.

The Complainant complains about the fact that an early decision was made to deem the vehicle a write-off. In this regard, the Complainant states that the garage to which the vehicle was brought contacted him on Friday 6 July 2018 to advise that the vehicle was a write-off. The Complainant states that when he asked for a breakdown of the repair costs, he was advised that it was "*a class B write off uneconomical to repair*". The Complainant essentially takes issue with the analysis that the vehicle was "*uneconomical to repair*" and takes the view that the Provider should have paid for the repair of the car. The Complainant highlights that, following the processing of the claim, he was "*left with no car and not enough money to buy another*".

One aspect of the Complainant's complaint which was amplified in more recent correspondence to this office is the Complainant's contention that the decision to deem the car a write-off was made on 2 July 2018 in the course of the original phone call when the "*agent had already classed the car as write off*", but that this was not communicated to him, thereby reducing his options. The evidence does not support this assertion. Whereas the agent who took the call on 2 July 2018 may or may not have had a view on the condition of the car, it is clear that the decision to deem to the car a write-off was not communicated to the Complainant until after the garage had taken custody of the car. The Provider maintains that the garage outlined the car's condition after it had examined the vehicle, a proposition the Complainant rejects. It is certainly clear that it was the garage (rather than the Provider itself) that informed the Complainant of the position. The Complainant's assertion that the decision was taken on foot of some sort of inappropriate process is not borne out by the evidence and I accept that the decision to deem the car a write-off was made by the garage following an inspection, at minimum a visual inspection, of the vehicle.

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It is possible that this decision confirmed a position the Provider already suspected to be the case, however the significant detail is that the garage did indeed confirm the position.

The important issue however is simply whether the car was indeed a write-off. This is a decision that is properly reached when a car has been rendered un-roadworthy or when the cost of repair is commercially unviable given the value of the vehicle. In response to the Complainant's complaint regarding the failure to provide him with a repair estimate, the Provider, in its Final Response Letter, stated:

> *No repair estimates are carried out on vehicles which are deemed to be a total loss.*

The Provider ultimately assessed the value of the Complainant's vehicle in the amount of €1,600. The Complainant was paid €1,100 by the Provider and recouped the excess payable under his policy of €500 from the Motor Insurers' Bureau of Ireland [MIBI]. I accept, by reference to the MIBI agreement in force at the time, and by reference to the protocols in operation, that this was the appropriate and proper way to process the claim. (I will return to this below.)

With regard to the costs of repair, and in response to direct queries raised by this office, the Provider states, in the first instance, that the vehicle may not have been capable of safe repair given the extent of the damage.

However, the Provider goes on to say that the motor engineer that originally examined the vehicle estimated that repairs would have cost in excess of €4,000. The Provider further advises that the "*case was subsequently referred to* [the Provider's] *Chief Motor Engineer*" who concurred with the decision to deem the car a write-off. In response to the questions raised by this office, the Provider has furnished a written estimate for repairs in its letter of 7 November 2019 in the amount of €4,378.32 inclusive of VAT. (Photographs supplied by the Provider depict significant damage to the passenger side front wing including to the suspension and wheel and there appears to be damage of some description to at least four separate panels.) The Complainant has not provided any separate report or estimate proposing a different figure for repairs.

With regard to the pre-accident value (PAV) of the vehicle, the Provider emailed the Complainant on 12 July 2018 indicating that it considered the PAV to be €1,600. As part of its submission to this office, the Provider has furnished examples of similar vehicles (cars of the same make and model and year as that of the Complainant's) for sale in or around the same period asking prices of €1,495, €1,495 and €1,100 respectively. The Complainant has not provided any contrary valuation for the vehicle notwithstanding that he claims the figure of €1,600 to be an undervaluation.

The Provider offered the Complainant €1,100 on 12 July 2018 in settlement of his claim, that figure being the PAV less the excess of €500 applicable on the policy. The Complainant accepted this offer in writing in a signed letter received by the Provider on 17 July 2018 and the funds were paid over on 18 July 2018, 16 days after the damage was suffered.

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The Complainant was advised that he could seek to recoup the excess which had been deducted (€500) from the MIBI which he subsequently did.

By reference to the terms and conditions of the policy (as reproduced above), I accept that in circumstances where the Provider assesses the cost of repairs of a vehicle to be greater that the PAV of the vehicle, the Provider is entitled to deem a car to be a write-off and to offer an insured the PAV (less any excess applicable) rather than having to bear the cost of repair.

In this case, I accept that the Provider *has* substantiated that the cost of repair of the vehicle was (substantially) greater that the PAV of the vehicle. In this regard, I might note that, though the Complainant in his submissions to this office takes issue with the PAV of the vehicle (notwithstanding that he agreed in writing to it) on the basis that his vehicle was particularly well maintained and therefore capable of attracting a higher valuation than those vehicles used as comparators by the Provider. I have been provided with no evidence that the PAV could have been greater than the costs of repairs. Indeed, the difference between the two figures can only have been substantial on any calculation. Of further note is that the report provided by the Garda Síochána in respect of the incident describes the Complainant's car as a "*total write off*" (describing a different vehicle involved in the accident as a "*write off*" only.)

In light of the foregoing, I accept that the Provider has acted reasonably in its processing of the Complainant's claim.

It is noteworthy that, though the Complainant seeks as an outcome to his complaint "*compensation for correct value of car",* he has provided no competing valuation; as a matter of fact, the Complainant has already been paid the amount of the only valuation put before me in evidence. I note he was paid a figure higher than each of the three comparators employed by the Provider.

A secondary aspect of the decision to deem the Complainant's vehicle a write-off is whether the Complainant was advised of his right to have an independent assessment carried out for provision to the Provider. I note the contract of insurance does not expressly provide the Complainant with the right to appoint an independent assessor or with the right to be informed of any entitlement to same. The Provider has nonetheless furnished this office with a copy of the "*claims stationary*" in use at the time the Complainant made his claim. The following is set out thereon:

> ***Other Information***
>
> *You may appoint a Loss Assessor to assist you with your claim at your own expense.*
>
> *Such costs are not covered under your insurance policy. Our preference is to deal directly with you.*

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In light of the above, and in circumstances where the Complainant never sought, in any of his communications with the Provider to assert that the PAV was greater than the cost of repairs, I am not satisfied that the Complainant has substantiated this aspect of his complaint. There was certainly, in my view, no denial of any opportunity to arrange an independent assessment; no independent assessment was requested.

There are a number of other grievances advanced by the Complainant which I will also address. The Complainant raised a complaint regarding the fact that the claim was processed through his own comprehensive insurance policy rather than a claim being "*made against the offending driver for repairs*". The 'offending driver' in this case was uninsured. As such, it was not possible to make a claim against the offending driver's insurer. The MIBI was created for the very purpose of providing protection to the victims of crashes caused by uninsured or untraced drivers. The agreement and the protocols in place provide that, in such cases, and where the victim has the benefit of a comprehensive policy, the claim is processed through the victim's own comprehensive policy. The system expressly dictates that any such claims will not have any impact on the victim's no claims bonus. This is precisely what occurred here, and I accept that matters were processed in the correct and proper manner.

The Complainant complains that it was not until December 2018 that the Provider confirmed that his no claims bonus would not be affected. The Provider seeks to explain this by reference to the date on which the MIBI formally confirmed that the offending driver was uninsured. Whereas it was suspected from an early date that the offending driver was uninsured, this fact was not formally confirmed to the Provider until 4 December 2018 when a response from MIBI issued. The Provider communicated with the Complainant the following day.

The Provider relies, in support of its position, upon correspondence it sent to the MIBI in the intervening period seeking the relevant confirmation. In circumstances where there was a delay on the part of the MIBI in formally confirming that the offending driver was uninsured, in my Preliminary Decision I had stated that *"I do not view the delay on the part of the Provider in confirming the 'no claims bonus' position as unreasonable and indeed the possibility of such a delay is identified in the terms of the policy as reproduced above. Once the required information was provided to the Provider, the Provider furnished the necessary confirmation to the Complainant in a very prompt fashion".*

In response to the above, by way of his post Preliminary Decision submission, the Complainant highlighted that *"in* [the Provider's] *submission they claim that they reinstated my no claims bonus after MIBI finalised their part, This is untrue as I never received an updated or reinstated certificate of no claims discount from* [the Provider]*".*

The Provider responded to the submission of the Complainant and stated that "*a proof of a full Five years No Claims Bonus letter was issued to the Complainant on 13 July 2020".*

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The Complainant then, in his post Preliminary Decision submission dated **29 July 2020,** submitted that his no claims bonus had not been previously restored. The Complainant stated:

> *"Please find enclosed letter stating no claims bonus dated 3rd July* [2020] *form (sic)* [the Provider]*, despite* [the Provider] *claiming that my no claims bonus had been reinstated to 5 years plus claims free in 20xx19 (sic) this was not the case, as I had to ring them several times before 3rd July asking for the actual no claims certificate. It was only last week when* [the Provider] *sent the updated one".*

On **2 November 2020,** I wrote to the Provider outlining the submission of the Complainant. I did so to ensure I was in possession of all the necessary evidence to complete my adjudication. I requested the Provider to:

> *"confirm if it has reinstated the Complainant's no claims bonus and if so, confirm the date that it reinstated the Complainant's no claim bonus and provide proof of this reinstatement".*

The Provider, highlighted its previous submissions, and reiterated that it's "*Claims Handler issued a letter to* [the Complainant] *on 5 December 2018 advising that "Your No Claims Discount has not been affected as a result of this incident"*. The Provider further references that its Final Response letter issued to the Complainant on 7 January 2019 detailed "*as the third party vehicle has been confirmed as uninsured we must deal with the claim as per MIBI protocol which states the claim is processed as a comprehensive claim on your policy and your no claims bonus is not affected".*

The Provider then offered evidence that it reinstated the no claims discount for the Complainant on the date that its claims handler issued its letter to the Complainant on **5 December 2018.**

The evidence offered is "*a screen shot"* from the Provider's *"Computer System which shows that the claim was marked "Allow NCD: Y" (NCD is for No Claims Discount and Y is for Yes) and this also shows it was last amended on 5 December 2018".*

The Provider then offered its response to letter dated **3 July 2020**, which appeared to show the Complainant's NCB as being at zero years.

The Provider detailed that:

> "[the Complainant] *requested confirmation of his No Claims Bonus on* ***3 July 2020****. A Proof of No Claims Bonus document was issued to him. The document that was, issued to him on* ***3 July 2020*** *was incorrect. He contacted* [the Provider] *on* ***7 July 2020****, and we clarified that he had a full No Claims Bonus. The correct letter confirming his full No Claims Bonus was issued to him on* ***13 July 2020****, a copy of which is attached".*

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It would appear based on the evidence and submissions that the Complainant's NCB was correctly reinstated, and the Complainant was correctly informed of this on **5 December 2018** and in the Final Response Letter on **7 January 2019**.

While the Provider, informed the Complainant of this, it is most disappointing that the letter received by the Complainant on **3 July 2020** was incorrect and contained the wrong information relating to his NCB, which contradicted what he had been previously told by the Provider.

However, this was corrected, after the Complainant made contact with the Provider on **7 July 2020**, and the Provider submits that on this call "it *clarified that he had a full No Claims Bonus"* and "*The correct letter confirming his full No Claims Bonus was issued to him on **13 July 2020".***

Having considered the above, it remains my decision that I do not view the delay on the part of the Provider in confirming the 'no claims bonus' position as unreasonable and indeed the possibility of such a delay was identified in the terms of the policy as reproduced earlier above in my Decision. Once the required information was provided to the Provider, the Provider furnished the necessary confirmation to the Complainant in a prompt fashion. While it is disappointing that the Complainant did receive a letter containing incorrect information on **3 July** 2020, this was quickly corrected. Furthermore, he had been initially notified correctly on **5 December 2018.**

The Complainant takes issue with the failure on the part of the Provider to refund the premia on his policy referable to the period beginning on the date of loss -2 July 2018- and finishing on the date the policy was due to expire – 10 August 2018 (the Complainant incorrectly cites 13 August 2018). The Provider points out, in the first instance, that the Complainant retained the benefit of his insurance in the period during which he was provided with a replacement rental vehicle ending on 12 July 2018. The Provider goes on to point out that, by reference to the terms of the Complainant's policy, and in circumstances where the Complainant's policy was in place for less than a year but had less than three months remaining, no refund was owing. I have reviewed the terms and condition of the policy and in particular, the cancellation section of the policy (as reproduced above), and I accept that the Provider is entitled to have adopted the position it adopted.

There is no contractual entitlement to the refund of any "*unused part*" of an insurance policy absent the cancellation of that policy, contrary to the Complainant's apparent position. Notwithstanding the foregoing, I note that the Provider may have refunded certain premia.

Finally, in my Preliminary Decision I had detailed:

> *"The Complainant asserts that the Provider gave poor customer service. I have reviewed all of the written correspondence exchanged between the parties and I have considered the content of the 25 phone recordings furnished in evidence by the Provider and I am not satisfied that the Complainant has substantiated his complaint regarding alleged poor customer service".*

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With the exception of the letter of **3 July 2020**, which contained the incorrect information, subsequently corrected on **13 July 2020**, I have been furnished with no evidence that the Complainant was proffered poor customer service from the Provider. Having reviewed all of the evidence and submissions, including the recordings of 25 phone calls furnished in evidence, I find no evidence that the Provider has acted other than in a fair and reasonable manner.

For the reasons set out in this Decision, I do not uphold this complaint.

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

25 January 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.**