An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

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| **Decision Ref:** | 2021-0045 |
| **Sector:** | Insurance |
| **Product / Service:** | Car |
| **Conduct(s) complained of:** | Lapse/cancellation of policy<br>Delayed or inadequate communication<br>Failure to provide product/service information<br>Maladministration<br>Mis-selling (motor) |
| **Outcome:** | Rejected |

## LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns a motor insurance policy.

### The Complainant's Case

The Complainant contends that she arranged a motor insurance policy through the Provider and that it wrote to her on the **28 January 2014** providing policy documentation which included a Certificate of Insurance which confirmed that the *"Period of cover"* was *"from **28/01/2014 11:16 to 24/01/2015 23:**59".*

The Complainant contends that she was telephoned by the Provider on **17 April 2014** at 5pm and that it advised that her *"Insurance Certificate was no longer valid with immediate effect".* The Complainant asserts that the Provider:

> *"essentially advised me that I had no insurance cover in the event of me driving my car that evening and going forward the only solution to me was to take out another insurance policy with immediate effect and with immediate cost to me and that I has essentially lost any premium left on the cover left."*

The Complainant asserts that since this conversation with the Provider on **17 April 2014**, she has established that the insurance company:

> *"actually ceased the carrying on of business with effect from **24th January 2014**. Therefore it was without due care and sheer negligence* [that the Provider] *sold me a year policy* [on the **28 January 2014**] *at the cost of €535 for a policy and which was not valid."*

**The Provider's Case**

The Provider states in its Final Response letter that:

> *"On the **27th January 2014** we were advised by* [the insurance company] *that they would no longer be underwriting new policies effective from the previous **Friday 24th January**…Insurance companies sometimes withdraw from certain markets and this was not an extraordinary event."*

The Provider goes on to state that:

> *"On Thursday morning **17th April 2014** we learned that* [the insurance company] *had gone into receivership and the advice we received from the authorities was that for the protection of policyholders we should obtain cover for those affected elsewhere."*

The Provider says that it sold the policy to the Complainant well in advance of being advised of any issues with the underwriter.

**The Complaint for Adjudication**

The complaint is that the Provider wrongfully arranged a motor insurance policy for the Complainant with an insurer that had previously advised that it had *"ceased writing new business".*

The Complainant wants the Provider to refund the annual premium of €535, which she paid for the policy in question.

**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.

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A Preliminary Decision was issued to the parties on **1 February 2021**, 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.

The Complainant requested a further copy of the Preliminary Decision in hard copy to be transmitted to her by post, but neither party made any further or additional submissions, within the period permitted. In those circumstances, the final determination of this Office is set out below.

**Analysis**

The Complainant in this matter rang the Provider on **21 January 2014** seeking assistance with the putting in place of a motor insurance policy. Pursuant to the Provider's advice, a policy was incepted. The policy was underwritten by an insurer (hereinafter 'the Insurer') which subsequently went into receivership (on 17 April 2014) and then, some two weeks later, on 30 April 2014 it went into liquidation.

In essence, the Complainant contends that, at the time when the policy was incepted, the Provider knew, or ought to have known, not to place insurance with this particular insurer. She says that, in doing so, the Provider acted without "*due care*", in what amounted to "*negligence*".

The Complainant relies on two arguments in support of her complaint. The first is that the Insurer had "*ceased renewal of business from 24 January 2014*", and the second is that the Provider "*sold* [her] *a new policy as* [her] *broker on 28 January 2014*

I note that on **21 January 2014**, the Complainant contacted the Provider by phone and sought quotes for motor insurance. Quotes were provided to her and, on **22 January 2014**, the Complainant purchased and paid for an insurance policy underwritten by the Insurer, which was to cover the period from 00:01 on 24 January 2014 to 24 January 2015.

The policy certificate and disc were sent to the Complainant, however apparently, these were not received, understandably prompting the Complainant to call to the Provider's office on **28 January 2014** to query the matter. Arising from this query, the Provider supplied the Complainant with replacement documents on the same day. These replacement documents noted the start date of the insurance period as being **28 January 2014** rather than 24 January 2014. The Provider has provided the following explanation for this:

> *The Electronic Data Interchange (EDI) system only allows replacement documents be issued from the current date (the date the duplicate is requested) which is why the replacement certificate shows 28/01/2014 to 24/01/2015, we do not have a copy of the original certificate, however* [the Insurer's] *no claims bonus &* [the Insurer's] *cancellation schedule attached shows that the policy was incepted on 24/01/2014.*

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In light of the above, I don't accept the Complainant's characterisation of the policy as one that was sold on 28 January 2014. The policy had already been sold on **22 January 2014** and this is borne out by the receipt for payment made, dated this date and indeed the Complainant has herself supplied a bank statement showing the processing of the payment on the following day. I note that the policy then came into force immediately after midnight on 23 January 2014 at **00:01** on **24 January 2014**.

The other foundation of the Complainant's complaint is the contention that the Insurer had ceased renewal of business from 24 January 2014. In one sense, this is not overly relevant to the resolution of this complaint, because the policy had been sold on 22 January 2014, in advance of this date (though it had come into effect on the 24 January 2014). It is appropriate to point out nonetheless that the Provider maintains that it was first notified of any issue on 27 January 2014 when it was first advised by the Insurer that "*there was going to be an orderly run off of business and all cover would remain in place*".

I have been supplied with a copy of a letter dated **27 January 2014**, from the Insurer which notifies recipients that the Insurer has "*ceased writing new business and issuing further renewals with effect from close of business Friday 24 January 2014*". This letter confirmed that the Insurer would however be maintaining cover on existing policies.

In the circumstances, I am satisfied that the Complainant was clearly the victim (and one of many no doubt) of an unfortunate series of events. I do not accept however that she has established that there was any failure by or deficit of 'due care' on the part of the Provider, or that it acted wrongfully in its dealings with her.

I don't accept that there was any reasonable basis on which the Provider might have known of the Insurer's financial turmoil, on the date when it sold the policy on 22 January 2014. Indeed, on the basis of the evidence available, there was also no reasonable basis on which the Provider might have known of these matters, before the Complainant's policy came into effect at 00:01 on 24 January 2014. The notification did not issue to the Provider until 27 January 2014 and that notification referred only to a cessation of the writing of new business from close of business on 24 January 2014, 17 hours after the Complainant's policy had already come into force.

Finally, the Complainant points towards a clause in her insurance policy providing for the return of a certain percentage of premium in the event of the cancellation of the policy within the first year of insurance. This is a provision binding the Insurer, rather than the Provider, though it seems that it has since become clear that the Insurer was not in a position to honour this provision.

In light of the entirety of the foregoing, and in the absence of evidence of wrongdoing by the Provider or any conduct on its part coming within the provisions of ***Section 60(2)*** of the ***Financial Services and Pensions Ombudsman Act 2017*** that could ground a finding in favour of the Complainant, I am not in a position to uphold the complaint.

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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.**

**MARYROSE MCGOVERN**
**DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN**

23 February 2021

**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.**