An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0308
Sector:	Insurance
Product / Service:	Household Contents
Conduct(s) complained of:	Rejection of claim - accidental damage Complaint handling (Consumer Protection Code)
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint concerns a Home Insurance Policy.

The First Complainant contacted the Provider to query whether an incident causing damage would be covered. The Provider had advised that as the First Complainant did not have Accidental Damage cover, that the reported incident would not be covered. The incident that was the subject of the enquiry, was later notified by the Provider as a claim to the Insurance Industry's claims' database.

The complaint is that the Provider incorrectly recorded a claim under the Complainants' policy for an incident which was not covered by the policy.

The Complainants' Case

The Complainants contend that they suffered damage to a carpet as a result of a spillage of bleach and that they contacted their Home Insurance Provider *"to discuss* [their] *options"*. The Complainants assert that the Provider informed them that they *"did not have cover for accidental damage"* and that as a result the damage to the carpet was not covered by the policy. The Complainants state that they *"questioned this but did not get a satisfactory answer"*.

The Complainants state that they *"never made any claim"*.

The Complainants assert that when renewal of the policy was due, they changed insurance provider, as they say that they got a better deal with another company. The Complainants go on to state that their new insurance provider subsequently wrote to them to advise that they had not disclosed to it that they had a claim with their previous Provider for damage to the carpet.

The Complainants want the Provider to:

1. Remove the record of the claim from the Industry's *"database"*;
2. Confirm in writing that no claim was made by the Complainants;
3. Compensate them for the inconvenience suffered.

<u>The Provider's Case</u>

The Provider states that when the Complainants contacted it to notify the *"incident"* pertaining to the complaint, it explained that such an incident would not be covered under the policy as they had not selected the accidental damage optional extra cover. The Provider asserts that the Complainants then indicated that they would seek legal opinion on the matter and that the Provider advised that it would need to set up a claim on the Complainants' policy in order to issue a written confirmation.

The Provider states that it is not in a position to retract the claim information sent to the Industry's database as it was a formal claim that the Complainants wished to proceed with at the time. The Provider says the claims' team issued a claims' experience letter noting the details of the claim showing nil payments which the Complainants can forward to their current insurer.

<u>Evidence</u>

<u>Your Home Statement of Facts</u>
This is a document that the Provider states it issued at inception of the policy in 2014. It includes the following:

> *"Important Notes*
>
> *Claims History*
>
> *Under the conditions of your policy you must tell us about any insurance related incidents (such as fire, water damage, theft or an accident) whether or not they give rise to a claim. When you tell us about an incident we will pass information relating to it to a database. We may search these databases when you apply for insurance, in the event of an incident or claim, or at time of renewal to validate your claims history or that of any other person or property likely to be involved in the policy or claim".*

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Policy Wording

> *"Data Protection*
> *Information about claims (whether by our customers or third parties) made under policies that we provide is collected by us when a claim is made and placed on an industry database of claims known as Insurance Link. This information may be shared with other insurance companies, self-insurers or statutory authorities".*

Claim Form

> *"To assist us in handling your claim and prevent / detect fraud, we may share your data (where appropriate / applicable) as follows:*
> *..*
> *In addition, information about claims (whether by our customers or third-parties) is collected by us when a claim is made under a policy and placed on the insurance industry claims database known as InsuranceLink, maintained by Insurance Ireland. This information may be shared with other insurance companies, self-insurers or statutory authorities. The purpose of InsuranceLink is to protect customers by helping insurers identify incorrect information and fraudulent claims".*

The Complaint for Adjudication

The complaint is that the Provider incorrectly recorded a claim under the Complainants' policy for a peril which was not covered by the policy.

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

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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 **30 July 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.

A Submissions dated **17 August 2021** from the Provider and submission dated **02 September 2021** from the Complainant, were received after I issued my Preliminary Decision to the parties. These submissions were exchanged between the parties. I have considered the contents of these additional submissions, and all the submissions and evidence, for the purpose of setting my final determination below.

The policy was first purchased on **01 September 2014** over the telephone with an inception date of **20 September 2014**. The policy was then renewed annually. The policy lapsed at the renewal date on **20 September 2019**.

The Provider states that there were two separate complaints received. The Provider says that the first complaint was received on the **08 July 2019** on what the Provider describes as the claim notification call. The Provider states that the First Complainant was dissatisfied that the damage was not covered and that it was not explained to him adequately at policy inception what the policy benefits/cover entailed.

The Provider states that the second complaint (the complaint being adjudicated upon here), was received by telephone on the **07 October 2019**. The First Complainant expressed his dissatisfaction that the Provider had registered a claim on the policy and subsequently sent the claim information to the Insurance Industry's Claims Database.

The Provider was asked by this Office to clarify if the Provider defines the term *"claim"* within its policy wording and if not, to explain the reason it is not defined.

The Provider's response was that it does not define what "claim" means within the policy wording and instead relies on the normal meaning; *'an application for compensation under the terms of an insurance policy'*. The Provider states that defined words within the policy document are those which have specific meaning within the terms of the policy.

In the Provider's Final Response Letter dated **15 November 2019**, the Provider states that in the telephone call of **08 July 2019:**

> *"*[The First Complainant] *requested written confirmation why* [the] *claim was not covered and* [the first Complainant] *indicated that* [they] *would seek legal opinion on the matter. The claims handler advised he would need to set up a claim on [the] policy in order to do same and a claim declinature letter was issued to* [the Complainants] *outlining the above."*

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In the above regard the Provider was asked by this Office to clarify the Provider's standard procedure when a customer contacts the Provider to "*discuss*" if cover is in force for an incident.

The Provider's response is that if a customer telephones to enquire if a particular circumstance that has occurred is covered by the policy, the Claims Team can check policy cover in place and advise accordingly without having to formally register a claim on the policy.

The Provider states that, as the First Complainant sought a formal written letter as to why his claim was not covered under the policy and his intention to seek legal opinion, a claim was required to be formally registered in order for it to issue a claim declinature letter which created a claim reference number and claim file.

The Provider was asked to clarify whether the claim was *"set up"* on the policy, following the discussion referred to by the Provider, solely to facilitate the issue of the *"declinature letter" and if not to* confirm if a claim is always set up following such cover discussions with customers.

The Provider's response is that in order to issue a claim declinature letter, a claim is required to be registered on the policy. The Provider says that in instances where a customer makes a general enquiry to check if an incident is covered a formal claim is not required to be registered.

The Provider was asked by this office to advise if the implications of recording a claim against the Complainants' policy were fully explained to the First Complainant when he telephoned the Provider to *"discuss"* the incident.

The Provider's response is that on the claim notification call of the **08 July 2019**, the claim handler advised he would be required to set up a claim in order to issue a claim declinature letter as requested. The Provider states that as set out in the Complainants' policy document it is outlined under the Data Protection section that the Provider may share claims information with the Insurance Industry's Database. The Provider says this was also outlined in the claims pack issued to the customer on the **09 July 2019**, as follows:

"Please note that we will retain a record of this claim and may share certain information with other insurers and interested parties, where necessary and appropriate. However, all data is retained and used in accordance with Irish Data Protection Law."

The Provider was asked by this office whether the Provider was satisfied that it is reasonable to record a claim against a policy where cover was not applicable under the insurance policy.

The Provider's response is that the claim was recorded against the policy as the insured did not accept that the incident was not covered by the policy and expressly sought a written explanation as to why. The Provider states as advised by the claims' handler in order for a

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claim to be formally declined, a claim is required to be registered and the formal claim declinature process followed.

The Provider was asked by this office to clarify the Provider's statement that:

> *"We are not in a position to retract the claim information sent to the Insurance [Industry's]* database *as it was a formal claim that [the Complainants] wished to proceed with at the time."*

The Provider states that following the Complainants' current Insurer seeking information about his claim with it, the Complainant contacted the Provider requesting that it be removed from the Insurance Industry's database. The Provider says that the categories of claim that are sent to the database include Property Damage, Motor Damage and Public Liability.

The Provider submits that should a proposer seek insurance from a provider they are required to disclose any relevant claim that the provider may request as part of their underwriting criteria, for example, any claim in last three years.

The Provider says it is satisfied that the Complainant was made aware that a claim was being set up in order to formally issue a declinature letter. The Provider states that it was the Complainants' intention to make a claim in the first instance by contacting the claims team and he requested the Provider send out a Loss Adjuster to inspect the damage.

The Provider submits that Claim correspondence was issued by way of claim form, claim declinature letter etc. all of which included a claim reference number. The Provider says a claim and claim reference number was also referred to in several instances in the Final Response letters.

The Provider states that as part of the renewal pack that was issued, it included the statement of claims history which noted the Accident Damage claim. The Provider states that at this juncture, the claim was still open and the claim status advised '*outstanding*'.

A statement of claim history was subsequently issued on the **25 September 2019** advising zero payment and claim closed.

The Provider was asked by this office to respond to the Complainants' contention that they contacted the Provider to *"discuss [their] options"* and that they *"never made any claim".*

The Provider's response is that should a customer contact it querying cover in circumstances such as in this complaint, the claims handler outlines that no Extended Accidental Damage in place and explains how the policy operates and no formal claim is set up.

The Provider states that in this case however, the First Complainant did not accept the stated position and advised of his intention to seek legal opinion and wished for a written explanation be given as to why the claim was not covered. The Provider says that the

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claims handler advised that in order to do so he would be required to set up a claim. The Provider states that subsequently a claim declinature letter was issued, so the Complainants were aware that whilst no payment was issued a claim was noted on the policy. It is the Provider's position that for a formal claim declinature letter to be issued, it is necessary for a claim to be registered on the policy which generates a claim number and claim a file.

The Provider submits that there is a discount available to customers if they have been claims free, and this policy is noted as being claims free as there was no claim payment made, so the relevant discount was applied. The Provider submits that there was no claims loading applied.

In the Complainants' submission of **11 August 2020** the Complainants state that after reviewing the documents and listening to all the audio files, they do not accept they made a claim to the Provider regarding the incident that occurred in their premises. The Complainants say that from listening to the audio with the Provider's representative, they accept that they had a conversation regarding this incident and it was brought to their attention that they were not covered for "accidental damage". The Complainants state that from the audio file they note the Provider's agent made a comment that in order to progress with a complaint regarding not being covered, *"he would have to make a claim"*, but at no point did they agree to this. The Complainants state that they also note, the claim form included in the documents was not populated nor signed by them hence, it is their position that no claim was made.

The Complainants submit that when changing insurance provider, they were asked *"had [they] made a claim in the last 5 years"* to which they responded *"no".* The Complainants state that it was brought to their attention that the Provider, against which this complaint is made, had recorded that in 2019 they had unsuccessfully made a claim, which the Complainants say in their opinion is untrue and disingenuous as the audio files confirm.

The First Complainant states he was merely enquiring about the possibility of making a claim and when informed he was not covered, requested to make a complaint to discuss why he was not covered. The Complainants say that this does not constitute them making a claim. The Complainants state that by doing this the Provider has made them look untruthful and they feel, has damaged their integrity. The Complainants state that they view this very seriously.

In the Complainants' submission of **08 October 2020** they state that whatever internal procedures exist within the Provider to deal with enquiries should not result in a claim being registered on a central database.

<u>Analysis</u>

The telephone conversation **08 July 2019** is of particular significance**.** Having listened to and considered the content of the recording of that telephone call, I accept that the Provider's representative did initially say that he would have to set up a claim to issue a

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declinature letter explaining why the reported incident was not covered. However, that was at the early stage of what transpired to be a 26-minute conversation.

It is very clear from the content of the telephone call of **08 July 2019** that during the call, there was a subsequent discussion as to whether a claim was being pursued by the Complainant, whether a claim was required to be set up by the Provider' representative, or whether a complaint was being raised by the First Complainant as regards the cover that was provided and the information that the First Complainant was given when he incepted the policy.

While initially the Provider's representative stated that he (the Provider's representative) would have to set up a claim to issue a declinature letter, the conversation did turn (and end) to the matter being raised by the First Complainant as a complaint.

The First Complainant clearly stated to the Provider's representative that:

> *"Not to the claims department, because they would come up with the same gobbled de gook as you are giving to me."*

The First Complainant was of the position that cover from initial inception of the policy was:

> *"Not explained as should have been.".*

The Provider's representative stated:

> *"I can offer you the Complaints' procedure then, I can offer you the complaint's team"*

The Provider's representative also stated:

> *"I can get a complaint raised"*

The Provider's representative later stated:

> *"Are you looking to register a complaint now or will I set the letter [claim declinature letter] up first"*

In response to the above comment by the Provider's representative, the First Complainant answered:

> *"That works hand in glove, what I am saying to you clearly, I am not very happy with [the Provider] in general with their attitude towards the claim, from the client, taking my premiums under false pretences with the understanding that I was covered under my policy."*

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The Provider's representative later comments were that:

> *"I am going to pass on to the complaint's team". "Letter to state why not covered"*
>
> *"I will have complaints' team explain"*
>
> *"I will have to pass it to the complaints' team"*
>
> *"I will get this set up here now as a claim and have the letter issued as to why it is not covered, before it goes to the complaints, or if you want me to go the complaints, I can send it"*

In response to the above the First Complainant clearly stated that:

> *"Yes I do and I want you to highlight … that point is not being brought up when you take out contents cover, that it should be made more clear it doesn't cover what we are talking about. …"*

The Provider's representative's closing comments were that:

> *"I will have to get complaints to review, they will get back to you ..."*
>
> *"Normally contact you within 5 days, and then 40 days to get letter out to you".*

From the above it is clear that the First Complainant made contact with the Provider on **08 July 2019** to discuss an incident, and to establish whether the resulting damage was covered under the policy. What subsequently transpired in this telephone call was that, on being told that the damage would not be covered, the First Complainant wanted to raise a complaint. Having listened to the call I accept that the Complainants did not seek to pursue the matter as a claim. The First Complainant may have initially, on that call, sought to make a claim. However, it is clear that when he was informed that the incident concerned was not covered by his policy, the First Complainant sought to establish why the cover available, and the cover not available, under the policy was not explained better during the initial set up of the policy. He expressed the view several times that he considered that the extent of cover was not fully explained when he incepted the policy.

The First Complainant was given the option of having the claims department look at the claim, or pursuing the matter as a complaint. The First Complainant clearly choose to have the matter raised as a complaint. It is clear that at the end of the telephone call, that this was the Complainant's understanding, and it was also the Provider's representative's understanding.

I would acknowledge that the Provider's agent appeared to find the conversation difficult as the Complainant made generalised statements about the Provider and the insurance industry generally and posed hypothetical situations. Nonetheless the Provider's agent was clearly trying to be helpful. However, what was absent from the telephone call of **08**

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July 2019 is any communication from the Provider's representative as to the possibility of the notified incident being entered on the Insurance Industry's claims' database.

While the Provider refers to information on the database being set out in the policy provisions (not under any "Claim" heading but contained in a Data Protection Notice), I do not accept that it clearly sets out that making an enquiry as to whether an incident is covered would count as a claim, or that such enquiries were something that would be reported to the Industry's claims' database. I note that the Provider was much clearer on this point in its Statement of Fact document (which issued at the inception of the policy in 2014, some 5 years previous to the incident in 2019), a document that is separate from the policy provisions. In the Statement of Fact document it states:

> *"Under the conditions of your policy you must tell us about any insurance related incidents (such as fire, water damage, theft or an accident) whether or not they give rise to a claim. When you tell us about an incident we will pass information relating to it to a database".*

I accept that had the Provider incorporated this into its policy documentation, or specifically advised this to the First Complainant in the telephone call of **08 July 2019**, it would have better informed the Complainants as to what would or would not be reported to the Insurance Industry's database.

Having regard to all of the above, I accept that (i) the Complainants were not adequately informed (in the policy provisions or in the telephone call of **08 July 2019**) of the possibility of the incident being classified as a claim or something that would be reported to the Insurance Industry's claim's database, and (ii) the First Complainant clearly communicated in the telephone call of **08 July 2019** that he wanted to raise a complaint rather than make a claim. I believe the information he received from the Provider's representative in the telephone call led him to believe that this was what was going to happen.

The Consumer Protection Code states:

> *A regulated entity must ensure that all information it provides to a consumer is clear, accurate, up to date, and written in plain English. Key information must be brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information.*

In my Preliminary Decision I noted the Provider had stated that it was not in a position to retract the claim information sent to the Industry's database. In the circumstances of the complaint, I believed this to be unreasonable and unacceptable.

For the reasons outlined I proposed in the Preliminary Decision to uphold the complaint and to direct that (a) the Provider have the database record indicating that the Complainants' made a claim on their policy deleted, (b) to issue a letter to the Complainants reflecting that the Complainants did not make a claim, but merely contacted the Provider to establish whether or not a particular incident was covered under the policy

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and (c) pay the Complainants a compensatory payment of €1,500 (one thousand and five hundred euro).

I had further proposed to direct that if the Provider could not have the claim information deleted from the industry database, that the Provider was to pay a sum of €50 (fifty euro) to the Complainants for each calendar month (from the date of the final decision) that the database reflects that the Complainants made a claim.

In the Provider's post Preliminary Decision submission of **17 August 2021**, the Provider advised that it had arranged for the claim to be removed from the Insurance Link database with immediate effect. I welcome this, albeit belated, action by the Provider.

Therefore, I uphold this complaint and direct that (a) the Provider issue a letter to the Complainants reflecting that the Complainants did not make a claim, but merely contacted the Provider to establish whether or not a particular incident was covered under the policy and (b) pay the Complainants a compensatory payment of €1,500 (one thousand and five hundred euro).

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is upheld on the grounds prescribed in ***Section 60(2) b) and (g) –*** as I believe the conduct of the Provider was unreasonable and improper.

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to issue the Complainants with a letter to reflect that the Complainants did not make a claim and pay the Complainants the compensatory payment of €1,500. The compensatory payment is to be made 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.

- The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

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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

08 September 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

ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.