Decision Ref:	2021-0557
Sector:	Insurance
Product / Service:	Household Buildings
Conduct(s) complained of:	Rejection of claim - accidental damage Claim handling delays or issues Non-receipt of money
Outcome:	Substantially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint is in relation to the sale of a home insurance policy by the Provider.

The Complainants' Case

The First Complainant completed an online request for quotation for home insurance on **23 March 2019** through the Provider's website. Following completion of the online form the First Complainant received a quotation. On **12 April 2019**, the First Complainant called and spoke with an agent of the Provider concerning the online quotation they had received. The Provider's agent provided information regarding the cost of year one and two of the policy and explained that alternative providers were also available. At this stage, the First Complainant stated that they were happy to proceed. The Provider's telephone agent again verified the information as provided by the First Complainant online. The First Complainant stated that she answered all questions truthfully at the time of purchasing the policy.

On **12 April 2019**, a 'Welcome Pack' was issued by email to the Complainants including the following:

1. The Policy Schedule
2. The Policy Receipt
3. The Statement of Fact
4. The Letter of Indemnity

The email provided links to the documents outlined below:

1. The Policy Document
2. The Insurance Product Information Document
3. The Terms of Business including a schedule of fees and charges
4. Policy Assumptions

On **22 August 2019**, the Complainants submitted a claim on their insurance policy following a leak in their property which caused substantial damage to the kitchen and one bedroom. This claim was rejected by the underwriter of the policy and the policy was considered void as information regarding the property's flat roof had not been declared at the time of inception of the policy.

The Complainants believe an error occurred when purchasing the policy through the Provider and the level of risk was misrepresented by the Provider. The First Complainant has stated that she did not tick any box indicating that the property did not have a flat roof. Furthermore, the First Complainant strongly denies that she was asked any questions regarding the type of roof on her property online or on her telephone conversation on **12 April 2019** prior to the purchase of the property.

The Complainants made further submissions to this Office, dated **11 February 2021**, wherein the First Complainant stated that she strongly disagrees that she was ever asked a question concerning the roof of her property being flat.

Ultimately, the Complainants want the Provider to pay for the repair their home, kitchen and bedroom at a cost of €19,500.

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The Provider's Case

In its Final Response Letter dated **13 November 2019**, the Provider has stated that the Complainants were made aware of the flat roof policy on two separate occasions:

1. Prior to purchase in the policy assumptions document; and

2. After the successful purchase of the home insurance policy, the 'Welcome Pack' including a Statement of Fact was issued, in which details regarding the flat roof policy were outlined on page 2 of the document.

The Provider has furnished screenshots of the website the Complainants would have used to obtain a quote. It states that prior to obtaining the quote, the Complainants were asked to tick a box confirming that they understood that the quote was based on certain assumptions. The Provider states that these assumptions could be accessed through a link embedded in the word "Assumptions". Furthermore, the Provider states that following the selection of the policy cover by the Complainants, the assumptions were flagged a second time as follows:

> *"In addition to the information you have provided, this quotation is based on your agreement to the listed Assumption (with the link to assumptions)"*.

The Provider states that when the Complainant received a home insurance quote from its website on **25 March 2019**, a quotation email issued to them and they were requested to read the *"policy assumptions"*, one of which stated that *"not more than 20% of the roof is flat…"*.

The Provider also states that the flat roof was a material circumstance/fact which the Complainants were under a duty to disclose to the Provider, as it would influence the Provider's decision as to the fixing of the premium and/or determining whether it would take on the risk. The Provider states that the policy documentation noted that a failure *"to disclose material facts could result in your contract being invalidated/cancelled"*.

In a submission to this Office dated **19 February 2021** the Provider acknowledged that the First Complainant was not asked about the construction of the roof during the **12 April 2019** phone call. The Provider stated that as the Complainants had already completed the process online there was no need to follow the call script in full.

The Complaints for Adjudication

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The complaints are that:

(a) When the First Complainant completed an online request for a quotation for a policy of home insurance on **23 March 2019** through the Provider's website and, subsequently, on **12 April 2019** spoke with the Provider's agent in relation to the online quotation, the Provider did not seek information regarding the roof of the property; and

(b) The Provider misrepresented the risk in relation to the roof of the property when incepting the policy and mis-sold the Complainants a policy which was not suitable for their financial needs and which resulted in a subsequent claim being declined by the underwriter of 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 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 29 November 2021, 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.

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

In respect of the complaint that when the First Complainant completed an online request for a quotation for a policy of home insurance on **23 March 2019** through the Provider's website and, subsequently, on **12 April 2019** spoke with the Provider's agent in relation to the online quotation, the Provider did not seek information regarding the roof of the property, I note the following:

- In order to obtain a quote, the Complainants had to tick a box online confirming that they understood that the quote was based on certain assumptions. One of those assumptions was that not more than 20% of the roof of the property was flat;
- Once the Complainants had selected their policy cover, the assumptions were flagged a second time, with a link to the assumptions being provided;
- On **25 March 2019**, the Complainants obtained a home insurance quote and provided within that email was a request to read the policy assumptions, one of which was that *"not more than 20% of the roof is flat"*; and
- On **12 April 2019**, the Complainants confirmed that they wished to proceed with the quote received during telephone conversation with the Provider.

I note that on the telephone call between the First Complainant and the Provider's agent, the agent omitted to ask the First Complainant whether 20% or more of the property's roof was flat. This question is contained within the Provider's home insurance new business script. I note the Provider's contention that as the Complainants had already completed the process online there was no need to fully go through the form. From considering the call recording it is clear that the question relating to the flat roof was skipped by mistake by the Provider's agent.

This was a most serious omission by the Provider's agent. The script the Provider's agent was required to follow is set out in a document titled:

> [PROVIDER] INSURANCE LIMITED
> HOME INSURANCE NEW BUSINESS SCRIPT

The specific and relevant question is set out under the heading:

> STEP 2 – RISK DATA COLLECTION
> QUALIFYING QUESTIONS

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- **Is more than 20%*of the roof flat or has mineral felt covering and this portion of the roof is more than 11 years old?**
  ** Refer to Benefits matrix for underwriters' criteria on flat roofs*

Criteria such as flat roofs are extremely important. This is particularly so given that some insurers will not in fact provide cover at all depending on whether a flat roof is in existence or depending on the extent of any such flat roof.

It is clear that the Provider is fully aware of this from the question on the Script set out above, including the note included with an asterix relating to the need to inform a potential purchaser of the underwriters' criteria.

I believe it was most unreasonable for the Provider firstly not to ask and now to assert that it was somehow not necessary to ask this crucial question.

Further, I find it unreasonable for the Provider to assert that the Complainants did not act "*with reasonable care*". I believe the Provider has acted in an unreasonable manner.

It failed to ask the Complainants a question, the answer to which has very significant implications. Failure to ask the Complainants this question has resulted in the most serious of consequences.

Not alone was the Complainants' insurance claim denied by the Provider, they also had their insurance policy cancelled.

Having an insurance policy cancelled can make it virtually impossible to get insurance on a person's home in the future. Therefore, requirements which, if not complied with by a proposer for an insurance policy, could result in a policy being cancelled by an insurer is crucial information which should, in my opinion, have been very clearly communicated to the Complainants before the sale.

I believe the Provider should have taken more care in the questions it asked when it sold this policy of insurance.

Notwithstanding the omission of the Provider's agent to mention the flat roof issue on the phone call, I accept that the issue of whether the property had a flat roof was brought to the Complainants attention on at least three occasions prior to the policy being incepted and the Complainants indicated that they understood the assumptions the policy was based on.

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In the interests of completeness, I also note that post the sale of the policy, the Complainants were issued with confirmation emails on **12 April 2019** and **16 April 2019** which contained the policy assumptions and these emails requested the Complainants to read the documents attached and contact the Provider if any clarifications were necessary.

While I would have expected the Complainants to read the assumptions the policy is based upon, prior to entering into the insurance contract, I do not accept it is sufficient for the Provider to rely on these assumptions in circumstances where it did not ask the appropriate questions at the time it sold the policy.

I also note the Provider's submission that the flat roof was a material fact which the Complainants should have brought to its attention.

Here again, I believe if the Provider was of the view that the flat roof was such a material fact, it should have asked the question set out in its own Risk Data Collection Qualifying Questions.

For the reasons outlined in this Decision and what I consider to be the unreasonable conduct of the Provider, I substantially uphold this complaint. Given the serious consequences the Complainants suffered, I believe substantial compensation is merited. However, I do also accept that the Complainants bear some responsibility for relying simply on the phone call with the Provider and apparently not reading the assumptions.

For this reason, I direct the Provider to pay a sum of €15,000 to the Complainants for the inconvenience caused. I also direct the Provider to furnish the Complainants with a letter outlining the circumstances of this complaint decision that they can produce to any insurance company in the future to explain why their policy of insurance was cancelled.

In arriving at this amount, I am accepting that both parties bear some responsibility for the unfortunate circumstances in which the Complainants find themselves.

Conclusion

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

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Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to (i) make a compensatory payment to the Complainants in the sum of €15,000, 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 and (ii) furnish the Complainants with a letter outlining the circumstances of this complaint decision that they can produce to any insurance company in the future to explain why their policy of insurance was cancelled.

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

21 December 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,

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and

(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.