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Financial Ombudsman Service

*essential reading for
financial firms and
consumer advisers*

bringing you news from the Financial Ombudsman Service and focusing each month on complaints about investment, insurance or banking & loans

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about this insurance issue of *ombudsman news*

The topics we feature in this edition of *ombudsman news* include the insurance complaints handled by the caseworkers in our assessment team. We know that both firms and customers welcome the early resolution of cases and our caseworkers aim to settle matters quickly through informal, agreed settlements. Of course, this is not always possible because of the complexity of the issues involved. But even so, we will give the parties to a dispute an early view about the likely outcome whenever we can.

Both firms and their customers are making increasing use of the telephone for a wide range of transactions. Clearly this is convenient for them, but it can also give rise to disputes. So this edition highlights cases where the ability to pinpoint exactly who said what – by listening to a tape recording of a disputed conversation – has been critical to resolving a case. We also look at situations where the titles of insurance policies have apparently misled customers into expecting more than the policies actually deliver.

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1 ‘I never said that!’ – the importance of telephone recordings

Both firms and their customers are making increasing use of the telephone for a wide range of transactions. And subsequent disputes about exactly who said what feature more and more frequently in our caseload. When this happens, it is obviously far easier to resolve matters if the firm has tape-recorded calls, or followed them up with a clear and agreed written statement of what was discussed. We can otherwise be left to try and resolve the matter by assessing conflicting versions of critical conversations, taking account of the wider circumstances of the case and our knowledge of insurers’ procedures.

Recordings are clearly important where a telephone conversation takes the place of a completed and agreed proposal form. But calls relating to claims also give rise to disputes. Did the customer report the theft of this item or not? Did the insurer agree to that repair proceeding without delay? Did the firm inform the customer that the required medical treatment was not covered?

Some time ago, the Insurance Ombudsman Bureau stressed the importance of firms recording critical telephone transactions, or of their being able to demonstrate their version of events in some other convincing way. We are pleased to note that a number of firms do now appear, as a matter of course, to make and retain good quality recordings of critical calls. We regard this as good industry practice and we expect to be able to resolve disputes about what was or was not said by referring to these

recordings. If recordings are not available, we will look to the firm to set out why – on the balance of probabilities – we should accept its version of events rather than the customer’s.

Where we cannot determine with any confidence what took place, we may decide to give the customer the benefit of any doubt and/or to conclude that there has been a genuine misunderstanding. In such instances, we will try to place the parties in the position we believe they would have been in had the misunderstanding not occurred. In cases of alleged non-disclosure, for example, where we think that a request for information (or the response to it) was uncertain, we may review the claim as though the customer had given the correct information.

The following case studies illustrate some of the benefits of recording calls and show our approach where there is no clear record of what took place.

... it is obviously far easier to resolve matters if the firm has tape-recorded calls.

case studies – the importance of telephone recordings

■ 18/01

household – non-disclosure – proposal – proof of non-disclosure.

Mr B's lender sent him a leaflet advertising premium discounts for new household buildings and contents insurance policies. He applied for a policy by telephone and it was issued on 1 March 2000.

In November the following year, after settling a claim from Mr B for water damage, the insurer searched the industry database. It discovered that – between February 1995 and August 1999 – Mr B had made eight claims of which it had no record. The insurer had been aware of only one previous claim and said it would never have agreed to insure him if it had known he had made so many previous claims. It cancelled his policy and offered to pay him the difference between the premiums he had paid to date and the amount it had paid to settle his water damage claim.

Mr B said that when he applied for the policy, the member of staff he had spoken to had said she required details only of his most recent claim. However, the lender said it had a note made by another staff member that, in a later conversation, Mr B had denied making any previous claims. He had also refused to provide confirmation from his last insurer about his claims history.

complaint upheld

There was no recording of the telephone conversation when Mr B applied for the policy. So the insurer could not prove that it had asked him clear questions about matters it considered important for assessing his application. There was nothing to support its argument that he had failed to disclose all the information it considered material and it could not prove that Mr B misrepresented the details of his claims history.

We took account of the lender's note of Mr B's subsequent telephone conversation. However, we did not agree that this was sufficient to demonstrate *either* that the sales staff had asked him clear questions about relevant matters *or* that he had given misleading information. We decided the insurer was not entitled to cancel the insurance or to recover its payment of the water damage claim.

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■ 18/02

travel – exclusion for pre-existing medical conditions – exception for conditions agreed by insurer – whether insurer agreed to cover policyholder's heart condition.

Mr and Mrs W's son invited them to join a family holiday in Las Vegas and he paid for their trip and insurance. The travel agent said that Mr and Mrs W should call the insurance company's medical advice line to discuss their health. Mrs W did this and told the adviser that her husband had suffered from diabetes and angina for some years.

While in Las Vegas, Mr W had a heart attack and was admitted to hospital. The family notified the insurer's emergency medical service. After some confusion about the policy cover, the emergency service told the hospital that there was no cover for Mr W's heart condition and that it would not meet his expenses.

Mrs W said she had been told that the insurer would cover both of Mr W's conditions. The insurer said it had agreed to cover the diabetes without charge. But it had said it would cover the heart condition only if the couple paid a further premium of £33.60 and agreed an excess of £350. As they had not paid, the heart condition was excluded. The insurer said that the policy terms excluded Mr W's heart condition from cover, so it had not needed to send the couple written confirmation of this.

The insurer paid for Mr W to return to the UK, but it rejected the claim for his hospital fees of about £250,000. Mr W died shortly after his return home.

Mrs W maintained that her claim was valid and said she would have made the additional payment if she had been asked to do so.

complaint upheld

We generally settle complaints based on the paperwork and other evidence that the firm and the customer provide, rather than at a hearing, where both sides to the dispute meet face to face. However, we decided that a hearing would be helpful in

this case, so that both parties could put forward their versions of events.

The insurer based its position on a computer note made at the time of Mrs W's call. This said '*not interested in cover for heart*'. Mrs W was firm in her conviction that she had not been asked to pay an additional premium to cover her husband's heart condition.

We found Mrs W's account generally convincing, particularly since she had taken the trouble to telephone the advice line before the holiday. The insurer had an obligation to check that Mrs W understood the implications of not paying the additional premium it said it had quoted her. She might not have agreed to pay, even if she had understood clearly that this meant she could not make any claim arising from her husband's heart condition. However, we decided this was unlikely. It seemed possible that there had been an innocent misunderstanding.

It was unfortunate that the insurer did not record telephone conversations with its policyholders and had not sent the couple any written confirmation of what had been agreed. It left the position regarding Mr W's heart condition open to misunderstanding. It also meant that – had there been any dispute about the insurer's agreeing to cover the diabetes without additional charge, and amending the terms of the policy – there was no evidence other than the insurer's computer record.

We required the insurer to put Mrs W back in the position she would have been in if:

- there had been no misunderstanding;
and
- she had paid the additional amount required to cover her husband's heart condition.

We awarded her £100,000 – the maximum amount we can order a firm to pay.

However, we accepted that if the firm met the balance of the claim, it could deduct the amount she would have paid for the additional premium and the £350 excess.

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- 18/03
motor – non-disclosure – innocent non-disclosure – whether insurer treated non-disclosure as serious.

Mr C arranged motor insurance over the telephone for himself and for his wife as a 'named driver'. The insurer sent him a printed statement of the questions and answers on which it had based its decision to offer him insurance. It asked him to check the statement and let it know if anything needed correcting. One of the answers confirmed that neither he nor his wife had any motoring convictions in the past five years.

Some time later, after Mr C had put in a claim for damage done to the car during an attempted theft, the insurer discovered that both Mr and Mrs C had convictions for speeding. So it told Mr C it was treating the policy as void and would not deal with the claim.

Mr C insisted that he had disclosed his conviction when he telephoned for a quotation. But he admitted that he had not checked the statement carefully before he signed it. The insurer conceded that Mrs C's conviction was not important. However, it said it would have increased the premium by about 5% if it had been aware of Mr C's conviction.

complaint upheld

We accepted Mr C's assertion that his failure to disclose his conviction was not deliberate and that he had genuinely overlooked the mis-statement on the pre-printed form. The firm told us that if Mr C had disclosed the convictions, it would have offered cover for a minimal premium increase – about £20.

Non-disclosure is a serious matter. But in the circumstances of this case, it seemed to us unreasonable for the firm to avoid meeting the claim on the grounds of Mr C's non-disclosure. We thought it likely that if Mr C had told the firm about the convictions, he would have accepted the quotation and the firm would subsequently have met the claim. So we required the insurer to reimburse the cost of repairs, after recalculating the premium to include the increase, and deducting this recalculated premium from the total sum it paid Mr C.

■ 18/04

household – non-disclosure – oral representations – burden of proof.

Mr O applied by telephone for household insurance. He answered various questions and the insurer then sent him a statement of the facts it considered relevant to his application. It asked Mr O to check the statement and let it know if any of the facts had been recorded incorrectly. The statement read in part: *'Neither you, nor anyone normally living with you, have ever been convicted of, or have any prosecutions pending for, any criminal offence (other than motoring offences).'* Mr O did not make any corrections.

Some time later, Mr O needed to make a claim. In response to a question about convictions, he stated on the claim form that he did not have any. However, when a claims investigator interviewed him, he said he had been convicted only once – for theft – when he was 18. The insurer made further enquiries and found that more recently – in 1997 – Mr O had been convicted for causing criminal damage.

The insurer cancelled Mr O's insurance and said it would not have issued the policy if it had been aware of the conviction. Mr O insisted that he had told the telesales operator about it, even though he did not consider it relevant to his household insurance.

complaint rejected

Given Mr O's incorrect statement on the claim form, we were unable to accept his assertion that he had disclosed his conviction when he applied for the insurance. We considered the insurer had been fully justified in treating the insurance as if it had never been issued. It therefore had no liability for meeting Mr O's claim.

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■ 18/05

motor – non-disclosure – call recorded by insurer – whether proof of non-disclosure.

Mr A's son telephoned the insurer to arrange motor insurance for himself and his father. After receiving the policy, he telephoned the insurer again to say it had made a mistake. He said his father, rather than himself, should be named as the policyholder and main driver. He stated that his father was the registered owner of the car. The insurer then issued new papers.

When the car was reported stolen, the insurer investigated the claim and found that it was the son who was the owner and main user, not the father. Mr A confirmed this. He said they had registered the policy in his name because the premium was cheaper this way. The insurer then cancelled the insurance, saying it would not have issued this policy if it had known the true situation.

Mr A argued that the car belonged to the whole family and had been a joint purchase, even though it was registered in

the son's name. The insurer had recorded the calls and produced a transcript of the son's second call, in which he said the firm had made a 'mistake' in naming his father as the policyholder.

Mr A then argued that he did not speak or read English and he claimed that the investigator had not recorded his statement correctly.

complaint rejected

We were not satisfied that Mr A had given the insurer correct information when it agreed to issue this policy. Mr A's son stated clearly that he was not the main user and that it was a mistake to issue the policy in his name.

Mr A's first statement to the investigator confirmed that his son was the car owner and main user. Mr A subsequently contradicted this, but we noted that his signed statement included numerous alterations which he had added and initialled.

We concluded that the insurer was fully entitled to cancel the insurance and reject Mr A's theft claim.

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... the insurer would not have issued the policy if it had been aware of the conviction.

2 our assessment team and insurance complaints

The March and May 2002 issues of *ombudsman news* outlined how the caseworkers in our assessment teams explore ways to resolve as many complaints as possible at the earliest stages – through informal, agreed settlements. This can greatly reduce the number of complaints that require the often lengthy and time-consuming investigation that leads to a formal decision. Generally speaking – the more quickly we can resolve a dispute – the happier both sides are.

Of course, there will always be some cases that can only be resolved fairly after a full investigation and a formal decision. But around 35% of the insurance complaints we handle are now settled by members of the assessment team taking a careful look at the facts and bringing the two parties together by mediation or conciliation.

Sometimes all that is needed is for us to reassure a consumer that, for example, their allowing the insurer to inspect their damaged property is a necessary step towards dealing with their claim. Or we may be able to help the insurer take a fresh look at a case and reach a decision. The two parties may then go on to resolve these cases without any further involvement from us.

In other cases, we will set out our view of the merits of the complaint. We try to do this over the telephone wherever possible. This is usually the most helpful way of explaining matters and it allows us to respond, there and then, to any questions raised. Consumers are often pleased just to be able to talk the situation through with a neutral party.

We rely a great deal on the cooperation of firms. It is important that they are prompt in sending us the paperwork we ask for, and that we can contact them easily by telephone to talk through aspects of the case. It is also essential that, once a firm has agreed with us that it will make an offer, it makes a note of this agreement and does not subsequently attempt to withdraw or amend the offer.

... consumers are often pleased just to be able to talk the situation through with a neutral party.

case studies

The following cases illustrate some of the wide range of complaints that caseworkers in the assessment team have resolved in recent months.

■ 18/06

travel – cancellation – cancellation as a ‘direct consequence of compulsory quarantine or subpoena’ – whether claim by policyholder held on remand valid.

Mr H took out a single trip travel policy for his holiday to Benidorm. However, he was unable to take the holiday. Three days before he was due to travel he was arrested and kept in custody for seven days.

The insurer rejected his cancellation claim. It said that the policy covered cancellation only in certain specified circumstances and this was not one of them. Mr H argued that his claim was valid because cancellation as a ‘*direct consequence of compulsory quarantine ... [or] subpoena*’ was covered.

complaint rejected

We did not agree that Mr H was in ‘compulsory quarantine’ while he was held on remand. His detention may have been similar to being subpoenaed to appear in court but it was not the same. The reason he was unable to travel was because he was in prison, not because he was required to appear in court. In the circumstances, the insurer was justified in rejecting Mr H’s claim.

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■ 18/07

payment protection – insured increasing loan but not insurance – how insurer should calculate benefits.

Mrs E arranged a mortgage in 1995 and took out payment protection insurance through the lender to cover her repayments. On three occasions during the next six years, she arranged remortgages of her property with the same lender.

In 2001, Mrs E was made redundant and submitted a claim under the policy. The insurer accepted her claim, but it calculated the benefit that was payable to her each month on the basis of her monthly mortgage payment in 1995. This was insufficient to cover the increased repayments that resulted from the later remortgages.

Mrs E argued that the benefit payable under the policy should have increased each time she remortgaged her property, to protect the revised monthly payments. The insurer said it had been *her* responsibility to ensure the policy cover was adequate.

complaint upheld

In our view, each time the remortgage was arranged, the insurer should have suggested to Mrs E that she should increase her policy cover. It should also have drawn her attention to the inadequacy of the benefit payable under the policy unless she did so. This would have been good insurance practice, since insurers and intermediaries arranging insurance policies have a duty to ensure that the policy is suitable for the policyholder's needs and resources.

The insurer agreed to recalculate Mrs E's benefits as if she had increased the cover each time she remortgaged her property. It backdated this additional payment to the start of her claim, deducting the amount she would have paid in premiums for the increased cover.

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■ 18/08

household buildings – storm – proof of storm.

Mr M, whose house is on top of a mountain in South Wales, submitted a claim for storm damage to the rear windows. He said that in July 2001, storm force winds had caused serious damage to all the windows at the rear of his house. However, he did not submit the claim until October 2001 and by then he had replaced all the windows and doors.

The loss adjuster appointed by the insurer to inspect the damage had found nothing left to inspect – the glazier had disposed of the old windows and doors. The insurer rejected the claim on the basis that there was no evidence of storm damage. Mr M sent the insurer a letter from the glazier stating that the windows were replaced because they were in a '*very weatherbeaten state, particularly those at the rear*'.

complaint rejected

We spoke to the glazier, who indicated that the windows had not been damaged during a single incident of stormy weather, but were in a state of general decay resulting from the normal weather conditions in that area.❖

Weather reports recorded strong winds during July 2001, but there was insufficient evidence to indicate these had been ‘storm force’. We concluded that the windows had not been damaged by storm force winds and we rejected the complaint.

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■ 18/09
travel – non-disclosure – exclusion for pre-existing medical conditions – whether insured required to disclose treatment for related conditions.

Mr N took out insurance to cover his holiday in Canada in May 2001. The policy included a declaration that he *‘had not suffered from or received treatment for ... a heart-related condition, hypertension, or a stroke ... [or] received in-patient treatment, has been prescribed medication or has had a change of medication during the last 12 months ...’*.

Mr N told the agent that he had ‘dormant’ angina and disclosed his age. As a result, the insurance premium was doubled. He did not mention any other conditions. While on holiday he suffered a stroke and incurred substantial medical costs. The insurer would not reimburse Mr N’s medical expenses. It said this was because of his failure to disclose that, in 2000, he had suffered from mild hypertension and had been referred to a consultant for ‘intermittent claudication’ (leg cramps).

Mr N disputed this decision. He submitted evidence from his doctor that the episode of hypertension had ‘resolved spontaneously’. Although Mr N had received antihypertensive treatment, this was for ankle oedema (related to the claudication) and not for hypertension.

complaint upheld

We concluded that the evidence did not support the insurer’s decision that Mr N had failed to disclose a medical condition he was required to make known. The medical evidence confirmed that the antihypertensive treatment Mr N received was not for hypertension.

His condition of claudication/ankle oedema was not directly related to the disability that led to his claim – the stroke – so the insurer was not entitled to reject the claim. Mr N had not failed to disclose hypertension; he had not received treatment for that condition within the excluded period. The insurer agreed to meet the claim and to add interest.

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■ 18/10
extended warranty – proof – policyholder claiming for second of two identical losses – evidence required to prove loss valid.

Mr D had two fridge-freezers. When one of them broke down and had to be replaced, he took out extended warranty insurance to cover both the new fridge-freezer and the one he already had. Unfortunately, just three weeks later, the old fridge-freezer

broke down and that too had to be replaced. Mr D submitted a claim for a replacement and for compensation for the food that had been spoilt. He also claimed for the cost of other food that he had intended to store in the fridge-freezer which broke down, and that he had since had to throw away because it would not fit in the remaining freezer.

The insurer rejected Mr D's claim on the ground that it related to the earlier incident, that took place before the start date of the insurance. Mr D refuted this and insisted that the second breakdown was covered.

complaint upheld in part

Mr D produced evidence showing that when the first fridge-freezer had broken down, it had been removed and replaced. This proved that he had owned two identical models.

The insurer agreed to deal with the claim and also to pay £130 for the spoilt frozen food. However, it refused to reimburse the cost of the food that Mr D had intended to store in the freezer. We agreed that there was no cover under the insurance for this part of his loss.

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- 18/11 **household buildings – non-disclosure – cancellation – whether insurer entitled to refuse to meet cost of work completed before policy cancelled.**

Mr J applied for household insurance in January 2001. When asked about his insurance history, he disclosed three

previous claims, for which he had been paid a total of £2,800. The insurer sent him a statement of facts for checking, together with a direct debit mandate for the payment of premium instalments. One of the statements confirmed that no insurer had ever refused to cover Mr J.

In June 2001, Mr J's pigeon loft caught fire and was damaged beyond repair. He submitted a claim form and two estimates for replacement of the loft. The insurer accepted his claim and told him to proceed. However, it then made enquiries. It found that Mr J had failed to disclose that two insurance companies had refused to insure him. It also discovered that he had not disclosed all his previous claims, for which he had received a total of £24,000.

The insurer refused to pay for the new pigeon loft. It cancelled the insurance and refunded the premiums Mr J had paid. Mr J asserted that he had never received the statement of facts, although he had signed and returned the direct debit mandate. He denied giving incorrect information to the insurer. He claimed he had read out over the phone to the insurer a letter from his previous insurer, saying it would no longer continue to insure him.

complaint upheld in part

Non-disclosure is a serious allegation. The information that a proposer (someone applying for insurance) provides to an insurer is the basis of the contract and only the proposer can answer the insurer's questions. If Mr J had given false information to the insurer, it would have been fully justified in cancelling the policy.

... Mr J failed to disclose that two insurance companies had refused to insure him.

But we were not satisfied that Mr J *had* provided incorrect information. He had not been asked to give written answers to the insurer's questions, or even to sign the form on which the insurer had recorded the information he had provided. It was possible that he had not received the statement of facts or that he had failed to check it carefully. The statement of facts was the only record of his telephone conversation with the insurer.

We accepted that the insurer would have refused to issue this policy if it had been aware of Mr J's claims experience. The contract had therefore been agreed on the basis of a fundamental mistake, so the insurer was entitled to cancel it. However, we thought it would be unfair to allow the cancellation to prejudice Mr J. He had started work on the replacement loft on the clear understanding that the insurer had accepted his claim. The insurer agreed to meet the cost of all the work that had been carried out up until the time it notified Mr J that it was cancelling the insurance.

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- 18/12
motor – accessories – valuation – whether policyholder entitled to cost of new replacement.

Mr F was involved in an accident with a third party. Both cars were insured with the same company. The third party was 100% liable for the damage to Mr F's car and the insurer settled Mr F's claim on a

'total loss' basis. Mr F also received further payments from the insurance company on behalf of the third party.

The insurer agreed to Mr F's request to retain the car's CD player and roof bars. Mr F thought he might also want to keep the tow bar, although he did not mention this. However, when he got his replacement car, he found that it was a different model and that the old CD player and roof bars did not fit. So he told the insurer he was claiming the cost of a new CD player, roof bars and tow bar.

The insurer said there was no cover for these losses, but it agreed to increase its settlement to reflect their market value, since he could not use them in his new car. It paid Mr F a further £140 for the CD player and £50 for the tow bar. It made no payment for the roof bars, but offered to assess their value if Mr F sent them in.

complaint rejected

We did not agree that Mr F was entitled to the cost of a new CD player, roof bars and tow bar. His insurer's liability was limited to the market value of the car's accessories, adjusted for '*wear, tear and loss of value*' due to their age. The insurer had calculated its offer fairly and we did not consider there were any grounds for increasing it.

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3 misleading descriptions

We see a small number of disputes where we feel the policyholder has been seriously disadvantaged by a misleading description of an insurance policy. Customers who see something purporting to be '*personal accident insurance*' expect it to provide a reasonably wide-ranging cover for a variety of accidents that might occur. In a few cases, however, although the policy heading or the associated leaflet appear to promise the same wide-ranging cover as other policies with a similar title, the reality falls far short of this.

We take the view that, when judging what the policy provides, a customer is entitled to rely – at least to some extent – on the policy headlines. Where a policy description is not borne out by the small print, we will consider whether the customer could have had any reasonable expectations of cover on the wider basis. We look at what a reasonable person would have concluded about the nature of the cover from the information available to them. Would they readily have understood the restricted nature of the policy on offer or would they have gained the clear impression that wider cover would be provided?

Where appropriate, we will conclude that the firm has not adequately explained the main features of the policy, in the way it is required to do under the General Insurance Standards Council code, and that it may not have done enough to ensure the product is suitable for the policyholder's needs.

The remedy in such cases will not be a simple matter of returning the customer's premiums. Where better alternative cover is readily available, we are likely to conclude that the firm should handle the claim as if its unusual and/or misleading restrictions on cover did not apply.

... the name of the policy was misleading and he would not have bought it if he had understood how restricted the cover was.

case studies – misleading descriptions

■ 18/13

extended warranty – upholstery – meaning of ‘upholstery’.

When Mr V bought a sofa in 1997, he took out extended warranty insurance to protect it. The policy was headed – ‘*A Five Year Policy for Upholstery (excluding leather)*’. The following year, he found that a section of the upholstery was coming loose and separating, so he claimed the cost of repairs. The insurer told him that the cover was limited to ‘*structural defects*’ and did not provide indemnity for problems with the upholstery.

complaint upheld

There was a clear conflict between the actual terms of the policy and the description of the policy cover on its front page. Mr V said that the name of the policy was misleading and that he would not have bought the policy if he had understood how restricted the cover was.

We did not accept the insurer’s argument that the policy only covered ‘*structural defects*’ with ‘*upholstery*’. The policy did not define ‘*upholstery*’, and its ordinary meaning is the fabric that covers furniture. If the insurer intended the word to be defined in a more restricted way, it should have made this clear.

Since the insurer was unable to show that the limited nature of the policy cover had been made clear to Mr V, we concluded it was not justified in rejecting his claim. We also awarded Mr V £100 compensation for the insurer’s poor claims handling.

■ 18/14

travel – driving – breakdown and recovery insurance – whether providing comprehensive motor cover.

Mr I took out holiday motoring insurance specifically to cover his European motoring holiday. He had an accident while on the holiday, which resulted in his car being written-off. His travel insurer refused to meet his claim, on the ground that the policy only covered ‘breakdown and recovery’ of his car. It told him he should claim under his UK motor insurance.

Mr I was dissatisfied with this response. He argued that he had been led to believe that the travel insurance provided him with the same level of cover – abroad – that he held in the UK (fully comprehensive motor insurance). If he had been correctly informed about the policy, he would not have purchased it, particularly since his motor insurer would have provided fully comprehensive cover in Europe if he had paid an additional premium.

complaint upheld

We were not satisfied that the insurer had used its ‘best endeavours’ to ensure the policy was suitable for Mr I’s needs, as it was required to do under the terms of the Association of British Insurers’ Code for the Selling of General Insurance. The insurer accepted our recommendation that it should deal with the claim as if the policy covered the full loss, and that it should refund the storage charges Mr I had paid, together with interest.

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■ 18/15

household contents – limit of cover – brochure promising wider cover than policy terms – whether insurer entitled to rely on policy exclusion.

Mrs K took out the household insurance recommended by her lender and chose the top of the range offered – ‘*Supercover Special*’. The brochure described it as ‘*unlimited contents cover – accidental damage and personal possession cover outside the home*’ and ‘*one of the most complete covers available*’. It confirmed that personal possessions, including sports equipment and children’s bikes, were covered up to £1,500 for any one article.

The explanatory leaflet stated that the policy did not cover ‘*motor vehicles, caravans, trailers, aircraft, watercraft or spare parts and accessories*’. However, it warned – ‘*This leaflet is just a guide and does not summarise all aspects of the cover; only the policy document does this.*’

When Mrs K made a claim for the theft of her son’s baby-quad bike, the insurer rejected it, citing the policy exclusion for ‘*mechanically propelled vehicles*’. It said the quad bike should have been covered by motor insurance. Mrs K objected, arguing that she had never received a copy of the policy document and that the leaflet suggested that the bike was covered. She also pointed out that her son was only seven years old and could not have used the bike on the road or taken out motor insurance.

complaint upheld

Whether a baby-quad bike was a ‘*motor vehicle*’ or a ‘*mechanically propelled vehicle*’ was debatable. However, we did not need to

decide that point. There was a clear contradiction between the policy exclusion and the wording of the leaflet. Not only did it expressly include ‘children’s bikes’, but it stated there was ‘unlimited’ contents cover. It did not seem reasonable to assume Mrs K should have known that the insurer did not consider her son’s bike to be part of the ‘contents’ of her house.

The insurer had not worded its policy leaflet in a clear and unambiguous way, so Mrs K was entitled to the benefit of the wording that was most favourable to her. We required the firm to meet her claim.

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■ 18/16
household contents – renewal – notification of new restriction on benefits – whether leaflet documenting change constituted sufficient notification.

Mrs H had household insurance for some years. In March 2001, her car was broken into while she was visiting a hospital and possessions were stolen from the locked car boot. She submitted a claim for £2,385 and provided receipts.

The insurer accepted her claim, subject to the policy limit of £1,000, and it deducted the policy excess of £50 from its settlement. Mrs H complained, saying her policy did not refer to such a limit. The insurer said it had imposed the limit when the policy was renewed in 1999.

The changed terms introduced at that time meant that the insurer would not meet claims for – *‘Theft from unattended road vehicles other than from a locked, concealed luggage boot ... following a forced and violent entry to a securely locked vehicle. The most the insurer will pay for any one event is £1,000.’*

Mrs H denied receiving any information about the change of terms. Although she had moved house in 1999, she had kept all the documents that the insurer had sent her. The insurer produced computer records to prove it had sent Mrs H notification of the change.

complaint upheld

We could not determine whether Mrs H had received the insurer’s notification. However, even if she had, we did not consider the notification was sufficient to draw her attention to such an important change in the policy cover. Any significant restriction in benefits needs to be highlighted but the leaflet did not do this adequately. So it was not reasonable for the insurer to rely on the restriction when it calculated its settlement of her claim.

In addition, we considered the wording of the exclusion unambiguous. It could be argued that the phrase ‘any one event’ did not refer to thefts from a locked, concealed luggage boot. However, in view of our first conclusion, we did not need to make a decision on this point.

Finally, the insurer had not calculated its settlement correctly. It should have deducted the excess before it applied the

policy limit. We were surprised that the insurer had not noticed this error when it reviewed the complaint. We required the insurer to waive Mrs H's excess – as compensation – and to pay the balance of the amount she had claimed, together with interest.

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■ 18/17
household contents – renewal – change of policy terms – need to highlight change.

Miss L's golf clubs were too big to fit in the boot of her car so she folded down one of the back seats and placed the clubs there. When she returned from an afternoon's play, she forgot to bring the clubs indoors. By the next morning, they had been stolen. The insurer rejected her claim. It said that her household contents insurance only covered thefts *'from a locked, concealed luggage boot'* of an unattended car.

complaint upheld

We agreed with the insurer that Miss L's loss was caught by the wording of the exclusion. As at least parts of the golf clubs were visible, they had not been taken from a *'concealed'* luggage boot.

However, we were concerned that the policy terms did not contain this exclusion. The insurer explained that it was added to the policy with effect from the date of renewal in August 1999 and it said it had sent Miss L documents explaining this at the time. Miss L said she had not received any such documents. The insurer claimed to have sent Miss L:

- a standard letter referring to the renewal;
- a page setting out the premium and direct debit details;
- a schedule providing a general breakdown of the cover;
- an advertisement for travel insurance; and
- the policy update entitled *'important changes to your home protection policy'*.

We did not consider that this set of papers – noting the restriction on cover in the middle of the 'update' – was adequate to draw Miss L's attention to the change. There was no warning that part of the existing cover had been withdrawn and we decided that this fact had not been sufficiently highlighted or properly explained. It is important that adverse changes are prominently announced. We required the insurer to meet Miss L's claim in full and to add interest.

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■ 18/18
household buildings – flood – rising water table – cesspit – whether 'damage' caused to cesspit by 'flood'.

Mr G's house was 150 years old and served by a cesspit, not connected to mains sewerage. Following unusually heavy rainfall between September 2000 and February 2001, the cesspit was becoming full of water within hours of being emptied. Mr G's sanitary and washing facilities became unusable. He submitted a claim under his

household buildings insurance for the cost of remedial work, claiming the cesspit had been damaged by *'escape of water'* or *'flood'*.

Mr G's insurer rejected his claim, explaining that damage due to escape of water was only covered if water had escaped from a fixed water system. In Mr G's case, the reverse was true, since water appeared to be entering the cesspit from the outflow pipes. And the insurer said that *'flood'* only occurred if there was a *'rapid accumulation or sudden release of water from an external source'*.

complaint upheld

According to a recent decision by the Court of Appeal, the word *'flood'* should be construed in its ordinary and natural sense and can include prolonged and steady rain or a steady, slow build-up of water.

In this case, the cesspit had been affected by rising ground water. It was not an *'escape of water'* but could be described as a *'flood'*. The water had not caused physical damage to the cesspit but it had prevented Mr G from using it as usual. This was a *'loss'* and it was therefore covered by the insurance.

We put it to the insurer that Mr G's claim was valid and that he was also entitled to compensation for the insurer's delay in accepting liability. This had meant that Mr G and his family were left without proper sanitary facilities for some months. The insurer accepted our conclusions and agreed to meet the claim and to pay £1,000 compensation for distress and inconvenience.

.....

■ 18/19

household – storm – proof of storm – proof that damage caused by storm.

Mr S noticed damage to his roof tiles and internal decorations. He had the damage repaired and submitted a claim to the insurer. The insurer rejected the claim after the repairer it sent to look at the damage noted that there were visible signs of wear and tear on the roof.

Mr S submitted a report from his builder, denying any wear and tear and saying the damage was due to a storm. The insurer obtained weather reports that showed there were no storm conditions at the time Mr S noticed the damage. Mr S then conceded that he did not use the damaged bedroom often, so he was unsure when the storm had occurred.

complaint rejected

It was up to the claimant to show that the damage was due to a particular storm and not merely to poor weather over a period of time, or to general wear and tear. We did not require the insurer to meet the claim. There was no evidence that the damage to the roof had been caused by a storm, or even that there had been a storm around the time of the claim.

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■ 18/20

personal accident – motor accidents – policyholder assaulted when getting into car – whether assault covered under policy.

Mr Y submitted a claim under his '4-Way Accident Cash Plan', when he was assaulted outside a food and wine shop by the shop owner, and injured his knee.

The insurer rejected his claim on the ground that the policy only covered him if he sustained an accident when he was getting into or out of a private car or public conveyance, or if a vehicle struck him when he was walking on a public road. Mr Y argued that his claim was valid because he had been assaulted while he was getting into his car, after leaving the shop.

The insurer refused to make any payment. It referred to Mr Y's initial statement about the injury, which had not mentioned his car at all.

complaint rejected

Mr Y was unable to produce any evidence to support his amended description of the incident. Given that he had not originally mentioned the car, we were not convinced that the incident occurred as he claimed. Even if we *had* been convinced about this, the claim still did not meet the strict criteria of the policy, which limited benefits to injuries sustained as a result of a motor accident.

.....

- 18/21 **motor – non-disclosure – clear questions – modifications – whether tinted windows a ‘modification’.**

When Miss M took out motor insurance, she was asked to disclose any modifications that had been made to her car, such as changes ‘to engine, body, wheel, suspension’. She informed the insurer that the car had a body kit but she did not mention any other modifications.

Some time later, after she put in a claim for theft damage to the car, the engineer appointed by the insurer to inspect the car noted that it had tinted windows. The insurer rejected her claim and immediately cancelled her insurance from the start date. It said she should have mentioned the tinted windows, since they constituted a ‘*modification*’ and it would not have issued the policy on any terms if it had known about them. Miss M then had to act quickly to obtain insurance with another firm, and she had to pay a much higher amount for it.

complaint upheld

It was debatable whether the windows were part of the car’s ‘body’ and whether tinted windows were a modification that Miss M was required to disclose. We were satisfied that she had genuinely not realised that she needed to tell the insurer about the windows. We thought the insurer should at least have asked her to explain why she failed to mention the windows, instead of just cancelling her insurance without warning.

We decided that the firm had not been justified in cancelling the insurance. Miss M had by this time taken out an alternative policy with a different firm. So we suggested that the earlier policy should be treated as having been cancelled by *her* rather than by the insurer. She should give back to the insurer part of the premiums it had refunded, from the policy start date until the new insurance began. In any event, we decided that the insurer had to reimburse Miss M for the cost of repairing the car, plus interest. We also decided that the insurer should pay her £300 compensation for the distress and inconvenience it had caused.

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■ 18/22

**mechanical breakdown warranty –
exclusion for external oil leaks –
meaning of ‘external’.**

The camshaft oil seals on Mr R’s car broke down and oil leaked on to the cam belt, which was contained in housing at the end of the engine, the housing being sealed with a gasket. Mr R arranged for the necessary repairs – steam-cleaning of components and replacement of the cam cover gasket and the oil seals. He then claimed back the cost of the repairs from his insurer.

The insurer rejected the claim on the ground that the policy excluded ‘*external oil leaks*’. It explained that it would cover internal oil leaks, such as a leak into the cylinders from a blown head gasket. However, it would not pay for any leak outside the main engine block, sump and cylinder head. Mr R argued that the wording of the exclusion was ambiguous.

complaint upheld

We concluded that the insurer had interpreted the exclusion too restrictively. We did not think it was reasonable to expect policyholders to appreciate the narrow distinction it was making between different types of oil leaks. And we did not agree that an oil leak into a housing, due to the failure of the oil seals, would generally be regarded as ‘external’. We therefore required the insurer to meet the claim in full, plus interest.

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■ 18/23

medical expenses – transfer from ‘a similar existing plan’ – whether previous insurance arrangements were ‘a similar existing plan’.

Mr T was a member of his employer’s private medical expenses insurance scheme until 1 September 1993, when he transferred into a personal scheme with the same insurer. Then in September 1999, he cancelled that policy and took out a similar policy with a different firm, whose explanatory literature promised that ‘*cover may be transferred from a similar existing plan and future claims made for acute conditions originating at the time you were participating in a previous plan will be honoured. No health questions will be asked or medical examinations required.*’

In July 2000, Mr T saw a consultant about recurrent groin pain and underwent investigations and a colonoscopy. However, after making enquiries, the insurance company rejected his claim to have his costs reimbursed. It said Mr T had not been entitled to an automatic transfer because his previous insurer had not asked him any questions about his health before it issued him with cover. It also concluded that his illness had ‘originated’ before he had taken out the personal insurance cover in 1993, because he had received the same treatment in 1987. It did not accept that Mr T’s corporate membership was relevant.

Mr T argued that his 1987 claim had been met by the insurance company that covered him at that time and also that his current claim was for a different illness, even

though the treatment was the same. He pointed out that the current insurer had not told him that his cover could only be *‘transferred’* if his previous insurer had asked questions about his health before offering him insurance. In response, the insurer said that Mr T should have understood the terms on which it would allow cover to be transferred.

complaint upheld

The condition on which the insurer relied in rejecting Mr T’s claim stipulated that cover could only be transferred *‘from a similar existing plan’*. It did not define this term or make it clear that the previous scheme would not qualify unless it had been underwritten on the basis of questions about the policyholder’s health.

We concluded that it would have been difficult for anyone to understand the insurer’s requirements. Moreover, the explanatory literature only emphasised the ease of transfer, not the insurer’s restrictions.

We considered that the insurer should have asked Mr T specific questions on any matters it regarded as vital, before agreeing to provide cover. We decided that all Mr T’s previous insurances – both the corporate and the personal schemes – should be treated as *‘a similar existing plan’*.

We also concluded that the 1987 illness was too remote to be considered as *‘an illness that ... originated before the enrolment’*. The insurer was not entitled to reject Mr T’s claim on either of the grounds it cited. We required it to reimburse Mr T in full and to add interest to its payment.

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■ 18/24

payment protection – unemployment – unemployment defined as redundancy – whether policy restriction made clear to borrower before sale of policy.

Mr B took out insurance to protect his loan repayments. His lender arranged a *‘Life, Disability and Unemployment’* policy. When Mr B became unemployed, he made a claim. The insurer refused to meet his loan repayments, stating that the policy only provided benefits if he became redundant. The policy defined *‘unemployed’* as *‘being without work due directly to your redundancy or business failure’*. It also relied on the policy definition of *‘redundancy’*: *‘employment being terminated due solely to your employer ceasing or reducing the activities for which you were engaged’*.

Mr B argued that he *was* redundant because he had received a redundancy payment, but the insurer did not agree. It pointed to evidence from Mr B’s former employer, showing that he had been dismissed because he was incapable of performing his duties satisfactorily.

complaint upheld

The policy title referred to *‘unemployment’* cover, but the policy did not include this benefit and restricted cover to redundancy situations. This restriction was only apparent after a close reading of the policy, including the definitions section. However, the insurer had named and marketed the insurance as if it covered *all* unemployment. It did not do this, so the insurer had to ensure that the lender selling the policy made the actual scope of the cover clear.

to potential purchasers before they committed themselves.

There was no evidence that the lender selling this policy had drawn Mr B's attention to the limitations of cover and we accepted on balance that the policy had been mis-sold. We did not consider that it would be fair merely to give Mr B a premium refund – if he had known the policy did not cover all unemployment, he could have bought wider cover from another insurance company. He had been prejudiced by the lender's failure to explain the terms of this insurance.

We were satisfied that Mr B had become unemployed through no fault of his own. So we required the insurer to meet his claim and to pay any interest or arrears charges he had incurred.

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■ 18/25
personal accident – mis-sale – road and travel plan – bicyclist – whether policy misrepresented to policyholder.

Mr M and his partner took out a 'Road and Travel Plan' in 1996. The policy benefits were set out in a table. Shortly before taking out this plan, Mr M's partner had been involved in a road traffic accident and had been distressed to find that the insurance she had at the time did not provide any cover for her injuries.

In 2001, Mr M was injured while riding his bicycle. No other vehicle was involved in the accident. He submitted a claim, but the insurer refused to make any payment. It told him the policy only covered accidents involving motor vehicles or public transport. Mr M said this restriction had not been explained to him and he asked for a full refund of his premiums.

complaint rejected

The policy's title indicated that it was concerned with road accidents involving motor vehicles. In fact, it only provided cover for policyholders injured in accidents if they were *in* a vehicle or if they were a pedestrian, pedal cyclist or passenger on public transport and had an accident *with* a vehicle. We were unable to accept Mr M's allegation that he was led to believe that the policy covered *any* personal accident. Nor did we agree that the policy was unsuitable for his needs and was mis-sold to him. He was not entitled to a full premium refund.

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