ombudsman news
from the **insurance** division
Financial Ombudsman Service
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Financial Ombudsman Service

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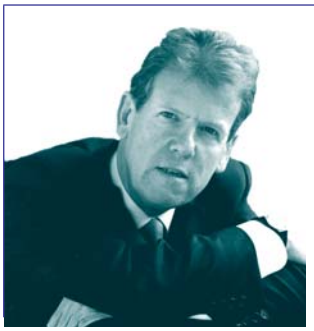

welcome to ombudsman news

by **Walter Merricks**
chief ombudsman
financial ombudsman service

I am delighted to introduce this first issue of *ombudsman news*. Each month we will bring you news from one of our three divisions – investment, banking and loans and – this month - our insurance division, headed by Tony Boorman.

ombudsman news is aimed primarily at firms and professionals working in the relevant areas of financial services, and at consumer advice agencies, but it may also be of more general interest. We hope you will find it a helpful source of information about our activities. We welcome your comments and suggestions.

We do not yet know from HM Treasury the exact date when the new single set of ombudsman rules under which we are to operate will come into effect. However the rules are now available. If you would like to find out more about them and how they will affect your firm, please contact our technical advice desk. We provide a number of services to firms and professional advisers and will be happy to help you. You'll find further details of these services, and how to contact us, on the back cover.

by **Tony Boorman**
principal ombudsman
insurance division

about this issue of ombudsman news

Every three months, *ombudsman news* will focus on the work of the insurance division, replacing the quarterly Bulletins formerly published by the Insurance Ombudsman Bureau. We will review our work dealing with general insurance matters over the preceding quarter and report on some of the major themes that have emerged. We hope this will provide a helpful source of reference and that our views will feed directly into firms' own complaint-handling.

This first issue is unusual in that it looks back over eight months rather than three. During this time, we have investigated over 5,000 cases and responded to tens of thousands of customer enquiries.

'We hope this will provide a helpful source of reference and that our views will feed directly into firms' own complaint-handling.'

We focus on exclusion clauses and set out where we currently stand on this and other issues which have caused particular concern to insurers and policyholders in recent months. We also give some recent case studies.

Our report reflects the work of all in the Financial Ombudsman Service who have contributed to resolving general insurance disputes. However, particular thanks go to Reidy Flynn, Alan Freedman and Brigitte Philbey for editing the contents. Together with my fellow ombudsmen in the insurance division, Reidy Flynn, Michael Lovegrove and Steve Lilley, I hope you will find this an interesting and useful publication. We welcome your comments.

1 overview

Exclusion clauses are an accepted and well-understood part of all general insurance products. The insurer describes the areas of claim it is prepared to cover, then sets out the particular circumstances it believes it is necessary or appropriate to exclude. The salesperson, in accordance with the industry codes, explains the main elements of the policy (including the exclusions). When choosing a product, the potential policyholder takes account of the cover available and the effect of the exclusions.

That's the theory. The practice can be rather different – as illustrated by the number of problems policyholders bring to us about insurers' use of exclusion clauses. Customers are often concerned that insurers use 'small print' exclusions to justify rejecting claims where customers thought they were covered. Of course, such concerns do not always lead us to criticise the insurer. Where exclusions are clearly expressed and of general application, they are an entirely appropriate part of the insurance contract and the ombudsman will uphold them. In this issue, however, we set out a number of cases where we concluded we could not support the wording of an exclusion, or where the facts of the case did not justify relying on the exclusion.

'Two types of exclusion have given rise to particular concerns and debates with insurers and policyholders.'

'Where exclusions are clearly expressed and of general application, they are an entirely appropriate part of the insurance contract and the ombudsman will uphold them.'

Two types of exclusion have given rise to particular concerns and debates with insurers and policyholders:

- those that dramatically reduce the range of cover actually provided from that set out in the cover section of the policy; and
- those where insurers exclude cover unless policyholders exercise a degree of care over their possessions or well-being which goes significantly beyond the degree of care most of us actually exercise.

Exclusions of the first type may occur where the marketing of policies suggests a scope of cover that, taking the exclusions into account, the insurer never intended. Sometimes this is simply a matter of customer misunderstanding. However, in other cases it can raise concerns that the customer was misled when making the purchase.

This problem is not restricted to one sector of the industry but is of particular concern to policyholders of health-related products, where examples include:

- exclusions dealing with pre-existing medical conditions;
- exclusion of mental illness from sickness cover in travel and loan protection policies; and
- exclusion of chronic conditions in private medical expenses policies.

‘Many of these exclusions are problematic...and they can fundamentally alter the value of the product.’

Many of these exclusions are problematic. They generally involve terms that are not well understood by policyholders, such as ‘chronic’ and ‘pre-existing condition’, and they can fundamentally alter the value of the product. On page 5 we look in more detail at specific problems that arise from the chronic condition exclusion.

The second sort of exclusion concerns circumstances where insurers exclude cover unless policyholders exercise a degree of care which goes significantly beyond that which most of us actually exercise. Insurers rely on the exclusions to reject claims arising from the very circumstances for which policyholders sought the protection of insurance in the first place – circumstances they may understandably consider part of the normal everyday course of events.

I imagine most of us, for example, have left the car keys in the ignition for a moment while we got out of the car to pay at a petrol station or collect the final item from the hallway of our home before setting out on a journey. Foolish – possibly – but common behaviour and not, I suggest, generally indicative of a policyholder’s failure to take reasonable care of his car. I am concerned by the apparent increase in insurers’ reliance on such exclusions. On page 11 we discuss our stance on unattended cars and keys left in the ignition.

Insurers are, of course, free to decide on the extent of cover they wish to provide. But if exclusions require policyholders to take abnormal precautions to protect their well-being, I do not consider them reasonable unless the significance of the exclusion was brought very clearly to the policyholder’s attention at the point of sale.

I expect most of us view general insurance products as an uninteresting but necessary purchase. As with other products, we rely on marketing material for information about what we are buying. In many sectors of the industry, customers see insurance as a standard commodity – differing very little from one provider to another. The idea that they take the care over choosing a policy that perhaps they should is clearly not borne out by the facts. New and convenient methods of sale, not least the internet, tend to encourage a view that insurance is something we can obtain without too much thought. A recent advertisement for an internet-based service made much of the fact that car insurance could be bought during the television commercial break. We comment on internet sales on page 32 of this issue.

These trends are not new and will not be reversed but they have consequences for the way policies are written. They are also an important background to our view on the degree to which insurers should be able to rely on exclusions in individual cases. My view is that unless insurers take steps to address these issues, the ombudsmen will, over time, have to place less weight on the significance of exclusions and more on the general environment in which the policy was sold.

Tony Boorman
principal ombudsman, insurance division

2 chronic medical conditions

Private medical expenses insurance is a relatively small but growing sector of our casework. The distinction between chronic and acute medical conditions has received considerable attention in recent months, not just in our casework but also in public debate. The exclusion of medical expenses claims because an insurer deems the medical condition ***chronic*** can come as a real shock to the patient/policyholder. We have had to adjudicate on a steady stream of such cases in recent months.

The marketing of private medical expenses insurance often alludes to the well-publicised difficulties of the NHS and to the potential peace of mind offered by insurance which gives ready access to private treatment, offsetting the financial consequences. Policyholders' expectations are therefore high.

By their nature, private medical claims are often made at a time of very real pain and suffering. Medical expenses insurers generally recognise this and treat claims with sensitivity.

significance of acute/chronic distinction

It is a general feature of private medical expenses insurance that chronic conditions are excluded from cover or that cover is limited to acute conditions. The industry is presently working on common definitions of 'chronic' and 'acute' but insurers need to do more to clarify the distinction. They also need to do more to explain to policyholders the significance of excluding chronic conditions.

While different insurers use different definitions of 'acute' and 'chronic' at present, the general intention is much the same. For example, in its policy document, one insurer explains a 'chronic' condition as follows:

"This term is used to describe conditions which, with current medical knowledge, treatment can alleviate but not cure. Examples of this would be allergies, asthma, eczema, arthritis, irritable bowel syndrome etc. Whether or not a particular complaint is chronic or acute is defined in medical dictionaries. These definitions will form the basis of our decision."

By contrast, this is how an 'acute' condition is described :

"This term is used to describe a condition of rapid onset, severe symptoms and brief duration. Examples of this will be appendicitis or tonsillitis. It may also include conditions resulting from chronic illnesses but which can be cured or substantially cured. An example of this would be a hip replacement or heart bypass surgery."

'The exclusion of medical expenses claims because an insurer deems the medical condition chronic can come as a real shock to the patient.'

In practice, it is often far from straightforward to interpret what constitutes a *"chronic condition"* and referring to a medical dictionary, as the definition suggests, is of little help.

Excluding chronic conditions means a wide range of common ailments, such as asthma, eczema, arthritis and diabetes are simply not covered by private medical insurance, even if the condition only arose after the insurance was taken out. More significant conditions, such as dementia and Parkinson's disease, where treatment is presently unlikely to bring about a cure, are also not covered.

But the distinction between acute and chronic goes much further than categorising different medical conditions.

when a life-threatening condition becomes chronic

One particularly troublesome area is where a serious medical condition deteriorates and various forms of treatment are tried without success. For example, an insurer may initially accept a condition such as cancer as 'acute' but then, over time, reassess it as 'chronic'. In effect, the insurer says "the doctors have tried these treatments (operations or whatever) to cure your condition and they haven't worked. We don't think now that you can be cured and whatever the doctors may say, further treatment is really just about relieving symptoms not bringing about a cure. On that basis we will not cover further treatment."

However, the point at which this change applies is often not readily identifiable. In some cases, no doubt, once a treatment has failed it is clear to all concerned that further treatment is primarily for the temporary relief of symptoms. It is not in any sense a cure – hence the condition becomes chronic. In other cases, the point of transition is much more open to debate and requires a greater degree of judgement on the part of the insurer.

In many situations, the announcement that the insurer now considers the condition chronic is tantamount to saying that, in the insurer's view, the patient will not recover. This can obviously be extremely distressing to policyholders and their relatives, particularly as the patient's own medical advisers may not have reached this potentially terminal diagnosis, or may not have communicated it to the patient and his relatives. Such cases must therefore be handled with considerable sensitivity.

‘It is essential that the significance of the exclusion is fully explained to policyholders before they buy the insurance.’

informing policyholders

Excluding chronic cases from cover is a particularly significant term in these policies. It means the scope of the cover provided is far more limited than potential customers often realise.

The ombudsmen are not convinced that using the sometimes fine distinctions between acute and chronic conditions in such difficult circumstances is helpful to the image of insurers in this market. We question whether it is appropriate for them to use the chronic exclusion to refuse critically-ill patients the funding for further treatment where:

- the insurer has previously funded treatment of the condition;
- general medical opinion would recommend further treatment; and
- the patient’s medical team can demonstrate that further treatment may stabilise the patient’s condition so that he or she can lead a more or less normal life.

In any event, we would expect to see insurers in such cases having an active and close dialogue with the patient and his medical team about the nature and availability of cover for further treatment. We would be most unlikely to support an insurer who ignores opportunities for such discussions and then terminates cover shortly before a major operation is to take place.

It is therefore unfortunate that the distinctions between acute and chronic conditions are little understood by customers and are so reliant on the particular interpretation given by insurers themselves. This may, of itself, place customers at an unfair disadvantage. The distinction between ‘chronic’ and ‘acute’ is not one most of us make when discussing our illnesses. Nor, in our experience, do doctors make this distinction.

The interpretation of this exclusion has far-reaching consequences for policyholders. It means it is unlikely an insurer will meet any costs for treating many common conditions and may not cover treatment when conditions deteriorate. So it is essential that the significance of the exclusion is fully explained to policyholders before they buy the insurance. Insurers will understand that, if this is not done, the ombudsmen are unlikely to support their rejecting claims that rely heavily on the insurer’s interpretation of this exclusion.

case studies – chronic medical conditions

01/01

medical expenses – exclusion – chronic conditions – formerly acute condition – whether insurer required to notify policyholder when condition considered chronic.

The policyholder suffered from heart disease and received various treatments between 1998 and 1999. The insurer met his claims for the cost of these treatments, making payments of approximately £40,000. Open heart surgery was recommended in August 1999 but, for reasons which were unclear, the insurer did not receive the claim form until 20 September 1999.

The insurer made enquiries and, on 8 October, notified the hospital that it had decided the policyholder's condition was chronic so it would not meet his claim. The policy specifically excluded 'treatment of a chronic condition'. It defined 'chronic' as 'a disease where you need observation or care, and treatment will only relieve or control the symptoms but not cure the medical condition'. The policyholder was informed of this decision either that day or on 9 October. Nevertheless, surgery was performed as scheduled on 13 October. The policyholder did not survive and his widow claimed £11,595 to meet the cost of surgery.

complaint upheld

The operation was clearly a serious one and the prognosis was uncertain. But there was some significant prospect that the operation would successfully arrest the decline in the policyholder's condition without the need for further extensive treatment.

Whether this would have amounted to a 'cure' was debatable. However, the insurer failed to give the policyholder any notice that it had decided his condition had become chronic. Given the conflicting medical evidence and the need for urgent action in September 1999, the insurer should have accepted the claim. It might then have explained that any further treatment would be excluded. We required the insurer to meet the cost of the treatment.

01/02

medical expenses – acute illness or injury – 'occurrence of brief duration' – meaning of 'brief duration'.

The policyholder was involved in a motor accident in May 1999 and sustained serious injuries, leaving her paralysed below the waist. She was hospitalised for three months. The insurer met all her medical costs. The policyholder continued to receive physiotherapy as an outpatient until December 1999. The insurer then decided her condition was no longer acute and terminated payments. It relied on the policy definition of 'treatment'. This provided that benefit was only payable for 'surgical or medical procedures the sole

purpose of which is the cure or relief of acute illness or injury. An acute illness or injury is characterised by an occurrence of brief duration, after which the insured person returns to his/her normal state and degree of activity'.

The policyholder argued that further physiotherapy was essential for her recovery and cited her consultant's opinion that her condition was still acute. He considered she would continue to improve and expected her to achieve 90% of her previous functional abilities within one to two years. The insurer maintained it had always intended to transfer the policyholder's treatment to the NHS. However, it produced no evidence to prove her condition was no longer acute.

complaint upheld

Although the policy only covered 'acute' illness or injury, this was not clearly defined. We considered that the phrase 'occurrence of brief duration' should be interpreted according to the extent of the injury. For example, a broken finger might mean a few days' disability, whereas a broken back – as in this case – would mean many months'.

The medical evidence established that the policyholder's condition would continue to improve as a result of treatment. We were therefore satisfied that it was still acute and thus covered under the policy. We also agreed with the policyholder that her claim had not been administrated properly. However, the insurer's apology and its ex gratia payment of £1,800 towards the cost of the policyholder's home care were sufficient compensation for the distress caused.

01/03

n **medical expenses – exclusion – pre-existing condition – whether undiagnosed condition excluded.**

The policyholder submitted a claim under his company medical scheme for his daughter's tonsillectomy and adenoidectomy. The insurer rejected the claim on the ground that the daughter's GP disclosed that she had suffered from tonsillitis since 1991, almost seven years before the policy was purchased.

The policyholder complained about this decision. He stated that surgery had not been recommended until February 1999 and contended that his daughter's consultations had been for illnesses typical of childhood, not indicative of a serious condition which had not been diagnosed.

complaint rejected

The clinical notes revealed a long history of bouts of tonsillitis which were not indicative of ordinary childhood infections. The policy clearly excluded claims for treatment of any illness or related condition which originated prior to the policy cover. The insurer was therefore fully entitled not to accept liability for the daughter's operations.

01/04

medical expenses – exclusion – pre-existing condition – representations by insurer's agent – whether insurer estopped from relying on exclusion.

In December 1998, when the policyholder decided to switch insurers, she had had medical expenses cover for over 20 years. She discussed her situation with the new insurer's agent, who completed an application form for her. Details of previous medical problems were recorded on the form. Before she signed the form, she asked the agent to double-check her position and ensure she would maintain her existing level of cover.

In October/November 1999, the policyholder began experiencing pain in her hip and requested a claim form. She saw her consultant the following month and he recommended a complete hip replacement without delay. The insurer refused to meet the cost of surgery on the ground that it was due to a pre-existing medical condition.

The policyholder contended that she had informed the agent of a previous hip operation in February 1996, with further surgery in December 1996. She said the agent had advised her that the insurer did not consider as relevant any operations which took place more than two years before the start date. He had also confirmed that her level of cover would remain the same. She said she had never received any policy documents and was not aware of an exclusion for pre-existing conditions.

The insurer agreed to meet the consultation fee and X-ray costs and to return the premiums paid by the policyholder, but refused to reimburse the £12,000 cost of her private operation.

complaint upheld

We were satisfied that the policyholder had the highest possible level of cover under her first policy. The insurer no longer employed the agent and was unable to investigate how the subsequent policy had been sold. As there was nothing to rebut the policyholder's allegations, we accepted her version of events.

The actions of the insurer and/or its agent had seriously prejudiced the policyholder's position and we did not agree that a premium refund was an acceptable settlement. The insurer accepted our recommendation that the policy should be reinstated – subject to payment of the outstanding premiums – and that the claim should be met, in accordance with the level of cover originally selected. It also agreed to pay £500 compensation for distress and inconvenience.

01/05

medical expenses – group scheme – provision of medical services in UK – policyholder resident abroad – whether overseas medical expenses covered.

The policyholders retired in 1989 and moved to Mallorca. They had been allowed to continue as members of their employer's private medical insurance

scheme after their retirement, paying the premiums personally. It was not drawn to their attention that cover was restricted to 'medical services specified in this Policy if they are provided in the United Kingdom, Channel Islands or Isle of Man'.

Their employer asserted that it had written to them in 1994, explaining that cover was not provided for people residing abroad. The policyholders did not receive that letter as it was sent to the wrong address. In any event, the employer continued to collect premiums and renew the policy.

One of the policyholders needed dental surgery and part of the treatment was carried out in Mallorca. He submitted a claim for the cost of this and also for further treatment he required. The insurer rejected the claims on the ground that there was no cover for treatment performed abroad.

complaint upheld

There was no formal agency agreement between the employer and the insurer. However, we considered that by confirming the policyholders' membership of the scheme after they retired and collecting their premiums, the employer was acting as the insurer's agent. Given that the policy was clearly unsuitable for the policyholders, we decided the claims should be settled without reference to the restriction on where treatment could be performed.

The policy included cover for "oral surgical operations", so the policyholder's claims were valid if the territorial restriction were ignored. We required the insurer to meet the cost of both treatments.

3 keys in cars

Drivers generally believe that if they take reasonable care of their vehicle, their motor insurer will pay for stolen cars under both comprehensive and third party, fire and theft policies. So their annoyance at finding their car has been stolen is compounded if the insurer then rejects a theft claim by relying on a policy term which excludes liability in certain situations. Not surprisingly, in the complaints made to us, the fact that most motor insurers will not pay for stolen cars when the keys have been 'left in or near the vehicle' often comes as a nasty surprise to policyholders.

We take the view that exclusions involving keys in cars and unattended vehicles should be understood in the overall context of the policy offering cover for theft of the vehicle. Some insurers seem to handle claims as if such exclusions established an absolute position. If the key is in the car then they will not meet a theft claim. This means that, for example, even car-jackings are treated as excluded. We do not accept this. First, it does not concur with the way the courts have interpreted the 'unattended' test. Second, such an interpretation represents a significant restriction on the cover provided. In our view, this restriction is unusual and onerous and – generally – has not been drawn sufficiently to the policyholder's attention.

'It is not reasonable to expect policyholders to be fully aware of their obligations unless they are highlighted at the point of sale...'

If insurers intend to use exclusions of this type to defeat the sort of claims most people would expect to be met, they will have to give these terms extra prominence. It is not enough, in our opinion, for insurers to say the policyholder had an opportunity to read his policy and to understand what the insurer would not pay for. If an insurer will not pay for some thefts, then it must make this abundantly clear.

Furthermore, good practice means insurers must tell policyholders if they require them to take a particular action, especially if failure to do so means a significant part of the cover provided by the policy will not operate. It is not reasonable to expect policyholders to be fully aware of their obligations unless they are highlighted at the point of sale (and at renewal, especially if the exclusion was introduced at renewal). This ensures policyholders do not remain in ignorance of the insurer's requirements.

relevant legal cases

In handling individual disputes, our present approach is consistent with that taken by the courts. First, it is clear that without an exclusion dealing with keys in cars and unattended vehicles, an insurer can only reject a claim for theft of a car if the policyholder has breached the general condition to take reasonable care of the vehicle. Following the test laid down by the Court of Appeal in ***Sofi v Prudential Assurance,*** the insurer has, in effect, to prove the policyholder has been reckless. In many cases, insurers have found it impossible to produce evidence to support such a conclusion.

Second, we need to consider what 'unattended' means. Here, three cases are of particular relevance: ***Starfire Diamond Rings Ltd v Angel*** [1962] 2 Lloyd's Rep 217, CA; ***Langford v Legal & General*** [1986] 2 LLR 103; and ***T O'Donoghue v Harding*** [1988] 2 LLR 281. The test of whether something is 'unattended' was propounded by Lord Denning in ***Starfire Diamond Rings Ltd v Angel.*** In order not to be unattended, the vehicle must have been kept under observation so that there was someone able to observe any attempt to interfere with it and to prevent any unauthorised interference. In ***Langford v Legal & General***, the court decided a vehicle was attended; it was out of the policyholder's sight for five seconds at most and she saw the thieves interfering with her vehicle through the kitchen window.

In ***O'Donoghue v Harding***, the insured parked his car on a petrol station forecourt at the pump nearest the kiosk. He went into the kiosk for approximately two minutes, during which time a thief crept along the side of the vehicle out of his view and stole a bag from the car. The policy excluded theft of or from a motor vehicle when it was left unattended. The judge found that the insured 'could keep a more or less constant observation on his car and he was only distracted when he was signing his American Express slip and collecting his VAT slip... this would have been a matter of 2 or 3 seconds at the most'. He went on to explain that he did not take Lord Denning in ***Starfire Diamond Rings Ltd v Angel***

'...this ensures policyholders do not remain in ignorance of the insurer's requirements.'

to mean the driver had to have an all-round vision of the vehicle. Nor did he consider there was any obligation on the driver to keep the whole of the car on all four sides under observation for all of the time. In his view, Lord Denning's requirement to keep the vehicle under observation did no more than impose a duty of common care on the driver.

Our current approach

At least one case (***Hayward v Norwich Union***) is currently being considered by the courts and may provide us with further guidance on our stance. At present, we adopt a robust approach, taking account of all relevant circumstances, such as:

- the car's value and its attractiveness to thieves (the degree of attention required of a Porsche owner might reasonably be assumed to be greater than that of a Lada owner);
- the surrounding neighbourhood (the degree of attention required in a secluded rural area might well be less than that required at a busy inner-city petrol station);
- the degree to which the driver was able to keep the vehicle under observation; and
- the length of time the driver anticipated the car being unoccupied.

We also bear in mind general attitudes to the specific risk. If the complainant's behaviour is likely to be regarded by other drivers as 'reasonable', we are unlikely to agree the claim was validly rejected. So, for example, we do not consider that someone who leaves his car engine running while he opens or closes his garage has necessarily behaved recklessly. Nor do we agree that his claim is covered by a keys-in-car exclusion; the car has not been 'left' when the owner is no more than a few feet away.

case studies – keys in cars

The case studies below illustrate some of the situations where we have agreed that the policyholder's claim was valid.

01/06

n **motor – theft – exclusion for theft if keys left in car – whether policyholder in breach of exclusion.**

The policyholder stopped his car on his driveway and got out, leaving the engine running and the door open, in order to lift up his garage door. However, before doing so he stopped to put his briefcase in the unlocked porch adjacent to his garage. As he did this he heard a noise and turned round to see someone jump into his car and reverse away at high speed. He was very close to the car but could not prevent it from being stolen.

The insurer declined the claim on the basis of exclusion for 'losses arising from the use of keys which had been left in or around the vehicle'.

.....

01/07

n The policyholder arranged cover for her Fiat Marea, over the telephone, on 9 August 1999. The next day the vehicle was stolen while she was paying for petrol. She said she had inadvertently left her keys in the ignition.

The insurer rejected the claim, relying on a policy term excluding theft 'if the insured vehicle has not been locked, windows and sunroof closed and keys removed, when left unattended or unoccupied'. The policyholder maintained that when she telephoned to arrange the insurance she had been told all the good points of the policy but not about the restrictions, and the policy did not arrive until after the car was stolen.

.....

01/08

n The policyholder was picking up his children from school. He left his car in a busy street with the door shut but the keys in the ignition while he went to speak to his son, about eight feet behind the car. Less than two minutes later, two youths ran up, jumped into the car and drove off, despite the policyholder's best efforts to stop them. The youths were involved in an accident and the policyholder's car was a total write-off.

The insurer refused payment on the ground that the policy excluded claims for theft if 'the car is left unattended or unoccupied and the doors and boot are not locked or any window or roof opening/hood has not been secured closed or if the keys are not removed from the car'. It said that the policy wording was clear and that the commentary in the policy also explained that theft was not covered 'unless the car is fully locked and the keys are removed when it is left unattended or unoccupied'.

The policyholder argued that he had left the car on the spur of the moment because he needed to speak to his son; he had been only feet away and the car had been in sight the whole time.

01/09

n The policyholder reversed his car out of his garage and got out of the car to return briefly to the house, leaving the car keys in the ignition and closing but not locking the car door. He said he had only been away from the car for approximately 30 seconds but came back out of the house to find the car had been stolen. The insurer declined the claim on the ground that the policy excluded theft 'if the car is left unattended or unoccupied and the doors and boot are not locked or any roof opening/hood has not been secured closed or if the keys are not removed from the car'.

complaints upheld

We considered the four complaints above were valid. We interpreted these exclusions as removing theft cover only when the car driver has clearly gone away from the vehicle. This applies regardless of whether the exclusion referred to leaving the vehicle 'unattended' or simply stated there was no theft cover if the keys had been 'left'. This interpretation required evidence that the driver had either gone a significant distance from the vehicle or had left it for an extended period. It was not sufficient for the driver merely to have turned his back or gone inside his home briefly. While we would not generally interpret such exclusions in a wide sense, we would not require insurers to meet this type of claim if we were satisfied the driver had behaved in a reckless fashion.

The following case summaries illustrate complaints we rejected.

01/010

n **motor – theft – lack of reasonable care – policyholder aware of risks – whether loss excluded.**

In May 1999, the policyholder paid £17,000 cash for a Volkswagen Golf GTI turbo to be imported from Belgium. He arranged insurance to take effect on the anticipated delivery date. Nine days after accepting the car, he filled it with petrol. Later that afternoon, he returned to the filling station to put the car through the jet wash.

Leaving the key on the driver's seat, he went to the tap to wash his hands. The policyholder noticed a man who did not appear to have a car and who was standing in front of the jet wash. However, the policyholder did not feel particularly concerned. As he was washing, he heard a car revving up. At first he did not realise the car was his, but then he saw it being driven out of the garage by the man he noticed earlier.

The insurer rejected the theft claim on the ground that the policyholder had breached the duty to take reasonable care of his car.

complaint rejected

The courts had decided that the duty of reasonable care was breached if the individual acted 'recklessly' – meaning that the individual recognised a risk but deliberately took no steps to avoid it or took steps that were clearly inadequate.

In this case, the policyholder saw someone loitering near his car but had left the car unlocked with the keys on the driver's seat. We were satisfied he had taken no steps to protect his car from a known risk of theft.

01/011

n **motor – theft – exclusion for car left unattended and doors unlocked – whether car left unattended.**

The policyholder was building a house and, in January 1999, visited it to drop off some equipment. He parked his Mazda off the road, leaving it unlocked and the car key among a bunch of keys in the lock on the front door of the house. The car was stolen and was later recovered in a damaged condition, requiring nearly £3,000 to repair.

The insurer rejected the claim. It explained that the policy excluded liability for thefts if 'the car is left unattended or unoccupied and the doors.... are not locked'. The policyholder argued that he had acted reasonably and he produced photographs showing that the car would have been visible only to someone close to the house. He also pointed out that his household insurer had met his claim for tools and equipment stolen with the car.

complaint rejected

We were satisfied that the car was both unattended and unoccupied at the time of the theft. We accepted that the household insurer was satisfied that the policyholder had behaved reasonably, but that was not the motor insurer's reason for declining liability and was therefore not relevant in this situation.

01/012

n **motor – theft – exclusion for theft if keys left in unattended car – whether car unattended.**

The policyholder's husband parked their Landrover Discovery in front of a terraced house where he was working. He removed the keys from the ignition, but left the vehicle unlocked. A spare set of keys was kept in the car in the pocket on the driver's side. The driver entered the house to close windows upstairs and downstairs and to set the alarm. He returned to the pavement to see the car disappearing up the road.

The insurer rejected the policyholder's theft claim on the ground that the policy excluded any claim for 'loss or damage if the Motor Car has not been locked, with the windows closed and ignition key removed, when left unattended or unoccupied'.

complaint rejected

The case law established that an item was 'unattended' if someone was not in a position to observe any attempt to interfere with it, and was close enough to have a reasonable prospect of preventing any unauthorised interference. It was clear that the husband had not been in any position to observe the attempt to interfere with the vehicle. We were satisfied that the car was 'unattended' and therefore within the scope of the exclusion.

4 extended warranties

Around 10% of our complaints concern extended warranties. These policies are generally intended to cover unexpected breakdown of appliances after the expiry of the normal guarantee period, but in our experience, policyholders frequently misunderstand them. The policies provide for repairs to be carried out – usually by a person appointed by the insurer. Customers often find that the sales assistant will push the sale of extended warranties as part of the purchase of, for example, a washing machine or video cassette recorder. However, the sales assistant gives little, if any, explanation about the nature of the warranty, although its cost often makes up a significant proportion of the overall transaction.

So it is perhaps not surprising that almost all the complainants seem to have believed their policy offered protection against everything that might go wrong with the product. In practice, policies differ. Most are narrow in scope and include numerous exclusions. Furthermore, if other possessions are damaged at the same time – such as the clothes being washed in a faulty machine – that damage is often not covered. Perhaps more significantly, while some policies provide 'new for old' cover, others limit repairs or replacement to the 'market value' of the appliance. Some state that 'market value' should be determined by deducting annual depreciation allowances. This can significantly reduce the amount of cover provided.

‘It is perhaps not surprising that almost all the complainants believed their policy offered protection against everything that might go wrong with the product.’

The variations in the product and the complexity that often underlies the policies suggest considerable care is required at the point of sale. Practice, however, seems to be less than ideal. Most of these policies are sold by relatively untrained staff who may not understand the insurance cover. In many cases, we take the view that the sale did not comply with the Association of British Insurers’ Code (and now would also not comply with the General Insurance Standards Council code), because insufficient steps have been taken to draw the policyholder’s attention to the important features of the policy.

In addition to limitations on cover, many extended warranties include complex procedural requirements that the policyholder is expected to follow in order to make a valid claim. A variation on this is ‘cashback’ offers. These are designed to refund the premium at the end of the period of cover if no claim has been made. Not surprisingly, the idea of ‘no claim - no cost’ is heavily marketed and is attractive to many customers.

In practice, however, the policyholders’ ability to claim the cashback turns on their adhering scrupulously to various administrative procedures, within strict time limits. For example, if they fail to register with the insurer within a specified period they will not be entitled to claim the promised premium refund. Moreover, payment will only be made to those who remember to claim their entitlement in the month after their cover expires, typically five years later!

We have not yet been persuaded that any of these claims was validly rejected on the ground of policyholders’ delay, whether in initially registering or in presenting the claim. Indeed our initial view is that such requirements may represent unfair terms, especially where little or no effort has been made to draw the customer’s attention to these complex requirements.

In assessing all these complaints, we take a common sense approach. As well as the precise terms of the policy, we consider both the literature provided to policyholders and the policyholders’ account of the sales process. In general, we uphold a greater proportion of such complaints than average. Until these policies are sold by fully trained staff and described clearly in the supporting leaflets, we are unlikely to see a significant reduction either in the number of these complaints or in the proportion we uphold.

case studies – extended warranties

01/013

extended warranty – option to repair or replace – extent of insurer's obligation if repair or replacement impossible.

The policyholder paid £300 for a five-year warranty in July 1997, covering her new suite of furniture against a number of eventualities including staining. An armchair was stained in February 1999 and the policyholder put in a claim. The insurer sent her a stain removal kit, but this did not successfully clean the chair.

After making two unsuccessful attempts to remove the stain, the claims administrator finally advised the policyholder that the fabric would have to be replaced. The policyholder was asked to submit a fabric sample for matching. Four months passed but the administrator failed to obtain new fabric. Given the lack of progress, the policyholder demanded that her policy be cancelled and that she should get compensation and a refund of the premium. The insurer cancelled the policy and returned the premium, but did not offer any compensation. It stated that the premium refund was the full extent of its liability.

complaint upheld

The insurer's decision to allow the policyholder to cancel as if this brought its liability fully to an end was disingenuous. It had already accepted the claim and, as it had been unable either to remove the stain or replace the fabric, the insurer was required by the terms of the warranty to replace the damaged furniture if no other solution could be found.

The insurer accepted that the policyholder had not been adequately compensated. It acknowledged that she might have felt less aggrieved and frustrated, and therefore less likely to cancel, if it had kept her informed of the progress of her claim. Following our involvement, in addition to the premium it had already agreed to refund, as compensation for distress and inconvenience, the insurer offered to pay the cost of re-dyeing the suite (subject to a limit of the full cost of replacing it). We considered this the appropriate response.

01/014

extended warranty – cashback offer – time limit for registration – policyholder in breach of time limit – whether insurer entitled to refuse to register policyholder.

The policyholder took out a five-year extended warranty when she bought a teletext televideo in October 1997. One of the features was a cashback offer, described as 'Make a claim or your money back!' Policyholders could obtain a full premium refund if they made no claim during the period. However, the terms of the policy stated that this offer only applied if policyholders registered for the scheme within 21 days of purchasing the policy.

The policyholder did not register until January 1999. The insurer refused to accept her registration. It argued that she had not complied with the policy terms and that her breach had prejudiced its position. It contended that it was essential to have accurate information about the potential risk in order to make adequate reinsurance arrangements.

complaint upheld

The cashback offer was one of the elements of cover provided for the purchase price of the policy. It was emphasised in the marketing material as a significant benefit. We appreciated that the insurer wanted information regarding potential claims. However, it was not acceptable that largely procedural obstacles should be placed in the way of policyholders, primarily to minimise the number of otherwise justifiable claims. 'Small print' procedural requirements such as this were wholly inappropriate and might well be considered unfair contract terms.

We therefore required the insurer to issue the policyholder with a certificate of registration and to pay her £25 to compensate her for her costs in pursuing her complaint.

We noted that the policy also stipulated that a cashback claim would only be valid if the policyholder returned the certificate to the insurer within 30 days of the end of cover. Although this clause had not formed any part of this complaint, we considered it likely that a claimant's failure to meet the insurer's strict deadline would not be sufficient ground for rejecting the claim.

01/015

n **extended warranty – repairs – delay – whether policyholder entitled to compensation.**

The policyholder began to experience problems with his video cassette recorder (VCR) in May 1999. He notified his insurer, in accordance with his extended warranty, and his VCR was taken away for repair. It was returned in mid-June but broke down again in late August. It was taken away again but the tester was unable to trace the fault until it had been returned once more to the policyholder. It was eventually restored to full working order in November.

The policyholder sought compensation from the insurer for six months' loss of use, poor claims handling and inconvenience. He said he had to make at least 50 calls to the insurer and had been visited 25 times by technicians. He had been given a replacement VCR while his was undergoing repairs, but only for two weeks. He also claimed that his warranty period should be extended for a further six months.

complaint rejected

While we did not doubt that the policyholder had experienced much inconvenience, we did not agree that the insurer or repairer had failed to provide a satisfactory standard of service. The fault was difficult to diagnose and only became known when the VCR was replaced in its usual cabinet.

It could not be said that the policyholder had lost the benefit of six months' cover under the warranty. If another fault had appeared, the insurer would have met a claim. The insurer was not obliged to arrange for the loan of equipment while repairs were being carried out, or to offer compensation for inconvenience.

5 travel insurance

Travel insurance accounts for about one in ten of our complaints and many claims involve personal tragedies - at home or while on holiday - as our case studies demonstrate.

Travel policies tend to be fairly complex because they cover a wider range of risks than any other type of insurance – from cancellation to loss of luggage, hospitalisation and death claims. If cover were not described broadly, it might never be understood. So exclusions play an important role in defining the cover provided. For example, broadly speaking, cancellation-cover specifically excludes anything predictable.

Most holidaymakers understand that no policy offers them unlimited cover, either for what they may claim for or for how much they will be paid. But if an insurer wishes to rely on a provision which significantly reduces what the policy says it provides, it will have to show that this provision was drawn to the customer's attention before the policy was sold. Relevant evidence here might include explanatory literature given to the customer before sale or a statement from the person selling the policy. It is clear, however, that the extended sales chain for these policies (many of which are sold directly by travel companies or high street travel agents) can give rise to justifiable concerns from customers about the sales process.

‘Travel insurance accounts for about one in ten of our complaints and many claims involve personal tragedies.’

In general, our approach is to determine whether the exclusion is an important reduction to the cover marketed by the insurer. If it is, we may well conclude that it would not be fair for the insurer to rely on it to reject an otherwise valid claim.

This approach is not the same, however, as assessing the importance of the exclusion by reference to the policyholder’s particular situation. Unless the circumstances were such that the policyholder requested cover against a specific contingency, we are unlikely to conclude that the exclusion should be judged on the basis of how its operation has affected the policyholder.

case studies – travel insurance

01/016

n **maladministration – travel – repatriation – failure to embalm body before repatriation – whether insurer responsible for failure.**

The complainant’s son and daughter-in-law went on holiday to Madeira, where the son died following a heart attack. The widow contacted the assistance company appointed by the insurer to arrange repatriation of the body and local funeral directors were instructed.

When the mother went to view her son’s body in the UK, she was not allowed to see it as it had not been embalmed before repatriation and had deteriorated badly. The mother was greatly distressed. She complained to the insurer, which undertook extensive enquiries and liaised with the local British Consulate. It was established that the funeral directors were not on the assistance company’s approved list.

The funeral directors explained that they would not normally carry out embalming unless they received specific instructions to do so. The Consulate confirmed that embalming was not the usual practice in Madeira. The mother considered that the failure to ensure the body was embalmed resulted from the insurer’s wish to cut costs.

The insurer stated that embalming expenses were reasonable and necessary and that it would have met the charges. It contended that only an error had prevented its general practice being followed in this case. Normally, the assistance company would have contacted local funeral directors. They did not do so in this case because the funeral directors were not on its approved list. It could not be established who had appointed them. And the insurer was not able to identify who had been responsible for the decision not to embalm to body.

complaint upheld in part

The failure to embalm the body resulted from a series of oversights and genuine errors on the part of a number of organisations. These oversights and errors did not seem part of any attempt by the insurer, or any of the other parties, to avoid their proper responsibilities. However, we concluded that the insurer, through its agents – the assistance company and funeral directors – had failed to provide the service it should have done. All of these had also failed to give the mother's initial concerns the attention they deserved.

The insurer confirmed it would implement steps to ensure that, in future, embalming would always be specifically requested. It would advise all its assistance companies that it would meet the cost of preparing a body for repatriation.

The mother had made it clear that her complaint was not about financial compensation. Nevertheless, we required the organisations concerned to provide a full apology and to make donations to the British Heart Foundation.

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01/017

n **travel – cancellation – duty of disclosure – change in medical condition – whether policyholder under continuing duty to disclose any change in medical condition.**

In June 1999, the policyholder booked a cruise for himself and his fiancée from 5-20 March 2000 and took out insurance. He signed a declaration relating to himself, anyone travelling with him and anyone else whose health might affect the trip. This stated that no one was waiting for an operation, hospital consultation or other hospital treatment or investigations. The declaration stated that –

"If there is a change in your medical condition or the medical condition of anyone who the trip depends on (after you take out this insurance, but before you travel) and you can no longer agree with the declaration, you must contact [the insurance company]. We will then tell you if cover can continue. If we cannot continue cover, you can claim for the cost of cancelling your holiday at that time.

"If you do not tell us about anything we have asked for above, we may not pay your claim."

The fiancée's mother was diagnosed with cancer in December 1999. She underwent surgery in January 2000 but was told in February that further treatment would be required. The policyholder cancelled the cruise then and claimed reimbursement under his travel insurance.

The insurer settled the claim by paying £250 – the cost of cancelling in December 1999. The policyholder sought reimbursement of the full cancellation charge of £1,394.

complaint upheld

The declaration imposed two duties of disclosure on the policyholder, the second of which was an extended or continuing duty that applied to the period – just over eight months – immediately before departure. We regarded the continuing duty of disclosure as both unusual and unduly onerous. It was not inconceivable that, after a policyholder had notified a change in someone's medical position, the policyholder and insurer might hold conflicting views about whether cancellation was necessary at that stage.

The practical effect of the declaration was to make the insurer the sole arbiter of whether any policyholder should cancel the holiday. We considered this inherently unfair and a possible contravention of the Unfair Terms in Consumer Contracts Regulations 1999.

We were not persuaded that the policyholder should have cancelled in December 1999. There was no evidence that he and his fiancée had realised at that time that they should cancel the cruise immediately, even though it was not due to take place for 11 weeks. The insurer accepted our recommendation and paid the balance of the charges plus interest.

01/018

travel – personal accident – total and irrecoverable loss of sight – policyholder retaining 3% vision – whether loss of sight claim valid.

The policyholder went on holiday with her family to Florida on 1 January 1998. Three days after arriving, they were involved in a serious road accident. They contacted the assistance company and the policyholder and her daughter were hospitalised.

The policyholder submitted a claim for loss of sight under the personal accident section of the policy. She said she had no useful vision in her left eye and there was no prospect of improvement. The insurer insisted on obtaining additional medical evidence.

The insurer's consultant concluded that the policyholder had lost all central vision but retained a small amount of peripheral vision, which he estimated at 2-3%. In his opinion,'In theory, [the policyholder] had retained sight in the left eye. However, it was so minimal, it [would] be of no practical use to her. For practical purposes, [the policyholder] had lost all sight with the left eye'.

The policy stipulated that the £25,000 benefit was payable only for 'total and irrecoverable loss of all sight in one or both eyes'. The insurer contended that this provision should be interpreted literally and that therefore the claim was not valid. However, following our involvement, it offered an ex gratia payment of £12,500. The policyholder considered her claim should be met in full.

complaint upheld

We noted that the World Health Organisation defined ' profound blindness' as the inability to distinguish fingers at a distance of 10 feet. The Royal National Institute for the Blind advised that only about 18% of blind people were classed as totally blind and the majority of those could distinguish between light and dark.

We concluded that 'sight' implied an ability to discern objects. On this basis we were satisfied that the policyholder had, for all practical purposes, suffered a total loss of sight. We required the insurer to meet the claim in full, together with interest, from the date of the accident.

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01/019

n **travel – curtailment – requirement that policyholder return home – earthquake – policyholders relocating at holiday destination – whether holiday curtailed – whether assistance company authorised expenses.**

The policyholder and his family were on holiday in Cyprus when, on 11 August, there was a series of earthquakes, one of which shook their holiday apartment so violently that the occupants were evacuated. They returned to the apartment for the next two nights but by 13 August cracks had appeared. The family was frightened, tremors were continuing and the policyholder decided to move them out of the apartment. He claimed the cost of re-arranging his family's holiday.

The insurer rejected the claim. It explained that curtailment of a holiday was only covered if the policyholders returned to the UK. The policy did not cover relocation at the holiday destination. The policyholder maintained this was unfair as the policy did not exclude earthquake.

complaint rejected

Earthquakes were not excluded by the policy but they did not need to be – they were not covered in the first place. The nearest section of the policy to the policyholder's circumstances was curtailment. This provided that the insurer would pay if the holiday was curtailed by a policyholder's returning home before the end of the holiday because of specified reasons such as death, illness, *etc*. But it did not include curtailment following a natural disaster in the holiday destination.

We were required to look beyond the strict legal position and to make a decision which was fair and reasonable in all the circumstances. Had the policyholder returned home, matters might have been different. In this case, whatever the policyholder's fears, they were not

sufficient to cause him to return home before the scheduled date. We concluded that the insurer had acted reasonably.

01/020

travel – curtailment – cover limited to disaster at home – earthquake at resort – whether policyholders' claim covered.

In October 1999 the Turkish holiday of these policyholders (aged 74 and 76) was disrupted by a severe earthquake. Their tour operator offered to fly them home immediately but they decided to remain. They slept that night on the beach but changed their minds about continuing the holiday when the magnitude of the disaster became clearer. The hotelier was unwilling to allow guests to sleep in the hotel and suggested they slept instead on loungers by the pool. Further earth tremors could not be ruled out, so the tour operator flew the policyholders home at no cost.

The policyholders made a claim for curtailment. This was refused on the ground that the policy did not cover curtailment following an earthquake. The policyholders argued that this was unfair, as Acts of God were not excluded.

complaint upheld

If a particular risk was not covered by the policy in the first place, it was irrelevant whether or not it was excluded. So far as cutting short the holiday was concerned, the policy covered curtailment in the event of the death, injury or illness of the policyholders *etc,* or if the policyholders had to return home because of burglary, fire, *etc* affecting their home in the UK. There was no cover for curtailment following a natural disaster in the holiday destination.

However, we were required to make a decision which was fair and reasonable in all the circumstances. In our view, when they took out the travel insurance as part of the holiday package, the policyholders would have envisaged that it would cover them for exactly the type of problem they had encountered. The absence of cover for events giving rise to a real need to curtail the holiday restricted the cover and had not been highlighted in the policy material. According to the insurer's position, the policyholders would only have had a justifiable claim if they had become ill or been injured. It was arguable that this was a significant possibility, given the policyholders' ages and their having to sleep in the open. Taking all these points into consideration, we decided the fair and reasonable solution was for the insurer to meet the claim.

01/021

n **travel – curtailment – death of relative – relative resident abroad – whether policyholder's return to UK covered.**

Following the death of his mother in Kenya, the policyholder and his wife had to return home to the UK from their holiday in Amsterdam. The insurer refused to meet the claim as the policyholder's mother was not resident in the UK. It referred to the policy section which covered curtailment due to "the death, severe injury or serious illness of an immediate relative resident in the United Kingdom".

complaint upheld

Although the policy wording was unambiguous, we considered that its application was unfair in the circumstances. The country in which the policyholder's mother was resident at the time of her death did not seem relevant, as he and his wife had first to return home to the United Kingdom. The insurer agreed to meet the claim.

'Policyholders frequently assert that they failed to disclose information because they genuinely did not appreciate it was required by the insurer.'

6 non-disclosure

relevance of previous claims and losses

The vast majority of household and motor proposal forms ask if a policyholder has had any recent claims, losses or accidents, typically within the last three years. We have been asked how we view cases where – at the time the policyholder claims in these circumstances – an undisclosed loss may be more than three years old. We treat the 'cut off' point as the last occasion before the claim – be it a policy inception or a renewal – when the policyholder was under a duty to disclose material facts to the insurer.

To take a simple example, if – at the time of the proposal – in answer to a question about losses, a policyholder failed to disclose a loss which took place two years and six months previously, then that should only count as a material non-disclosure for the first year of the policy. It should cease to be of relevance after the first renewal. However, it would still be relevant for a claim made nine months after policy inception.

non-disclosure and sales

The Association of British Insurers' (ABI) Code of Practice for the selling of general insurance imposes the following specific requirement on an intermediary when a proposal form is completed:

"...(to) ensure that the consequences of non-disclosure and inaccuracies are pointed out to a prospective policyholder by drawing his attention to the relevant statement in the proposal form and by explaining them himself to the prospective policyholder."

To comply with the ABI Statement of General Insurance Practice, there ought to be a 'relevant statement' in the proposal form, setting out the consequences of failing to disclose all material facts, and warning that if the proposer is in any doubt about facts considered material, he should disclose them.

The Code Monitoring Committee carries out a mystery shopping exercise every year or so, to monitor Code compliance. For the Committee's 1999/2000 research programme, mystery shoppers bought a number of policies. The intention was to establish the extent to which insurers are complying with the Code's requirement to explain the consequences of non-disclosure. The result of this part of the exercise was extremely disappointing: in only 15 per cent of cases was any sort of an explanation given.

The new General Insurance Standards Council Code includes a commitment that members will 'explain your [policyholder's] duty to give insurers information before cover begins and during the policy, and what may happen if you do not'. This might be seen as going further in implying an obligation on customers than we normally consider to be reasonable. However, evidence from the Committee report suggests this is not a commitment which is well observed at present by insurers and intermediaries.

Policyholders frequently assert that they failed to disclose information because they genuinely did not appreciate it was required by the insurer. Alternatively, they may have followed an intermediary's advice when completing a proposal form. We do not always accept such assertions, but the evidence of the Committee suggests that many intermediaries and insurers fail to comply with the requirements of the Codes. In these circumstances, unless firms can demonstrate having used reasonable endeavours to ensure compliance, we may be rather more inclined to support the policyholder's position in such cases than we have done in the past.

case studies – non-disclosure

01/022

motor – non-disclosure – "accidents or losses" – whether policyholder required to disclose unsuccessful claims.

The policyholder applied for motor insurance. The proposal form asked: 'Have you or anyone who will drive been involved in any motor accidents or made a claim (fault or non-fault including thefts) during the last five years?' His answer was 'No.'

When the policyholder's car was stolen, the insurer learnt that he had made a theft claim under his previous motor policy within the five year period. The insurer voided the policy from its start date and rejected the policyholder's claim. The policyholder argued that he did not have to disclose his previous theft claim because the insurer concerned had decided not to meet it.

complaint rejected

The policyholder's answer on the proposal form was incorrect. Although the question was confined to claims and did not extend to losses not claimed for, it was clearly worded: it was not limited to successful claims, nor did it ask what the outcome was. The policyholder had pursued his previous claim all the way to a conclusion and ought to have disclosed it. The insurer was fully entitled to treat the policy as void.

01/023

motor – non-disclosure – mistake – whether insurer entitled to cancel policy.

In June 1999 the policyholder applied for motor insurance over the telephone. The insurer's standard practice was to ask about claims made within the previous three years. The policyholder remembered that he had made a claim, but was not sure whether it fell within that time span. He maintained that he mentioned this to the insurer's telesales operator, who told him she would check the position. When the proposal form arrived without any mention of the claim, the policyholder signed it, assuming the insurer's investigation had revealed it was more than three years old. In reality, the insurer had not carried out any investigations, and the claim was not noted on its records.

A few weeks later, the policyholder's car was stolen. On investigating his claim, the insurer discovered he had made a motor theft claim previously, in August 1997. The insurer refused to indemnify the policyholder for his loss, on the ground that he had failed to disclose the earlier claim on the proposal form.

complaint upheld

There was no tape-recording of the policyholder's initial telephone call, so it was difficult to know exactly what was said. At worst, however, it seemed to us that the non-disclosure resulted from a misunderstanding, and – on a balance of probabilities – we were satisfied the policyholder had acted innocently.

The insurer would only have charged a small additional premium had it known about the previous claim. In the circumstances, we asked the insurer to meet the present claim in full, with interest.

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01/024

n **motor – non-disclosure – "accident or loss" – named driver – whether policyholder obliged to disclose named driver's loss.**

The policyholder applied for motor insurance, answering 'no' to the following two questions on the proposal form:

"Has the car been altered/modified from the maker's specification (including the addition of optional fit accessories such as spoilers, skirts, alloy wheels etc.?)

"Have YOU or ANY PERSON who will drive ... during the past five years been involved in any accident or loss (irrespective of blame and of whether a claim resulted)?"

When the insurer investigated a new claim, it came to light that the car had been fitted with oversized alloy wheels, spoilers, and chrome wheel arches, and that the policyholder's husband, a named driver on the policy, had made two significant claims in the previous five years. The insurer refused to meet the claim and cancelled the policy from its start date.

The policyholder stated that she had bought the car with the all the modifications already fitted, and she assumed they were all part of the car's original specification. She further explained that she did not realise her husband had made one of the two earlier claims, and that his other claim had been rejected because he had only third party cover at the time.

complaint rejected

On the evidence presented, we accepted the policyholder genuinely believed the car was not modified when she bought it. The fact remained, however, that she failed to disclose her husband's previous claims. The question in issue was clear and unambiguous, and asked for details of any 'loss' irrespective of whether a claim was made. The policyholder ought, therefore, to have appreciated the need to disclose those previous incidents. By not doing so, she misled the insurer into accepting a risk it would only otherwise have agreed to cover, if at all, in return for a substantially higher premium.

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01/025

n **household contents – non-disclosure – "property stolen, lost or damaged" – whether policyholder liable to disclose attempted break-in.**

The policyholder applied for household contents insurance. His local bank manager completed a proposal form on his behalf, which he signed. One of the questions asked was: 'Have you or any member of your household ... had any

property or possessions stolen, lost or damaged or had any claims made against you, in the last three years (whether insured or not)?' The policyholder remembered telling the bank manager of an attempted break-in which occurred some months previously.

The advice he said he was given in reply was that, because the intruders had not gained entry into the house or stolen anything, the incident did not count as a burglary and need not be mentioned on the form.

This previous incident came to light when the insurer appointed loss adjusters to investigate two burglaries. The insurer refused to pay either claim, and voided the policy from its start date. The policyholder was aggrieved, and sought reinstatement of the policy, payment of both claims and compensation for inconvenience suffered.

complaint upheld

On the question as worded, the policyholder had not supplied an incorrect answer. The question would have had to be phrased differently to elicit disclosure of an attempted burglary which did not result in any quantifiable loss. Even if there had been quantifiable loss, and the policyholder had declared the attempted break-in, it was apparent from the insurer's underwriting guidelines that it would still have been prepared to accept the risk. The insurer agreed to reinstate the policy, deal with both claims, and pay compensation of £250.

Finally, as the next case shows, insurers also need to disclose relevant information to policyholders.

01/026

n **motor – renewal – policy replaced – insurer failing to notify policyholder of new policy terms – whether insurer entitled to rely on new terms.**

The policyholder bought a new car in April 1998. He was given a year's free insurance as part of the purchase arrangements. The policy provided, amongst other benefits, that if the car were damaged beyond economic repair within two years, the insurer would replace it with a new car of the same make and specification.

The policy was due to expire on 23 April 1999. On 1 April, the policyholder received a letter from the dealer offering to renew the policy. The letter enclosed a new proposal form and details of the new cover but did not draw attention to any differences. The policy had a new title but was underwritten by the same insurer.

The policyholder was involved in an accident in December 1999 and his car was written off. The insurer settled his claim by paying the market value, but the policyholder contended he was entitled to a new model. The insurer explained that this benefit had been limited to the first policy and was not included in the terms of the second policy. The policyholder argued that he had been misled.

complaint upheld

The insurer had offered two years' free insurance to some purchasers, but this was not available to purchasers of the model bought by the policyholder. He was therefore not offered renewal of his policy, only the option of taking out a new policy. However, the same policy booklet was given to both types of purchaser.

We were satisfied that the policyholder had not understood that cover under the new policy was different from that under the first one. The insurer's agent's offer to 'renew' the policy on behalf of the insurer had led the policyholder to misunderstand the nature of the cover being arranged. The insurer's duty to notify changes in cover had not been met, so the insurer should deal with the claim as if the original policy terms applied.

The insurer accepted our view that the policyholder was entitled to be paid the balance of the cost of a new car, plus interest, together with his out-of-pocket expenses of £25.

7 internet sales

We are frequently asked by the industry for our views on internet sales. We have not, to date, had to consider any case where the nature of such a sale has been a relevant matter at dispute. With the increasing emphasis on internet sales, however, this can only be a matter of time.

In principle the internet has a number of advantages as a sales channel. It can allow a potential policyholder to review and compare competing policies, at leisure. It can also ensure both parties have access to a common and contemporary record of the transaction and of the information they exchange. A well-designed site allows for common questions to be answered clearly, accurately and consistently.

However, there are at least as many potential pitfalls. In practice, the guidance available to policyholders is often limited. There is little evidence that they are alerted to differences in policies other than those of price, except for a general exhortation to study policies carefully. Instead, many sites – particularly those operated by intermediaries – are advertised for the convenience and speed of transaction. This, taken together with site design, can reinforce a view that the policies quoted are largely identical for all practical purposes except price.

‘Carefully designed sites could also help provide customers with reliable and focused advice on the implications of policy differences.’

Industry codes on sales apply as much to internet sales as to other types. It remains important to draw customers’ attention to the main features of the policy and to be in a position to advise on its suitability. It would be a matter of concern if firms interpreted this as simply requiring customers to tick a general acceptance box, rather in the style of certain software licence agreements. While the matter would need to be considered in a test case, our initial reaction is that such a restricted interpretation of industry code requirements is unlikely to be supported by an ombudsman.

The internet provides a good opportunity to highlight both the major points in a particular policy and significant variations between different policies. We suggest this might best be achieved without the need to move between pages and, ideally, in an interactive way, which requires customers to confirm that their attention has been drawn to each significant policy feature. Customers should be able to read the full policy being offered, on-line, before completing the purchase. Carefully designed sites could also help provide customers with reliable and focused advice on the implications of those policy differences. We hope the industry will take up the challenge of producing informative and customer-focused sites.

Of course, the ready availability of competitive quotations is of general benefit for customers. However, this may result in some difficulties for a small number of them. Having completed the required information to the best of their ability, these customers may seek a cheaper quotation by re-visiting the site and providing revised information. Sometimes this may be an entirely genuine attempt to provide, as accurately as possible, the information the insurer has requested. In other cases, however, it may amount to deliberate non-disclosure of material facts.

A well-designed system should be able to track such cases and ensure customers are directly alerted to the consequences of non-disclosure. Some insurers might argue that those policyholders who are foolhardy enough to misinform them face the risk that, should a claim arise, the insurer will repudiate it for non-disclosure. However, where the insurer (or an intermediary) is aware that a policyholder revised information before purchase, it seems to me it is duty bound to make clear the consequences of non-disclosure.

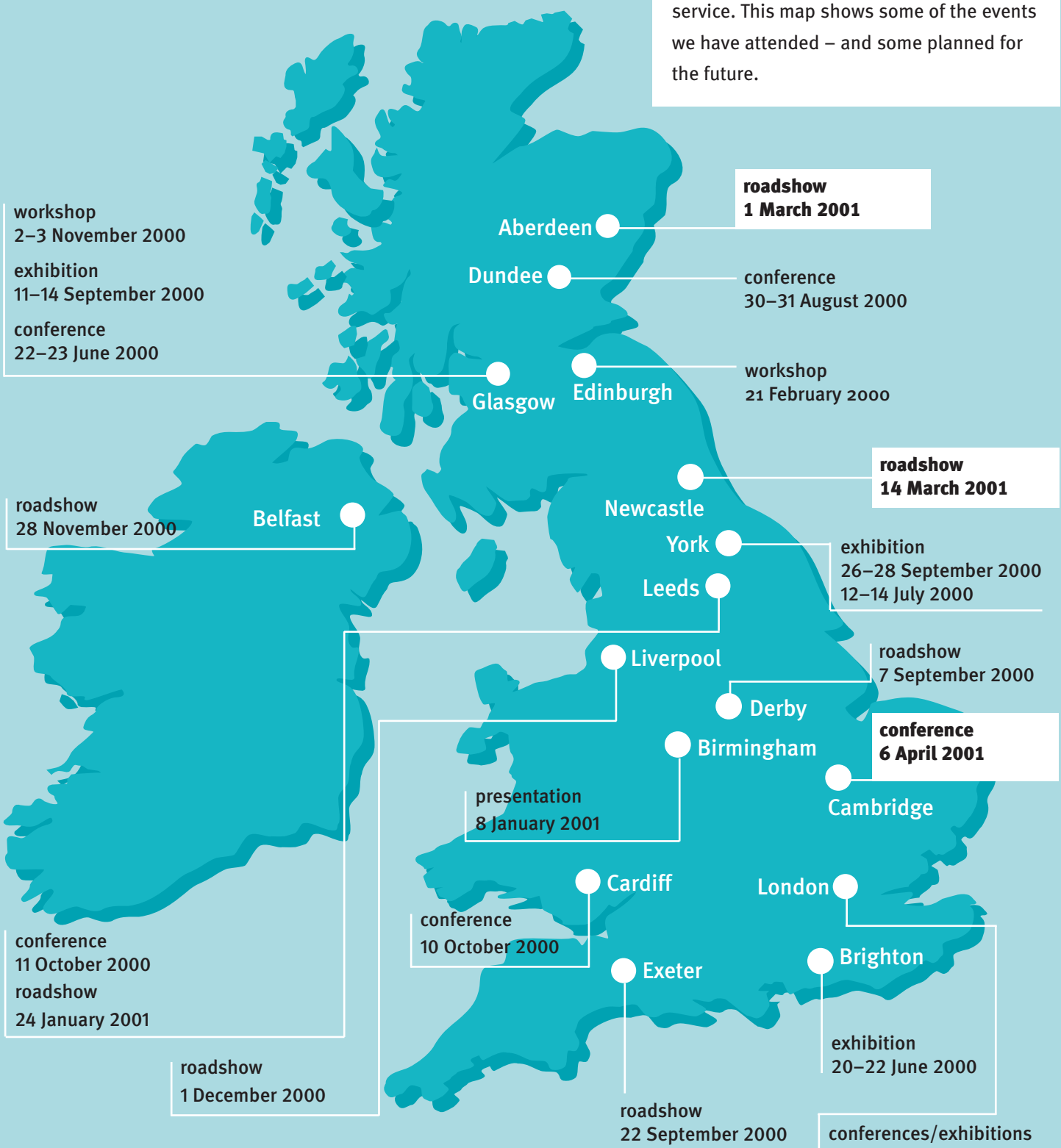
Any case that might come to us on these points will, of course, need to be considered on its own merits. However, it seems likely that we would be looking for evidence from the firm of:

- the overall design of the site at the time of initial application;
- the questions asked of the customer (and options for any standard answers);
- the steps the customer had to take to complete the transaction, including the highlighting of major policy features;
- any revisions by the policyholder to the information provided; and
- any warnings given to the customer.

Insurers will wish to note these points in their own complaint handling. If they do not have a clear record of the site design, information given by the customer, and policy wording at the time of the application, we will need to rely heavily on the customer's recollection of the application process.

the financial ombudsman service – out and about

By taking part in exhibitions, workshops and roadshows all over the country, we meet consumers, consumer advisers and people working in financial services – and spread the word about the new ombudsman service. This map shows some of the events we have attended – and some planned for the future.



See the back cover for details of our next event.

Come and meet us in Newcastle upon Tyne on Wednesday 14 March 2001

On Wednesday 14 March we will be at the Post House Hotel, New Bridge Street, from 10.00am to 2.00pm to answer your questions and tell you more about the new service.

There's no need to register in advance – just drop in.

If you can't come but want more information, please contact us on 020 7964 1400 or email technical.advice@financial-ombudsman.org.uk

And for up to the minute information about us and our activities – check our website www.financial-ombudsman.org.uk

'we provide a number of useful services'

how we can help

technical advice desk

guidance on ombudsman practice and procedures – for consumer advisers and professional complaints handlers

We can:

- explain how the ombudsman service works
- answer technical queries
- explain how the new ombudsman rules will affect your firm
- provide general guidance on how the ombudsman is likely to view specific issues.

technical.advice@financial-ombudsman.org.uk
phone 020 7964 1400

external liaison

We can:

- visit you to discuss issues relating to the ombudsman service;
- arrange for your staff to visit us.

Contact graham.cox@financial-ombudsman.org.uk

phone 020 7964 0132

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technical advice desk 020 7964 1400

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