complaint

Mrs B says AXA France IARD ("AXA") mis-sold her a payment protection insurance ("PPI") policy.

I can't consider this complaint against the policy seller directly because the sale took place before it, or its predecessor-in-title, was regulated by the then Financial Services Authority (FSA) for insurance intermediation activities, or otherwise covered by our jurisdiction.

The party that at the time of the sale was the policy insurer, has accepted that the seller was acting as its agent at the time – so it accepted responsibility for the sale. Following a transfer of business, AXA has taken on that responsibility. To keep things simple, I'll only refer to AXA in this decision, rather than any other business.

background and summary to complaint

Mrs B bought the policy in October 2000 at the same time as taking out a hire-purchase agreement. She applied for the hire-purchase agreement and PPI policy in store.

The policy provided cover for accident, sickness unemployment and life – subject to its exclusions and limitations. It offered to repay the monthly repayment of Mrs B's hire-purchase agreement in the event of Mrs B being unable to work due to accident, sickness and unemployment.

The policy cost £2.59 a month (£28.05 over the course of the agreement) and the premium would continue to have to be paid in the event of a successful claim.

At the time, Mrs B was employed as a computer operator. She has told us she was entitled to at least three months' full sick pay and some redundancy pay. She didn't have any other means of repaying her agreement if she wasn't working. Mrs B has said she was in good health at the time of the sale although she'd experienced medical conditions in the past.

Mrs B's representative has made lengthy and substantial representations on her behalf.

I will not restate them all here, but I have read and considered them all carefully. In summary, Mrs B's representative says:

- AXA failed to meet the sales standards which applied at the time. In those circumstances, applying the regulator's rules and guidance for businesses on handling PPI complaints under DISP App 3, it should be presumed Mrs B wouldn't have taken out the policy and the complaint should be upheld. Mrs B's representatives believe there to be no evidence to rebut that presumption;

- The policy excluded or limited claims for back pain and stress, which are some of the most common reasons people are off work. This significantly reduced the value of cover;

- The true costs including interest and the fact it was unlikely you could make a successful claim meant the policy was of inherently poor value as shown by the low claims ratio. The common law duty of utmost good faith means AXA should have told Mrs B about the poor value;

- The common law duty of utmost good faith also means AXA should have explained the significance of the exclusions and limitations of cover to Mrs B and the impact they would have had on her chances of making a claim; and

- The information Mrs B received was misleading. These policies were promoted as providing peace of mind, but the number of exclusions and limitations on the scope of the cover meant this was untrue.

Our adjudicator did not uphold the complaint – both parties have seen and provided their responses to the adjudicator's opinion. Mrs B disagreed with the adjudicator's opinion.

As the complaint couldn't be resolved informally, it has been passed to me for a final decision.

my findings

Although I have only included a summary of the complaint, I have read and considered all the evidence and arguments available to me from the outset, in order to decide what is, in my opinion, fair and reasonable in all the circumstances of this complaint.

relevant considerations

When considering what is fair and reasonable, I am required to take into account: relevant law and regulations; relevant regulators' rules, guidance and standards; relevant codes of practice; and, where appropriate, what I consider to have been good industry practice at the time. The Financial Ombudsman Service has set out its general approach to PPI complaints on our website and published some example final decisions that set out in detail how these relevant considerations may apply to PPI sales like Mrs B's. I don't intend to set that out in much detail here but I've taken this into account in deciding Mrs B's complaint.

This sale took place in 2000, before the sale of general insurance products like this became regulated in January 2005. So, the FSA's (and FCA's) overarching Principles for Businesses and insurance conduct rules (ICOB and ICOBs) aren't applicable to this complaint, nor is the FCA's Perimeter Guidance (PERG).

The credit agreement itself was with a third-party and not AXA. That means the unfair relationship provisions set out in s.140A of the Consumer Credit Act, the Supreme Court judgment in *Plevin* about s.140 of that Act and the rules and guidance made by the FCA about the handling of complaints about the non-disclosure of commission in light of the *Plevin* judgment, aren't applicable.

There were a number of industry codes in existence at that time, which I am satisfied are applicable to my consideration of what is fair and reasonable in the circumstances of this complaint:

The General Insurance Standards Council's General Insurance Code for private customers – the 'GISC Code'.

This sale was made during a period of industry 'self-regulation' by the General Insurance Standards Council (GISC). It published the GISC Code, which set out minimum standards of good practice for its members to follow when selling insurance, including PPI.

The Association of British Insurers' General Insurance Business Code of Practice for all intermediaries (Including Employees of Insurance Companies) other than Registered Insurance Brokers – 'The ABI Code'.

The ABI Code was supplemented by:

- Guidance on the application of the ABI Code
- The ABI Statement of Practice for Payment Protection Insurance
- The ABI General Business Code of Practice for Telephone Sales, Direct Marketing/Direct Mail and the Internet
- The Resume for Intermediaries

Among other things, the Code said that *"As a condition of membership of the Association of British Insurers (ABI), members undertake to enforce this Code and to use their best endeavors to ensure that all those involved in selling their policies observe its provisions."* AXA was a member of the ABI and the seller – its agent – was acting as an intermediary.

The Finance & Leasing Association (FLA) Code of Practice

This code was introduced in 1992, and set out standards of good practice for the finance and leasing industry. Section 4 of the code covered Credit Protection Insurance.

As I've explained, AXA was a member of the ABI, so it was subject to the ABI Code and its associated requirements. The seller – but not AXA – was a member of the FLA and subscribed to the FLA Code, so I consider it reasonable to assume that the seller (as a member of the FLA) should have complied with its code when selling PPI, and this extends to when it was acting as an agent of AXA.

So I am satisfied it is right that I should take these codes into account when deciding what is, in my opinion, fair and reasonable in the circumstances of Mrs B's case.

I've also taken account of relevant law in reaching my decision, including: the law relating to negligence, misrepresentation and contract (including the express and implied duty on professional advisers to give advice with reasonable skill, care and diligence); the law relating to the duty of utmost good faith; and the law relating to causation and remoteness.

Under the transitional provisions which continue to apply to complaints like this about acts or omissions before 1 December 2001, I am also required to take into account what determination the relevant former scheme – in this case the Insurance Ombudsman Bureau – might have been expected to reach in relation to an equivalent complaint. I note that under the Insurance Ombudsman's terms of reference the Ombudsman was required to decide complaints by reference to what was, in his opinion, fair and reasonable in all the circumstances – and that the Ombudsman was required to observe any applicable rule of law or relevant judicial authority.

I am also mindful of the evidential provisions and guidance set out at DISP App 3, first issued by the FSA in 2010, which sets out how firms should handle complaints relating to the sale of PPI. This sale took place before insurance mediation became a regulated activity, so AXA was required to take into account the provisions in DISP App 3 as if they were guidance when considering Mrs B's complaint.

key questions

Taking the relevant considerations into account, it seems to me that the key questions I need to consider in deciding what is in my opinion fair and reasonable in all the circumstances of this complaint, are:

- If AXA gave advice, whether it advised Mrs B with reasonable care and skill – in particular, whether the policy was appropriate or 'suitable' for her, given her needs and circumstances.

- Whether AXA gave Mrs B sufficient, appropriate and timely information to enable her to make an informed choice about whether to take out the policy, including drawing to her attention and highlighting – in a clear, fair and not misleading way – the main provisions of the policy and significant limitations and exclusions.

- If, having considered these questions, I determine the complaint in favour of Mrs B, I must then go on to consider whether and to what extent Mrs B suffered loss or damage and what I consider would amount to fair compensation for that loss or damage.

Having carefully considered the above and the information provided by both Mrs B and AXA, I've decided not to uphold Mrs B's complaint. I've set out my reasoning below.

did Mrs B know she had a choice?

AXA had to make it clear that the PPI policy was optional. AXA has provided a copy of the hire purchase agreement Mrs B signed. I can see there's a separate section for the PPI which makes it clear the PPI is optional. Mrs B has signed separately to say she wanted the PPI and she's signed the completed form too.

Taking everything into account, I think it's more likely that Mrs B knew the policy was optional and she agreed to take it out without undue pressure.

did AXA provide advice?

AXA says that advice wasn't provided during this sale. This means AXA didn't have to check if the PPI was suitable for Mrs B. Instead, it had to give her sufficient, appropriate and timely information to enable Mrs B to make an informed choice about whether to take out the policy, including drawing to her attention and highlighting – in a clear, fair and not misleading way – the main provisions of the policy and significant limitations and exclusions.

the information

I'm satisfied it's more likely than not Mrs B was given a broad description of what the policy was intended to cover (that is that the policy would protect her payments if Mrs B was unable to work through accident, sickness and unemployment) and of the approximate costs. I've reached this conclusion because I think it's unlikely Mrs B would have taken out the policy without any sense of what the policy was for and of how much the premium might be.

But the evidence from the time of sale doesn't tell us whether AXA gave sufficient information about the exclusions or limitations before Mrs B agreed to take out the policy.

So I don't think AXA gave Mrs B sufficient, appropriate and timely information to enable her to make an informed choice about whether to take out the policy, including drawing her attention and highlighting – in a clear, fair and not misleading way – the main provisions of the policy and significant limitations and exclusions.

I have considered how my findings interact with the FCA's list of significant failings in its guidance for firms handling PPI complaints set out at DISP App 3. And for the reasons set out above, I am persuaded that there were significant failings in this case.

In addition to the failings I've highlighted above, Mrs B's representative has raised a number of general points in regard to the requirements on a business when providing information in PPI sales. It suggests these points apply to all PPI complaints, like Mrs B's. I have considered these carefully and summarised them as:

- The common law duty of utmost good faith means the business should have explained the low claims ratio – what Mrs B's representative considers to be 'poor value'.

- The common law duty of utmost good faith means the business shouldn't have just told Mrs B about the limitations and exclusions, it should have gone further and explained the significance of them to her.

I'm not persuaded by Mrs B's representative's views on this. The duty of utmost good faith in insurance law imposed a duty on both parties to the contract to disclose material facts and not to make material misrepresentations. While I cannot be certain what a court would say – I think it is unlikely that a court would find that this extended to the insurer having to disclose the claims ratio information or explaining the significance of the limitations and exclusions in the way Mrs B has suggested. And taking into account the law, industry codes and standards of good industry practice applicable to this complaint, I don't think it would be fair or reasonable to impose such requirements on AXA.

what effect did AXA's shortcomings have on Mrs B? To what extent did Mrs B suffer loss or damage as a result?

I have found that AXA did not do all it should have done when it sold this policy to Mrs B. So I have gone on to consider whether it would be fair and reasonable to conclude Mrs B suffered loss and damage as a result. To answer this, I must decide whether or not Mrs B would have still taken out the policy, had AXA done things properly.

Mrs B says she would not have taken it out and believes that I should presume this to be the case given the significant failings identified above.

As this was a non-advised sale, Mrs B had to weigh up in her own mind the cost of the policy against the benefits offered and the potential consequences if she didn't insure against the risk of being unable to work.

As I've found above, Mrs B chose to take this policy out. So I consider that it's reasonable to conclude she had some interest in the benefits offered by this type of insurance. But she made this decision based on incomplete information. So what Mrs B thought she was getting is not *exactly* what she got. The extent to which this differed is a relevant consideration when determining if Mrs B has suffered any loss or detriment.

The information Mrs B was given about the cost and benefit was clear. But the information about other aspects of the policy, such as limitations and exclusions, wasn't as clear as it should have been.

Possibly the most significant differences between what Mrs B thought she had bought and what she actually bought were the following:

- The policy excluded claims relating to medical conditions that Mrs B knew about or ought to have known about within 12 months before the start date of the policy;
- The policy contained limitations on claims relating to back and mental health conditions placing more onerous evidential requirements to support a claim on those grounds;
- The policy limited, and in some situations, excluded unemployment cover if Mrs B wasn't a permanent employee;
- The requirement that in order to be eligible for a disability claim – Mrs B be unable to do her own job, a similar job or any paid work which her experience, education or training reasonably qualified her to do.

I do accept that there is a possibility that the limitations and exclusions above might well have caused Mrs B pause for thought – and may well have caused her to conclude that the policy was not as good as she thought and she might have decided not to proceed. The limitations on the cover, when coupled with the other shortcomings in this sale, might have dissuaded some consumers in slightly different circumstances from Mrs B from taking out the policy.

But, the evidence about Mrs B's circumstances at the time of sale shows that the policy wasn't fundamentally wrong or unsuitable for her. She was eligible for its benefits and it provided cover that, despite its limitations and exclusions, could've proved valuable to her should the insured risks have become a reality. I also haven't seen any evidence to suggest she would've been caught by any of the significant exclusions – Mrs B didn't have any pre-existing medical conditions which might have been excluded from cover and was in permanent employment. So, I still think she had some good reasons to take the policy out.

I accept back pain and mental health conditions are common problems and the steps required to make a disability claim for these conditions were more onerous than Mrs B might reasonably have expected. But it's unlikely she would have expected to be able to make a disability claim without having to provide some evidence to support that claim. And while this limitation might have dissuaded some consumers in slightly different circumstances to Mrs B from taking out the policy, Mrs B, in her circumstances, still had some good reasons to take it out.

If Mrs B had known she could only claim for disability if she was unable to do both her job and 'any paid work' which in the insurer's view she might reasonably become qualified for, it might have played into her thinking about what she would have done. And I accept it may have given her pause for thought – although it's possible she may not have been overly concerned given that if Mrs B was unable (through disability) to carry on her own occupation the chances that she would be able to take up a similar occupation would also, in all probability, be limited.

Having considered all of the evidence and arguments in this case, I consider it more likely than not that Mrs B would still have taken out the policy. The policy was sufficiently close to what it is likely she thought she was getting and provided benefits that would help her manage the consequences were Mrs B made redundant, or unable to work through the accident or disability. In the circumstances I consider it more likely than not that Mrs B would have taken out the policy in any event notwithstanding the limitations on cover.

Mrs B's representatives say the rules about how to handle PPI complaints (DISP App 3) make it clear that, where a significant failing is identified, it should be presumed the consumer wouldn't have taken out PPI, unless there is evidence to outweigh the presumption. They say we should follow this other than in exceptional circumstances.

That guidance is for firms, but it is a relevant consideration so I take it into account along with many other things when I decide what is in my opinion fair and reasonable. Considering the purpose of the guidance, I don't think it was ever intended to be at odds with the approach I have taken.

I have thought about what outcome applying the FCA's guidance to this complaint might lead to. In the language of DISP App 3, I have found it would be reasonable to conclude there were substantial flaws in the sales process. In those circumstances, DISP App 3 says it should be presumed Mrs B would not have bought the PPI she bought *unless*, in the particular circumstances of the complaint, there is evidence to rebut the presumption.

I am satisfied, applying DISP App 3, it is reasonable to conclude the presumption is rebutted in the particular facts and circumstances of this complaint. Taking into account Mrs B's circumstances as detailed above, I consider it reasonable to conclude the position Mrs B found herself in as a result of the sale was the same position she would have been in had the 'breach' or 'significant' failings not occurred.

Mrs B believes the presumption may only be rebutted when the flaws in the sales process were immaterial, that the flaws in this case were highly material and we have failed to give proper weight to the evidence – including her own comments that she would not have taken out the policy. I am not persuaded by these arguments.

Even if I am ultimately departing from the guidance for firms set out at DISP App 3 (which I don't consider I am), I am only doing so because I do not consider, in this case, that it would represent fair compensation to put Mrs B in the position she would have been in if she had not bought the policy.

That is because, while I accept it is possible that she would not have taken out the policy, I am satisfied that of the two possibilities, it is more likely than not that she would still have taken out the PPI had she been given clear, fair and not misleading information about the policy she was buying. So I'm not persuaded it would be fair and reasonable in those circumstances, to conclude AXA should pay Mrs B compensation, as that would put her in a better position than she would have been in if everything had happened as it should have done.

I'm also aware that Mrs B thinks AXA misrepresented the terms of the policy in how it described the PPI. While I accept there is a possibility a court might conclude some of AXA's statements misrepresented the contract, in my opinion the reason why AXA failed to act fairly and reasonably was not because of what it did or didn't say in the information it provided – but because the overall information AXA gave Mrs B, in the way it did, was

insufficient to meet the standards I consider it fair and reasonable to expect it to have met in 2000 when providing information about an insurance policy.

I've also thought about the approach Mrs B's representative says a court might take if it were to find AXA negligently misrepresented the contract to Mrs B and about the remedy a court might award if it were to find that AXA had been in breach of its duty of utmost good faith. But this doesn't persuade me to alter my conclusions about what is fair and reasonable in all the circumstances of the complaint – including what I think is fair compensation in the circumstances of this case. For the reasons I've already set out I don't think it would be fair and reasonable to put Mrs B in a better position than if everything had happened as it should have done.

my decision

Overall, having considered all the evidence and arguments to decide what is, in my opinion, fair and reasonable in all the circumstances of this complaint and for the reasons I have set out above, I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs B to accept or reject my decision before 31 January 2021.

Sally Allbeury
ombudsman