complaint

Mr H says he was mis-sold 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 France IARD ("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

AXA has told us Mr H paid less than £4 in PPI premiums in total over the life of the policy.

Mr H was sold the policy in 2002 when taking out a store card via a leaflet he was given. He was employed at the time as a farmhand and had been there five years. From what he's told us, he was entitled to no more than statutory pay for sickness and redundancy and didn't have any other means, like savings, to pay his card with if he couldn't work. From what Mr H has told us, at the time of the sale he was in good health and hadn't had any health issues.

The PPI policy provided cover for accident, sickness and unemployment, and life cover, subject to its exclusions and limitations. For a successful disability or unemployment claim, it offered to pay 15% of Mr H's card balance. It cost at the time £1 per £100 of the monthly outstanding balance. The premium still had to be paid during a successful claim and attracted interest. The life cover, subject to its terms, would clear the card balance on death.

The policy also provided purchase protection and price protection. Mr H hasn't complained about this element of the insurance policy so I will not consider it further in this decision.

Mr H's representative has made lengthy and substantial representations on his behalf. I'll not restate them all here, but I have read and considered them all carefully. In summary, Mr H'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 Mr H wouldn't have taken the policy and the complaint should be upheld. Mr H'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 Mr H 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 Mr H and the impact they would have had on his chances of making a claim; and

- The information Mr H 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 didn't uphold the complaint – both parties have seen and had a chance to give their responses to the adjudicator's opinion. Mr H disagreed with the adjudicator's opinion for several reasons. As the complaint couldn't be resolved informally, it has been passed to me for a 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'm 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 Mr H's. I don't intend to set that out in much detail here but I've taken this into account in deciding Mr H's complaint.

This sale took place in 2002 before the sale of general insurance products like this became regulated by the FSA 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 the 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."* The insurer 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, the insurer was a member of the ABI, so it was subject to the ABI Code and its associated requirements. The seller – but not the insurer – 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 the insurer.

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 Mr H's case.

I have 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.

I'm 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 Mr H'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 Mr H with reasonable care and skill – in particular, whether the policy was appropriate or 'suitable' for him, given his needs and circumstances.

- Whether AXA gave Mr H sufficient, appropriate and timely information to enable him to make an informed choice about whether to take the policy, including drawing to his 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 Mr H, I must then go on to consider whether and to what extent Mr H 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 Mr H and AXA, I've decided not to uphold Mr H's complaint. I've set out my reasoning below.

did Mr H know he had a choice?

AXA had to make it clear the PPI was optional. Mr H has said he had no interest in PPI and has said it was just added as part of the package with his card. But his credit agreement had a separate PPI section with a space to sign if PPI was wanted – and Mr H signed this space. Nothing on the credit agreement says PPI has to be taken or says Mr H had to sign in the space for the PPI if he didn't want the cover. Taking everything into account, I think it more likely Mr H knew the policy was optional and agreed to take it without undue pressure.

did AXA provide advice?

AXA says it didn't provide advice during this sale. With this in mind, and taking into account all Mr H has told us, I'm persuaded AXA didn't provide advice. This means AXA didn't have to check if the PPI was suitable for Mr H. Instead, it had to give him sufficient, appropriate and timely information to enable Mr H to make an informed choice about whether to take the policy, including drawing to his attention and highlighting – in a clear, fair and not misleading way – the main provisions of the policy and significant limitations and exclusions.

the information

AXA has provided us with Mr H's credit agreement – showing that PPI had been selected. I've also seen a copy of terms and conditions which I accept - on a balance of probabilities - applied to policies like Mr H's. Looking at the information provided to Mr H at the time, I don't think AXA gave him the information he fairly and reasonably needed to make an informed decision about whether or not to take the policy.

This sale took place via an instore leaflet Mr H was given. I don't know what AXA told Mr H about the PPI, but I think it's unlikely he would've agreed to take it without having at least a broad understanding of the cover it provided – i.e. life, accident, sickness and unemployment cover. And I think it's unlikely he would've thought it was free.

Also, I bear in mind that below where Mr H signed for the PPI, his credit agreement said: *"Please debit my Account with the relevant monthly premium until further notice"* - which would've also given an indication the cover wasn't free – and the agreement elsewhere referred to the cover as costing *"just 1p for every pound on your monthly balance"*.

But it was AXA's responsibility to draw to Mr H's attention the important information – i.e. the key information about the nature of the cover and any significant exclusions and limitations which might be relevant to his decision. I don't think it's likely AXA did enough to do this. For

example, I don't think it's likely the true cost of the policy was made clear to Mr H, including the need to maintain premiums during a claim or that payments would attract interest. In addition, it's unlikely AXA adequately drew to his attention the main provisions of the policy and significant limitations and exclusions.

So I don't think AXA gave Mr H sufficient, appropriate and timely information to enable him to make an informed choice about whether to take the policy, including drawing his attention to 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'm persuaded there were significant failings in this case.

In addition to the failings I've highlighted above, Mr H's representative has raised a number of general points in regards to the requirements on a business when providing information in PPI sales. It suggests these points apply to all PPI complaints, like Mr H'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 Mr H's representative considers to be 'poor value'.

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

I'm not persuaded by Mr H'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 can't be certain what a court would say – I think it unlikely 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 Mr H 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 Mr H? To what extent did he 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 Mr H. So I have gone on to consider whether it would be fair and reasonable to conclude he suffered loss and damage as a result. To answer this, I must decide whether or not Mr H would have still taken the policy, had AXA done things properly. Mr H says he wouldn't have taken it and believes I should presume this to be the case given the significant failings identified above.

As this was a non-advised sale, Mr H had to weigh up in his own mind the cost of the policy against the benefits offered and the potential consequences if he didn't insure against the risk of being unable to work. As I've found above, he chose to take this policy. So I consider it reasonable to conclude he had some interest in the benefits offered by this type of policy. But he made this decision based on incomplete information. So what Mr H thought he was getting isn't *exactly* what he got. The extent to which this differed is a relevant consideration when determining if Mr H has suffered any loss or detriment.

In relation to the costs, I'm satisfied Mr H ought reasonably to have known he would have to pay something for the PPI and that it would cover a portion of his outstanding balance. But, I accept that AXA didn't make clear the on-going cost information. So while Mr H didn't know some things, the ultimate position in the event of a successful claim was not dissimilar to what he would reasonably have thought from the information he based his decision to take the policy on and found acceptable.

Possibly the most significant differences between what Mr H thought he had bought and what he actually bought were the following:

- The policy excluded claims relating to health issues Mr H knew or should have known about, or for which he had been advised or treated by a medical practitioner in the 12 months before the policy start;
- 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 Mr H wasn't a permanent employee; and
- The requirement that, in order to be eligible for a disability claim, Mr H be stopped from doing his own or any similar job - and be stopped from doing any paid work his experience, education or training reasonably qualified him to do.

I do accept there's a possibility the limitations or exclusions above might well have caused Mr H pause for thought – and may well have caused him to conclude that the policy was not as good as he thought and he 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 Mr H from taking the policy.

But, the evidence about Mr H's circumstances at the time of sale shows the policy wasn't fundamentally wrong for him. He was eligible for its benefits and it provided cover that, despite its limitations and exclusions, could've proven valuable to him should the insured risks have become a reality. I also haven't seen any evidence to suggest Mr H would've been caught by any of the significant exclusions – he didn't have any pre-existing medical conditions and was in permanent employment. Mr H has said he couldn't have claimed due to being in a high-risk occupation, but the PPI didn't restrict claims for high-risk occupations and nothing about Mr H's occupation would've made it more difficult for him to claim. So, I think Mr H still had some good reasons to take the policy.

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 Mr H might reasonably have expected. But it's unlikely he would've expected to be able to make a disability claim without having to provide some evidence to support that claim. And while this limitation might've dissuaded some consumers in slightly different circumstances to Mr H from taking the policy, Mr H, in his circumstances, still had some good reasons to take it.

If Mr H had known he could only claim for disability if he were not only unable to do his own or any similar job, but also unable to do any paid work his education, experience or training might reasonably qualify him to do, it might have played into his thinking about what to do. And I accept it may have given him pause for thought – but, given Mr H's circumstances and limited other means, on balance I think he would've still been interested in taking the cover.

Having considered all the evidence and arguments in this case, I consider it more likely than not Mr H would've still taken the PPI. The policy was sufficiently close to what he thought he

was getting and, aside from statutory benefits, he didn't have any other means of paying his card if he couldn't work due to accident, sickness or redundancy. And, in those circumstances, I consider it more likely than not Mr H would've taken the policy in any event.

Mr H'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 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 Mr H would not have bought the PPI he 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 Mr H's circumstances as detailed above, I consider it reasonable to conclude the position Mr H found himself in as a result of the sale was the same position he would have been in had the 'breach' or 'significant' failings not occurred.

Mr H 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 his own comments that he would not have taken 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 Mr H in the position he would have been in if he had not bought the policy.

That's because, while I accept it's possible Mr H wouldn't have taken the policy, I'm satisfied that, of the two possibilities, it's more likely than not he would've still taken the PPI had he been given clear, fair and not misleading information about the policy he was buying. So I'm not persuaded it would be fair and reasonable, in those circumstances, to conclude AXA should pay Mr H compensation, as that would put him in a better position than he would've been in had everything happened as it should have done.

I'm also aware Mr H 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 Mr H, in the way it did, was insufficient to meet the standards I consider it fair and reasonable to expect it to have met in 2002 when providing information about an insurance policy.

I've also thought about the approach Mr H's representative says a court might take if it were to find AXA negligently misrepresented the contract to Mr H and about the remedy a court might award if it were to find 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 Mr H in a better position than if everything had happened as it should have done.

my final 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 Mr H to accept or reject my decision before 21 October 2021.

Richard Sheridan
ombudsman