Before the Arbiter for Financial Services

Case ASF 083/2021

XD

(the Complainant/the Insured)

vs

ArgoGlobal SE (SE 2)

(the Service Provider/the Insurance/

The Insurer)

Sitting of the 8 February 2022

The Arbiter,

Having seen the complaint whereby the Complainant states that he had a home insurance cover with the Service Provider. His property in the UK was burgled on the 25 May 2019, and he immediately placed a claim with the insurance company to be indemnified for the stolen goods.

He was seen by a claims handler and loss adjuster where he detailed the stolen objects. Since submitting the necessary supporting documents, he repeatedly chased up the claim for 20 months. On certain occasions he was left hanging on the phone with no response, or re-directed to staff that were not able to assist him with the claim, or made false promises about finalising the claim.

He obtained legal advice from a relative and, thereupon, he sent the insurance company more evidence stating that he had met his obligations and had fulfilled both his duty of disclosure and fair presentation of the claim.

He also provided all the information relating to the material circumstances he knew of. He provided all the information to put a prudent insurer on notice '*that it needed to make further enquiries that I was not in possession of a safe'.*[1]

After he was advised to contact the UK Ombudsman for Financial Services, he was told that the complaint should be directed to the Office of the Arbiter for Financial Services in Malta since the insurance company was based in Malta.

The main thrust of the Complaint is that the insurance company had failed to settle the case in 24 months after the initial claim despite the fact that he had provided all the necessary information in a timely manner and answered all the questions put forward by the Service Provider or its representatives.

On occasions, he was 'fobbed off' with poor explanations and the insurer refused to take responsibility for its legal obligations and duties and to honour the Terms and Conditions of the policy.

The stolen objects were the following:

Audemars Piguet Royal Oak Chronograph Safari watch;

Rolex submarine watch;

Paneral Kuminor Marina Watch;

Men's platinum wedding ring;

Ladies diamond engagement ring;

Ladies Cartier love bracelet

Partner's passport

Cash: 400 US Dollars and 500 Euros.

Having seen the reply of the Service Provider whereby it states that:

[1] *A Fol. 3*

We take our responsibility to treat customers fairly very seriously and we carefully consider the merits of every claim against the specific policy wording before reaching a final decision.

In May 2019 the policyholder's home was burgled and they made a claim for the theft of various items. The only remaining issue between the parties is the claim for indemnity for the stolen Audermans Piguet Royal Oak watch. This claim has not been accepted on the basis that it should have been kept in a safe at the time of the theft. Instead, it was in a display case.

This is contrary to the Personal Custody/Safe Warranty in the policy. The policy is clear in relation to what is and is not covered. The Personal Custody/Safe Warranty provides cover in three instances: (1) whilst the watch is being worn; (2) whilst it is being handled; or (3) whilst in a locked safe. Although the policyholder declared that they did not have a safe installed at their premises, the extent of the cover provided is clearly stated in the policy.

Before purchasing the policy, there are various documents for customers such as the policyholder to review. The customer is required to tick a box to confirm that they have read and agreed the terms and conditions of the policy before they are able to complete the purchase of cover. Page 10 of the policy documents provided at the time the policy was purchased includes the Endorsement 'Personal Custody/Safe Warranty'.

In these circumstances, we consider that it was made clear to the policyholder prior to accepting the quote that there was a limitation to the cover being purchased. We refute any suggestion that we are responsible for the policyholder's failure to read and understand the restriction in cover. As the Warranty applies, we are not liable under the policy terms and conditions.

Furthermore, the policy premium was calculated on the basis that there is no cover for the watch outside of a safe. Endorsements such as this are fairly standard for theft cover on high value items. If cover were available without this type of restriction, i.e., to cover theft if the watch was left in a display case, we believe that the premium charged would have been substantially higher.

Having seen all the documents and heard the parties

Considers

The Arbiter will decide the case with reference to what in his opinion is fair, equitable and reasonable in the particular circumstances and substantive merits of the case.[2]

The Arbiter has to decide the case on the basis of the proofs submitted by both parties and is obliged by law to deal with the particular circumstances of the case on the basis of fairness, equity and reasonableness.

The Complainant's Version

During the sitting of the 19 October 2021,[3] the Complainant explained that he purchased a home insurance policy through a comparative website and stated the high value of his objects on the application form. Asked in the application form whether he was in possession of a safe, he clearly stated that he was not in possession of a safe.

The insurance company accepted to cover him.

On the 25 May 2019 his property got burgled and '*that high value item was stolen along with other items and some cash'.*[4]

Immediately he placed a claim for the theft of the stolen items and he '*really struggled to get any feedback from the organisation. It was a protracted process.'*[5]

In the end, the insurance company failed to pay him for the stolen watch which is the high value item on the policy. The insurer told him that they declined his claim because he should have kept it in a safe. He emphasises that he had told the insurer at the point of sale of the policy that he did not have a safe and they accepted to insure him. He had made that statement '*in the policy'.*[6]

The Complainant further states that it took him two years of numerous phone calls, numerous emails, through the height of the pandemic, to receive a final reply from the insurance company. He worked as a Consultant in the Emergency

[2] Chapter 555 of the Laws of Malta, (CAP. 555) Art. 19(3)(b)
[3] *A Fol.* 113 *et seq.*
[4] *Ibid.*
[5] *Ibid.*
[6] *Ibid.*

Services during a stressful time, and the stress was further compounded by the delay from the insurance company to resolve the issue.

He further states that the insurer had told him that there was no forced entry, but the police asserted that it was a forced entry.

The insurer directed him to the UK Ombudsman for Financial Services only to be told to refer the case to the OAFS in Malta.

Finally, the Complainant states that:

'*I told the insurance company that I have said everything I could. I have been open, honest and factual in my disclosure to disclose full and honest information and they said that was my requirement. On the basis of that, it is the requirement of the insurance company to act in an appropriate manner which they have not done.*

Someone from the insurance company phoned me and said that I should not have been given an insurance policy since on the policy I clearly stated that I do not have a safe. And we are still contesting the payout of the high value item'.[7]

On cross-examination, the Complainant was asked whether prior to making the final click on online purchasing, he was aware that there is a section which states that his policy had endorsements that might apply and if confirmed by clicking the acceptance, there would be a limit on theft items, he stated that since all this happened more than two and a half years ago, he does not remember this detail.

The Service Provider's Version

The Service Provider did not produce any oral evidence but made a final submission which essentially states that, at the point of sale, the Complainant was required to approve and acknowledge certain terms and conditions of the policy, including that there are certain endorsements within the policy.

The second submission is in relation to standard market practice. The Service Provider states that there were warranties within the policy; and the cover in question was available with the standard endorsements. Had the Complainant

[7] *A Fol*. 114

lost his watch, or mugged and the watch was taken, the policy would have provided cover. What the policy does not cover is when the insured item is left unattended without being locked in a safe. That is the reason that there is no cover in place.

The Service Provider further states that Endorsement 35 attached to the policy, is to the effect that the Insurer does not cover items costing several thousands of pounds when left unattended unless they are within a safe.

Moreover, the Service Provider notes that in the submitted documents, there was a signed statement given by the Complainant on the 21 August at 3.00 p.m. in his residence in Brighton and, among the items declared to be stolen, was a Panerai Luminor men's watch purchased in Dubai 2014 for GBP5,000 and a Cartier love bracelet purchased in Dubai in 2016 for GBP1,500.

Several weeks later, during the investigation, the insurance investigator asked the Claimant to provide the receipts for the watch and bracelet and any Customs documents. At the time, the Claimant declared that the items were not purchased but they were gifts by relatives.

Further Considerations

The Complaint basically revolves around the fact that the insurance company did not honour the claim because it states that the Complainant failed to keep the high value watch in a safe when unattended.

On the other hand, the Complainant submits that when purchasing the policy, he was asked in the proposal form whether he had a safe and he answered in the negative. In spite of this disclosure, the insurer still granted him cover. If the insurance did not cover high value objects if not kept in a safe, they should have denied him cover and not refuting the claim on the basis that the high value watch was not kept in a safe.

The Arbiter has to base his decision on the proofs brought before him by the parties.

The Essence of the Complaint

The Complainant basically submitted:

1) That the Insurer procrastinated for a long time to give him a final reply on the claim;

2) That the Insurer did not act fairly by refuting his claim.

The Service Provider states in its reply that the only contention remaining between the parties is the claim for the indemnity for the stolen Audermans's Piguet Royal Oak watch. This is not contested by the Complainant and, in his evidence, he only makes reference to this high value watch.

The Key Players

Reading through the correspondence and emails exchanged between the parties, it transpires that:

Dial Direct - arranged and administered the insurance cover;

Geo Underwriting - dealt with claims presented to them;

Davies Group - were appointed by Geo Underwriting to deal with the Complainant's claim.[8]

The Juridical Context

The contract of insurance is based on the willingness of the insured and the insurer to enter into a contractual relationship whereby the insured pays a premium to cover certain risks, and the insurer obliges itself to indemnify the insured if such risk occurs.

The insurance contract has been described both by the Maltese Courts[9] and courts in other jurisdictions as an *aleatory* contract. The term 'aleatory' is derived from the Latin word for gambler: *aleator.*

'A contract is aleatory when a party's duty to perform is conditional on the occurrence of an event that neither party to the contract is certain will occur. In other words, performance is contingent upon the happening of a fortuitous event. In the context of insurance, this means that the insurer may or may not pay more in benefits than premiums paid. Thus, the insured loses the gamble if

[8] *A Fol.* 10-11

[9] *Angelo Spiteri vs Citadel Insurance p.l.c.,* (Court of Appeal) (CA) (inf), 28 /04/2004

there is no loss or if the premiums paid exceed the cost of any loss. Conversely, the insurer loses the gamble when a loss occurs.'[10]

The contractual relationship commences when a proposal is made by the insured to obtain an insurance cover and, when accepted by the insurer, the contract is considered complete as there will be consensus *ad idem*.

This is crystallized in Ivamy[11] as follows:

'This proposal indicates the basis upon which the proposer is prepared to contract and it is up to the insurer to decide whether to provide cover and, if so, at what premium.'

That is why the contract of insurance has been described as a contract based on the utmost good faith of the contracting parties because, once bound, they should honour their respective obligations with the *highest degree* of good faith.

The Maltese Courts have also held that *uberrimae fidei* applies to both parties and subsists during the whole duration of the contract;[12] meaning that the utmost good faith subsists also during its execution. While the insured is *inter alia* obliged to pay the premium and disclose all material facts that could impinge on the risks of the policy, the insurer has the primary obligation to honour the claim in an honest, fast and fair way.

In dealing with a claim the insurer must:

1. Consider the insured's interests with the same consideration it gives its own interests. This means that the insurer must give the policy holder the benefit of the doubt.

2. Look for reasons to find coverage, not for reasons to deny coverage. The insurer should be looking for reasons to pay the claim, not reasons to deny it.

[10] Thomas C. Cady and Georgia Lee Gates, Post Claim Underwriting, (West Virginia, University College of Law), (The Research Repository) Vol 102, Issue 4, Vol. 5, pp.4-5
[11] *General Principles of Insurance, 4th Edition, 1979 p:107*
[12] *Gasan Mamo Insurance Limited v. Van Reeven et*, (First Hall, Civil Court, (PA) 8/05/2017

3. Not view the process as insurance company versus policy holder but as honest partners to the same contract.
4. Promptly and fairly investigate every claim.
5. Promptly pay the claim if payment is owed.
6. Give an adequate explanation to the policy holder if the claim is denied.

Of relevance in this case is the notion of *post claim underwriting*. Historically, insurance underwriting knows its origins in the seventeenth century at Lloyds Coffee House in London, where shippers would give a description of their ship, the voyage to be undertaken, the merchandise on board, etc., and the prospective insurance patron would estimate the risk involved and decide whether to assume the risk at an agreed premium. This is the origin of insurance underwriting.

As has been authoritatively stated:[13]

‘*"underwriting" is a risk assessment conducted* ***pre-issuance*** *and* ***pre-loss****. Obviously, this sequence is necessary to allow the insurer to ascertain the probability of its incurring liability for any loss that the insured might sustain and, therefore, whether it wishes to assume the risk of that loss. In addition, by determining the likelihood of any future loss, the insurer is able to set an appropriate premium amount for the applied coverage.*

Concomitantly, the traditional sequence of underwriting enables the insured to determine whether the cost of the risk aversion offered is sufficiently eco-nomical to induce the purchase of insurance.

In addition, if the insurance is purchased, the insured can rest easy in the knowledge that in the event of a loss there will be coverage. Therefore, the traditional sequence of underwriting naturally gives rise to a judicial mandate that "an insurer has an obligation to its insureds to do its underwriting at the time a policy application is made, not after a claim is filed”.’

[13] Thomas C. Cady and Georgia Lee Gates, Post Claim Underwriting, (West Virginia, University College of Law), (The Research Repository) Vol. 102, Issue 4, Vol. 5, p. 4-5

Post Claim Underwriting happens when the insurer does not carry out the underwriting at the initial stage and prior to the acceptance of risk:

'*Post claim underwriting, however, creates a process that is a complete in-version of the established sequence of underwriting. When an insurer engages in post claim underwriting, it "wait[s] until a claim has been filed to obtain information and make underwriting decisions which should have been made when the application [for insurance] was made, not after the policy was issued." In other words, the insurer does not assess an insured's eligibility for insurance, according to the risk he presents, until after insurance has been purchased and a claim has been made.*'[14]

This would facilitate the insurer's ability to refute the claim. In so doing, the insurer would be considered to have acted in bad faith thereby abandoning the obligation of utmost good faith which is the basis of the contract of insurance.

The above juridical principles will be examined and applied to the facts of this case, and the Arbiter will decide whether the Complaint is *fair, equitable and reasonable in the particular circumstances of this case*.[15]

The Question of Procrastination of the Claim

The Arbiter will first decide the question of alleged procrastination on the part of the insurer.

The Arbiter has examined the correspondence exchanged between the Complainant and the various entities appointed by the Service Provider to handle the claim. It is clearly evident that the Service Provider or its appointees did not deal with the claim in an expedient manner, and they themselves admitted that the processing of the claim took a longer time than reasonably expected.

This is *inter alia* proven by the fact that Direct Group (Davies Group) acknowledged their failings, and on the 13 November 2019, they sent the Complainant a cheque for £100 for the delay in dealing with his claim.[16]

[14] *Ibid.*
[15] Chapter 555 of the Laws of Malta, Article 19(3)(b)
[16] *A Fol.* 27

Moreover, the Arbiter notes that from the documents filed in this case, it transpires that a final response about the high value watch was given by the insurer months after the Complainant had filed the claim.

The Arbiter is of the opinion that the insurer, its representatives or intermediaries, failed in their duty to decide the claim within a reasonable time. This will be taken into consideration later on in this decision.

Whether the Service Provider was justified in refusing the claim

The main reason given by the Service Provider for refusing the claim was that the Complainant did not keep his high value watch within a safe. The Service Provider stated that there was an endorsement to this effect and mentions Endorsement 35.

However, the Arbiter notes that neither party has presented the Insurance Policy Document and, even more so, the endorsements referred to by the Service Provider. Furthermore, the Service Provider did not produce any evidence to this effect but only made remarks during its final submissions (which in themselves are not proofs of the case).

For this reason, the Arbiter is not in a position to examine and verify these endorsements and any warranty forming part of the policy.

Moreover, the Service Provider has stated in its reply that '*the policy premium was calculated on the basis that there is no cover for the watch outside a safe … If cover were available without this type of restriction, i.e., to cover theft if the watch was left in a display case, we believe that the premium charged would have been substantially higher.'*[17]

The Arbiter sees this point and basically agrees with the Service Provider that the higher the risk, the higher would be the premium charged. However, in this particular case, the Complainant had declared in the proposal form that he had no safe and the Service Provider was in a position either to decline the proposal or to charge a higher premium. The Service Provider only raised its concern that the watch was not kept in a safe when it was faced with the claim. Had the Complainant been informed that he should not be given cover without having a

[17] *A Fol.* 109

safe, he would have been in a position either to buy a safe, to suggest and agree on a higher premium or to seek the services of another insurer.

As has already been stated above in this decision, the **underwriting of risks must precede the loss and the claim**, and not the other way round. It is the insurer's right and obligation to check the proposal form submitted by the insured and flag any inconsistency with the standard form contract of insurance at the initial stage, and not after it has been faced with a claim. Otherwise, the insurer would be indulging in post claim underwriting.

Admittedly, the Insurer knew that the Complainant did not have a safe and it follows that in not having a safe, he did not have the possibility of keeping his high value watch in it.

The Complainant exercised his duty of disclosure diligently, and it is expected that the Insurer would also assume its obligations as explained above in this decision.

Once the insurer accepted the proposal form, as filed by the insured, it accepted all the risks arising from it. The insurer had all the possibility of either charging a higher premium or refusing the cover. When the Insured paid the premium, he had every right to assume that his declaration of not possessing a safe will not militate against him if the fortuitous event would materialise as, in fact, it did.

It would have been different had the Insured declared that he was in the possession of a safe when, in reality, he did not: that would have clearly been a fraudulent claim which could have been easily avoided by the Insurer.

However, in this case, the Complainant was transparent and correct and, consequently, he is entitled to the reasonable expectation that if his value watch was lost or stolen, he would be indemnified by the Insurer. If the insured cannot have his mind at rest that the insurer would accept a legitimate claim, there would be no scope for an insurance cover. Once a person is insured, the risk is transferred to the insurer who should act fairly and reasonably and accept the claim. This is even more so in standard form contracts where the insured is not given the opportunity to negotiate its terms.

The Service Provider argues that the Complainant had ticked the box signifying that he had read the terms and conditions of the policy. The Arbiter is of the

opinion that if the Complainant was responsible by ticking a box in the split of a second on an online transaction, the Service Provider cannot be absolved in not carrying a proper underwriting exercise at the inception stage, when it had all the time to check whether the proposal form was acceptable, especially, when the Complainant made it amply clear that he did not possess a safe.

The reasonable and legitimate expectations of the consumer[18] to have his mind at rest after buying an insurance cover should be respected and honoured.

It is not equitable, fair or reasonable on the part of the Insurer to accept the premium with the knowledge that the Complainant did not possess a safe and flag inconsistency with a warranty or endorsement **after a claim was submitted**; thus, depriving the insured from a possible cover from another insurer and leaving him exposed to risks that to his knowledge were covered by paying the agreed premium.

For the above-mentioned reasons, the Arbiter decides that the Complaint is equitable, fair and reasonable in the particular circumstances of the case and is accepting it as long as it is compatible with this decision.

Compensation

In virtue of Article 26(3)(c)(iv) of Chapter 555 of the Laws of Malta, the Arbiter orders ArgoGlobal SE to pay the Complainant the value of the Audemars Piguet Royal Oak watch.

The Complainant has indicated that the replacement value of the watch is £19,000, but the insurance cover is capped at £10,000.[19]

The Service Provider did not contest these figures in its Reply.[20]

Therefore, the Arbiter is ordering ArgoGlobal SE to pay the Complainant the sum of £10,000, provided that the policy does not provide for a lesser amount, which then would apply.

[18] Chapter 555, Art. 19(3)(b)
[19] *A Fol.* 21
[20] *A Fol.* 109

With legal interest at the rate of 8% per annum from the date of this decision until the date of effective payment.

The costs of these proceedings are to be borne by the Service Provider.

Dr Reno Borg
Arbiter for Financial Services