

DG

(‘Complainant’)

vs

Riverside Insurance Agency Limited

(C 94792)

(‘Riverside’ or ‘Service Provider’)

Sitting of 30 April 2026

The Arbiter,

This Complaint concerns the refusal of the Service Provider to settle a claim for €5,000 made by Complainant on his Car Rental Excess – Single Trip insurance policy¹.

Having seen the complaint², whereby the Complainant explains his claim was refused for these main reasons:

1. Riverside alleges that Complainant was not acting in good faith in not disclosing that he had another insurance policy and tried to make a claim for the same incident on both policies thus attempting to enrich himself through double recovery of what he actually paid by way of excess to the rental company.
2. The value of the rented vehicle exceeded the limit of €120,000 for which the Excess cover applied.

¹ Page (p.) p. 49 - 76

² P. 1 - 6 and attachments p. 7 - 76

In rebuttal of Riverside's refusal to meet his claim, he submitted:

'Executive Summary - Case No. ASF 057/2026

To the Office of the Arbiter for Financial Services,

This case concerns the rejection of an insurance claim by Riverside and the classification of the policyholder's conduct as fraudulent, based solely on the submission of a claim to another insurance provider.

The central issue is whether such conduct can reasonably be considered fraudulent in the absence of any evidence of intent to deceive or to obtain an unjustified financial benefit.

The facts demonstrate that the policyholder did not receive clear insurance documentation at the time of purchase, and relied on a system-generated message from the insurer indicating that the claim was invalid and that the loss fell outside the policy period. This reasonably led the policyholder to believe that coverage was not in force and to seek assistance from an alternative insurer.

Furthermore, no proper investigation was carried out by the insurer, no clarification was requested from the policyholder prior to the fraud allegation, and there is no evidence that any compensation was received or that any attempt was made to obtain double recovery.

Accordingly, the decision to reject the claim and to classify the conduct as fraudulent appears to be based on assumptions rather than substantiated evidence, and raises concerns regarding the fairness and objectivity of the claims assessment process.

In light of the above, it is respectfully requested that the Office of the Arbiter for Financial Services reassess the case and determine the validity of the insurer's decision in accordance with the facts and available evidence.

Detailed Statement with Chronological Timeline - Case No. ASF 057/2026

I hereby submit a detailed and structured account of the chronological sequence of events, in response to the position taken by Riverside regarding the allegation of fraudulent conduct against me. I categorically reject this allegation, as it is unsupported by any substantive evidence.

First: Purchase of Riverside Policy (09/10/2025)

On 09/10/2025 at approximately 17:42, a request was made to purchase an insurance policy from Riverside (Attachment No. 1).

At that time, I did not receive any clear insurance documentation or Insurance Product Information Document (IPID) that could be relied upon to confirm that coverage had become active. While the company relies on the fact that I logged into the online portal, mere login does not constitute proof that I reviewed the policy, understood its contents, or confirmed that coverage was in force.

Furthermore, the company's online portal does not present the policy documentation in a clear or accessible manner. Instead, it requires navigation through multiple pages and platforms, making it practically difficult to locate or verify the existence and status of the policy. To the best of my recollection, I was unable to complete this process or access any clear document confirming coverage, and therefore exited the portal without obtaining any definitive confirmation.

Accordingly, the conclusion that I had full knowledge of an active policy is unsupported by any evidence.

In this context, I formally request that the company provide clear technical evidence demonstrating that the insurance documents were not only sent but effectively delivered to my email in box in a clear and accessible format. A mere system-generated assertion of dispatch does not constitute proof of receipt or awareness of the policy contents.

Second: Purchase of Cover4Rentals Policy

On the same day, at approximately 17:50, and due to the lack of clarity regarding the first policy, the absence of any documentation received by email, and the fact that no payment had been deducted from my card at that time, I proceeded to purchase an alternative insurance policy from Cover4Rentals.

This policy was immediately confirmed via email, with all relevant documentation provided, and payment was successfully processed (Attachment No. 2: Policy Confirmation Email).

My sole intention was to ensure that valid and confirmed coverage was in place, and not to obtain duplicate coverage for the purpose of unjust enrichment.

Third: Occurrence of the Incident (11/10/2025)

The incident occurred on 11/10/2025 during the rental period, which falls within the coverage period of the Riverside policy. This is supported by the attached documentation, including the incident report with the vehicle owner (Attachment No. 3).

I expressly reject any assumptions made by the insurer regarding the circumstances of the incident.

Fourth: System Message Upon Attempt to Submit Claim (06/11/2025)

On 06/11/2025 at approximately 17:02, I attempted to inquire about the status of the Riverside policy in order to confirm whether coverage was active.

During this process, I was redirected to the Orchard Administration platform, which required repeated navigation across multiple pages and repeated data entry. The system also required frequent refreshing and re-submission, making the process complex and unclear.

When attempting to submit the claim, I received a clear system message stating that the claim was invalid, that the loss did not fall within the policy period, and that the claim could not be processed (Attachment No. 4: System Message).

This message was explicit and unambiguous, and led me to reasonably believe that the Riverside policy was not active or that the claim was not valid. As a result, I was unable to proceed further through that platform.

Fifth: Submission of Claim to Cover4Rentals

Based on the message generated by Riverside's own system, I proceeded on the same day at approximately 17:30 to submit a claim to Cover4Rentals via email, where the process was straightforward and clear (Attachment No. 5: Email confirming receipt and processing of the claim).

Sixth: Good Faith Inquiry

Five days later, on 10 November 2025, I received a communication from Riverside via Orchard Administration requesting additional information regarding the claim (Attachment No. 6).

At that point, I logged in again and submitted a clear and direct inquiry:

"Am I actually insured, and has a claim been formally registered under my name?"

This question is documented (Attachment No. 7) and demonstrates that I was actively seeking clarification of my insurance status, rather than attempting to conceal any information.

However, instead of responding to this inquiry, my claim was immediately rejected and I was accused of fraud, without any explanation, without any request for clarification, and without any verification of the facts or of whether any compensation had been received (Attachment No. 8).

This sequence of events clearly indicates that the decision was made without conducting an adequate investigation or providing me with a fair opportunity to clarify my position.

Seventh: Absence of Inquiry by the Company

Despite relying on the existence of another insurance policy as the basis for the allegation, Riverside:

- *Did not ask me at any stage whether I held another policy*
- *Did not provide me with any opportunity to disclose or clarify*
- *Did not raise any direct question prior to making the allegation of fraud.*

This raises a fundamental question:

How can my conduct be classified as fraudulent without any prior inquiry into whether another policy existed?

Eighth: Allegation of Non-Disclosure

The company alleges that I failed to disclose the existence of another policy. However:

- *I was never asked to provide such disclosure*
- *There is no documented evidence that I deliberately concealed this information*
- *I proactively contacted the company and requested clarification of my insurance status in a clear and direct manner*

Accordingly, this cannot reasonably be interpreted as evidence of fraudulent intent.

Ninth: Allegation of Fraud

The company relies on the existence of two policies and the submission of two claims. However:

- *I did not receive any compensation from any party*
- *No financial gain or double recovery occurred*
- *There is no evidence of intent to obtain double compensation.*

Furthermore, my conduct, particularly my direct inquiries, demonstrates good faith and a genuine effort to clarify the insurance position.

Tenth: Vehicle Value

The company has further attempted to support its position by asserting that the vehicle value exceeds €120,000, without providing any formal evidence to substantiate this claim.

This assertion appears speculative and unsupported by documentation.

Conclusion

There was no fraudulent intent on my part.

No compensation was received from any insurer.

My actions were based on a clear system message indicating that the claim was invalid.

I was never asked about the existence of another policy prior to being accused of fraud.

The claim was rejected based on assumptions rather than evidence.

In light of the above, I respectfully request that your Office reassess this case objectively and determine the validity of the insurer's decision to reject the claim and to classify my conduct as fraudulent in the absence of sufficient evidence.

Yours faithfully,

DG

Hage 18 March 2026'.³

Reply of the Service Provider

Having seen the reply⁴ by the Service Provider, where they state:

'[The Complainant] purchased an excess reimbursement policy to cover the excess he would be liable to pay under the rental company's collision damage waiver in the event of damage to or theft of a hire vehicle.

[the Complainant] submitted a claim for €5,000 as a result of charges paid to the rental company after damage to a hire car. Our claim handlers are required to review documents to substantiate all claims, as part of their internal checks they found that [the Complainant] had also submitted an identical claim with another insurer, Cover4Rentals which is a trading name for Eversure.

Hire car excess reimbursement insurance by its nature is susceptible to certain types of fraud because it reimburses the policyholder a fixed excess amount rather than covering the repair costs directly.

A common fraud scenario involves a policyholder purchasing multiple excess reimbursement policies for the same rental period. The individual then deliberately causes minor damage to the vehicle, pays the excess charged by the hire company, and submits claims to each insurer for the full excess amount. By recovering the same excess multiple times, the policyholder profits from the incident.

³ P. 126 - 131

⁴ P. 80 – 82 with attachments p. 83 - 124

Typical warning signs include customers holding more than one excess reimbursement policy for the same hire, and claims involving minor, low-impact damage with no third-party involvement. The damage is often the fault of the driver, such as reversing into a bollard or scraping the vehicle while parking rather than accidental collisions beyond the driver's control.

[The Complainant]'s incident fits within this type of fraud as he had at least two policies covering the same hire, and the damage was caused by him while he parked the vehicle and struck a metal post which he did not see and the parking sensors on the car apparently failed to detect. [The Complainant] was advised that this constitutes fraudulent and dishonest activity and as such the claim was declined.

[The Complainant] then confirmed that he did have another policy in place with another insurer and did make a claim with them, although they have since declined that claim due to the value of the vehicle. [The Complainant] alleged it was a misunderstanding, that he was unaware the policy was active, bought alternative cover elsewhere, and filed a claim there due to our team's messaging.

This explanation from [the Complainant] does not make sense when considering the timeline.

- *9 October 2025 at 15:50 (17:50 CEST) - [the Complainant] purchased an excess reimbursement policy with Eversure.*
- *9 October 2025 at 16:17 – [the Complainant] started the quote for his Riverside Malta policy online.*
- *9 October 2025 at 16:41 - The payment was debited from [the Complainant]'s Mastercard.*
- *9 October 2025 at 16:42 - The purchase confirmation was sent to xxxxxxxxxxxx@gmail.com*
- *9 October 2025 at 16:44 - [the Complainant] then logged into his customer portal where he would have seen the policy was active, his policy documents could be accessed here.*

This indicates that [the Complainant] was aware he had more than one live policy.

I think it would be reasonable to expect [the Complainant] to have contacted us if he were concerned that the payment hadn't gone through or if he had any other reason to believe there was an issue with the policy, but [the Complainant] did not contact us.

Prior to submitting his claim, [the Complainant] accessed his customer portal again on 4 November 2025 at 14:13 and viewed his certificate, this can be seen in the screenshots of our system provided.

[The Complainant] completed his claim submission for €5,000 with our claim handlers Orchard Administration on 6 November 2025 at 17:02. [the Complainant] had initially input the date of loss (the date the damage occurred) as 5 July. As his policy covered the period 11 October 2025 – 13 October 2025, the system automatically generated a message to advise "The loss did not occur during the policy period." [The Complainant] responded within three minutes to state that the incident had occurred on 11 October 2025, this was then corrected and that date was of course within the policy period.

The claim handlers responded to [the Complainant] within one working day and requested some further information to assess his claim, as the date had been corrected this was not mentioned again. By this time [the Complainant] had already submitted a claim for €5,000 with Eversure, they have confirmed this was submitted on 6 November 2026 at 17:30.

When his claim had been declined [the Complainant] initially stated that he only submitted the second claim with Eversure "solely because [the] system told me my claim was invalid."

[The Complainant] maintained that he was unsure whether his Riverside policy was valid because he was confused by the claim messaging, and that his second claim to Eversure was "a direct consequence" of the claim messaging.

Considering the above, we do not accept that the claim messaging is what led to [the Complainant] having purchased and claimed against two policies. The timeline shows that this explanation simply does not make sense given that [the Complainant] bought two policies with Riverside and Eversure on 9 October 2025 prior to submitting a claim and receiving any communication from the claim

team, and submitted both claims on 6 November 2025, immediately one after the other.

[The Complainant] later told the claim handlers he was unaware of having been insured under more than one policy and that he believed his claim should be covered following the process of “dual insurance.” As above, [the Complainant] purchased both the Eversure policy and Riverside Malta policy within hours of each other, and submitted the claims within 30 minutes of each other, so we think it unlikely that [the Complainant] was unaware of either policy.

Page 11 of the policy booklet outlines the general conditions of the policy and states “Where there is Dual Insurance, please let Us know, so that We can pay (“contribute”) Our proportion of the claim.” [The Complainant] did not make the claim handlers aware of another policy or claim, nor did he make a claim for a proportional amount. He submitted a claim for the full costs of €5,000 with both Orchard Administration and with Eversure’s claim team.

From looking at the timeline of events and [the Complainant’s] conflicting reasons for having submitted more than one claim, we are satisfied that [the Complainant] purposefully and knowingly purchased (at least) one other excess reimbursement policy and then submitted claims for both policies with the intention of receiving the reimbursement of €5,000 from each policy, therefore, making a financial gain of (at least) €5,000. As such, page 10 which outlines the general exclusions to the policy:

“The following exclusions apply across Your whole insurance policy. We will not pay any claim, or be liable for, any of the following:

- 14. Resulting from fraudulent, dishonest, illegal activities or a criminal act committed by You.”*

We would also add that if we had not declined [the Complainant’s] claim on the grounds of fraud, it would likely remain a decline due to the value of the rented vehicle. As the claim was declined due to fraud, no further investigation was carried out, however, the claim handlers can see from the information they have that vehicles of that make and model are likely valued at over €120,000. The policy booklet confirms on page 4 the eligibility for this policy:

“Eligibility

When You applied for this insurance, We asked You to confirm that You were eligible for cover. The eligibility requirements are as follows:

3. The Rented Vehicle has a maximum recommended retail price of €120,000 at the Rental Agreement’s Start Date and is a maximum of twenty (20) years old since the date of first registration.”

As such, if the vehicle is outside of the eligibility criteria, we would also decline the claim based on the vehicle which is the same reason Eversure declined [the Complainant’s) claim.

We have attached all correspondence and documents that we believe are relevant to this complaint. However, should you require any further information from us, please do not hesitate in contacting the undersigned.⁵

Hearings

The first hearing scheduled for 20 March 2026 had to be postponed due to late submission from the Complainant.

At the second hearing held on 16 April 2026, the Service Provider decided to skip cross-examining the Complainant’s submissions, and presented their own evidence through George Said who said:

‘In the Executive Summary, [the Complainant] alleges that he did not receive clear insurance documentation at the time of purchase. We have documentary and system-generated proof that the purchase confirmation was sent to his e-mail address, xxxxxxxx@gmail.com on the 9th of October 2025 at 16:42 hours. [the Complainant] then logged into his customer portal where he would have seen the policy and that it was active. He could have seen his policy documentation, including the certificate wording, and the IPID, and all this could be accessed over there.

He also states that we relied on a system-generated message from us indicating that the claim was invalid. Now, really and truly, what [the

⁵ P. 80 - 82

Complainant] is referring to here is an automatic message from the claim system because he inputted the date of the accident as the 5th of July, whereas the incident had actually occurred on the 11th of October of 2025. So, when he put in the wrong accident date as the 5th of July, it was not within the policy period between the 11th and the 13th of October. And the system, of course, automatically told him, 'Sorry, the loss did not occur during the policy period'.

In this case, [the Complainant] responded and he corrected the date he had inputted originally, and he inputted that the accident occurred on the 11th of October 2025. When this was corrected - and this was now within the policy period - things could be processed. The point to make here is that [the Complainant] submitted his claim and received this message on the 6th of November. So, this does not explain why he had already purchased multiple policies on the 9th of October. And that is almost a month before.

Next, I will counter [the Complainant]'s claim that no proper investigation was carried out by the insurer. All we can say is that Orchard Administration Limited, which is the company to which the Claim Handling is outsourced by Riverside Insurance Agency Malta Limited, have actually followed an internal fraud process. The investigation involves contacting a network of other insurers of the same class and category of business in order to check for duplicate policies.

Eversure, Cover4Rentals, replied to advise that [the Complainant] had purchased a policy with them and had also already attempted to claim with them. So, we did not get this out of the clouds. We did our own checks and one of the competitors confirmed that [the Complainant] had actually purchased another policy and had also attempted to make a claim for the full amount of €5,000.

[The Complainant] says that there is no evidence that any compensation was received and that there was an attempt to make a double recovery. Well, the fact that [the Complainant] has not received a settlement from either us or Eversure does not change our findings meaning that there was an attempt to get double indemnity. The fact that he was unsuccessful does not negate his intention to get double indemnity. He submitted a claim for €5,000 with us and also submitted a claim for €5,000 with Eversure, both on the 6th of November 2025, one immediately after the other, which shows that he attempted to make a recovery on both.

My last point on the Executive Summary is that these are assumptions rather than substantiated evidence. We have submitted to the Arbiter the evidence we have relied on. The decision to decline is based on a review of our system, the way the events occurred one after the other, the timeline and confirmation from another company that excess reimbursement was purchased from them and was attempted to be claimed from them.

I now turn to the first point where he states that he did not receive any clear insurance documentation or policy product information document.

I say that our system shows that this is completely untrue, and that he immediately received a confirmation of purchase. Also, he could have viewed the full policy documentation from the system. And, of course, this is a system which has gone through internal controls in order to ensure that it is clear, very customer friendly, and such proof, such compliance, such tests, have come from internal people, compliance officers, and also the MFSA itself.

I am rebutting the allegation that [the Complainant] did not review his policy documentation and he could not understand the contents or confirm that cover was in force. The fact that he got the policies is confirmation that cover is in force. And, in spite of all the trouble we go to in order to make sure that the policy is legible, graphically well presented, this does not take away the responsibility from [the Complainant] to he himself check that the policy which he has bought is the policy which he needs and that he has understood. And if he had not understood any point, then he should have made contact by e-mail, by web chat, by phone with our advisors who are always there to clear matters with the clients.

Mr. Arbiter, I think it is pertinent to note - as this is being projected that we are presenting something which the client does not understand, that we are intentionally cheating our client when this is, of course, not the case - that we take big pride in our Trust Pilot rating of 4.8 which is proof of people who praise not just the policy presentation, not just the cover, not just the service, but also the handling of the claims.

At the start of the second point, he states that no payment had been deducted from his card at the time of purchase. We have documentary proof that this is untrue and that the premium of €17.28 cents was debited from [the

Complainant's MasterCard at the time of the purchase. And this is confirmed on our payment system. Such proof can be provided to the Arbiter.

[The Complainant] claims in point two, that he required repeated navigation across multiple pages and repeated data entry making the process unclear and complex. I have already pointed this out in my previous submission that he could always have gone to our customer service guys to clear any misunderstanding or lack of understanding if he was experiencing difficulty.

[The Complainant] says that the message he got was explicit and unambiguous and led him to reasonably believe that Riverside policy was not active or that the claim was not valid. And that as a result, he was unable to proceed through his platform. My reply to that point is that the message was given because [the Complainant] had input in the wrong date of accident and, thus, he could not proceed through the platform.

In the fifth point, [the Complainant] says that:

"Based on the message generated by Riverside's own system, I proceeded on the same day at approximately 17:30 to submit a claim to Cover4Rentals via e-mail."

This message was generated to [the Complainant] due to his mistake in entering the wrong date, which he knew about and which he corrected straight away. He did not wait for any answer from our claims handler for this before submitting another claim to Eversure. He did this right away. This is evidence that [the Complainant] knew he had a policy in place with Riverside Malta, and it does not make any sense that he would attempt to make a claim on a policy he believed was never there. You make a claim if you believe that the policy is in force. If you believe the policy is not in force, then you do not make a claim.

In point 6, [the Complainant] says that his claim was immediately rejected and that he was accused of fraud without any explanation and without request for clarification or without any verification of the facts. And, as to whether he had actually received any compensation or not.

Clarification was not actually sought from [the Complainant] because it was not necessary, because the investigation had already taken place. And we had already been in communication with Eversure who confirmed that he had bought a policy and he had made a claim. [the Complainant] was not asked whether compensation was received as this was not relevant because, as

previously stated, the fact that he was not successful with either of his claims does not contradict or go against his malicious intent to claim from two policies.

The basis of what we have been through is that there has been definite proof that two policies were issued, two claims were made. And he was duly debited from his card. So, we do have proof to that effect. So, once we had conducted our thorough investigation, then we could not go into the merits of any other thing because really and truly, we even did not go into the merits of the value of the vehicle which, of course, goes beyond what our policy limit would cover, meaning our policy does not apply over €120,000?

So, we have proof from the portal of Comparis (a Swiss independent online comparison service which gives, amongst others, comparisons for cars), which places an identical vehicle at CHF180,000 or CHF190,000, we have two proofs which basically take the value of the second-hand vehicle at over EUR185,000 and in the second instance over EUR200,000.

[The Complainant] also said he does not have responsibility as we never asked him if he had another policy in force. [The Complainant] has a basic insurance requirement of duty of disclosure. It is not standard practice to ask for dual insurance in the initial journey of the quote. However, it is [the Complainant]'s responsibility to disclose this material fact to the insurance that he had another policy in force, and he also failed to do this at claim stage.⁶

The Complainant had no cross-examination questions on the evidence of Riverside.

The Arbiter requested Riverside to submit documentary evidence to support their verbal submissions and especially on the value of the rented car which is reported to exceed the €120,000 policy limit.⁷

The Arbiter,

having seen the statements made and evidence given by the Complainant;

having seen the statements made and evidence given by the Service Provider;

⁶ P. 143 - 147

⁷ P.148 - 155

Considers

Whether Riverside provided solid evidence to justify their refusal to meet the Complainant's claim, being the core subject matter of this Complaint.

Decision

The Arbiter is bound to adjudicate, in terms of Article 19(3)(b) of Chapter 555 of the Laws of Malta, by reference to what, in his opinion, is fair, equitable, and reasonable in the particular circumstances and substantive merits of the case.

The Arbiter hereby decides that the Complainant's explanations for issuing a double policy and making a double claim for the same incident lack credibility.

The Arbiter is morally convinced that the Service Provider has good reasons to refuse the claim on the basis of facts which give rise to strong suspicions that the claim was not being made in good faith and is in breach of exclusion 14 in Section 4 of the policy⁸.

Furthermore, the evidence⁹ submitted by the Service Provider that the rented vehicle had a commercial value exceeding the policy limit of €120,000 and was, therefore, excluded from eligibility for policy cover¹⁰ originates from a reliable independent source.

The Complaint is hereby dismissed, and parties are to carry their respective costs of the proceedings.

Alfred Mifsud
Arbiter for Financial Services

⁸ P. 113

⁹ P. 154 - 155

¹⁰ P.107 – Eligibility: point 3

Information Note related to the Arbiter's decision

Right of Appeal

The Arbiter's Decision is legally binding on the parties, subject only to the right of an appeal regulated by article 27 of the Arbiter for Financial Services Act (Cap. 555) ('the Act') to the Court of Appeal (Inferior Jurisdiction), not later than twenty (20) days from the date of notification of the Decision or, in the event of a request for clarification or correction of the Decision requested in terms of article 26(4) of the Act, from the date of notification of such interpretation or clarification or correction as provided for under article 27(3) of the Act.

Any requests for clarification of the award or requests to correct any errors in computation or clerical or typographical or similar errors requested in terms of article 26(4) of the Act, are to be filed with the Arbiter, with a copy to the other party, within fifteen (15) days from notification of the Decision in terms of the said article.

In accordance with established practice, the Arbiter's Decision will be uploaded on the OAFS website. Personal details of the Complainant(s) will be anonymised in terms of article 11(1)(f) of the Act.