Before the Arbiter for Financial Services

Case ASF 109/2026

OG

('Complainant')

vs

RCI Insurance Limited

(C 45786) ('Service Provider')

Sitting of 12 November 2026

The Arbiter,

Having seen the complaint[1] of 9 April 2026, whereby the Complainant seeks compensation amounting to **€3,417.75,** in respect of a refund of lease instalments that should have been covered by the Temporary Total Disability clause in a Payment Protection Insurance Policy, which amount includes compensation for financial and administrative prejudice caused and 8 % interest on the capital sum due.

The complainant claims that on 3 October 2024, he was placed on medical leave due to a deterioration of his health condition. This situation ultimately led to his dismissal for total medical unfitness on 2 October 2025, following an official decision issued by the Occupational Health Service.

Following the onset of his incapacity, he requested the activation of the Total Temporary Disability (TTD/ITT) benefit under the Payment Protection Insurance offered in France and attached to his vehicle lease agreements (FR22054167V and FR25254086V). In support of his request, he provided the available

[1] Pages (P.) 1 – 9 and attachments p. 10 - 323

administrative and medical documents, including social security certificates and the official notice of unfitness issued by the occupational health service. The Service Provider conditioned the payment of benefits on the transmission of additional medical information concerning his diagnosis. He provided the documents in his possession without restriction. However, he claims that no additional medical reports exist, as no hospitalisation or specialised examinations were carried out that could produce further documentation. In response to his requests, the medical service mainly referred to standard contractual exclusion clauses without addressing the official medical evidence confirming his professional incapacity.

The Complainant explains that, in May 2025, there was a transition between two vehicle lease contracts. However, this did not create a new insured risk and corresponded to the continuation of the same contractual relationship within the same financial group and insurance framework. He observes that, before submitting this complaint, he contacted mediation bodies in France following guidance received from the Service Provider representatives in France, but these organisations confirmed that they were not competent to handle the dispute because the Service Provider is established under Maltese law.

He continues to note that the Service Provider has failed to handle his claim in a fair and transparent manner for several reasons. These are namely the following:

(i) refusal to honour a valid insurance claim: his Total Temporary Disability (TTD / ITT) began on 3 October 2024. He submitted official documents confirming his incapacity, including social security certificates and the formal notice of medical unfitness issued by the Occupational Health Service on 2 October 2025. Despite these documents, the insurer has refused payment and has relied mainly on standard exclusion clauses without addressing the official evidence of my incapacity;

(ii) contract transition used to deny coverage: in May 2025, while he was already on long-term medical leave, the Service Provider encouraged him to terminate his existing lease contract and replace it with a new one in relation to a vehicle with similar characteristics. He was not warned that this administrative change could later be used to challenge his ongoing insurance rights by

presenting his disability as a "*pre-existing condition*" in relation to the new contract;

(iii) lack of transparency and repeated delays: for more than a year, the claim was not resolved. His requests for a clear explanation of the calculation of the benefits and for a detailed response regarding the coverage remained unanswered. Most responses received consisted of generic references to contractual clauses rather than a clear explanation of the decision applied to his specific situation;

(iv) difficulty accessing mediation: following guidance from Mobilize customer services (the Service Provider's intermediary in France), he attempted to seek mediation in France. However, the competent mediation bodies declared themselves not competent because the insurer is established under Maltese law.

Consequently, he was left without an effective local dispute resolution mechanism and had to submit his complaint before this Office.

Reply of Service Provider

The **Service Provider replied**[2] **on 4 May 2026** stating:

"*We refer to the complaint transmitted to RCI Insurance Ltd ("RCI") by the Office of the Arbiter for Financial Services concerning the activation of the Temporary Total Disability ("TTD") benefit under the Payment Protection Insurance offered in France ("DIPE") in relation to an event declared as occurring on 3 October 2024.*

The complainant refers to two financing/lease contracts (FR22054167V and FR25254086V). The insured event relied upon is dated 3 October 2024. On that basis, the TTD request can only be assessed under the contract in force at that date, i.e. FR22054167V.

Contract FR25254086V post-dates the event relied upon and constitutes a separate contract with its own effective date. A TTD claim cannot be accepted for an event occurring prior to its inception.

[2] P. 326 - 328

Under the DIPE Terms and Conditions applicable to FR22054167V (included in the complaint file, DIPE Terms and Conditions, section II "Definitions"), TTD is a state recognised by the insurer on medical advice, following accident or illness medically established and covered by the contract, where the insured's incapacity exceeds 66% and prevents the insured from performing any professional activity or any other income-generating occupation.

The same Terms and Conditions confirm that the 66% threshold is assessed by medical expertise using the contractual medical assessment scale combining professional and functional incapacity (DIPE Terms and Conditions, section V "Scope of Guarantees" - Disability Insurance).

The DIPE Terms and Conditions provide that benefits become payable from the 121st calendar day of total and uninterrupted work stoppage (i.e. a 120-day waiting period), running from day 1 of the work stoppage (DIPE Terms and Conditions, section V "Scope of Guarantees" – Disability Insurance").

The DIPE Terms and Conditions list the documents required for TTD claims, including:

– a medical certificate specifying the nature of the illness,

– the work stoppage declaration,

– Social Security statements,

– notification of incapacity/invalidity pension (where applicable), and

– statements evidencing payment of relevant allowances/benefits,

(all as set out in the DIPE Terms and Conditions, section V "Scope of Guarantees" – Disability Insurance"). Furthermore, the Terms and Conditions also provide that, in all cases, the insurer may request additional supporting documents and may require any expertise or examination deemed necessary; the insured must provide these and/or submit to such assessment in order to preserve entitlement. Medical documents may be transmitted under confidential cover to the medical adviser of the claims handler (DIAC acting as RCI Insurance Third Party Administrator) and/or to the medical expert designated by the insurer, in accordance with the contractual process described in the Terms and Conditions. Accordingly, medical confidentiality is safeguarded within the contractual

process and the insurer's requests are designed to be fulfilled via a confidential medical route.

As reflected in the correspondence included in the complaint bundle (letter dated 20 November 2025), the complainant was informed that, in order to assess the TTD request, it is necessary to receive the documentation completed by the attending physician and that, without those elements, the assessment cannot be progressed.

In the absence of the contractually required medical evidence (and/or the insured's submission to any medical review requested under the policy), RCI Insurance cannot complete the contractual TTD assessment and therefore cannot confirm entitlement or quantify any benefit payable.

We acknowledge the occupational health documentation referenced by the complainant. However, under the DIPE policy, TTD must be assessed against the contractual definition and recognised by the insurer on medical advice, including the incapacity threshold exceeding 66% as assessed by expertise. Occupational health "unfitness" does not, by itself, satisfy the policy test or replace the contractually required medical documentation.

The complainant also raises points regarding direct debits/instalments and billing. These operational matters are handled by Mobilize Financial Services/DIAC and are separate from the insurer's coverage assessment.

RCI Insurance remains willing to progress and conclude the TTD assessment promptly if the complainant provides the required medical documentation via the confidential medical route specified in the DIPE Terms and Conditions (including documentation completed by the attending physician and any other contractually required supporting evidence). Upon receipt, RCI Insurance will be able to complete the medical assessment in accordance with the policy definition and the policy terms (including any applicable conditions, limitations and exclusions) and issue a reasoned final position with reference to the policy wording and the medical assessment.

In parallel, a separate communication will be sent directly to the complainant summarising the above position and reiterating the confidential medical

submission route, so that he is clearly informed of the steps required to allow the contractual assessment to be completed."

Hearing

At the **hearing held on 29 September 2026**[3], appeared the Complainant unassisted and for the Service Provider appeared Dr Annalisa Debono and Ms Melanie Kervaut.

The Complainant confirmed on oath the contents of his complaint and solemnly declared:

"***I am here because my insurance, RCI or DIAC bank, has refused to pay a single euro of my sick leave benefits. Eventually, I became completely disabled. My doctor put me on total sick leave on October 3rd in 2024. I remained employed under my work contract, but I could not work due to my health.***

To show my complete good faith, I kept paying all my monthly car payments out of my own pocket for nearly a year. It was only in September 2025, when my savings ran out, that I actually opened my insurance claim. And yet RCI or DIAC paid no fee.

In May 2025, I swapped my leased car for a new one with the same dealer, DIAC, under my same customer ID. My illness never stopped. For the French insurance law, changing the car does not concern an ongoing health claim so RCI claim the new contract is separate, but they actually approved my jobless insurance on this exact new car in 2026. On top of that, DIAC Bank reports zero debt balance to the Bank of France on September 15 of 2026.

So, I want to emphasise that I am not asking for an astronomical amount. I am simply asking for the exact unpaid monthly lease. They are paying only for my sick leave. This anti-procedure has already taken more than one year to reach your Office. It has caused me financial harm, bank fees and stress. All I am asking today is for a fair resolution and what is rightfully owed to me*".*

When requested by the Arbiter to confirm whether the issue related to instalments from June to January, or rather from June to October (5 months) and

[3] P. 330 - 337

that the rate went up from €210 to €333, the Complainant confirmed that this was correct.

When queried by the Arbiter as to why since he was in an unpleasant situation, he nonetheless changed the contract to a higher amount, the Complainant observed that he did not change for a higher amount and continued to explain:

"***I just reviewed to continue to have a car, and the new car has a new amount. When I was sick, I could pay that but not in the last ten or more months. I changed the car because I needed a car to continue my life and to travel. I was told that it was normal to have an increase because the price and the life had been updated, and it's more and that I have more option of it and I can change, I can continue to have the car without accepting the new option****".*

When asked by the Arbiter whether he could continue paying the same amount as with the old car, he replied that he could not pay for the rest of the car under the first contract. He noted that he was given a new car. He could pay the option for this car because his salary could afford it, but his sickness continued for about one year and the more he remained sick, the less money he had.

Upon a request by the Arbiter for an explanation of the roles of the various parties involved in this case, namely, DIAC, Mobilize Financial Services and the Service Provider itself, Ms Kervaut explained:

"***Essentially, I say that we are part of the Renault Group. So RCI Insurance provides insurance for cars which are sold through the Renault Group. DIAC is the bank in France which is our intermediary. We are the insurers based in Malta and we provide services under freedom of services to various countries including France as in this case.***

DIAC is our intermediary in France; they provide finance contracts and also distribute our insurance products. Apart from that relationship, in return, DIAC have a relationship with ancillary insurance intermediaries who are the dealers in the country. So, the client would go to a dealer, a car dealer, part of the Renault Group network. They would be able to buy or lease a car from the dealer, and the dealer can offer our insurance, like the one bought by the Complainant, **together** ***with the finance product which would cover the***

financial package of the car. So, the client can buy the whole package; the client can buy the car, they can finance it and they will be also offered insurance.

Mobilize Financial Services is our brand name; DIAC operates as Mobilize Financial Services in France. So, DIAC and Mobilize Financial Services are the same. One is the company; one is the trade name*".*

Ms Kervaut further explained that*:*

"You would have the option to buy or lease. And if you're buying, you can buy in instalments, which would be a financial offer to the bank as well and the bank can offer to cover that loan through insurance as well. We are the underwriters and risk carriers of that insurance".

Upon cross-examination, the Complainant confirmed that, he had a lease contract which expired and that he had two options: to buy the car, which was not the option that he chose or to take out a new lease agreement for a new vehicle, which is why he ended up having two contracts. He returned the car to receive the new car and there is another insurance of the Service Provider, Sigma which continues to take money for the first contract when he had already returned the first vehicle.

When asked by the Arbiter whether there was a new insurance contract with the Service Provider when he changed the vehicle, the Complainant affirmed that it was the same policy but with more options. He maintained that he cannot cancel the contract because it is the only way to continue having the same contract and the same car as the first one.

Upon reference by the Arbiter to Ms Kervaut's statement where she refers to two contracts and whether the second contract is subject to a separate policy with the Service Provider, Ms. Kervaut replied:

"***In the second contract, there are two signatures. Each contract was signed by the Complainant, and they have their own policy terms. And each contract from a financial or an insurance point of view has its differences, I will say, terms and conditions. He signed two contracts, one in 2023, if I remember correctly, and one in 2025. This is why also the instalments are different. I am referring to what I said in my reply: 'We are only responsible for this first contract. So, we're not responsible for the second car****."*

Ms Kervaut confirmed the understanding of the Arbiter that the Service Provider claims it is only responsible for the first cover, which was cancelled in May and not for the second cover since the event had happened before.

The Arbiter queried whether the Complainant understands that the issue is as follows: he had a policy cover for his illness, and if he provides the Service Provider the right documentation, they were prepared to consider his claim. However, in any event, his claim arrives up to May 2025 because that was when the contract ended. If the Complainant signed a new contract, which was after May 2025, the Service Provider claimed that they will not pay the Complainant under the new contract because the event had already happened before the new contract was signed and any insurance will only pay for events which happen after the contract is signed.

The Complainant affirmed that:

"***I understand their part, but when I look into the French law, it does not permit the insurance to cut or do anything against me because my illness permits me to continue to pay".***

When requested by the Arbiter to explain to the Complainant which documents are required from him so that they can at least consider that part of the claim for which he might be covered, Ms. Kervaut replied:

"***Basically, we are asking OG to do a gesture on his favour; we compromise on the medical certificate given the illness, the root cause of the temporary disability, and we provided him with a questionnaire where a GP could just answer by 'Yes' or 'No', giving us a view on whether he was fitting into any of our exclusions. Following that, we had taken a decision that his claim was valid based on the declaration of his doctor, and this was given to our legal department to answer his complaint***".

The Service Provider representative claimed that they accepted the Complainant's request to repay his instalment after the excess period, which she believed was 120 days, had passed under the first contract which is the first leasing. She proceeded to confirm that this related to the Complainant's reference to five instalments, from January to May, of which the Service Provider agreed to pay three full instalments and a part and further observed:

"***The excess period stopped on the 31st of January 2025, and his (the Complainant's) contract stopped on the 9th of May 2025. So, in total he has three full instalments to be repaid of €210 and another period due to the daily indemnity of €70. ... As we are paying pro rata, after his excess period, he has 10 days to be repaid as well out of the other instalments where the months were full***".

On a concluding note, the Complainant emphasised that "***under French insurance law, which governs my policy, my disability claims start on October 3rd, 2024, swapping my leasing car in May 2025 with the same financing company does not normally cancel an ongoing health claim. Normally RCI, DIAC or Sigma, they have a lot of names, are legally bound to cover my entire sick leave up to the 18-month limit*".**

Consideration and analysis

The Arbiter,

Having seen the statements made and evidence given by the Complainant,

Having seen the reply and evidence of the Service Provider and further submissions made by both Parties,

Considers

The case concerns two payment protection insurance contracts (PPI) namely Policy No. FR22054167V (inception date of 10 September 2022 and an expiry date of 9 May 2025) and FR25254086V (inception date 2nd May 2025 and an expiry date 29 May 2029). This insurance product is designed to provide financial protection to customers who enter into a motor vehicle financing or leasing agreement.

In the event of death, disability arising from illness or accident resulting in a cessation of work, or unemployment, the policy is intended to cover the insured's repayment obligations arising under the associated financing or leasing agreement. When a customer purchases or leases a vehicle through an authorised dealer, the insurance product is offered at the point of sale.

The point of contention between the Parties revolves around whether the Temporary Total Disability (TTD) benefit being claimed by the Complainant can

be claimed under only one or both contracts. Whereas the Complainant claims that even though there were two contracts the contractual and customer relationship between the Parties is to be considered as a continuous one and hence, allowing the TTD benefit to accrue under both contracts from the original insured event of 3 October 2024 right until August 2025, the Service Provider alleges that the claim in relation to the second contract (FR25254086V) cannot be accepted since this contract started after the date of the event.

The Service Provider confirms that it has, in the course of the proceedings relating to the claim, accepted the claim for TTD under the first contract, namely Policy No. FR22054167V and offered the Complainant the sum of EUR 700.10 in full and final settlement of the claim relating to TTD, corresponding to the eligible benefit period between: 3 October 2024 (date of commencement of incapacity); and 9 May 2025 (expiry date of the policy), following deduction of the contractual 120-day waiting period during which no benefits are payable under the policy terms and conditions.

It is noted that the existence of two separate contractual agreements has never been contested by the Parties. The insured event in question is dated 3 October 2024 whereas the claim was notified to the Service Provider's intermediary, Mobilize Financial Services, on 27 August 2025, at the time when the second contract was in force.

It is unclear whether the Complainant was requested to do a full disclosure of any risks which he was aware of as at the time when he entered into the second contract with the Service Provider. Nonetheless, it is an accepted principle of jurisprudence, that the duty of disclosure is always implied when entering into a contract of insurance[4]. This allows the insurer to assess the full risk before underwriting the insured. However, consideration of the fulfilment of the disclosure requisite or otherwise by the Complainant is irrelevant for the decision on this case.

This is so, since it cannot be contested that the first contract was terminated when a new one was entered into. Any claims being made by the Complainant

4 https://www.um.edu.mt/library/oar/bitstream/123456789/104012/1/The_insurance_utmost_good_faith_principle_the_case_of_Malta_2021.pdf

must be considered within the context of the contract which was in force at the time that the insured event occurred. Indeed, this seems to be an accepted principle even under the French Insurance Code[5] to which the Complainant refers, although the Arbiter declares he has no authority to interpret French law.

The Arbiter has to judge the complaint by reference to what is fair, equitable and reasonable in the particular circumstances and substantive merits of the case.[6]

Decision

For the reasons explained above, the Arbiter partially rejects the Complainant's claim for the amount of three thousand, four hundred and seventeen euro and seventy-five cents (€3,417.75) and upholds it for the amount of seven hundred euro and ten cents (EUR 700.10)**,** corresponding to the eligible benefit period between 3 October 2024 (date of commencement of incapacity) and 9 May 2025 (expiry date of the policy), taking into consideration the excess period stipulated by the policy.

Each party is to bear its own costs of the proceedings.

Alfred Mifsud
Arbiter for Financial Services

[5] Article 124-4 of the French Insurance Code:
https://www.legifrance.gouv.fr/codes/article_lc/LEGIARTI000006792609
[6] Article 19(3)(b) of CAP. 555 of the Laws of Malta.

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.