

ANNUAL REPORT TUARASCÁIL BHLIANTÚIL

2007



Financial Services
Ombudsman

Our Mission

To adjudicate on unresolved disputes between Complainants and Financial Service Providers in an independent and impartial manner thereby enhancing the financial services environment for all sectors.



Financial Services
Ombudsman

Annual Report | 2007

TUARASCÁIL BHLIANTÚIL

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Financial Services Ombudsman

Our role at a glance

As Financial Services Ombudsman I can investigate, in an impartial and independent manner, complaints from individual customers and small businesses who have unresolved disputes with financial service providers who are either regulated by the Financial Regulator or are subject to the terms of the Consumer Credit Act 1995.

I can award compensation of up to €250,000 where a complaint is upheld. My Decisions as Ombudsman are binding on both parties subject only to an appeal by either the complainant or the financial service provider to the High Court.

My role is therefore a quasi-judicial one and whether a complaint can be upheld or not is determined on the basis of evidence furnished, examined and reviewed.

CHAIRPERSON'S REPORT



2007 was a busy year for the Council. Much of the business of the Council related to discharging its statutory functions as prescribed by the Central Bank and Financial Services Authority of Ireland Act 2004, which are:

- (a) to prescribe guidelines under which the Ombudsman is to operate, and
- (b) to determine the levies and charges payable for the performance of services provided by the Ombudsman, and
- (c) to appoint the Ombudsman and each Deputy Ombudsman, and
- (d) to keep under review the efficiency and effectiveness of the Ombudsman's Office and to advise the Minister, either at the Minister's request or at its own initiative, on any matter relevant to the operation of the Office, and
- (e) to advise the Ombudsman on any matter on which the Ombudsman seeks advice, and
- (f) to carry out such other activities as are prescribed by Section 57 BD (1) of the Act.

The Council ensured compliance with Government policy on the pay and conditions of service of the Ombudsman, the Deputy Ombudsmen and all staff members, as well as Government guidelines on the payment of Council Members' fees and expenses. The Council also noted compliance by the Ombudsman with the Guidelines for the Appraisal and Management of Capital Expenditure Proposals.

The Council observes strict adherence to the provisions of the Standards and Ethics in Public Office legislation and has ensured, and will continue to ensure, that the appropriate Statements of Interests are made both by the Council Members and by the relevant staff of the Office of the Financial Services Ombudsman.

The Council Corporate Governance Manual, which was reviewed and updated during 2007, serves as a Code of Practice for Council Members that complies with the relevant provisions of Part VIIB of the Central Bank and Financial Services Authority of Ireland Act, 2004 (the Act), and, save for derogations approved by the Minister, with the relevant provisions of the Code of Practice for the Governance of State Bodies and the "On Board" guide. While the Code of Practice for the Governance of State Bodies makes provision for situations where parts of the Code may not be "appropriate" or "relevant" in its application to a particular

public sector body, the Council will respect and adhere to, as far as is practicable, the principles of the Code in its entirety. The requirements of the Code of Practice for the Governance of State Bodies are supplementary to, and do not affect, existing statutory requirements and other obligations imposed by the Companies Acts, the specific statutory provisions relating to the State body itself and any other relevant legislation.

While the Ombudsman is responsible for the operational aspects of the Office's finances, the Council, acting on the advice of the Minister for Finance, has overall responsibility for accounting standards and for monitoring the effectiveness thereof. The work of the Audit Committee, to assist Council and the Ombudsman in fulfilling their responsibilities relating to the financial reporting process, the internal audit process, the statutory audit process and the process for monitoring compliance with laws and regulations, is ongoing in this regard. The Internal Audit function was contracted out to a specialist firm in 2005, a risk assessment carried out and a three-year programme put in place. This process is ongoing, with all procedures for financial reporting, internal audit, procurement and asset disposal being monitored and reviewed regularly and with reports and recommendations being submitted to the Audit Committee.

A statement on the system of internal financial control, is included with the Financial Statements at page 36.

A Corporate Governance Code and a Code of Business Conduct for the Financial Services Ombudsman and Staff Members have been in place since 2005 and have been, and continue to be, adhered to by all staff members. Both of these Codes are constantly monitored and kept under review to ensure that the staff of the Office adheres to the highest standards of governance.

The Council notes and welcomes the amendments in the Markets in Financial Instruments and Miscellaneous Provisions Act 2007 which gave indemnity to Council members and where regulation was extended to retail credit firms and home reversion firms.

Council has no role regarding complaints resolution, as this is statutorily the independent function of the Financial Services Ombudsman. However, Council is impressed with the overall

throughput of the Office and acknowledges that its workload has increased considerably during the year.

The term of the current and second Council will end in October 2008. On 1 October 2004, I became the first Chairperson, and when I consider the progress made since then, I am mindful that much of what has been achieved would not have been possible but for the co-operation of my colleagues on the Council who gave unstintingly of their time and expertise to ensure that our functions were carried out in a proper, efficient and effective manner and the Secretary to the Council, Gemma Normile, who ensured that meetings and the business of the Council were conducted in a timely and proper manner and that liaisons between the Council and the Ombudsman were at all times appropriate and seamless.

I wish to take this opportunity to pay special tribute to the Tánaiste and Minister for Finance and, in particular, the staff of his Department, who have always been generous in giving of their time, support and counsel.

Finally, I wish to thank Joe Meade, Deputy Ombudsmen Caroline Gill and Gerry Murphy and all of the staff for maintaining the highest professional standards and for ensuring an effective and cost-efficient Office, with a well-earned, positive public profile after just three years in existence.



Con Power
Chairperson

Financial Services Ombudsman Council

29 February 2008

FOREWORD FROM THE FINANCIAL SERVICES OMBUDSMAN

I am pleased to present to the Financial Services Ombudsman Council my third Annual Report as Financial Services Ombudsman detailing activities for 2007. As a statutory body that came into being on 1 April 2005, I am more than satisfied that significant progress has been achieved in a relatively short period.

CONTEXT TO MY ROLE

Consumers will, and are, entitled to complain. Financial Service Providers will, and do, make mistakes. Against that background, matters that have not been resolved are referred to me. I only receive a small percentage of complaints relative to the total number of financial transactions undertaken but how these are handled by Financial Service Providers is what ultimately matters. I do not uphold every complaint as I am an independent and impartial arbiter of unresolved disputes and not a consumer champion or an advocate though my decisions do lead to improvements for consumers. I publish selected Case Studies generally every six months to enlighten everyone as to what type of cases I deal with and what lessons can be learned. Every Financial Service Provider wants satisfied customers but that may never be 100% achievable. The Government's continuing emphasis on having a well regulated financial services sector, the Financial Regulator's statutory Consumer Protection Code, increased awareness by consumers, and clearer focus by the industry on treating the customer fairly combined with my role cannot but enhance the financial services environment overall for everybody.

2007 AT A GLANCE

I regard 2007 as a year when all of the initial start-up concerns, headaches and procedures were put behind us and a most productive year followed. Of significance in 2007 was that (a) the new complaints processing system (b) the new accounting systems and (c) the overall integration of staff has ensured that the Office operates very effectively.

In short during 2007:

- 4,374 new complaints were received representing an increase of 15% over 2006
- 1,053 cases were carried forward on 1 January 2007, accordingly I had to deal with 5,427 cases during 2007
- 4,534 cases were concluded after review or investigation



- 2,690 complaints were resolved in Complainants' favour – 59%
- 10,400 phone calls were received
- 70,000 visits were made to our website
- many personal callers came to the Office for advice and guidance
- Office administration was highly effective and efficient overall
- relations and co-operation with Complainants, Financial Service Providers, Financial Regulator, Pensions Ombudsman, National Consumer Agency and other state agencies were very satisfactory.

Some 11,600 complaints have been received since we began on 1 April 2005 and at the end of 2007 only 893 complaints remained to be investigated - 700 were received during the last two months of the year. At 31 December 2007, 14 decisions of mine have been appealed to the High Court which represents just 0.17% of cases decided on by me.

Indeed following the settlement in my favour in the Irish Nationwide Building Society judicial review proceedings I understand that full refunds have now been made to all other customers following a 'look back' exercise undertaken as a result of my request and under the general superintendence of the Financial Regulator.

COMPLAINTS ISSUES

Significant decisions and compensation awards were made during the year. However, the size of the award is not what matters; rather that the person who has complained and the financial service provider concerned get a fair and impartial decision from me. Though very complex matters arose during the year they were dealt with in a professional and proper manner. We have not shirked our responsibility to deal with some extremely difficult cases in a short period of time.

Serious concerns I have regarding sales of investment products to the elderly; inappropriate investment advice

being given in the sale of properties and matters relating to the sale of income protection policies and permanent health insurance policies are detailed later. These concerns will have to be addressed by the industry.

This Report also outlines matters I cannot consider and Complainants have to accept that as Ombudsman I have to perform my role in line with my statutory responsibilities and that I am not a consumer champion or advocate *per se*.

The High Court judgment in the Quinn Direct appeal case defined and clarified the limits of my authority as Ombudsman. It was necessary that this matter was determined at an early stage and that was the reason why I insisted that the matter be dealt with through the Commercial Court at the earliest possible opportunity. I am grateful that an appeal that was lodged in May 2007 had judgment delivered by October 2007. I have put in place new procedures to ensure that the limits of my power as laid down in the judgement will not materially affect the operations of the Office. The Minister for Finance is considering at my request whether legislation should be amended in the light of this judgment. I express my thanks to my legal team for the work they carry out when Court matters arise.

The publication of Case Studies on three occasions during 2007 has added significantly to the profile of the Office. The media plays an important role in this regard as it has highlighted the various matters which have been raised. However, in line with my impartial statutory role I publish decisions that are both for and against Complainants and I appreciate that the media acknowledges that fact.

CO-OPERATION WITH OTHER AGENCIES

Relations and co-operation with the Financial Regulator, the Pensions Ombudsman and the National Consumer Agency have been very important to my role and there have been no unnecessary overlaps when we all perform our respective statutory roles. The Memorandums of Understanding that are in place have ensured that all organisations work to the mutual benefit of each other.

Internationally the Office dealt with EU wide complaints through the FIN NET system and also participated in the International Network of Financial Ombudsmen annual conference in London. I was also honoured to address a World Bank sponsored seminar in Bratislava whose purpose was to consider establishing financial consumer protection regimes in Eastern Europe and Asia.

The sponsoring department for my Office is the Department of Finance; in that regard I wish to express my sincere appreciation to the Tánaiste and Minister for Finance and all the departmental staff for the support and guidance they continued to give me throughout 2007; I am confident that this will continue in the future.

I also wish to put on record my appreciation of the co-operation I get from all Financial Service Providers when I refer complaints to them. It enables me to deal with complaints in a timely manner.

FUNDING

The Office is funded by statutory levy. The Office's running costs in 2007 were €3.7m. In the first few years of operation it was difficult to set a realistic budget; nevertheless it is heartening that for 2008 we did not have to increase the levy over the 2007 levy. It is regrettable that I had to pursue 100 intermediaries through the Courts for the minimum levy of €125. However, I felt in equity that all Financial Service Providers should pay up the levy and that nobody would escape paying what is laid down by statute. I trust I will not have to refer to this matter again.

STAFF

The progress in 2007 could not have been achieved without the commitment and zeal given by my staff, combined with their professionalism and impartiality. I am extremely grateful to all of my staff and I compliment them accordingly. It is with regret that I record the death of a distinguished colleague, Jim Devlin, during the year. He had a long career in the former Credit Institutions Ombudsman scheme and was a most valued colleague to me also.

Having a 'think in' day away from the Office with external input from legal, financial provider and media sectors as well as from the C & AG's Office and the Department of Finance contributed significantly to our overall development as an Office.

Our aim is to deal with everyone in a courteous and friendly manner. However Complainants can on occasions be extremely difficult; it can be stressful for staff when dealing with such a small minority of aggressive Complainants. Accordingly I arranged for a Clinical Psychologist to address the staff on how best to cope with these circumstances.

COUNCIL

I pay tribute to all the Council Members and in particular, the Chairperson, for ensuring that our respective roles continued to operate so smoothly. It can be rightly said that both the Council and I, as Ombudsman, have ensured that the various statutory functions that have been assigned to us and the complex issues that had to be addressed in our short existence are carried out in a most appropriate and proper manner.

OUTLOOK

Naturally in any successful year when our workload increased by 15% but where we did not have to take on but a small number of extra staff it would be easy to rest on our laurels. New or unforeseen challenges will arise but we all have to keep on striving to ensure that the service we provide to everybody is personal, fair, effective, professional, and timely but, above all, in line with our statutory mandate.

We may, on rare occasions, not meet those high standards we have set ourselves. Nevertheless it is our constant aim to ensure that we achieve even better progress in 2008 and thereby continue as a significant part of the enhanced regulatory framework for the financial services sector.



Joe Meade
Financial Services Ombudsman

29 February 2008

PART I

OUR ROLE AND OPERATIONS

PART I

OUR ROLE AND OPERATIONS

THE ROLE OF THE FINANCIAL SERVICES OMBUDSMAN

The Financial Services Ombudsman is a statutory officer who deals independently with complaints from consumers about their individual dealings with all Financial Service Providers that have not been resolved by the providers after they have been through the internal complaints resolution systems of the providers. The Ombudsman is therefore the arbiter of unresolved disputes and is impartial. Broader issues of consumer protection are the responsibility of the Irish Financial Regulator. All personal customers, limited companies with a turnover of €3m or less, unincorporated bodies, charities, clubs, partnerships, trusts etc. can complain to the Ombudsman.

It is a free service to the Complainant, compensation up to €250,000 can be awarded and decisions are binding subject to appeal to the High Court

CO-OPERATION WITH THE PENSIONS OMBUDSMAN AND THE FINANCIAL REGULATOR

Meetings were held at various stages throughout the year with both staff and management of this Office and staff and management of the Pensions Ombudsman and the Financial Regulator. The provisions of the Memorandums of Understanding to which the three offices are signatories are adhered to.

FIN-NET AND CROSS BORDER CO-OPERATION

The Financial Services Ombudsman is a member of FIN-NET. FIN-NET is a financial dispute resolution network of national out-of-court complaint schemes in the European Economic Area countries (the European Union Member States plus Iceland, Liechtenstein and Norway) that are responsible for handling disputes between consumers and Financial Service Providers, i.e. banks, insurance companies, investment firms and others. This network was launched by the European Commission in 2001.

Within FIN-NET, the schemes cooperate to provide consumers with easy access to out-of-court complaint procedures in cross-border cases. If a consumer in one country has a dispute with a Financial Service Provider from another country, FIN-NET members will put the consumer in touch with the relevant out-of-court complaint scheme and provide the necessary information about it.

During 2007, 107 complaints were referred to our Office through the FIN-NET scheme, 106 from the Financial Ombudsman Service in the UK and one from Le Mediateur de la Federation in France. In the same year this Office referred 79 complaints to other scheme members through the FIN-NET scheme, 77 of those to the Financial Ombudsman Service in the UK, one to the Dutch Security Institute and a further one to the Versicherungsombudsmann eV in Germany.

PUBLIC INFORMATION ROLE

This year was another busy and successful year in terms of raising the profile of the Office. Our success continues to depend upon the high level of public and market awareness of our role. In 2007 I took part in a number of radio, television, newspaper and industry magazine interviews. Staff attended and presented at a number of industry roadshows and exhibitions. The staff of the Office engaged in a wide range of public presentations to ensure that the public are well informed on the nature of the service provided by the Office. These events also served as a useful platform to gather feedback from the public. The presentations and events attended by the Financial Services Ombudsman and staff both, nationally and internationally, as well as attendances at this Office are as follows:

Presentations

(a) Ireland

Insurance Institutes - Cork, Dublin, Galway and Sligo
Law Society
Trinity College
Refugee Applications Commission
Irish Institute of Bankers and Banking Federation
Educational Building Society on two occasions
Institute of Credit Cooperative Administrators
Public Library Dublin
Dun Laoghaire Ladies Club
UCD
Ernst and Young

Leinster Society of Chartered Accountants
 Financial Trade shows in Dublin, Cork, Limerick and Galway
 Institute of European Affairs

(b) International

World Bank conference in Bratislava
 Annual International Conference of Financial Ombudsmen -
 London
 British and Irish Ombudsman Association

Visitors to the Office

Czech Republic Financial Arbitrer
 Canadian Banking Ombudsman
 USA Banking Ombudsman

Meetings

Professional Insurance Brokers Association
 Irish Brokers Association
 League of Credit Unions
 Irish Insurance Federation
 Irish Banking Federation
 VHI
 European Consumer Centre
 Society of the Irish Motor Industry
 IFSC based Financial Service Providers
 Individual Financial Service Providers
 Irish Credit Bureau
 International Financial Services Security Company
 Individuals

Miscellaneous

Articles in consumer and Financial Service Providers
 magazines
 Media interviews
 Web site competition for transition year students
 Attendance at various financial services functions

ORGANISATION MATTERS

***PERFORMANCE MANAGEMENT & DEVELOPMENT
 SYSTEMS***

The Office introduced a Performance Management &
 Development System (PMDS) for staff in 2007. Staff
 member's performance for the year was reviewed by his or her
 manager and a training and development plan was agreed.

STAFF TRAINING

The process of personal training and development continued
 for all staff in 2007. The training and development of staff
 may be carried out by formal 'in house' courses or by courses
 provided by professional external training companies. The
 Office encourages and assists all staff to take advantage of
 relevant further education at all stages of their career.

PARTNERSHIP

The Office is committed to Partnership, and the partnership
 approach is one in which staff are consulted and involved in
 the management and development of the Office.

CASE MANAGEMENT SYSTEM

Further development of the case management system took
 place in 2007. This included the facility to allow documents
 be scanned onto the system and the development of new
 management reports.

COLLECTION OF LEVIES

Statutory Levies are payable by Financial Service Providers to enable the Financial Services Ombudsman to carry out his statutory functions. The levy amounts are prescribed by the Financial Services Ombudsman Council with the consent of the Minister for Finance. Levies were collected in house from all Financial Service Providers with the exception of the Intermediaries. I engaged the services of a credit management company for the collection of levies from intermediaries. To date, only a small number of intermediaries have ignored these requests for levy payments and legal proceedings have been issued against them.

STRATEGY STATEMENT

The Strategy Statement and Business Plan 2007-2009 was published in September 2006. Its targets and objectives are under constant review and are being implemented in accordance with the timeframes outlined in the Statement.

CORPORATE GOVERNANCE

Overview

Corporate Governance for any organisation is a very important issue and must be taken seriously by both boards and management. In that regard, the Financial Services Ombudsman and the Financial Services Ombudsman Council are no different.

From our inception on 1 April 2005, strong emphasis has been placed on having a proper Corporate Governance culture in the organisation, while at the same time tailoring it to the needs of an organisation that is relatively small. In that regard, the following procedures have been put in place and are reviewed regularly by me, as Ombudsman, and by the Council:

- Corporate Governance Manual, Operating Procedures and Codes of Business Practice for Council and staff have been drawn up, are reviewed and amended when necessary; Council and I ensure that these procedures are adhered to.
- The Strategy Statement is drawn up after consultation and input from the staff, considered and approved by the Council and published. Its progress in achieving the targets and provisions is reviewed at the monthly

Management meeting while a report is made every six months to the Council for consideration and review.

- An external firm of accountants was recruited during 2005 by public competition to carry out internal audit.
- An Audit Committee has been established by me since 2005 which comprises of two Council Members and the Head of Audit in the Department of Environment and Local Government.
- The Internal Auditing firm reports to the Audit Committee, who having considered the issues raised and management's response, report both to the Ombudsman and to the Council. Any matters requiring attention are followed up. The firm also carries out a risk assessment either at the request of the Ombudsman, or of the Council, and also carries out any particular audit which would be requested by either party. In addition, any management letters from the Comptroller & Auditor General and management's response are considered and discussed with the Comptroller & Auditor General and the Audit Committee.
- At every meeting of the Council, I as Ombudsman, submit reports detailing activities in the previous period, a financial statement and statistics regarding throughput of complaints.
- Management Committee meetings are held every month in general at which the Ombudsman, the two Deputy Ombudsmen and the Head of Administration participate. Minutes of those meetings are published on the Office Intranet.
- Liaison is maintained with the Department of Finance and, where appropriate, guidance is sought and received on any particular issue.

All of the foregoing aim to ensure that good Corporate Governance is in place and where any deficiencies are brought to light, they are speedily and satisfactorily resolved. The matters are kept under constant review. Indeed during 2007 a governance subcommittee of the Council was also set up.

In addition to the foregoing, regular meetings are held by me with the staff to keep them up-to-date on various issues which are arising and minutes of those meetings are also posted on the Office Intranet. While not necessarily part of the

Corporate Governance, it does ensure that the organisation works on a cohesive basis. At investigation level, regular meetings are held between all of the various investigators to share ideas and to be aware of instances which may be cropping up of a systemic nature. Minutes of those meetings are sent to me, or I may attend some of the meetings also.

COMPLIANCE WITH LEGISLATION

The Office complies with all statutory requirements in the areas of Health and Safety, Equality, Parental Leave and in other areas as follows:

Freedom of Information Acts 1997 and 2003

The Freedom of Information Acts do not currently apply to the Office but may apply to administration aspects of the Office in future. Investigation files cannot be made available via Freedom of Information requests due to their statutory quasi judicial nature.

Ethics in Public Office Acts 1995 and 2001

The Office adheres to the provisions of the Acts and to Standards in Public Office Commission's Guidelines for Office Holders.

Official Languages Act 2003

The Office is fully compliant with the Official Languages Act 2003. Standard letters and documents are translated into Irish and the website has an Irish section also.

Data Protection Acts 1998 and 2003

The Office adheres to the provisions of the Data Protection Acts 1998 and 2003 and will constantly review this adherence. Due to the sensitive nature of the information the Office receives it is necessary that access to data is available only to those who are involved in the investigation of complaints.

THE FINANCIAL SERVICES OMBUDSMAN COUNCIL

MEMBERS OF COUNCIL

The Financial Services Ombudsman Council is appointed by the Minister for Finance. In October 2006 he appointed the following outgoing members of the first Council as members of the Financial Services Ombudsman Council for a further two year period.

Dr Con Power (Chairperson)

Mr Dermot Jewell

Mr Paul Joyce

Mr Paddy Leydon

Mr Paul Lynch

Mr Paddy Lyons

Mr Jim McMahan

Ms Caitríona Ní Charra

Mr Frank Wynn.

Ms Gemma Normile was Secretary to this Council until 31 January 2008

COUNCIL SUB-COMMITTEES

Audit Committee

Members: Paddy Lyons, Chairperson, Dermott Jewell, Noel O'Connell .

Finance Committee

Members: Paddy Lyons, Chairperson, Caitríona Ní Charra, Dermott Jewell, Paul Lynch, Dr Con Power.

Remuneration and Governance Committee

Members: Dr Con Power, Chairperson, Paddy Leydon, Frank Wynn.

MEETINGS

(a) Council

During 2007 the Council held 7 formal meetings. Attendance was as follows.

	Meetings
Con Power	7
Dermott Jewell	4
Paul Joyce	6
Paddy Leydon	7
Paul Lynch	7
Paddy Lyons	6
Jim McMahon	7
Caitriona Ní Charra	3
Frank Wynn	7

(b) Council Sub-Committees

Audit Committee

Met on four occasions

Finance Committee

Met on two occasions

Remuneration and Governance Committee

Met on two occasions

COUNCIL REMUNERATION AND EXPENSES

The Minister for Finance decides the level of fees to be paid to the Council members; €14,000 is paid to each member with €24,000 to the Chairperson. Claims for reimbursement of travel and subsistence expenses at current public service are submitted quarterly.

PART II
COMPLAINTS

PART II COMPLAINTS

OVERVIEW

The core business is complaints resolution and investigation. During 2007:

- 4,374 complaints were received, comprising 2,445 for the insurance sector and 1,929 for credit institutions. This was an increase of 15% over 2006 with a 23% increase for credit institutions and 10% for insurance complaints.
- As 1,053 cases were carried forward at 1 January the office dealt with 5,427 cases during 2007.
- A total of 4,534 complaints were resolved, comprising of 2,863 complaints concluded following investigation by me while a further 1,671 were resolved after having been referred to the internal complaints procedures of the providers. At year end 893 complaints were not finalised with some 1,100 complaints received in the last quarter of 2007.
- Of the complaints investigated 36% were upheld, 46% were not upheld, 12% were outside the statutory remit while 6% were referred either to other EEA Ombudsmen - chiefly in the UK - or other agencies.
- Overall 2,690 complaints were resolved in Complainants' favour when account is taken of the cases also resolved after referral to a Financial Service Provider's internal complaints procedure. Some 59% of complaints were resolved in the Complainants' favour.
- While many of the complaints, especially in the insurance, medical, investment and stock broking areas, concern extremely complex issues and resolution of these complaints does of necessity take some time, nevertheless during 2007, 84% of all complaints received were resolved compared to 79% in 2006.
- Account transactions, mortgages, lending problems, investments and credit card disputes were the main complaints received about Credit Institutions ;
- Motor, travel, life assurance and investment policies were the main Insurance sector complaints.

In July 2007 and January 2008 complaints trends data was published on our website.

OVERALL ACTIVITY		
	2007	2006
Complaints for investigation at 1 January	1053	1374
New complaints received	4374	3795
	5427	5169
Complaints resolved following		
Investigation by Ombudsman	2863	2565
Initial referral by Ombudsman to Financial Service Providers	1671	1551
	4534	4116
Complaints for investigation at 31 December	893	1053

COMPLAINTS RECEIVED			
	2007	2006	% increase
(a) Insurance Sector			
<i>Insurance Companies</i> Life	857	780	
<i>Non-Life</i>	1189	1106	
<i>Health Insurers</i>	182	100	
<i>Intermediaries</i>	147	142	
<i>Others</i>	70	101	
	2445	2229	10%
(b) Credit Institutions			
<i>Banks</i>	1588	1302	
<i>Building Societies</i>	99	116	
<i>Credit Unions</i>	56	33	
<i>Stockbrokers</i>	28	30	
<i>Intermediaries</i>	72	54	
<i>Others</i>	86	31	
	1929	1566	23%
Grand Total	4374	3795	15%

COMPLAINTS RESOLVED BY FINANCIAL SERVICE PROVIDER CATEGORY						
	Upheld	Amicable Resolution	Mediated Settlement	Not upheld	Outside Remit	Advisory Referrals
a) Insurance Sector						
Life Companies	76	208	99	458	99	33
Non Life Companies	80	407	224	377	78	45
Health Insurance	7	54	36	59	1	5
Intermediaries	10	39	23	41	18	8
Others	3	12	-	4	26	25
Total	176	720	382	939	222	116
b) Credit Institutions						
Banks	162	830	234	288	78	25
Building Societies	12	41	7	31	14	-
Credit Unions	8	11	6	16	8	1
Stockbrokers	5	8	5	18	1	3
Intermediaries	12	34	4	24	6	1
Others	3	27	3	4	17	32
Total	202	951	259	381	124	62
Grand Totals	378	1671	641	1320	346	178

COMPLAINTS RESOLVED SUMMARY			
	Insurance Sector	Credit Institutions	Total
(a) Amicably resolved after initial referral by Ombudsman to financial providers			
	720	951	1671
(b) Complaints concluded after investigation by Ombudsman			
Upheld	176	202	
Mediated Settlements	382	259	
Not Upheld	939	381	
Outside Remit	222	124	
Advisory Referrals	116	62	
	1835	1028	2863
Total	2555	1979	4534
(c) Resolved in Complainants' favour (Amicably, upheld and mediated)			
	1278	1412	2690
	50%	71%	59%

COMPLAINTS RECEIVED - AREA OF BUSINESS		
	2007	2006
(a) Credit Institutions		
Account Transactions	588	367
Mortgages	348	308
Credit Card Disputes	279	217
Lending Problems	272	212
Investment Disputes	154	179
Service Issues	51	81
ATM Disputes	91	69
SSIA issues	36	64
Foreign Exchange	24	53
Other	86	16
	1929	1566

COMPLAINTS RECEIVED - AREA OF BUSINESS		
	2007	2006
(b) Insurance Sector - Non Life		
Motor	482	345
Travel	387	501
Household Buildings	126	112
Payment / Loan Protection	93	84
Household Contents	72	32
Savings policy / SSIA's	37	32
Personal Accident	29	24
Mobile Phones	32	22
Commercial	31	28
Hospital Cash Plan	35	21
Computer	22	2
Miscellaneous	48	107
	1394	1310

COMPLAINTS RECEIVED - AREA OF BUSINESS		
(c) Insurance Sector - Medical and Life		
Medical Expenses	182	104
Life Assurance including PHI	299	231
Investment Policy	192	202
Pension	129	100
Endowment Policy	53	85
Mortgage Protection	90	76
Salary Protection or Income Continuance	62	69
Critical / Serious Illness	44	52
	1051	919

COMPLAINTS RECEIVED - NATURE OF COMPLAINT		
	2007	2006
Credit Institutions		
Maladministration	642	439
Unfair Treatment	395	442
Breach of Contract	220	224
Negligence	239	174
Fees and Charges	190	115
Misrepresentation	25	28
Credit rating	68	50
SSIA	36	64
Dormant accounts	11	3
Breach of Confidentiality	9	22
Interest Rates	94	5
	1929	1566

COMPLAINTS RECEIVED - NATURE OF COMPLAINT		
	2007	2006
Insurance Sector		
Repudiation of Claim	758	574
Claims Handling issues	210	211
Customer Care	141	194
Maladministration	169	132
Mis-selling	98	119
Policy Terms	60	94
Misrepresentation	87	85
Settlement Amount	123	80
Lapse/cancellation of policy	134	77
General Advice	51	67
Pre-existing Condition	48	65
Policy Reviews	86	64
Premium Rates	76	52
Non Disclosure	44	52
Surrender Value	62	51
Paid Up Policy values	67	51
Direct Debit	4	33
No Claims Bonus	26	23
Third Party Insurers	25	18
Commission / Charges	21	16
Subrogation	35	16
Bonus Rates	9	16
Policy renewal	21	14
Declined Quotation	13	13
Pre Accident Value	5	13
Unfair Treatment	11	11
Share allocation	2	9
Premium Collection	10	8
Fraud	4	4
Unclassified	45	67
	2445	2229

COMPLAINTS RECEIVED SINCE 2005			
(a) Yearly	<i>Insurance Credit</i>	<i>Institutions Sector</i>	<i>Total</i>
2007	2445	1929	4374
2006	2229	1566	3795
2005	2190	1147	3337
% Increase over 2006	10 %	23%	15%
% Increase over 2005	2 %	37%	14%
(b) Quarterly			
January – March			
2007	656	452	1108
2006	511	341	852
*2005	456	276	732
April – June			
2007	532	445	977
2006	449	324	773
2005	553	345	898
July – September			
2007	643	525	1168
2006	641	501	1142
2005	574	284	858
October - December			
2007	614	507	1121
2006	628	400	1028
2005	607	242	849

** These refer to the complaints received by the former voluntary Ombudsman schemes for Credit Institutions and the Insurance sector as the statutory Financial Services Ombudsman scheme commenced on 1 April 2005. 779 complaints on hand at 1 April 2005 were then transferred to the Financial Services Ombudsman for investigation.*

PUBLISHED DECISIONS

Significant 2007 decisions were published on the website in July and October 2007 and in January 2008. These are published in Part V of this Report and refer to

- Over €200,000 awarded to a professional Rugby player
- Mortgage Brokers giving investment property advice needs clarity and less confusion - €116,000 awarded in five instances
- Following the sale of farm for over €1.3m an 86 year old bachelor was advised to invest €850,000 in two 4 and 6 year fixed term bonds; €350,000 was retained in a demand deposit account with a further €150,000 in a current account - inappropriate advice
- Unsuitable €10,000 Investment sold to an unemployed single mother; sales practices of Insurance Company questioned
- Bank directed to furnish to the beneficiary of an army compensation award copy of payable order and €1,000 awarded for its failure to do so earlier
- Repatriation claim submitted by the parents of a deceased tourist was handled in an insensitive manner by Insurance Company
- Medical submissions by Insurance Company not accepted and Specified Illness cover award of €165,000 follows
- Widow feels a Credit Union nominated account 'disinherited' her out of €12,700
- ATM card cash withdrawals of large sums across Bank counters need review to prevent fraud
- Phone records help Ombudsman's work; payments of €310,000 and €35,000 arose but a complaint against a stockbroker was rejected
- Switching of Bank Account and abysmal lack of communication between Banks
- Sales advice by Insurance agents was unsatisfactory
- SSIA account opened at the wrong rate

- ❑ Relationship breakup can significantly affect life assurance policies
- ❑ House underinsured resulted in a reduced settlement amount
- ❑ Payment Protection Policies for construction industry workers
- ❑ Credit Card Fraud and 'on the town' event merits compensation of €2,500
- ❑ Injured carpenter gets €10,000 award following 'cold call' insurance policy sale
- ❑ Insurance Policy Review led to a proposed 200% increase in premiums
- ❑ Mortgage Protection Policy - €25,000 awarded in dispute over direct debit non payment of premium
- ❑ Travel Insurance - cancellation cost of €4,000 repaid
- ❑ Credit Card sent to wrong address - €4,500 compensation for fraudulent transactions
- ❑ Misleading Investment Advice by bank- €17,000 in compensation
- ❑ €8,000 award as Insurance Company did not seek Specialist Consultant's opinion
- ❑ Incorrect information supplied to holder of Approved Retirement Funds - €28,000 of management charges refunded
- ❑ Income Protection Policy - what constitutes farmers' income
- ❑ Confusion as to bank transactions by an elderly customer
- ❑ Insurer forwarded an incomplete company file to Ombudsman and a recommended compensation award doubled to €500
- ❑ Death Benefit Claim of €800,000 - non disclosure of prior medical condition
- ❑ Dormant Bank Account of €25,000 is ownerless
- ❑ Forged or stolen cheques lodged to a bank account

- ❑ Disposal of shares by stockbroker- conflict of interest complaint
- ❑ Motor Insurance Policy- vehicle not in a road worthy condition.

MAJOR ISSUES ARISING DURING 2007

INADEQUATE COMPUTER SYSTEMS LEAD TO UNDERPAYMENT OF INSURANCE POLICIES

In investigating a specific case I was informed that the Insurance Company reviewed its records in 2007 and noted that the last inflationary increase on the Life Insurance Plan was offered in June 1999. The Company advised that the annual increases were not offered after 1999 up to the time the Complainant's wife reached age 65 years because at this time the Company was migrating its computer systems to a new platform in order to improve service to **all** its customers. The Company confirmed that in the event of a claim the life cover plus the annual increases which would have applied over that time would have been paid, subject to normal claim requirements, although the lower premium had been paid. While I considered the Company's response satisfactory in this specific case I also awarded €300 for bad customer service.

I had concerns as to whether other policyholders were affected by the Company's migration of its computer systems and inquired what action the Company had taken with regard to those other policyholders affected, if any. I also referred the matter to the Financial Regulator to investigate the matter further with the Company and indeed industry wide. I stated that I would expect the Company to review all similar cases including those where claims had arisen since 1999 and where appropriate make the required adjustments to policies and also refund underpayments of claims.

Following my concerns the Company then initiated an investigation and discovered that between 100 and 200 other policies may be affected. All of these claim files have been recalled and these are being reviewed by the Company to determine exactly what action was taken on each file and identify any underpayment. The Company also expanded its investigation to look at all aspects of indexation and this has identified a further issue where they believe further underpayments have arisen. It has informed the Financial Regulator of both of these issues and is working on the best solution to be applied in each case in conjunction with the Regulator.

I commend the Company for its prompt response to my concerns.

ARMY DEAFNESS COMPENSATION

In the July 2007 published case studies I noted that a former Irish soldier was granted an Army Deafness Compensation award - he was represented by a firm of solicitors. The order made payable to him was sent to his solicitors by the Department of Defence. The Complainant was awarded IR£20,000 compensation and he alleged that without his permission or authority the solicitors in question lodged the payable order, made payable to the Complainant, to his (solicitor's) firm's account and having done so, deducted IR£2,500 in respect of fees (even though some IR£9,000 fees had already been paid by the Department) and forwarded the balance to the Complainant. His complaint to me was that the bank would not give him a copy of the cashed order as he was led to understand that his 'signature' was endorsed on the back of the order.

I did find against the Bank in that when the Complainant initially tried to pursue the matter, the Bank refused to provide any information to him on the grounds of its duty of confidentiality to its customer, the solicitors who had lodged the payable order. I awarded €1,000 in compensation and directed that a copy of the paid payable order be furnished to the Complainant. I also made it clear that this finding was made without prejudice to any other remedy, if any, that the Complainant may have elsewhere against the firm of solicitors concerned in respect of the IR£2,500 loss which he claimed against them.

Following publication of this case study my Office received 20 phone enquiries and 4 written complaints from other former soldiers who had also received Army Deafness Compensation awards. They alleged that solicitors had also deducted fees, already paid by the Department, before they received their compensation cheques.

I had to point out to them that I could not deal with their complaints as, unlike the case study complaint, they were only complaining about solicitors actions and not about actions of financial institutions. As these complaints were accordingly outside my statutory remit I informed them that they should take the matter up with the Law Society instead.

RETENTION OF TELEPHONE SALES RECORDS

I found in favour of a Complainant (who had entered into a contract with a Financial Service Provider over the 'phone) because the Financial Service Provider did not retain transcripts or records of the call. The Complainant's assertion, in the absence of other evidence from the Financial Service Provider, was deemed acceptable.

I note that many contracts and indeed other issues are carried out on line and over the telephone. In those circumstances I wish to point out to Financial Service Providers that where I am dealing with a complaint that hinges on contractual commitments entered into by telephone, I would be disposed to find in favour of a Complainant where the Provider could not provide the necessary evidence to rebut the claim being made. It would therefore be in the interests of the Providers to consider retaining appropriate records -including, where necessary, 'phone recordings relating to such contractual commitments - for the period within which a person can complain to me i.e. six years.

The Data Protection Commissioner was consulted by me and he did not see any difficulty with Providers retaining personal data including telephone records in such circumstances. He quite rightly pointed out that it would, of course, be important that Providers comply with their other obligations under data protection legislation notably that individuals be informed that conversations are being recorded and the purpose for which they are being recorded; that retained data only be used to defend claims (unless there is some other legitimate basis for its use); and that it be destroyed after the 6 year period (again, unless there is some other legitimate basis for retention beyond that period).

I informed the Financial Service Providers accordingly.

FOI REQUESTS NOT ACCEDED TO

A case was referred to my Office when the Insurance Company disallowed the Complainant's claim for Stomach Cancer under the Critical Illness Cover section of a protection plan. On the basis of the information recorded on the application form and there not being a full disclosure of health history thereon, my Investigating Officer held that the Company had acted within its rights in voiding the policy. The Complainant was not happy with this finding and asked me to review the matter. Of particular note at the review stage was a request by the Complainant to have sight of the documentation submitted to my Office by the Company

under the Freedom of Information Act.

In deciding the matter of access to documentation I stated that:

- The Freedom of Information Act does not currently apply to the Office but may apply to its administration function in future. In any event investigation files could not be made available under FOI due to their statutory quasi judicial nature. The Company in this case specifically claimed legal privilege over some of its documentation.
- I have regard to the parties' rights of privacy where appropriate and for the most part, the Complainant's own papers contained the information submitted by the Company in its file.
- The parties to a dispute can seek a review of the initial finding from the Office. This gives the parties a further opportunity to highlight areas of concern that they may have with the initial finding. There was no further information submitted in this instance by the Complainant when requesting the review of the finding issued.
- Where a review is requested, I review the initial finding and all the submissions made by both parties to the dispute and then issue my final decision on the matter.

I concurred with the initial finding issued by my staff and the complaint was not upheld.

As regards access under Freedom of Information I also note a High Court judgment, National Maternity Hospital v. Information Commissioner (Unreported, High Court Quirke, J., 30 March 2007) at p.34:

"I know of no principle of natural or constitutional law or justice which confers upon parties who make submissions to a decision-making body the right to respond to the submissions made by every other party who participates in the process. The review undertaken by the Commissioner was a statutory process which expressly envisaged and permitted the adoption of informal procedures."

INAPPROPRIATE INVESTMENT PRODUCTS SOLD TO ELDERLY PEOPLE

The matter of selling inappropriate investment products to elderly people continues to arise and is of concern. It is my stated position (see Annual Report 2006) that there is a particular duty of care required when selling a policy to a person of advanced years. If there were not additional safety procedures in place, the sale of particular policies to a person of advanced years may not be appropriate having regard to that person's advanced age, infirmity or other circumstance. I also appreciate that the Financial Regulator's Consumer Protection Code from July 2007 will bring a greater degree of improvement in this area.

In a case published in October 2007-detailed in the case studies section-I was particularly concerned about the issue. In brief an 86 year old bachelor farmer sold his farm for €1.4m; after advice from a bank official he invested €850,000 in two six- year fixed term insurance bonds which, when he died seven months later, were worth €50,000 less than the original investment; I directed that the €50,000 loss be made good to his estate. Though not part of the complaint I noted that another €150,000 was put in a current account and €350,000 in a demand deposit account.

I consider that all institutions should, as a matter of routine, review bank accounts of elderly people so that appropriate amounts are held in them and that the lowest or no interest rate, which applied in this particular instance, is not the norm for such investments. I have since being appointed Ombudsman in May 2005, published eight case studies about the unsuitability of investment products sold to the elderly and other matters affecting the elderly; I am disappointed that the issues are of a recurring nature.

I raised my general concerns on this matter with the Financial Regulator. It informed me that during 2004 and 2005 it asked Providers to conduct a Sales Process Review with regard to investment sales to the elderly and vulnerable customers. While the review identified some areas for potential improvements in Providers' sales practices no systemic issues of mis-selling to elderly customers were identified. The Regulator has encouraged firms to raise standards in this area of their sales practices and is keeping the matter under review.

TRAVEL INSURANCE –LOST CLOTHES AND RETENTION OF INVOICES

Travel insurance claims constitute a large percentage of complaints I have received since 2006. In 2007 387 travel insurance complaints were received. I have had numerous complaints to my Office from Complainants who have had claims declined for damaged baggage / clothing while abroad on holidays. In particular they consider that requests by insurance companies for receipts to be unfair and impractical.

One complaint had a claim declined for damaged baggage/clothing while abroad on holidays. Upon investigating the matter I overturned the Company's decision and upheld the Complainant's complaint. However, I was restricted in the amount I could compensate the Complainant, for the loss of his clothing, as the Company's policy terms and conditions were quite restrictive. The Company stated that it only pays out on claims where receipts/proof of purchase can be provided for all lost/damaged items.

I find that it is not fair and reasonable to expect a consumer to retain a proof of purchase for every item they purchase. This would mean that a consumer would have to retain receipts for a number of years as all items taken on holidays are not purchased around the time of the holiday departure. That said I also consider it appropriate that Insurance Companies have to take appropriate measures to ensure that a claim can be substantiated. In addition to this, I find that if a Travel Insurance Company does request receipts for claimed items it should be more clearly outlined on the policy schedule under the personal items section rather than towards the end of the policy terms and conditions booklet. This way at least the consumer would be made aware of the requirements at an early stage. Indeed one policy schedule did not mention that those covered items must be receipted. It also raises the question as to whether the particular policy under complaint is an appropriate one at all.

I have brought the matter to the attention of the Financial Regulator so that the matter may be rectified on an industry wide basis.

INTERMEDIARIES GIVING INVESTMENT PROPERTY ADVICE AND CONFLICTS OF INTEREST

In the January / July 2007 and January 2008 published decisions, I found that mortgage brokers had undisclosed

conflicts of interest when they sold investment apartments which they had an interest. One of the issues which arose in these disputes, apart from the conflict of interest was that the brokers in their defence stated that the principals who were acting for the broker were acting in a personal capacity. I did not accept that argument. In five complaints decided on I have awarded in total some €116,000 compensation.

In my opinion there is confusion as to the objectivity of the financial advice being given and indeed there is an unhealthy relationship when advice on property and general financial advice is given by the same broker. I appreciate that it must be difficult for consumers to determine whether such a person is operating as an estate agent or as a mortgage advisor. However, in the cases so far decided by me significant issues regarding independent financial advice and conflict of interest have arisen which I have brought to the attention of the Financial Regulator so that these issues may be considered in the overall review of the mortgage intermediary area. The Financial Regulator is to examine these matters with the industry.

PERMANENT HEALTH INSURANCE GROUP SCHEMES

I wrote to the Financial Regulator in November 2007 due to some concerns I had regarding Permanent Health Insurance/Salary Protection policies. Permanent Health Insurance disability complaints continue to be referred to the Office in significant numbers.

Permanent Health Insurance crosses a number of insurance policies and may be found in pension, life assurance, health insurance and investment policies. It is sold mainly to groups of employees through group schemes but it is also sold to individuals. Whilst some complaints relate to individual policies effected by Complainants and a Financial Services Provider, the majority of complaints relate to Group Permanent Health Insurance schemes effected between organisations and Financial Service Providers. Typically such schemes would have been put in place by unions, health boards, Government Departments etc. The Policies are between the union or employer involved and the Financial Service Provider, with the Complainants being the beneficiaries of same. The terms and conditions of these policies would have been approved and agreed upon between the policyholder i.e. the union or employer, and the Financial Service Provider. A large number of these schemes would be in operation for quite some time with some Complainants being members of schemes for between 10-15 years.

While there are different causes for complaint, the main complaint relates to the repudiation of claims for disability benefit on the grounds that the Complainant's medical condition fails to satisfy the policy definition of 'disability'. In many cases Complainants will have qualified for ill-health early retirement under their employer's pension scheme, and argue that, because they qualify for benefit under the pension scheme, they should automatically qualify for benefit under the permanent health insurance scheme. While each complaint is considered on its merits I had to point out to many Complainants that there are differences between a Financial Service Provider's criteria for qualifying for benefit and a former employer's criteria for early retirement due to ill health. The evaluation of a Complainant's condition is made in accordance with the terms and conditions of the insurance contract taking into consideration, *inter alia*, the definition of "Disability" contained therein. An increasing number of complaints concern claims for stress and anxiety conditions. In many of these cases the reasons behind a Complainant's illness are largely employment related and in many instances may not be factors in determining a Complainant's fitness to carry out the duties of his/her normal occupation under the terms of the policy.

Many Complainants have submitted that important information about and features of the schemes, including the difference in the criteria for qualifying for benefit, were not brought to their attention at the time of joining the scheme. Frequently Complainants state that they did not receive any scheme documentation or copies of the policy document. With regard to the sale of the policies, and the issue of what information Complainants may have received from a Financial Service Provider's agent, the Central Bank & Financial Services Authority of Ireland Act 2004 (which sets out my remit) must be noted. The Act provides:

"(3) A consumer is not entitled to make a complaint if the conduct complained of occurred more than 6 years before the complaint is made".

As a result I am therefore unable to examine the circumstances surrounding a Complainant's joining of a scheme during the 1990s.

Although I am unable to examine conduct occurring 6 years prior to the making of a complaint, it must be said that the complaints demonstrate that there has been inadequate regard to providing information to Complainants at the time of joining the scheme, and keeping them informed of relevant changes and alterations to terms and conditions. When changes and alterations are made they are usually negotiated between the relevant employer or the trade union and the

insurance company; as the employer or trade union may be the policyholder, in these circumstances the employer or the trade union should disseminate information to their employees or members.

Of course the Consumer Protection Code from 1 July 2007 has made matters more definitive but for the pre Code cases I suggested to the Financial Regulator to consider my comments and discuss the matters with the industry.

POLICY REVIEWS

My 2006 Annual Report dealt with the issue of Policy Reviews. However due to the recurrence of complaints received by my Office regarding Policy Reviews, I feel it is appropriate to address the issue again. Policy Reviews arise in Unit Linked Whole of Life Policies, where the cost of life cover is based on the age of the policyholder. The premium increases as the policyholder gets older. A Policy Review takes place, therefore, when it is necessary to consider the age of the policyholder, the premium being paid and the level of cover under the policy. The Policy Review provides an opportunity to assess whether the policyholder's life cover needs are met. In many instances, the premium being paid is not sufficient to maintain the existing life cover and the policyholder is provided with the option to increase premium to maintain the same level of cover or reduce the level of life cover.

Complainants often argue that they were not aware of Policy Reviews being part of their policy and they believed the initial premium would not change for the policy's duration. Investigations carried out to date indicate that the policy documentation provided to Complainants at the outset clearly set out the need to review the policy in the future. However, it is extremely important for Financial Service Providers to explain Policy Reviews to potential policyholders before the policy is sold. One recurring area of concern with Policy Reviews is that the review date as set out in the policy documentation is missed by the Financial Service Providers: where this has been found to have happened I have recommended an award or other remedy.

SURRENDER AND MATURITY VALUE OF INSURANCE POLICIES

In the course of reviewing a complaint in November 2007 in relation to a particular insurance company, the Complainant raised a general issue where he stated he had concerns

regarding the Company's overall responsibility to its Irish clients. He also stated that a number of clients have substantial business invested with the company sold on the strength of its original excellent track record. He felt that following a series of disastrous acquisitions he suspected the company did not want their funds performing well because of guaranteed annuities applicable to their pension funds, i.e. 11% guaranteed to a 65 year old male and 10% guaranteed to a 60 year old male.

I informed the Complainant that I can only deal with a specific complaint and that matters of such a general nature were not within my remit. However, I considered it appropriate to bring the matter to the attention of the Financial Regulator as it may find it useful when carrying out any prudential examination of this company or any overall review of it. I informed the Company of this referral also.

The Company informed me that it did not accept the Complainant's comments that the acquisitions were detrimental to policyholders. It also stated that the Financial Regulator was made aware of the changes in August 2007. It stated as well that there will always be a degree of smoothing between the amounts actually paid on a policy and the policy's asset share but smoothing is expected to have a neutral effect on payouts over time.

The Company's brochure states that:

- An asset share can move up and down depending mainly on the latest investment result
- Smoothing means either:
 - > Not always allowing the value given for a policy to move up or down as quickly as the asset share or
 - > If asset shares for similar policies starting at different times are different by irregular amounts the final bonus may be set to reduce such irregularities
- In either case the full effect of the investment result is allowed for over time

INCOME PROTECTION BENEFIT AND WHAT IS A DISABILITY

A complaint regarding non payment of Income Protection Benefit raised interesting issues about what is covered: how aware are customers when they purchase such an Insurance

product of its possible limitations and whether the conditions imposed by the Insurance Company in question were fair. I am concerned that many of these policies were being sold where the definition of blindness, or deafness or other ailments and disabilities may not have been fully explained to the consumers before they purchased such a policy. In my Final Decision while I stated that the Company had an arguable case under the contract that it need not pay, I found that in equity it had to.

Background to the Complaint

The Complainant commenced his policy with the Company in December 2002, which included serious illness cover and income protection. Following a brain haemorrhage / stroke in April 2006, the Complainant made a claim to the Company pursuant to the serious illness cover on the policy, and this claim was paid by the Company in September 2006. In October / November 2006 the Complainant made an additional claim to the Company seeking income protection benefit, but in May 2007 the claim was formally denied by the Company. The Complainant, who previously worked as a Sales Manager, said that because of his stroke, he will never work again. He has been registered as blind with the National Council for the Blind in Ireland (NCBI) since August 2007. In his complaint to me he sought payment of the income protection benefit pursuant to the policy which he purchased.

I noted that the Company stated that claims for income protection benefit, are evaluated, not as against an individual's ability or inability to work, but rather, against the "physical health test" criteria referred to in the Terms and Conditions of the policy. To have a valid claim, the Complainant must either:

- (a) *Be unable to perform 3 of 10 individual physical test or*
- (b) *He must be unable to "see" as defined by the policy.*

The Company acknowledged that because of the Complainant's visual field deficit (reduced peripheral vision) in addition to his loss of visual acuity he qualified for "Blind Registration" with NCBI. Nevertheless the Company said that the Complainant's loss of visual acuity was not sufficiently extensive to meet the criteria laid down in the Policy Conditions. The definition of "seeing" in the Policy Conditions was based on visual acuity alone. The Policy conditions included the following definitions:

Disability

“Disability is defined as satisfying the physical health test and/or the mental health test.....”

“The physical health test is satisfied if the Life Assured can simultaneously satisfy three or more of the first ten conditions described below or the eleventh condition only.

- (1) *Sitting in a chair*
- (2) *Getting up from a chair....*
- (3) *Standing*
- (4) *Walking*
- (5) *Lifting*
- (6) *Walking up and down stairs*
- (7) *Bending and kneeling*
- (8) *Using your hands*
- (9) *Reaching with your arms*
- (10) *Fits and blackouts*
- (11) *Seeing-*

You are certified either blind or partially sighted by an Irish Registered consultant Ophthalmologist. “Certified blind” means where you are so blind that you cannot do any work for which eyesight is essential. Your best corrected vision is not greater than 3/60 in the better of your 2 eyes.

“Certified partially sighted” means you are substantially and permanently disabled by defective vision caused by congenital defect or illness or injury. Your best corrected vision is not greater than 6/60 in the better of your 2 eyes.”

Consideration by me as Ombudsman

Before I made my final decision in November 2007 I referred to the following issues:

- One also has to be conscious as to what an ordinary person understands by ‘Income Protection’ and while cooling-off periods and policy documents outline various matters, the fact that no particular reference was highlighted in the promotional literature- albeit it in the policy conditions- that blindness could be quite limited is a matter that should be considered by the

Company in this case. However, equity comes into play in my role as Financial Services Ombudsman and I lay extremely high emphasis on the fact that a common understanding of an illness should, if it is not to be the case, be highlighted in a very prominent and important way and that all Sales Representatives should outline that very, very clearly before any purchase is made.

- In December 2006 the Complainant’s GP filled out a Medical Attendance Statement which one part of it indicated that he met three of the conditions, whilst in the other part he did not. Indeed I find the form, to say the very least, confusing in language and I strongly recommend that it should be reviewed urgently by the Company. In January 2007 the Company queried the discrepancy. In February 2007 the GP made a general statement but then in March he indicated that a GP was not the most appropriate person to assess the abilities test and that an examination by an Occupational Health Specialist would be more appropriate. It appears that this was not pursued by the Company as it had relied on the definition of blindness as outlined in its policy. However I commended the Company for trying to sort out this problem because of the lack of information being supplied by the doctors. I noted that the Neurologist in his report of May 2007 stated *“it is my opinion that he meets the criteria for visual deficit as described in the Physical Health test”*. Indeed in June 2007 the same Neurologist said *“I fail to understand what the difficulty is in terms of going ahead and granting him his cover as in his policy. Perhaps you should request a further medical opinion if you are debating in any way the opinion of the specialists here in this town.”* In its letter of July 2007 the Company indicated to the Complainant that *“your doctors have not confirmed that you are unable to do these tasks but that alternatively as a single test you must be unable to see as defined by the policy. The doctors have confirmed that while you suffer with a visual deficit, i.e. reduced peripheral vision, does not meet the definition of same in the policy conditions. I must also say that I understand that your own medical staff expressed a sympathetic opinion that they think you should be paid however the medical information provided does not support this.”*
- The foregoing did no credit, in my opinion, to the medical profession or to the Company. The plain fact is that the Complainant is blind, though not within the terms of the policy, cannot drive a car and is

unable to work. Whether he did meet the other criteria of the abilities test has been left undecided because the GP concerned would not so certify and the GP's suggested independent review was not carried out, even though it might be outside the terms of the contract. The Company has relied solely on the Blindness definition in the policy. That the Complainant should be required to suffer the ultimate consequences in these circumstances is in my opinion unreasonable and unjust

As regards the words in the policy illustration

"Income Protection provides you with a weekly income payment if you are unable to work and you satisfy the definition of disability contained in Section 4 of the Income Protection Policy Conditions".

The Company submitted that this sentence should be read as a whole sentence. This is reasonable. In my opinion, the words "unable to work" suggest some relevance and not sole relevance as the Company suggested to the process of assessing a claim for Income Protection. In spite of this the Company state that claims for Income Protection benefit will not be assessed against an individual's ability or inability to work, but solely on that individual's performance in the "abilities test". Be that as it may, I specifically make no finding in relation to the Company's practice of assessing claims by reference only to the abilities test, as it was unnecessary in this instance to do so.

Decision and Financial Regulator Referral

In my decision I stated that:

- The definition of blindness may not have been fully explained when the policy was sold and is not what an average and reasonable person may understand
- The Complainant cannot drive a car, is unable to work and is registered as blind by the NCBI
- The Neurologist appears to state that he met the Abilities Test though the GP not being as definitive as he should have been placed the company in an invidious position. However I think it was unfair and unreasonable that it did not take on board the GP's suggestion as to how the Complainant should be assessed for the abilities test.
- The confusion by the GP on the form is unfortunate

but the Complainant's own assessment in December 2006 was as frank and as truthful as I have come across in considering cases. He indicated that he did not meet condition 5 but could meet conditions 7-9 with difficulty.

For the foregoing reasons and having considered all the evidence I decided that the complaint was substantiated on the grounds that while the conduct complained of may have been in accordance with established practice, that practice as applied to the circumstances of this case was, in my considered opinion, unreasonable and unfair in its application to the Complainant. I also decided that the request by the Complainant to be given compensatory damages was unjustified. As a result, arrears of €21,000 were paid by the Company in January 2008, while the Complainant's current benefit is €1,400 a month.

On a general level I was concerned that many of these policies were being sold where the definition of blindness, or deafness or other ailments and disabilities may not have been fully explained to the consumers before they purchased such a policy. I considered it appropriate to refer this decision to the Financial Regulator for information and its applicability to other Companies. I appreciate that the requirements of the Regulator's Consumer Protection Code should enhance this area very much going forward from 2007. The Regulator informed me that it had already during 2007 carried out a review of the sales and complaints handling practices of life insurance companies in relation to Serious Illness Cover, a product which shares some of the characteristics of Income / Permanent Health Insurance. Resulting from this review the Regulator asked the industry, in January 2008, to assess how firms inform their customers as to the definition of the particular illnesses covered and requested firms to ensure that all consumers fully understood the key points of the products.

PART III
APPEALS

PART III

APPEALS

OVERVIEW

An appeal to the High Court is a statutory protection for both parties if they feel I have not made the right Decision and, indeed, a new statutory body can expect to have its powers tested early on. Naturally, I will vigorously defend my decisions and procedures, I will learn from the court's judgments and I do not regard it as the Ombudsman winning or the appellants winning. It is just part of the process.

11 appeals and 1 judicial review have been made to the Courts up to 31 December 2007 while I am a notice party in 2 other appeals brought against Financial Service Providers where I found in favour of the Provider. In summary 2 appeals and 1 judicial review application has been made by providers; 2 appeals by business interests and 9 by individuals. 3 of the appellants are representing themselves as lay litigants.

The judicial review and 3 appeal cases had been decided by 31 December 2007 - the Irish Nationwide Building Society case was settled in my favour; in the Ulster Bank case the High Court found in my favour on a preliminary issue but that is now under appeal to the Supreme Court; in the Quinn Direct case the Court found in favour of Quinn Direct and a Complainant withdrew an appeal. The remaining 10 appeals have been made by Complainants concerning either the amount of compensation which I awarded in 5 cases or where I did not uphold the complaint in the other 5 appeals. Therefore, in total, only 0.17% of my Decisions have been appealed to the High Court.

QUINN DIRECT HIGH COURT APPEAL

Background

The Complainant renewed his motor policy with the Company. Shortly afterwards he received a quotation from the Company in respect of a car he was thinking of buying. The Complainant subsequently bought the new car in March 2006 and when he rang the Company to switch policies, the car quotation he was then given was higher than the original quotation. He was unhappy that the quote was higher than the price he was originally quoted a month previous. In addition the Complainant was charged a €25 change of vehicle administration fee. The Complainant was unhappy that the quote had risen. He also expressed dissatisfaction that the Company allegedly debited his credit card with the new premium without his express permission. As the Complainant was unhappy with how his motor policy was being handled, he decided to cancel his policy altogether and

take up a new policy with a different company. When he cancelled his policy he was charged a €75 cancellation fee. The Complainant was not happy with this charge as he felt that he was being forced to cancel given the price he was being charged for the cover of his new car.

The Company stated that as regards the Complainant's quotation on his new car, rates can fluctuate on a daily basis due to market conditions and this is an exclusive right across the insurance industry. The Company also stated that the policy increase on the Complainant's premium included a €25 change of vehicle administration fee. The Company also stated that in relation to the cancellation fee levied, this was explained to the Complainant and was also stated in the policy handbook.

Decision

In my finding it was held that insurance rates can indeed fluctuate on a daily basis and a quotation can vary, even after one month. As regards the credit card payment I found that as the Company have strict guidelines in place as regards taking payment from customers, I was satisfied that this was done in this case. I found that as there was a specified cancellation fee in the policy documentation and was properly charged. I did not uphold these parts of the complaint.

The Company accepted that its correspondence to my Office and to the Complainant was not clear and may have been misleading on the various amounts charged. I concluded that although Companies are free to levy charges in relation to different services, they must be notified in the policy documentation so as to make consumers aware of same. Indeed the policy documentation was changed in June 2006 to indicate that an administration fee would be charged for a change of vehicle. I thus found the Company should pay the Complainant €50 in relation to the change of vehicle administration charge as the €25 change of vehicle administration fee was not itemised in the policy documentation until June 2006. While the Company stated that it disagreed with that decision it had refunded the Complainant the €50. Accordingly my April 2007 decision in this particular case was not appealed.

Direction

Section 57 CI(4) of the Central Bank and Financial Services Authority of Ireland Act 2004 which outlines my role and duty as Financial Services Ombudsman provides that I may direct the Financial Service Provider

(a) to review, rectify, mitigate or change the conduct complained of or its consequences.

I considered that such a direction under the Act was necessary because in my opinion its consequences were that other consumers could have been similarly charged an administration fee in relation to the change of vehicle. So as to rectify and mitigate these consequences and in accordance with my decision in this particular case I directed the Company to return these change of vehicle charges of €25 to consumers who were charged same, going back 6 years.

I also referred the matter to the Financial Regulator for any other action he may deem appropriate for this Company or others.

High Court Judgment

The Company appealed the direction chiefly on the grounds that I as Ombudsman did not have the power to make such a general direction. The High Court judgment delivered on the 5th October 2007 stated that as Ombudsman I do not have the power to make such a direction with retrospective effect under the legislation and I can only make directions in relation to a specific person or persons who have made a complaint. It also held that I have the power to direct a change of practice going forward.

I decided not to appeal the High Court judgment. I have asked the Minister for Finance to consider whether a legislative change is warranted. In the media release following the judgment I stated that my decision in the specific complaint was not appealed by Quinn Direct and therefore stands. Accordingly other customers of Quinn Direct who

feel that they were similarly affected can lodge a complaint with me and it will be dealt with in line with my normal procedures. I understand that the Financial Regulator has had discussions with Quinn Direct on the matter also.

In the light of the judgment, I considered, with my legal team, the effect (if any) on the other general direction given to Ulster Bank Investments Funds Limited, which is also the subject of Court proceedings. My general direction of February 2006 to Ulster Bank Investments Funds Limited was to compensate investors following decisions made by me in 8 complaints. I decided that the general direction no longer stood but the eight complaints decided on stood and the appeal was not affected by this decision. The Supreme Court has not as yet heard the appeal taken by the Bank against the High Court judgment delivered in November 2006.

PART IV

FINANCIAL STATEMENTS

REPORT OF THE COMPTROLLER AND AUDITOR GENERAL FOR PRESENTATION TO THE HOUSES OF THE OIREACHTAS

I have audited the financial statements of the Financial Services Ombudsman's Bureau for the year ended 31 December 2007 under the Central Bank Act 1942 as amended by the Central Bank and Financial Services Authority of Ireland Act 2004.

The financial statements, which have been prepared under the accounting policies set out therein, comprise the Statement of Accounting Policies, the Income and Expenditure Account, the Balance Sheet, the Cash Flow Statement and the related notes.

RESPECTIVE RESPONSIBILITIES OF THE OMBUDSMAN AND THE COMPTROLLER AND AUDITOR GENERAL

The Ombudsman is responsible for preparing the financial statements in accordance with the Central Bank Act 1942 as amended by the Central Bank and Financial Services Authority of Ireland Act 2004, and for ensuring the regularity of transactions. The Ombudsman prepares the financial statements in accordance with Generally Accepted Accounting Practice in Ireland. The accounting responsibilities of the Ombudsman are set out in the Statement of Responsibilities of the Financial Services Ombudsman.

My responsibility is to audit the financial statements in accordance with relevant legal and regulatory requirements and International Standards on Auditing (UK and Ireland).

I report my opinion as to whether the financial statements give a true and fair view, in accordance with Generally Accepted Accounting Practice in Ireland. I also report whether in my opinion proper books of account have been kept. In addition, I state whether the financial statements are in agreement with the books of account.

I report any material instance where moneys have not been applied for the purposes intended or where the transactions do not conform to the authorities governing them.

I also report if I have not obtained all the information and explanations necessary for the purposes of my audit.

I review whether the Statement on Internal Financial Control reflects the Bureau's compliance with the Code of Practice for the Governance of State Bodies and report any material instance where it does not do so, or if the statement is misleading or inconsistent with other information of which I am aware from my audit of the financial statements. I am not required to consider whether the Statement on Internal Financial Control covers all financial risks and controls, or to form an opinion on the effectiveness of the risk and control procedures.

I read other information contained in the Annual Report, and consider whether it is consistent with the audited financial

statements. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements.

BASIS OF AUDIT OPINION

In the exercise of my function as Comptroller and Auditor General, I conducted my audit of the financial statements in accordance with International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board and by reference to the special considerations which attach to State bodies in relation to their management and operation. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures and regularity of the financial transactions included in the financial statements. It also includes an assessment of the significant estimates and judgments made in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Bureau's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations that I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error. In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements.

Without qualifying my opinion I draw attention to note 9 of the financial statements which outlines the uncertainty regarding the ultimate financing and recognition of the pension liability.

OPINION

In my opinion, the financial statements give a true and fair view, in accordance with Generally Accepted Accounting Practice in Ireland, of the state of the Bureau's affairs at 31 December 2007 and of its income and expenditure for the year then ended.

In my opinion, proper books of account have been kept by the Bureau. The financial statements are in agreement with the books of account.



John Purcell
Comptroller and Auditor General

26 March 2008

STATEMENT OF RESPONSIBILITIES OF THE FINANCIAL SERVICES OMBUDSMAN

Sections 57 BP and BQ of the Central Bank Act 1942 as inserted by Section 16 of the Central Bank and Financial Services Authority of Ireland Act 2004 require the Financial Services Ombudsman to prepare financial statements in such form as may be approved by the Financial Services Ombudsman Council after consultation with the Minister for Finance. In preparing those financial statements, the Ombudsman is required to:

- ▣ Select suitable accounting policies and then apply them consistently;
- ▣ Make judgements and estimates that are reasonable and prudent;
- ▣ State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements;
- ▣ Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the Bureau will continue in operation.

The Ombudsman is responsible for keeping proper books of account, which disclose in a true and fair manner at any time the financial position of the Bureau and which enable it to ensure that the financial statements comply with Section 57 BQ of the Act. The Ombudsman is also responsible for safeguarding the assets of the Bureau and for taking reasonable steps for the prevention and detection of fraud and other irregularities.



Joe Meade
Financial Services Ombudsman

25 March 2008

STATEMENT ON THE SYSTEM OF INTERNAL FINANCIAL CONTROL

The Financial Services Ombudsman (Ombudsman) acknowledges as Ombudsman that he is responsible for the Financial Services Ombudsman's Bureau (Bureau) system of internal financial control.

The Ombudsman also acknowledges that such a system of internal financial control can provide only reasonable and not absolute assurance against material error.

The Ombudsman sets out the following key procedures designed to provide effective internal financial control within the Bureau:


- As provided for in Section 57BP of the Central Bank Act, 1942 as inserted by Section 16 of the Central Bank and Financial Services Authority of Ireland Act 2004, the Ombudsman is responsible for carrying on, managing and controlling generally the administration and business of the Bureau. The Ombudsman reports to the Financial Services Ombudsman Council (Council) at their meetings which are generally held on a bi-monthly basis.
- The Council and the Bureau have adopted and implemented a "Code of Practice for the Governance of the Financial Services Ombudsman Bureau" based on the Department of Finance "Code of Practice for Governance of State Bodies".
- The Ombudsman has also put in place a set of Financial Procedures setting out the financial instructions, notes of procedures and delegation practices. The Audit Committee reports to the Ombudsman and Council. The Committee met on four occasions in 2007. The Ombudsman monitors and reviews the efficiency of the system of internal procedure.

- The Internal Audit Firm carried out a risk assessment analysis of the Bureau and its business during 2007; implications of any such potential risks were evaluated and reviewed by the Ombudsman in 2007. Action was taken to ensure that the identified potential risks were being managed in an appropriate manner. A detailed internal audit programme of work was agreed and completed in 2007.

REVIEW OF INTERNAL CONTROLS

I have reviewed the effectiveness of the system of controls. I have examined the internal audit reports and the minutes of the audit committee meetings. Where control deficiencies are highlighted I ensure that remedial action is taken.

I also note that the internal audit programme of work is ongoing and I will ensure that any recommendations highlighted during the currency of the current internal audit programme will be implemented.



Joe Meade
Financial Services Ombudsman

25 March 2008

STATEMENT OF ACCOUNTING POLICIES

The accounting policies adopted in these financial statements are as follows:

BASIS OF ACCOUNTING

The financial statements are prepared under the accrual method of accounting, except as indicated below, and in accordance with generally accepted accounting principles under the historical cost convention.

LEVY INCOME

Council regulations made under the Central Bank and Financial Services Authority of Ireland Act, 2004 prescribe the amount to be levied for each category of financial service provider. Levy income represents the amounts receivable for each service provider calculated in accordance with the regulations and based upon providers identified by the Bureau and information supplied to it. Bad debts are written off where deemed irrecoverable.

TANGIBLE FIXED ASSETS

Tangible fixed assets are stated at cost less accumulated depreciation. Depreciation, charged to the Income and Expenditure Account, is calculated in order to write off the cost of fixed assets over their estimated useful lives, under the straight-line method, at the annual rate of 5% per annum for building refurbishment, 33¹/₃% for computer equipment and 25% for all other assets. A full year's depreciation is charged in the period of the acquisition.

CAPITAL ACCOUNT

The capital Account represents the unamortised value of income applied for capital purposes.

FOREIGN CURRENCIES

Transactions denominated in foreign currencies are converted into euro during the year at the exchange rate on the day of the transaction and are included in the Income and Expenditure Account for the period. Monetary assets and liabilities denominated in foreign currencies are converted into euro at exchange rates ruling at the balance sheet date and resulting gains and losses are included in the Income and Expenditure Account for the period.

SUPERANNUATION

For certain staff members the Bureau is in discussion with the Department of Finance regarding the future financing and management of a defined benefit superannuation scheme. Pending a decision on the matter a provision calculated as a percentage of relevant salaries has been made. (See note 9).

For other staff members the Bureau makes contributions to a defined contribution scheme. (See note 9).

These amounts are charged to the Income and Expenditure Account as they fall due.

ASSETS HELD UNDER LEASE

Assets financed by leasing agreements, which give rights approximating to ownership (finance lease) are treated as purchased outright with the corresponding liability to the leasing company shown as an obligation under liabilities.

Depreciation on such leased assets is charged to expenditure on the same basis as owned assets. The interest on such leases is charged to expenditure as it falls due.

INCOME AND EXPENDITURE ACCOUNT

For the year ended 31 December, 2007

	Notes	2007 €	2006 €
Income Receivable	2	4,408,993	3,499,816
Transfer (to) Capital Account	3	(478,859)	(66,860)
		3,930,134	3,432,956
Administration Costs	4	3,700,464	3,295,383
Surplus for the year		229,670	137,573
Balance at 1st January		1,045,409	907,836
Balance at 31st December		1,275,079	1,045,409

The Bureau has no gains or losses in the Financial Year other than those dealt with in the Income & Expenditure Account. The Statement of Accounting Policies and notes 1 to 13 form part of these Financial Statements.



Joe Meade
Financial Services Ombudsman

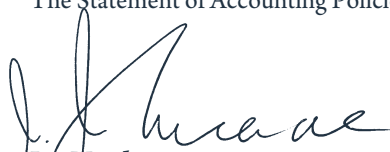
25 March 2008

BALANCE SHEET

at 31 December 2007

	Notes	2007 €	2006 €
Tangible Assets			
Fixed Assets	5	576,775	589,425
		576,775	589,425
Current Assets			
Bank and Cash		75,815	188
Bank Deposit Accounts		2,948,676	2,082,958
Debtors and Prepayments	7	24,765	23,366
		3,049,256	2,106,512
Creditors (amounts falling due within one year)			
Creditors and accruals	8	1,774,177	1,020,377
Bank		0	40,727
Short Term Loan Obligations	6	0	77,091
Short Term Lease Obligations	6	0	23,803
		1,774,177	1,161,998
Net current assets		1,275,079	944,514
Creditors (amounts falling due after one year)			
Long Term Loan Obligations	6	0	353,168
Long Term Lease Obligations	6	0	37,446
			390,614
Net Assets		1,851,854	1,143,325
Represented by			
Capital Account	3	576,775	97,916
Accumulated surplus at 31 December		1,275,079	1,045,409
		1,851,854	1,143,325

The Statement of Accounting Policies and notes 1 to 13 form an integral part of these Financial Statements.



Joe Meade
Financial Services Ombudsman

25 March 2008

CASH FLOW STATEMENT

for the year ended 31 December 2007

	2007 €	2006 €
Reconciliation of surplus to net cash inflow from operating activities		
Surplus for the year	229,670	137,573
Transfer to capital account	478,859	66,860
Depreciation charge	111,533	81,720
Interest (received)	(58,055)	(20,266)
(Increase) / decrease in debtors	(1,399)	131,938
Increase / (decrease) in creditors	753,800	186,578
Net Cash inflow from Operating Activities	1,514,408	584,403
Cash Flow Statement		
Net cash flow from operating activities	1,514,408	584,403
Capital Expenditure	(98,883)	(640,089)
Return on Investments and Servicing of Finance		
Interest received	82,369	35,133
Interest paid	(24,314)	(14,867)
Financing	(491,508)	491,508
Increase in cash	982,072	456,088
Reconciliation of Net Cash Flows to Movement in Net Funds		
Increase in cash in the year	982,072	456,088
Changes in net funds resulting from cash flow		
Net funds at beginning of the year	2,042,419	1,586,331
Net funds at the end of the year	3,024,491	2,042,419

The statement of Accounting Policies and notes 1 to 13 form an integral part of these Financial Statements.

NOTES

(forming part of the financial statements)

1. ESTABLISHMENT OF THE COUNCIL AND BUREAU

The Financial Services Ombudsman's Bureau, established under the Central Bank and Financial Services of Ireland Act, 2004, is a corporate entity and consists of the Financial Services Ombudsman, each Deputy Financial Services Ombudsman and the staff. It is a statutory body funded by levies from the financial service providers. The Bureau deals independently with complaints from consumers about their individual dealings with financial service providers that have not been resolved by the providers. It began operations on 1 April 2005 in line with the provisions of Statutory Instrument 455 of 2004.

The Financial Services Ombudsman Council is appointed by the Minister for Finance. Its functions as laid down in the Act are to:

- ▣ appoint the Ombudsman and each Deputy Ombudsman
- ▣ prescribe guidelines under which the Ombudsman is to operate
- ▣ determine the levies and charges payable for the performance of services provided by the Ombudsman
- ▣ approve the annual estimate of income and expenditure as prepared by the Ombudsman
- ▣ keep under review the efficiency and effectiveness of the Bureau and to advise the Minister for Finance on any matter relevant to the operation of the Bureau
- ▣ advise the Ombudsman on any matter on which the Ombudsman seeks advice.

The Council has no role whatsoever regarding complaints resolutions.

Council and Bureau Expenses

The expenses of the Council are met from Bureau Funds. The accounts reflect the full cost of Council and Bureau's expenses for the year ending 31 December 2007.

2. INCOME LEVY

Section 57 BD of the Central Bank Act 1942 as inserted by the Central Bank and Financial Services Authority of Ireland Act 2004 provides for the payment of an income levy by Financial Service Providers to the Bureau on terms determined by the Financial Services Ombudsman Council. The Central Bank Act 1942 (Financial Services Ombudsman Council) Regulations, 2006 set the actual rate for the year ending 31 December 2007.

Income for the period is as follows:

	2007	2006
	€	€
Levy	4,326,624	3,463,682
Other Income	0	1,001
Bank Interest	82,369	35,133
Total	4,408,993	3,499,816

3. CAPITAL ACCOUNT

	2007 €	2006 €
Opening balance	97,916	31,056
Transfer from/(to) Income and Expenditure Account		
Funds allocated to acquire fixed assets	98,883	82,110
Repayment of capital element of finance lease	61,250	
Repayment of capital element of loan	430,259	66,470
Amortisation in line with depreciation	(111,533)	(81,720)
	478,859	66,860
Balance at 31 December 2007	576,775	97,916

4. ADMINISTRATION COSTS

	2007 €	2006 €
Salaries and Staff Costs	1,681,022	1,438,050
Staff Pension Costs	396,059	405,581
Staff Training	22,394	23,415
Bad Debts	8,353	44,748
Bad Debt Provision	7,600	0
Council Remuneration	136,000	194,166
Council Expenses	40,714	20,885
Rent and Rates	243,158	217,242
Relocation Expenses	0	86,785
Building Loan / Lease	24,314	14,867
Maintenance	37,626	26,746
Conference and Travel	42,295	60,747
Consultancy Fees	191,400	190,016
Information Activities	69,047	108,079
Cleaning	23,459	16,670
Legal Fees	374,110	105,111
Insurance	9,197	4,692
Stationery Costs	39,658	70,998
Other Administration Costs	216,982	155,818
External Audit	13,750	19,590
Internal Audit	11,793	9,457
Depreciation	111,533	81,720
Total	3,700,464	3,295,383

Staff Numbers

The number of persons employed (permanent) in the financial year 2007 was 28 (25 in 2006).

5. TANGIBLE FIXED ASSETS

	Computer Equipment	Office Fitting, Furniture & Equipment	Building Refurbishment	Total
	€	€	€	€
Cost				
At 1 January 2007	90,875	108,714	485,000	684,589
Additions during period	61,102	37,781	Nil	98,883
At 31 December 2007	151,977	146,495	485,000	783,472
Accumulated Depreciation				
At 1 January 2007	39,567	31,347	24,250	95,164
Charge for period	50,659	36,624	24,250	111,533
At 31 December 2007	90,226	67,971	48,500	206,697
Net Book Value				
At 31 December 2007	61,751	78,524	436,500	576,775
At 31 December 2006	51,308	77,367	460,750	589,425

6. BANK LOAN AND FINANCE LEASE

Bank Loans and overdrafts are repayable as follows:	2007	2006
Amount due within one year	Nil	77,091
Amount due between 2 and five years	Nil	353,168
Amount due greater than 5 year.	Nil	Nil
Total	Nil	430,259

The bank loan was paid in full in November 2007.

OBLIGATIONS UNDER FINANCE LEASE

Amount payable under finance leases:	2007	2006
Amounts Payable within One year	Nil	23,803
Amounts Payable greater One year	Nil	37,446
Total	Nil	61,249

The Finance Lease was paid in full in November 2007.

7. PREPAYMENTS AND ACCRUED INCOME

	2007	2006
	€	€
Debtors	4,439	1,000
Accrued income	8,059	8,694
Prepayments	12,267	13,672
	24,765	23,366

8. CREDITORS (AMOUNTS FALLING DUE WITHIN ONE YEAR)

	2007	2006
	€	€
Trade creditors and accruals	343,300	77,393
Pension Contributions	1,430,876	942,984
	1,774,177	1,020,377

9. SUPERANNUATION

In accordance with Section 57BN of the Central Bank Act 1942, as inserted by Section 16 of the Central Bank and Financial Services Authority of Ireland Act 2004, the Council has drafted a superannuation scheme which has been submitted to the Minister for Finance for approval. The scheme is a contributory defined benefit superannuation scheme based on the Department of Finance Model Public Sector Scheme. Pending legislative confirmation of the pension finance arrangements, we present this information required by FRS 17 by way of a note only. The scheme is being operated on an administrative basis with the consent of the Minister.

The Ombudsman proposed to the Department of Finance that the liability for benefits paid under the Scheme should be assumed by the State in return for payment annually of a percentage of the salaries of scheme members. The Department of Finance then sought advice from the Office of the Attorney General on this issue and is satisfied that a legislative amendment will be required before it progresses the matter. In view of this requirement the Department proposes to introduce a legislative amendment at the next appropriate opportunity. The contributions to be paid over to the Exchequer will be at a level where the Exchequer is not exposed to liabilities in excess of the revenues accruing over the years to the Exchequer. The Minister reserves the right to adjust the rate of contribution in the future in line with future actuarial adjustments on costs. The Department of Finance also indicated that this overall approach to funding the superannuation scheme is consistent with the principle accepted that the overheads associated with establishing a funded scheme is not justified where the number of staff is relatively small.

In addition, staff who transferred from the former Insurance and Credit Institutions Ombudsman offices on the date of establishment could opt to continue with their existing defined contribution scheme. These schemes, which include life cover benefit, are administered by private pension providers. Once employee and employer contributions are paid over the Bureau has no further liability. Alternatively, transferred staff could opt to become members of the Bureau scheme from the date of transfer. In these cases the Bureau received amounts on surrender of the employee's entitlements under the defined contribution schemes. The amount will be used for the purchase of added years under the Bureau scheme in accordance with the provisions of Department of Finance Model Public Sector Scheme.

Employee contributions and amounts received in respect of entitlements surrendered by transferred employees are retained by the Bureau pending a decision by the Minister for Finance as to how the scheme should be managed. These amounts are included in creditors (see note 8).

The Pension liability at 31 December 2007 is €3,300,000. This is based on an actuarial valuation carried out by a qualified independent actuary using the financial assumptions below for the purpose of FRS 17 in respect of Bureau staff as at 31 December 2007. Under the proposed pension funding arrangements this liability would be reimbursed in full, as and when these liabilities fall due for payment.

The main financial assumptions used were:

	31 December 07
Discount rate	5.5%
Rate of increase in salaries	4.0%
Rate of increase in pension	4.0%
Inflation	2.0%

10. FINANCIAL COMMITMENTS

There are no capital commitments for capital expenditure as at 31 December 2007.

11. CONTINGENT LIABILITIES

There were no contingent liabilities as at 31 December 2007.

12. LEGAL ACTIONS

As at the 31 December 2007 an appeal to the Supreme Court has been made by a Financial Service Provider against a High Court judgement which considered matters following a decision made by the Ombudsman. The Ombudsman is defending this appeal. There are other appeals before the High Court which the Ombudsman is defending. In the event of costs being awarded by the High Court against the Ombudsman, these will be met by the Bureau.

13. COUNCIL MEMBERS – DISCLOSURE OF INTERESTS

The Council adopted procedures in accordance with guidelines issued by the Department of Finance in relation to disclosure of interests by Council members and these procedures have been adhered to in the period. There was one transaction in the year in relation to the Council's activities in which the Council members had any beneficial interest. A consultancy payment for the amount of €2,500 was made to one Council member for a special task carried out (outside of the member's normal duty). The matter was discussed at a Council meeting.

14. APPROVAL OF FINANCIAL STATEMENTS

The Financial Statements were approved by the Financial Services Ombudsman on 25th March 2008.



PART V
CASE STUDIES

PART V

CASE STUDIES

Ombudsman directs that more than €200,000 be paid to a former professional rugby player after his claim under the IRFU insurance policy was repudiated by the Insurance Company

The Irish Rugby Football Union (IRFU) has an insurance policy with an Insurance Company to cover players who may get injured. Professional rugby players are under contract to the IRFU and can qualify for a Permanent Total Disablement benefit if they cannot pursue their professional career, as a rugby player, after sustaining a serious injury.

This dispute involved a claim submitted by a former professional player. In August 2000, while under contract with the IRFU, the Complainant suffered a total dislocation of one knee while playing professional rugby in Ireland. The Complainant made various attempts at rehabilitation (which included participation at *amateur* rugby level) but these were unsuccessful. He had not played professional rugby since sustaining the initial injury and his contract with the IRFU was terminated in 2002. Four years after sustaining the injury, during which time he was under supervision by the IRFU medical team, it was concluded that he would not be able to return to professional rugby. The claim for *Permanent Total Disablement* was then submitted by the Complainant in 2004.

The Company repudiated the claim stating that it did not fall within the terms and conditions of the policy. The Company referred to the Complainant's ability to play amateur rugby since 2000 and that due to the late notification of the claim its position was therefore prejudiced as it had not been afforded the opportunity to medically assess his condition. The Complainant disputed the Company's decision and then referred the matter to the Ombudsman during 2006.

In considering the dispute the Ombudsman noted that the Policy clearly referred to playing rugby in a *professional capacity* and ability or inability to participate in *professional* rugby. Accordingly the Ombudsman decided that the cover had to be for the professional game only. If it was intended that both amateur and professional rugby would be covered by the same policy - and he had no knowledge of this - then the Policy as it existed was deficient. He noted with interest that the Company, the IRFU and its insurance advisors were, during March 2007, in discussions about what the policy covered. The Ombudsman was satisfied that it would be inequitable for the Complainant to suffer financial loss for

this lapse on the part of the Company, the IRFU and its advisors to clearly define what they thought was covered.

The Ombudsman then had to consider the late notification of the injury to the Company and whether its position was prejudiced as a result. The Ombudsman noted that:

- Whilst the policy was silent as regards notification, nevertheless, the IRFU had some duty to at least notify the Company. On the other hand the Company was lax and must accept blame in not ensuring that there was a proper procedure laid down as to the methods by which notifications should have been made, at what time and by whom.
- The reality was that in this particular situation a player sustained a genuine injury; made efforts to rehabilitate himself; his contract was terminated and despite the best medical assistance he had received, he was no longer able to pursue his chosen professional employment.
- There is an implied obligation of notification of an accident that may lead to an insurance claim. The Company not being on notice of a claim could, in normal circumstances, be prejudiced. However, in this case irrespective of when the Company was put on notice, and considering the medical evidence, it would not have altered the facts that the injury sustained in effect was, and is, a professional career ending injury.
- The Complainant genuinely tried as much as was humanly, medically and indeed sportingly possible to resume his professional career but it was not to be. It was then that he made the insurance claim - to which he felt he was entitled if the insurance contract was to be any way meaningful - to compensate him for his loss of employment.

In those circumstances, the Ombudsman had to bring equity into play in line with his statutory responsibilities. Accordingly the Ombudsman did not accept that the Company was prejudiced in being notified after a long period of time and as the policy was silent as regards notification anyway the Ombudsman decided that the policy should be construed in favour of the Complainant.

The Ombudsman directed the Insurance Company to pay the full benefit under the policy relating to the Complainant's claim - €190,461. Having due regard to the distress and expense this matter must have undoubtedly caused the

Complainant, he also directed the Company to pay the Complainant another €10,000 in compensation.

Furthermore the Ombudsman directed the Company and the IRFU to enter into urgent negotiations so as to ensure that proper notification systems were in place within three months from the date of his April 2007 decision. Because the IRFU was the holder of this policy, he copied his Decision to the IRFU for information and any actions which it deemed appropriate to take.

Mortgage Brokers giving investment property advice need more clarity and less confusion – compensation totalling €61,000 awarded in three instances

In the 2006 published decisions, the Ombudsman found that a mortgage broker had an undisclosed conflict of interest when he sold an investment apartment which he himself owned without disclosing the fact and the Ombudsman awarded €16,500 in compensation. One of the issues which arose in that dispute, apart from the conflict of interest, was that the broker in his defence stated that the principal who was acting for the broker was acting in a personal capacity. The Ombudsman did not accept that argument.

Another case concerned a woman who had money to invest as a result of a divorce settlement and had sought advice from a multi agency investment broker. Acting on the advice she was prevailed upon to invest €100,000 in a Bond and €51,000 as a deposit on the purchase of two apartments to be built in Liverpool. In regard to the purchase of the Bond she had no complaint. Her complaint was in respect of the advice to invest €51,000 in the two apartments. In respect of this investment, a deposit on two apartments, she was advised that she would not have to complete the purchase because the properties in question would be “*flipped over*” prior to closing and she would then have a handsome profit of approximately €20,000. She handed over the money for the deposit. Fourteen months later she was told by the broker that unfortunately due to a downward turn in the market for apartments in Liverpool, there would not now in fact be any “*flip over*” and that consequently she would now have to get a mortgage of €500,000 to complete the sale. In the event she was unable to do this and she forfeited her deposit of €51,000 and had to pay €3,000 in costs. In this case also, it was argued that the person doing the property deal was also carrying it

out in a personal capacity and was not employed by the intermediary. The Ombudsman did not accept that defence either and awarded the Complainant compensation totalling €40,000 for a property investment where she had lost €54,000.

The Ombudsman then received a further complaint involving another mortgage intermediary. In this case, again a property was involved where investment advice was sought and a property purchased. However a mortgage could not later be obtained and the matter did not work out to the satisfaction of the Complainant. In this instance the Ombudsman awarded €5,000 compensation towards costs incurred.

Two matters are of significant concern to the Ombudsman:

- In two instances the mortgage advisors tried to indicate that the person was acting in a personal capacity, when manifestly they were not. This may be arising in other cases which have not come to his attention.
- The type of investment advice being sought may be solely financial advice or, as in these three cases, combined with property purchases and mortgage facilities. Consumers have been given investment advice on the basis that the property can be acquired overseas; that a mortgage will be secured if needs be, but that it is more than likely the property will be “*flipped over*”, i.e. sold on, and therefore there will be no need to conclude the sale. When this does not happen the consumer may not be able to raise a mortgage and may be at a loss financially.

In the Ombudsman’s opinion there is alas confusion as to the objectivity of the financial advice being given and indeed there is an unhealthy relationship when advice on property and general financial advice is given by the same broker. The Ombudsman appreciates that it must be difficult for consumers to determine whether such a person is operating as an estate agent or as a mortgage advisor. However, in the three cases so far decided by the Ombudsman significant issues regarding independent financial advice and conflict of interest have arisen which he has brought to the attention of the Financial Regulator so that these issues may be considered in the overall review of the mortgage intermediary area.

Unsuitable € 10,000 Investment sold to an unemployed single mother - sales practices of Insurance Company questioned

This dispute related to a personal investment. The investment selected was a Unit Linked Fixed Interest Fund. Despite the selected Fund being the most conservative available from the Insurance Company it was not guaranteed to maintain the value of the investment.

The Complainant had €10,000 to invest which she had in a credit union account. She insisted that the Sales Representative told her he would look after her cash and she withdrew the €10,000 from the credit union and invested it in the Fund. She was dismayed on discovering after three months a fall of over €500 in value of her investment. A further fall some weeks later led to a higher loss and when she surrendered the policy eight months later she lost €1,100.

The Complainant felt she was misled as to the nature of the investment. The Company on the other hand stated that a Fact-Find was completed and pointed to documentation issued at the outset. The Company argued that the investment was affordable and was suitable for the Complainant's attitude to risk. The Ombudsman noted that a signed Fact-Find, completed by the Sales Representative, included the following

The client has money lodged with the Credit Union which she wants to move to get a better investment return. The "investment risk attitude" was classified as "slight". The Complainant was described as "single" and "unemployed". She had 2 young children dependents and was living with her parents.

While the Ombudsman recognised that a Fact-Find was completed and that explanatory documentation issued to the Complainant he considered, in the circumstances of the case that the Complainant relied on the representations of the Company's Sales Representative. The Ombudsman also felt that the Complainant did not understand that there could be a negative value, particularly in the early years. In his view, her circumstance as a top priority required the preservation of capital at all times. The Ombudsman understood her panic when the value fell repeatedly and considered that this investment plan was not a suitable investment vehicle for the Complainant and therefore should not have been offered to her.

The Ombudsman directed that it was appropriate that the investment of €10,000 should be returned in its entirety to the Complainant.

The Ombudsman would not expect many such Funds to be purchased by individuals generally. He would expect them to be usually part of a portfolio, to be switched into when the outlook for equities is seen as poor. Up front charges mean the Fund value cannot be positive in the first year. In an environment of rising interest rates, Unit Linked Fixed Interest Bond Prices will fall even though they are earning a guaranteed interest rate. Accordingly, the Ombudsman referred the matter to the Financial Regulator to review the sales practices of the Company and the appropriateness of selling Unit Linked Fixed Interest Bonds to low income clients who have limited capital.

Bank directed to furnish to the beneficiary of an army compensation award a copy of the payable order - made payable to him but lodged to his solicitor's account –and awarded € 1,000 for its failure to do so earlier

A former Irish soldier, who now lives in London, was granted an Army Deafness Compensation award and he was represented in Ireland by a firm of solicitors. The payable order made payable to him was sent to his solicitors by the Department of Defence.

The Complainant was awarded IR£20,000 compensation and he alleged that without his permission or authority the solicitors in question lodged the payable order, made payable to the Complainant, to his (solicitors) firm's account and having done so, deducted IR£2,500 in respect of fees (even though fees had already been paid by the Department) and forwarded the balance to the Complainant. The legal advice centre in London contacted the Ombudsman, on behalf of the Complainant, when the bank would not give him a copy of the cashed order as he was led to understand that his 'signature' was endorsed on the back of the order. The Ombudsman noted that the Complainant had himself maintained two Irish bank accounts in the same branch where the solicitors also had their account.

The complaint stated that the solicitors in question deducted a sum in respect of fees, without the express authorisation

from the client and the Ombudsman also noted that the £2,500 deduction was before the Law Society. It was not the role of the Ombudsman to consider the correctness or otherwise of the action of the solicitors.

The question for the Ombudsman to consider was whether the Collecting Bank had acted wrongfully in facilitating the transaction. The payable order was purported to have been endorsed by the Complainant but the Complainant stated, and the Ombudsman accepted, that the Complainant had never seen the payable order, let alone endorsed it. The Ombudsman, after getting the Bank to furnish him with a copy of the lodged payable order, was satisfied that the signature of endorsement could not be that of the Complainant. Having considered the matter the Ombudsman decided that the evidence did not disclose that the Bank had acted negligently or in bad faith so as to lose the protection of section 4 of the Cheques Act 1959 which is given to Collecting Banks. This section provides *inter alia* that where a bank in good faith and without negligence lodges a cheque to an account it is not negligent in its failure to concern itself with the absence of, or irregularity in, the endorsement of a cheque even where that account has no title to the cheque in question.

However, the Ombudsman did find against the Bank in that when the Complainant initially tried to pursue the matter, the Bank refused to provide any information to him on the grounds of its duty of confidentiality to its customer, the solicitors who had lodged the payable order. The Ombudsman found that the refusal of the Bank to provide any assistance whatsoever to the Complainant (e.g. in refusing to furnish him with a copy of the paid payable order, even though he was the true owner of it) was unreasonable in the circumstances and unfair to the Complainant.

The Ombudsman awarded €1,000 in compensation and directed that a copy of the paid payable order (front and back) be furnished to the Complainant. The Ombudsman also made it clear that this finding was made without prejudice to any other remedy, if any, that the Complainant may have elsewhere against the firm of solicitors concerned in respect of the IR£2,500 loss which he claimed against them.

Repatriation claim submitted by the parents of a deceased tourist was handled in an insensitive manner by Travel Insurance Company, hearsay evidence by the Company was not accepted by the Ombudsman and he directed the Company to pay £4,000 sterling

This dispute concerned the refusal by an Irish based Travel Insurance Company to pay a claim for repatriation costs of the deceased Insured under a Travel Insurance policy on the grounds that an exclusion under the policy applied to the circumstances of this case, namely that “the underwriter is not responsible for any claims arising from ... being under the influence of alcohol...”. The deceased Insured- a UK citizen- died while on holidays in Spain and a claim for the cost of repatriating his body was submitted to the Company. The benefit payable under the policy, the repatriation costs, were payable to the next of kin of the Insured, in this case, the Insured’s parents. The maximum amount of benefit payable under the policy in relation to repatriation expenses was £3,000 sterling.

The primary cause of death recorded on the Insured’s Death Certificate was Cardio Respiratory Failure and no secondary cause of death was recorded. The Company, in asserting that the Insured died as a result of being under the influence of alcohol, sought to rely on witness statements from companions of the Insured, the hotel director and resort manager of the hotel where the Insured died. The Company did not submit any autopsy report, coroner’s report or a toxicology report and did not rely on any such documents in its initial repudiation of the claim or indeed in its submissions made to the Ombudsman.

Based on the evidence submitted and the events surrounding this dispute the initial Finding by the Ombudsman’s Investigating Officer was that the evidence submitted by the Company was insufficient to prove, on the balance of probabilities, that the claim and, therefore, the death, arose as a result of the Insured “*being under the influence of alcohol*”. The Company was therefore requested to pay the repatriation expenses incurred in respect of the Insured, the Complainants had already been invoiced for this by the funeral assistance company, and an additional £500 sterling in compensation.

The Company was dissatisfied with this Finding and made further submissions on the matter to the Ombudsman. In his final decision the Ombudsman stated that

- When seeking to rely on an exclusion clause under a contract of insurance to deny the claim the burden of proof rests on the Insurance Company to prove that the circumstances of the loss fell within the exclusion.
- Where the standard of proof was *the balance of probabilities* the degree of probability required is proportionate to the nature and gravity of the issue in dispute.
- The nature and gravity of the allegation being made i.e. that the Insured's death arose as a result of the Insured "*being under the influence of alcohol*" must be taken into account and regard must be had to the effects such a determination would have on the Insured's family.
- In relation to the evidence submitted by the Company in support of its case the statement of the hotel director and resort manager in relation to what was said by third parties was purely hearsay in nature.
- The only probative value of the statements given by the companions of the Insured was as to alcohol consumed on the day prior to death not as to actual cause of death. Such statements must be considered having regard to the circumstances in which they were taken.
- He did not accept that the Company, the party who bears the burden of proof, should be allowed to rely on a lack of evidence in support of its contentions. The evidence available to the Company at the time of the claim and at the time of its refusal to pay the claim was not sufficient to entitle the Company to rely on the exclusion under the policy. The Company should have sought further evidence before repudiating the claim – at a minimum an autopsy report on the Insured.
- The Company did not cite any medical authority in support of its original case or indeed in its detailed submission to him.

The Ombudsman accordingly found the Company's handling, assessment and repudiation of the claim to be totally incorrect and *highly* insensitive to say the least. In upholding his Investigating Officer's Finding he directed the Company to pay the **total** repatriation expenses incurred in respect of the Insured - £3,396 sterling due to the funeral assistance company and any interest which may have accrued on the debt. He also directed that the Company pay the

Complainants £500 sterling for distress caused.

Medical submissions by Insurance Company not accepted by Ombudsman and Specified Illness Cover payment of €165,000 is made

This dispute concerned the refusal by an Insurance Company to pay a claim under a Specified Illness Cover Policy on the grounds that the Complainant's medical condition did not satisfy the policy definition for Myocardial Infarction (Heart Attack).

The Company requested and obtained a report from the Complainant's own General Practitioner and a Consultant Cardiologist. The Company proceeded to evaluate the Complainant's illness against the definition of Heart Attack under the policy. The Company asserted that based on the medical facts it concluded that the Complainant did not have a Heart Attack as defined under the plan.

On the basis of the conflicting medical opinions in relation to this case, the Ombudsman felt that it was appropriate to seek from a leading Consultant Cardiologist an independent medical opinion on the matter solely to give him some guidance from a medical perspective. It was not sought to be the ultimate determination of this dispute. The independent medical opinion stated that the Complainant did suffer from typical chest pain, that there were electrocardiography changes consistent with a diagnosis of myocardial infarction and that a rise in cardiac enzymes was noted.

The Ombudsman, in consideration of the medical evidence and the advice he received, was struck by two factors:-

- *the physical examination of the Complainant post admission to hospital*
- *the various opinions/advices in relation to the occurrence of Myocardial Infarction had to be considered in light of the contemporaneous reports of the Complainant's presenting condition(s).*

Whilst the Ombudsman acknowledged the individual advices proffered, he stated that it was his duty alone to make a decision on all of the facts presented and considered by him. The Ombudsman found on the balance of probabilities that the Complainant suffered a Myocardial Infarction within the

policy definition. Accordingly the complaint was upheld and €165,000 was paid to the Complainant.

Widow considers a Credit Union nominated account 'disinherited' her out of €12,700

The Ombudsman received two complaints arising from the system of Nomination Forms for Credit Union deposit accounts.

Under the Credit Union Act 1997, an account holder may nominate a person to receive up to €23,000 from an account on the death of that account holder.

In one of the complaints considered by the Ombudsman the account holder- an elderly man- nominated his daughter-in-law, a fact quite unknown to the account holder's wife. He apparently opened the account by withdrawing money from a bank account. On his death, 15 months later, the Credit Union paid out €12,700 to the daughter-in-law. The account holder's surviving spouse, a woman in her late 70s, brought a complaint to the Ombudsman that her legal entitlements were "set at nought" by this method of dealing with the deposit account of her late husband.

In this case and in the other case dealt with, the complaints were not upheld because the Ombudsman's investigation disclosed no fault or failure on the part of the Credit Unions concerned.

However, in the light of these two complaints the Ombudsman took the view that the circumstances of these cases raised wider questions of public policy in that the Nomination system may be unfair to people, such as surviving spouses. In effect the system could be used to deprive a surviving spouse of his/her statutory rights under the provisions of the Succession Act 1965.

In these circumstances the Ombudsman decided to refer the issue to the Registrar of Credit Unions (the Financial Regulator) so that full consideration could be given to the public policy issues raised arising from the circumstances disclosed by these complaints.

ATM card cash withdrawals of large sums across Bank counters needs review to prevent fraud

A customer had his ATM Card stolen from his place of work at lunchtime. Before he noticed the Card was stolen, a withdrawal was made at 2:26 p.m. and another one at 2:29 p.m. from ATM machines amounting to €550. Following this, at 3:37 p.m., the thief presented himself at the branch where the Complainant's account was held and asked for, and was given, €4,000 across the counter on production of the stolen ATM Card and the PIN.

The Ombudsman found that the customer must have been negligent in regard to his PIN and therefore the Bank could not be held liable when the Card and PIN were used at the ATM and the customer must bear the loss for these two transactions.

However, the Ombudsman felt the matter was altogether different in the case of the withdrawal which took place across the counter at the branch. He found that the Bank had not adhered to its own security provisions and in his opinion the Bank failed in its duty of care to the Complainant because of that. A withdrawal of €4,000 constitutes a substantial sum for any customer to withdraw in cash and a customer is entitled to expect that such sums will not be withdrawn from their accounts across a counter at a branch unless by themselves or somebody authorised by them on production of proper identification. Clearly nothing of the kind happened in this case where a thief and a fraudster simply had to present the stolen Card with the correct PIN in order to obtain €4,000 of the Complainant's money from his own Bank.

The Ombudsman was satisfied that the branch was negligent in facilitating the €4,000 withdrawal without asking for proof of identification beyond that of a Card and PIN. In those circumstances the Ombudsman awarded €4,000 to the Complainant in respect of this aspect of the complaint, but made no award as to the two transactions from the ATM machines.

Some weeks earlier a similar fraud was perpetrated against the same Bank at a branch in a different part of the city. In this case also the *modus operandi* was the same with the fraudster presenting himself at the account holder's branch and withdrawing €2,500 from the account on presentation of the Card and stating his PIN Number. In this case the Ombudsman ordered the payment of €2,500 compensation.

The Ombudsman also drew the attention of this particular Bank to what may possibly be a systemic failure in its systems or procedures and indicated that these procedures should be reviewed so as to prevent, or make less likely, this kind of fraud taking place again while acknowledging that ease of customer service was a Bank priority.

Phone records help Ombudsman's work; payments of €310,000 and €35,000 arose while a complaint against a stockbroker was rejected

Many dealings with financial service providers are conducted over the phone and are later confirmed by correspondence but not in every instance. For that reason Financial Service Providers record phone conversations and are allowed to retain them for a specified period of time, or where a dispute has arisen or where a potential dispute may arise. When investigating complaints the Ombudsman may call for transcripts or indeed the tapes of such phone conversations and on occasions providers themselves furnish them in response to matters raised by the Ombudsman's staff in the course of complaints investigations. The Ombudsman considered them to be of significant value to his work in the following three cases.

- An Insurance Company repudiated a claim made under a mortgage protection policy, stating that relevant medical information had not been disclosed when the policy was being set up. The Complainant and his wife had applied for a mortgage protection policy in January 2003. The policy was due to come into effect in March of that year. In February 2003 (one month before the policy was due to come into effect) the Complainant's wife was suddenly and unexpectedly diagnosed with a serious illness. Two years later she passed away and a claim was made under the policy. The Company repudiated the claim, stating that the Complainant's wife had not disclosed her serious illness before the policy came into effect. The Complainant denied this and stated that his wife had telephoned the Company upon diagnosis of her illness as she was worried that her illness may have affected the level of cover offered. As there were conflicting statements as to what information was given to the Company, the Company phone records for the period in question were requested by the
- Ombudsman. Following this request, the Company, on listening to the phone recordings, discovered that the Complainant's wife *had indeed* advised the Company of her illness in advance of the policy coming into effect but this information had not been properly recorded by the Company. As a result, the Company immediately paid the benefit under the policy which amounted to €305,000. While the Ombudsman complimented the Company for this prompt action he directed it to pay a further €5,000 in compensation for the distress undoubtedly caused at a very difficult time.
- In another case involving foreign exchange dealings a dispute arose as to an instruction given to an Irish based Financial Service Provider by a customer and where it was alleged he had lost €50,000. The customer, who resided in the UK, had insisted that the provider was negligent in not carrying out his directions; he had been a long standing customer and had engaged regularly in foreign exchange dealings and speculation by phone and email contact. Having read the transcripts of the conversation - the Ombudsman requested them after it was indicated in the provider's earlier submission that the transcripts supported its position - the Ombudsman was satisfied that the complaint was justified and awarded €35,000 in compensation.
- A Stockbroker and a client had entered into a contract under which the Stockbroker was to supply certain services in connection with the client's business. The complaint was that the Stockbroker's actions in terminating the agreement between the parties, without prior notice to the Complainant, constituted conduct that was unreasonable and unjust. The Ombudsman was satisfied, after listening to recordings of over eighty minutes of phone conversations between the parties, that the complaint was not justified.

Switching of Bank Account and abysmal lack of communication between Banks

A customer wished to transfer his account from one Bank (A) to another Bank (B) and instructed his Bank accordingly. Bank B sent the transfer form to Bank A, in accordance with the voluntary Banking Code of Practice for transfer of accounts.

The Manager of Bank A telephoned the Complainant to say that although he had received a form from Bank B, he could not act on it and was returning it to Bank B. In spite of the fact that the Complainant notified his Bank that he wanted to close his account, and sent a cheque to effect this, Bank A did nothing about it and continued to execute direct debits on the account. Bank A insisted that the account was never closed.

The Ombudsman found it surprising that the Manager of Bank A had never written to the Complainant to say that the account was still open. Eventually when the matter had been referred to the Head Offices of the Banks the wishes of the Complainant began to be implemented.

The Ombudsman found there was an abysmal lack of communication between Bank A and its customer and between the two Banks. It was obvious to him that the Code of Practice covering this situation had failed in this instance. He awarded €1,000 in compensation against Bank A and instructed that the Complainant should be repaid interest charged on his account during the ten months it took to sort out this matter.

Advice by Insurance sales agents was highly unsatisfactory

The Ombudsman, after investigating two complaints about two different Insurance Companies, considered that the advice given by their sales representatives was highly unsatisfactory.

Case A

The Complainant sought a return of her capital IR£ 17,500 plus interest on an Investment Bond arranged in 2000. While the Insurance Company acknowledged that on encashment in June 2004, after allowing for earlier partial encashments, a loss was sustained, it pointed out that the Bond did not have a

capital guarantee. This Bond was arranged in 2000 following the Complainant transferring a lump sum to a Bank to secure a loan for her son. The Complainant stated that she was happy to have the funds on deposit in the Bank but was advised to speak to a Representative of the Insurance Company, a tied agent of the bank, who persuaded her to place the funds in the Bond. In 2002, the Complainant discovered to her horror that the value had fallen by a considerable amount.

The Complainant explained in her submission to the Ombudsman that these funds were her retirement lump sum - her only financial security after 33 years in employment - and it was hard to see how their use in a non-guaranteed Bond could be justified. The Complainant also stated that she never received a Policy although the Ombudsman noted that it was assigned to the Bank as the loan guarantee. The Company pointed to the Application Form, signed by the Complainant, including the following: *"The value of the Bond can go down as well as up and is not guaranteed."* The Company also drew attention to the Bond Brochure and to a clear *"Word of Caution"* that values are not guaranteed. The Ombudsman noted however that a necessary Fact Find had not been completed by the Company.

While the Ombudsman considered that the Complainant had to take some responsibility for entering into the Bond he considered that more appropriate advice from the Bank and the Company would not have placed her in an equity linked investment on top of her commitment of the funds as security for a family loan. As the loss on the Bond was €4,700 he directed the Company to pay 75%, €3,500, in full and final settlement of the complaint.

Case B

The Complainants stated that they were canvassed on a number of occasions by an Insurance Company sales representative who, at the time the dispute was submitted to the Ombudsman, had left the Company and was not available for comment. The Complainants invested IR£3,000 on the representative's many alleged assurances that they were guaranteed a minimum return of their IR£3,000. This was a single premium plan invested in a European Equity Fund, it had no guarantees, and Fund value could go up and down. A minimum death benefit was payable. In the event the investment value fell. The Complainants asked the Ombudsman that the Company honour the guarantee they stated they were given by the Company Agent. They also sought compensation for the stress caused.

The Ombudsman expected a *Fact find* to have been completed at time of sale. This was not done on the explanation that one was completed 12 months earlier in relation to another Policy. In correspondence the Company also referred to the Complainants as “experienced investors” but this investment was only IR£3,000. The Ombudsman did not accept these statements as credible explanations.

The Company also pointed to the documentation issued, which explained the workings of the Policy and that the investment could fall in value. While the Ombudsman strongly believes that Policyholders must read the documentation issued to them, however, in the circumstances of this case he accepted that the Complainants relied totally on the sales representative’s advice. The Ombudsman considered that the Complainants invested in this product believing they were guaranteed at least their money back and he therefore directed the Company to refund the IR£3,000.

SSIA account opened at the wrong rate

A woman who opened an SSIA account at what she thought was a fixed rate of interest found, when the account matured five years later, that it had been all the time at a variable rate contrary to what she had agreed to. The Bank in question only offered a variable rate account.

The Ombudsman was struck by the fact that this person, when she opened her SSIA account, was an employee of a company-not a Financial Service Provider. Her employer was also actively promoting this particular SSIA product along with the Bank who was located in her employer’s premises. As her contributions were also deducted from her weekly wages it was considered by her as an easy way to save and therefore a very attractive product.

The Ombudsman also noted that she did not get a copy of the terms and conditions until she requested them when the account was about to mature. In those circumstances he considered that she may not have been acquainted with, or apprised of, all of the account’s finer points by the Bank.

Having examined the evidence submitted by both parties, the Ombudsman came to the conclusion that, on the balance of probabilities, the Complainant did seek an SSIA paying a fixed rate of interest and that she was led to believe she was getting this. So as to place the customer back in the position she would have been in if the SSIA had been at the fixed rate, the Ombudsman awarded her €1,000 in compensation.

Relationships break-up can significantly affect life assurance policies

The Complainant in this instance stated that he was unable to claim a critical illness benefit following a serious operation in February 2004, on the grounds that a previous policy held by him and his ex-partner had lapsed in April 2003. He alleged he had applied for a new single life policy providing cover for him but this had not been put in place by the Insurance Company. It appears that the relationship break-up occurred in late 2002.

The Complainant furnished to the Ombudsman a lengthy and detailed submission of conversations and meetings which took place between him and the Company’s Financial Advisor. The Complainant maintained that the Financial Advisor advised him to firstly let the joint life policy lapse, and then to take out a new single life policy in his own name. The Complainant stated that he had completed a proposal for a new policy in mid April 2003. On the other hand the Company submitted that the Complainant had advised the Financial Advisor that he was not in a position to maintain the monthly payments on the plan, and had agreed to contact him once he was in a better situation financially to either revive the current plan, or propose for a new plan on a single life basis. The Company stated that no proposal for a new policy had been received from the Complainant in 2003. However the Complainant’s ex partner had incepted a separate policy in March 2003 following a meeting with the same Advisor in early 2003.

As the two parties provided very different accounts of meetings and conversations which had taken place in and around 2003/2004, it was necessary for the Ombudsman’s Investigating Officer to have regard to the documentary evidence. This revealed that the Complainant had submitted, as part of his evidence, a Personal Finance Review dated February 2003, completed by the Company’s Financial Advisor which indicated that, while the Company’s recommendations were for the Complainant to address his life cover and critical illness shortfalls, the agreed action was for the Complainant to top up his AVC pension, and that the other shortfalls would be addressed at the next review, scheduled for February 2004.

The Investigating Officer found that there was no evidence that a proposal for a new plan or for the revival of the lapsed policy was ever completed by or on behalf of the Complainant. It was also found that no premium was paid by the Complainant to the Company in respect of a new policy,

and as a result was satisfied that there had been no consideration from the Complainant for a new single life policy. Both parties were given 25 days in line with Ombudsman's procedures to accept the Finding or to make further submissions before the Ombudsman came to a Final Decision.

The Complainant was unhappy with the Finding and requested to meet the Ombudsman. The Complainant had made requests during the course of the investigation to meet with the Investigating Officer, or the Ombudsman. As a general rule, Complainants are not met in person during the course of an investigation as most investigations are carried out by reviewing documentary evidence. However, there are occasions, particularly at final review stage, where the Ombudsman may decide to meet with either of the parties to elaborate on certain conditions or where the Ombudsman feels that persons may not be capable of expressing their genuine thoughts in writing. The Ombudsman felt that this was an occasion where it was appropriate to meet the Complainant. The Ombudsman is also empowered to take evidence under oath from employees of Financial Service Providers.

At the meeting between the Ombudsman, the Investigating Officer, and the Complainant, who was accompanied by a relative, the Complainant stated that he had been advised by the Company's Financial Advisor to let the life policy lapse and to contact him when he received the lapse notice from the Company. The Complainant stated that he and his relative met the Financial Advisor around April 2003, and that he completed a proposal for a new policy at this meeting, the relative confirming that he had witnessed the Complainant's completion of same and was willing to swear this under oath.

At a subsequent meeting between the Ombudsman, the Investigating Officer, and the Company's Financial Advisor, who was accompanied by the Company's Head of Sales Operations, the Advisor denied having advised the Complainant to let the policy lapse and to contact him once he received the lapse notice from the Company. In addition he stated that he had no recollection of a meeting in April 2003, and that the Complainant had not requested a new policy in April 2003. He also stated that the meetings which took place in the period 2003 to early 2004 were to do with encashing an SSIA policy, and topping up an AVC policy - the Ombudsman noted that the SSIA was encashed in January 2004 apparently against the Advisor's advice. With regard to notes of the meetings, he did not have any as, at the time, he kept his notes in a diary which he cleared every couple of months. He was also willing to give sworn evidence.

During the meetings the Ombudsman noted that the Financial Advisor personally knew the Complainant and his ex-partner very well and had advised them over many years on investments. Following those meetings, the Ombudsman considered that it was unnecessary to take evidence under oath, or indeed to seek sworn affidavits from all of the parties.

In arriving at his Final Decision, the Ombudsman stated that he fully accepted and recognised that both parties to the complaint had a genuine belief that they were correct in their recall of events. While he was mindful that the break-up of a relationship can cause emotional problems, he had to consider the matter in a fair, impartial and dispassionate manner and take account of all factors, including documentary evidence. He agreed with his Investigating Officer's finding and though not upholding the complaint the Ombudsman awarded €8,000 on the grounds that some aspects of the customer care by the Company were not to the standard that he would have expected including the record keeping by the Advisor.

In a general comment the Ombudsman noted that Financial Advisors of the Company generally meet with customers every year to review their financial situation and indeed to sell them some more products if needs be. The Ombudsman finds nothing inappropriate with that. However, where the Financial Advisor knows both parties and is aware of a relationship break-up, the Ombudsman requested that appropriate additional steps be taken by the Company to ensure that the serious consequences of a policy lapsing would be clearly drawn to their attention.

House being underinsured resulted in a reduced settlement amount

The Complainant submitted a claim under his household insurance policy for the subsidence of his private house. The Insurance Company stated that the building sum insured at the time of notification of the loss in 2002 was €237,000 having index linked the building sum insured up to that date, but it also stated that the building should have been insured for €270,000. The Company claimed that the Complainant's house was underinsured, applied the average clause and offered the Complainant €132,000 in settlement of his claim. The total reinstatement expenditure, according to the Complainant, amounted to €145,000.

The Complainant disputed that his private house was underinsured. He argued that the policy terms were ambiguous. However, the Ombudsman examined the terms of the policy and found them not to be ambiguous. The Complainant had various complaints in relation to his household insurance policy and its wording, but ultimately the Ombudsman advised him that there is an onus also on the Insured to determine whether or not the terms and conditions of cover are suitable to his needs, when effecting and /or renewing his annual household buildings and contents policies.

The Complainant also submitted that he relied on index linking over the years. The rates of index linking applied to the Complainant's building sum insured by the Company for the years previous to the submission of the claim were therefore examined. The Ombudsman noted that at the renewal date immediately prior to the date of loss, the Company applied a rate of index linking of 25% to the Complainant's building sum insured. The Complainant was made aware of the need for this particular rate by the Company in correspondence prior to its application as it had previously reviewed the general adequacy of the buildings and contents sums insured of the policies it provided and considered that many sums insured were inadequate. If the Complainant had not accepted this 25% rate of index linking, his house would have been significantly underinsured.

However the Ombudsman pointed out that whilst index linking partly assists in preventing underinsurance, it cannot be relied upon alone. He pointed out to the Complainant that index linking can only work properly if the sum insured

initially is correct. He commented that there is an onus on the Insured at all times to advise the insurance company of the correct valuation of his or her property for policy purposes and to review this valuation regularly. The Ombudsman noted that the Complainant's annual renewal notices also highlighted to the Complainant the importance of reviewing his sums insured annually and that if in doubt, it was the Insured's responsibility to seek appropriate advice in respect of the insured values.

In relation to the substantive part of this complaint, whether or not the Complainant's house was underinsured, the Ombudsman examined the submissions of both parties to the dispute. He also consulted the guidelines set out in the Society of Chartered Surveyors "Guide to House Rebuilding Insurance" (SCS Guide) for the relevant period and area in Ireland. These guides are available free of charge to the public and are intended to assist people in valuing houses for insurance purposes. The cost rates included in this guide are only a guideline to the minimum value for which an Insured should insure a house.

The measurements of the Complainant's building were requested from both parties and compared by the Ombudsman. The total floor area of the house was then calculated and multiplied by the relevant cost rate according to the SCS Guide to determine what the required sum insured should have been. The Ombudsman considered the cost rates used by the Company to calculate what the building sum insured should have been in 2002, and found that the cost rate it used also allowed for some benefit of the doubt in the Complainant's favour.

Having reviewed further information from the Company regarding its calculation of €132,000 the Ombudsman accepted that the average clause was correctly applied in this case. The Company's original offer of €132,000 to the Complainant was found to be correct, fair and reasonable and the complaint was not upheld by the Ombudsman.

Following the sale of farm for over €1.3m an 86 year old bachelor was advised to invest €850,000 in two 4 and 6 year fixed term bonds; €350,000 was retained in a demand deposit account with a further €150,000 in a current account - inappropriate advice

The Complainants were the Executors of the Estate of the deceased Policyholder who was aged over 86 years on his death in November 2004. The deceased bachelor closed the sale of his farm in early 2004 for a sum in excess of €1.3m. The complaint concerned the subsequent investment policies in insurance bonds (to the value of €850,000) that were recommended by a Bank acting as an Independent Intermediary. No complaint was made regarding €500,000 held in demand deposit and current bank accounts.

The insurance bond policies were effected in February and April of 2004 and were to run respectively for 5 years 11 months and 3 years 11 months. The policies did guarantee a return of capital, but only on maturity. At the date of death of the 86 year old policyholder some seven months later the surrender values were €50,000 less than the sums invested. The Ombudsman noted and appreciated that the Executors wanted to administer the estate in a timely manner and not wait for a further six years when the bonds matured with the guaranteed capital secured.

The Ombudsman's investigation and subsequent findings addressed the issue of whether the sale of the investment products to the 86 years old customer was correctly carried out. The Bank did have in place some measures relative to its sales process (which includes a Fact Find, the issuance of documentation with cooling-off notice and the accompanying of the Bank's sales manager who was known to the policyholder at the meeting with the policyholder). However, it is the Ombudsman's stated position (see Annual Report 2006) that there is a particular duty of care required when selling a policy to a person of advanced years. If there were not additional safety procedures in place, the sale of particular policies to a person of advanced years may not be appropriate having regard to that person's advanced age, infirmity or other circumstance.

While the Ombudsman noted that there was a warning in an Appendix to letters sent to the policyholder in this case regarding the Death Benefit under the policies i.e. *The value is*

not guaranteed and could be lower than the amount you invested, he found that other policy documentation were silent on the important fact that the fund values payable on death could be less than the amount invested.

The only documentation signed by the deceased was the application forms. Given the amount invested and the advanced age of the customer making the application (i.e. 86 years) one would have expected additional evidence of his consent and understanding of what he was entering into. Of particular concern to the Ombudsman in this case was that the deceased was not accompanied by an independent person when the documentation was signed. There was also no evidence of the deceased having had previous experience in investing in financial products other than savings through a deposit account and he noted that this particular investment strategy was not signed off at a senior level, as it should have been.

Having regard to the particular circumstances of this case and considering what was fair and reasonable, the Ombudsman decided that the Bank return the shortfall on the original investments i.e. bringing forward to the date of death the guarantee that would have applied at maturity. The award of return of the shortfall on the initial capital invested - €50,000- was given primarily on the basis that more should have been done by the Bank to ensure beyond doubt the policyholder's satisfaction with what had been advised.

In his decision the Ombudsman highlighted to the institution, additional (and what would be considered prudent) sales procedures for sales of investment products to customers of advanced years. Additional procedures would be for example: the requirement that a family member or independent professional third party be present (or at least evidence that this was suggested) when a policy is sold and that a senior member of management sign-off on the relevant documentation. A checklist signed by the policyholder is another method that could be put in place as an additional control when advising on investments.

The checklist would indicate that particular focus and attention was given to the following matters when the investment was arranged and would be signed by both parties and approved at a senior manager level:

- ▣ product booklet and Customer Information Notice,
- ▣ setting aside money for expected and any unexpected short term needs and also for emergencies,
- ▣ that the investment is a long term commitment and

that there is recommendation that it be held for a minimum of 3 to 5 years,

- ▣ the nature and limitations of any guarantees that are included in the product,
- ▣ the risk that attaches to the investment,
- ▣ any restrictions on encashment,
- ▣ any encashment penalties included in the product,
- ▣ the fund value payable on death may be less than the amount invested.

Whilst it did not form part of his investigation, as it was not part of the complaint, nevertheless, the Ombudsman was rather surprised with the advice given to the 86 year old customer to leave the balance of his monies i.e. €350,000 in a demand deposit account and €150,000 in a current account. The Ombudsman is aware that elderly people, or indeed other people, may want to leave large amounts in low or no interest bearing accounts while higher interest bearing accounts are available. However he considers that any bank manager and advisor should take all reasonable measures, particularly where very elderly people have a large amount to invest, that only reasonable amounts were so kept in such accounts with the balance in higher interest earning accounts. The managers should also ensure that a person would have ready access to funds in an emergency situation.

The Ombudsman considers that all institutions should, as a matter of routine, review bank accounts of elderly people so that appropriate amounts were held in them; that the lowest or no interest rate perhaps was not the norm. The Ombudsman appreciates that this is a delicate area for Financial Advisors as people, including elderly customers, can have definite and private views while being quite clear as to how they invest money but he wants reasonable safeguards and assurances nevertheless. He has raised the matter with the Financial Regulator also.

Payment Protection Policies for construction industry workers

In June 2004 the Complainant took out a vehicle finance loan. In addition to this he took out a payment protection policy as insurance against any loss of employment through redundancy, illness or injury. He commenced new employment with a builder in January 2005 to assist in the construction of new houses. In December 2005 the Complainant's employment was terminated.

As a result of this a claim was submitted against the payment protection policy in January 2006. After the Company investigated the matter and liaised with the Complainant's previous employer the claim was repudiated on the grounds that the Complainant had not been in full time employment.

Upon submission of the claim the Company requested specific documents in order to validate the claim. These included the Complainant's P45, letter from previous employer stating that Complainant was in full time employment, proof that the Complainant was in receipt of unemployment benefits and actively seeking employment. The Company stated that the letter provided by the employer was not sufficient to meet the policy conditions. The Company stated that the letter provided was not a severance letter as the Complainant was working on a contractual basis as he was only employed for the duration of the construction of specific houses. The Company also stated that as a result of the Complainant not being employed in permanent full time employment prior to his redundancy, he did not meet the requirements that would have entitled him to benefit under this policy.

The Ombudsman noted that the policy clearly stipulated that the claimant must be in **permanent** full time employment for a period of at least six months prior to the date of a claim. While the Ombudsman noted that the period of employment required was met by the Complainant he did not find that the employment could have been considered permanent. The letter provided by the previous employer clearly stated that the course of employment was only for the duration of the construction of a number of houses and there was no indication that the term of employment would continue after the construction of these houses.

The Ombudsman found that in order for the Complainant to benefit from this policy the insured peril, loss of employment, should have been an unexpected event and not known to the Complainant. The fact of the matter was that this was not an

unforeseen event and the Complainant knew that once the construction of these houses had been completed that he would be without employment. He found therefore that the term of employment could not be considered to be permanent and he did not find in favour of the Complainant on the repudiation issue.

However, the Ombudsman held that the product had been mis-sold to the Complainant as the seller should have been, and indeed was, aware of the nature of the Complainant's occupation. He directed that premiums totalling €2,100 were to be refunded by the Company to the Complainant as this contract of insurance had never been of any benefit to the Complainant.

Many employees in the building industry are employed on a contractual basis rather than as permanent employees. Accordingly this problem of mis-selling has further consequences across the building industry in relation to the selling of these products. He referred the matter to the Financial Regulator. The Regulator in response stated that an extensive review by him of sales practices in relation to payment protection insurance was carried out during 2005/6 following concerns raised about the sales practices for payment protection insurance and this was reported on in his 2006 annual report. Issues relating to past sales practices were not considered as prior to the Consumer Protection Code (Code), which came into full effect on 1 July 2007, there were no specific rules in relation to the sale of these products in place. The Regulator had noted from the review that refunds were not made in all cases where it emerged that payment protection insurance had been sold to an ineligible customer and in a letter to the industry in February 2007 directed that, in line with the Code, where policies are inadvertently sold to customers who are ineligible, firms have to have procedures in place to ensure that full refunds are made promptly to customers. As the particular complaint to the Ombudsman concerned a product sold in 2004 the matter fell outside the scope of the Code.

However, the Ombudsman considers it is possible that many people in the construction industry may have paid premiums prior to the Code coming into effect, for which, from the outset, they had no entitlement to benefit. The Ombudsman considers that this industry wide problem needs resolution. It is also possible that other people in contract type positions had similar policies which were and are of no benefit to them.

A Bank Manager allowing his personal affairs to be mixed with the business affairs of a customer gave rise to a conflict of interest - €10,000 compensation

The dangers of a Bank Manager allowing his personal affairs to be mixed with the business affairs of a customer so as to give rise to a possible conflict of interest were apparent in a case where a company was allowed to run up a large overdraft by a Bank Manager who was, at the time, having extensive renovations carried out on his family home by the said company. In the end the company could not manage its indebtedness; became insolvent and was wound up.

The company brought a case to the Ombudsman to the effect that the Manager ought not to have allowed the build up of debt and felt it was treated in a vindictive manner by the Manager. It appears problems over payment for the building work arose.

In reply to the Ombudsman's enquiries the bank said that it had no responsibility for what had happened because when the Manager had engaged the company he was acting in a private capacity, and not as a Bank Manager. However, the Ombudsman did not altogether accept this argument. He found on the contrary that the relationship between the Bank Manager and the customer was not entirely satisfactory and the bank could not simply 'wash its hands' of the affair.

The final indebtedness to the bank by the company was €15,000 and the Ombudsman directed that in the circumstances the bank should pay €10,000 by way of credit to the account, leaving a net indebtedness by the company of €5,000.

Mis-selling of Insurance Investment Fund- €10,000 awarded as management misled sales team and Financial Regulator asked to investigate Company

The Complainants - a husband and wife- sought compensation for loss of capital plus interest as they were led to believe the selected Insurance Investment Fund could not lose value while the Company pointed out that documentation issued specifically stated that the investment return was not guaranteed.

Though the husband worked with the Insurance Company in question he stated that he was never employed as a Personal Financial Adviser (PFA). The Complainants had relied on a PFA of the Company for investment advice. In 2001 they arranged a *With Profits Policies* with the Company's PFA and in March 2005 were approached by him and recommended a *Fixed Interest Unit Linked Policy*. This Policy came into force with an investment of €175,000. In July 2005, the PFA contacted them and advised that the *With Profits Policies* were not doing well and as a result they were mostly surrendered and the proceeds-€110,000- re-invested in the *Fixed Interest Unit Linked Fund*. A further top up of €100,000 from other sources was also added to this *Unit Linked Fund* shortly afterwards giving the Complainant's total investment in this Fund of €386,000 by August 2005.

The Complainants on noting the performance of the *Unit Linked Fund* switched their investments in April 2006 to a Cash Fund but stated that they shortly afterwards decided they could not trust the Company or the PFA. Accordingly they surrendered the Policy at a loss of approximately €10,000 by August 2006. The PFA no longer works with the Company.

In reviewing the matter the Ombudsman noted a statement from the PFA to the Complainants and submitted by the Complainants to the Company, where he insisted that the Complainants signed all the documents and "*I can confirm that you understood the Policy as I explained it to you comprehensively. But unfortunately it was not explained properly to me in the 1st instance so the information received by you could not have been accurate.*" The Ombudsman also noted that the PFA insisted that his management had told him there was no risk to capital in the *Fixed Interest Unit Linked Fund* - clearly this could not be the case.

The Ombudsman concluded that the PFA was the Company's Agent. The Code of Practice regarding General Sales Practice where the intermediary is a tied agent or employee stated that he must '*give advice only on those matters on which he is competent to deal and seek or recommend other specialist advice if this seems appropriate*'. In that regard the Ombudsman noted what the PFA stated in writing to the Complainant as outlined above and also the following

"The reason I told you the fixed interest fund was secure was because this is what I and other sales agents had been told by various people in the Company – including management and our corporate development team".

He also noted that the PFA informed his superiors about this case

"This all stems from me being told wrong information about this fund and not being able to get clear and proper information before it was too late"

Accordingly the Ombudsman decided that from the evidence submitted the Complainants were not accurately, correctly and fully informed as to the nature of the *Fixed Interest Unit Linked Fund*. He therefore asked the Company to refund the balance of the total investment- circa €10,000 – together with interest on all monies from the date of investment to date of payment at the rate the Company apply to late payment of claims.

As the sales practices of the Company raised concerns the Ombudsman referred the matter to the Financial Regulator as other cases like this may have arisen particularly as the PFA stated that other sales persons were misled by management. There could also be an issue of *churning* here as it was doubtful if it was in the policyholders' advantage to surrender mid-term and invest in another Fund. He had already referred to the Regulator another case of an inappropriate sale by the same company - regarding the sale to an unemployed single mother.

Credit Card Fraud and 'on the town' event merits compensation of €2,500

A night out, or perhaps more precisely, a morning out “on the town” in Brussels, had unfortunate consequences for a Credit Card holder. It appears he visited various night spots. At one place, officially described by the Credit Card Company as a “drinking place/alcoholic beverages merchant”, it appears from his Credit Card account that the Complainant made four purchases totalling €7,750.

One item was for €250 and was not disputed. The other transactions were for €2,500 each and were recorded on the system as having taken place at 4:40 a.m., 5:11 a.m. and 5:32 a.m. The Cardholder complained to the bank which refunded €2,000 of the total amount because the credit limit on the account had been exceeded by that amount. The Complainant complained to the Ombudsman that the bank should pay the full amount. The bank refused. Having investigated the case, the Ombudsman found that clearly the Complainant had been a victim of a “rip off” at this venue which he had attended. However the Ombudsman could not see how the bank should be held responsible for the entire cost of this “rip off”.

Nevertheless the Ombudsman decided that the bank’s security system ought to have done better when three transactions for €2,500 took place within one hour in the early hours of the morning in the city of Brussels and was not in line with the cardholder’s usual pattern of spend. As it turns out, not even a “ripple of unease” appears to have passed through the bank’s fraud prevention system. This, the Ombudsman considered, was a failure on the part of the bank.

In assessing compensation the Ombudsman took account of the fact that the bank had already refunded €2,000 to the Credit Card account and also took account of the fact that the Complainant must have been somewhat careless in securing his Card. The Ombudsman directed the bank to pay a further €2,500 in compensation.

Property Investment advice is still a problem - €55,000 awarded in two more cases

The Ombudsman in his July 2007 Case Studies, referred to the confusion and non declaration of conflicts of interest where investment advice was being given by Mortgage Brokers and where property was the investment vehicle. He referred these concerns to the Financial Regulator in early 2007 and two more cases came to his attention later 2007.

An investor who sought advice from a company offering investment advice on properties in Spain was advised to purchase a property. This involved effectively a deposit of €70,000 or 50% of the purchase price. He was advised by the Financial Service Provider that that was all that would be required, the idea being to sell on or “flip over” the property before closing and then get back the initial investment plus a profit and walk away. It didn’t turn out to be that simple. The property failed to sell or “flip over” and the Complainant had to borrow additional funds which he had not anticipated to complete the purchase.

The complaint in essence was that the investment strategy was flawed; that the property was over-valued anyway and that there had been a conflict of interest in that the advisor was also earning commission as an estate agent by selling the property on behalf of the developer, without disclosing this fact to the investor.

The Financial Service Provider denied that there was any conflict of interest. However the Ombudsman found that he had been using a business card on one side trading as a financial service provider, and on the other side using a different trade name as an estate agent. All his correspondence was on his financial service provider letterhead and emails.

The Ombudsman came to the conclusion that the Provider was offering financial investment advice to the Complainant involving the short term purchase and sale of a property in Spain. Notwithstanding his conflict of interest in earning commission by selling the same property to the Complainant on behalf of the developer of the site, the Ombudsman felt that the Provider in effect paid little attention to which particular entity he was operating under at any given time as was borne out by the double-sided business card which was given to the Complainant.

He also found that the Provider, in earning commission from the developer of the site for the sale of the property in respect of which he located a buyer, had a clear conflict of interest in recommending a property investment strategy to the Complainant which involved the short term purchase and almost immediate sale-on prior to closing the very property in question. The Provider could not, in the Ombudsman's opinion, be held to be offering any independent investment advice on property abroad when he was in fact acting as agent for the developer of the site, the subject of the proposed investment.

The Complainant appeared to have lost about €50,000 from his investment. The Ombudsman held that the Complainant himself was negligent in that he should not have embarked on the purchase of property in Spain without being satisfied that the market price of the property he was buying was in the correct range for the type of property being purchased and he held the Complainant 50% responsible for the loss which had occurred. In all the circumstances the Ombudsman directed that the Financial Service Provider pay the sum of €25,000 in compensation to the Complainant.

The Ombudsman also awarded compensation of €30,000 against another provider where an undisclosed conflict of interest arose -the only difference being that the property was in England.

Injured carpenter gets €10,000 award as bank did not keep recording of 'cold call' insurance policy sale; title of policy was also misleading

A dispute involving a misunderstanding arising from the selling of an insurance policy over the phone by a bank was submitted to the Ombudsman. The Complainant was a self-employed carpenter who suffered a serious injury at work in which he broke both his arms. He had purchased the policy some three weeks earlier.

When he made a claim under the policy, his claim was rejected. It turned out that the policy he had entered into was for 'personal accident insurance' but this policy provided cover only for 'permanent disability or death'. The Complainant was under the clear impression that the type of cover he had been sold provided cover for the type of accident he had had, but it did not.

It turned out during the Ombudsman's enquiries that the policy had been sold as a result of a telephone call from the bank to him as a credit card customer of the bank. It was unsolicited; a 'cold call'. The Ombudsman looked for a copy of the recorded conversation, or at least a transcript of it. The bank said that these were not available. The Ombudsman also noted that the detailed Policy Conditions did not issue until ten months after the accident occurred and this was not satisfactory.

The question the Ombudsman then had to consider was whether the Complainant had been misled by the bank's sales representative as to the type of policy he was buying. In considering this the Ombudsman noted, *inter alia*, that the Complainant had previously a Payment Protection Plan with the bank but this was cancelled by him, some months before the 'cold call' was received as he stated it came to light in his own review of his insurance needs that the policy only covered 3% of any balance outstanding on his credit card bill in the event that he was hospitalised for a period of 15 days or more.

The Ombudsman also noted that as he was self-employed, he had public liability insurance cover with another Company which would more than adequately cover the Complainant for this type of accident. However the Complainant stated that as he felt he was covered, and was led to understand that he was covered under the policy now in dispute when the accident did occur, he did not notify the other company within the 48 hours in which he was required to and therefore fell outside those terms. The Ombudsman was satisfied that the Complainant was conscious of what form of insurance cover he needed.

The Ombudsman concluded that since the contract had been entered into on the telephone it was not acceptable that no record was available as to what had transpired, e.g. whether all aspects of a complex policy were outlined clearly to the customer. He also found that the description of the policy was such as could well lead a reasonable Complainant to believe that he had cover for the kind of accident which happened to him unless the bank could prove otherwise to the Ombudsman. The bank was unable to do so and accordingly the Ombudsman decided to uphold this complaint and awarded compensation of €10,000. He also directed the Company and the Bank to change the title of the product as it was misleading to call it 'personal accident policy'.

The Ombudsman is conscious that many contracts and indeed other issues are carried out on line and over the 'phone. In those circumstances he pointed out to all Financial Service Providers that where he is dealing with a complaint

that hinges on contractual commitments entered into over the telephone he would be disposed to find in favour of a Complainant where the Provider could not provide the necessary evidence to rebut the claim being made. It would therefore be in the interests of the Providers to consider retaining appropriate records- including, where necessary, telephone recordings relating to such contractual commitments – for the period within which a person can complain to the Ombudsman i.e. six years.

Insurance Policy Review led to a proposed 200% increase in premiums

In September 1991 the Complainant took out Life Cover/Critical Illness protection with the Company and alleged that he was advised that for a monthly premium of IR£50 (€63) throughout his life he would receive the sum assured of IR£150,000 (€190,460) in the event of his death or critical illness.

The Complainant stated that he believed from the outset that the policy was designed to provide cover of a specific value for the entire of his life, giving certainty in the amount and circumstances of cover. The Company informed him in December 2005 that it had conducted a review of his policy and presented him with two options as follows:

- ▣ *In order to maintain the same cover of €190,461 to increase the monthly premium from €63 to €193 or*
- ▣ *For the same monthly premium of €63 to accept a lower cover level of €75,434.*

The Company, in a submission to the Ombudsman's Office, stated "the monthly charge for [the Complainant's] protection benefits exceeded his monthly premium towards the end of 2001. Although the growth on his fund value at that point covered the excess costs for a number of months, by early 2003 part of the fund was being used each month to cover the costs of protection benefits. At this point it would be expected that the fund would become negative at some date in the future." The Ombudsman noted that the Company did not make an offer to the Complainant of continued reduced cover (or increased premium) until December 2005. The Ombudsman found that information relating to the Complainant's depleting fund should have been communicated to him in 2001 and again in 2003 so that some remedial action might have been considered by him at an earlier date.

The Complainant's policy with the Company is a Unit Linked Whole of Life Policy. Life cover is charged for on a yearly basis and the premium rate increases with age. A Fund is built up in the early years but unless the initial premium is substantial the cost of the life cover in later years is greater than the premium and the Fund subsidises the cost of the life cover. In due course the Fund is exhausted and the result is a need for a review (an increase in premium or a reduction in the life cover). The core issue with this type of Policy is that the premium rate charged for the life cover increases with age each year and to maintain the sum assured becomes increasingly expensive. Usually, Unit Linked Whole of Life Policies contain a policy review condition which provides for a review after 10 years and thereafter every 5 years. This policy has, in fact, a more onerous condition as its provisions state:

"If any time after the second anniversary of the Date of Policy the number of units attaching to the Policy Account is negative the Company shall have the right to cancel the policy without value and all liability of the Company under the policy shall immediately cease."

The Company did not exercise its right to cancel the policy but instead offered to maintain the Benefits by a 200% premium increase or maintain the existing premium but thereby significantly reduce the Benefits by 60%. The Ombudsman considered that the policy was poorly worded and unfairly weighted in favour of the Company. In saying this he was particularly minded of the onerous nature of the policy condition and the fact that there is no policy review clause under this plan. Having said that he could not make a determination on the wording of the policy as the policy was sold more than six years before a complaint was made to him and so any such determination would be *ultra vires* the Ombudsman's statutory powers. The Ombudsman did, however, bring this aspect of the complaint to the attention of the Financial Regulator as other consumers may be similarly affected and other companies may have similar policies.

Having considered what was fair and reasonable the Ombudsman directed the Company to present a set of revised options to the Complainant, to take into account that the Company was to bear 50% of any cost of increase in cover and that the matter be reviewed again in five years time.

Mortgage Protection Policy - €25,000 awarded in dispute over direct debit non payment of premium

The Complainants - parents of the deceased assured - sought payment of a mortgage protection sum assured of €100,000 following the death of the Life Assured. The Company refused payment, pointing to the Policy having lapsed due to non-payment of the monthly premium.

The premium was payable on the 10th of each month by direct debit. The application for the premium due on 10th February 2006 was returned by the Bank "refer to debtor". The Company applied a second time later in the month, but advised the Life Assured that it was again returned by the Bank "refer to debtor". The Company wrote another letter to the Life Assured pointing out that the premium was still unpaid and advising that "we will continue to provide life cover under this policy for 30 days after the due date". The Company finally sent a letter advising the Assured that the policy had lapsed in March 2006. The Assured died tragically 3 days after the policy lapsed and - as a weekend intervened - more than likely had not received the Company letter regarding the lapsing of the policy.

It was argued by the Complainants that there were funds in the deceased's bank account from the end of the month in question and had an application for the premium been made on or after that date that it would have been paid.

In considering this case the Ombudsman noted during his investigation that :

- The Company has a rational system for dealing with unpaid direct debit applications i.e. it made a second application. The Company had previously issued four unpaid premiums reminder notices and the Assured did not communicate with the Company regarding same.
- A direct debit presented by the Company on the 10th December 2005 was unpaid. This direct debit request was again presented for payment on 30th December 2005 and was paid successfully. With regard to the February 2006 premium a request was made on 10th February 2006 but not paid. This was again presented for payment by the Company on 20th February 2006 and it was unsuccessful. It was argued by the Complainants that had the Company presented on the same date in February 2006 as it did in December

2005 i.e. at end of month, then there would have been sufficient monies in the account.

- The Complainants stated that that the deceased would have had no prior knowledge as to when the Company would seek to present the direct debit if the initial application was not successful. It was also confusing from a customer's point of view that though the policy stated that if a direct debit was unpaid no further direct debits would be presented until the requirements to recommence debiting had been fulfilled; clearly this was not the practice adopted by the Company in that it did further present for payment. It was also stated that what the deceased could not have known was what day that a request would be made for a second time, that this was not made clear to him in any letter, nor indeed, the policy terms and conditions or otherwise. It was argued that the deceased had only past direct debit presentations for payment by the Company to guide him.

The Ombudsman also noted that the Complainants pointed out that an intermediary (which is a member of the Group to which the Company belong), presented a direct debit on three occasions for the deceased's house insurance in February 2006. It was hard to reconcile this with the Company's policy regarding the life policy and would seem somewhat selective in all the circumstances. The Company in response to the Ombudsman's queries on this aspect stated that the Group to which it belongs has a number of companies operating in Ireland; that these companies are separate legal entities and operate independently of each other; that each company therefore is responsible for the implementation and operation of their own policies and procedures when administering their own distinct product offerings;

In his decision the Ombudsman stated that:

- The Company issued unpaid premiums reminder notices in February 2006 and the policyholder did not communicate with the Company regarding same. The onus is on the Policyholder to pay premium when due. If a Policyholder has elected to pay premiums by direct debit then he has a responsibility to see that his bank account is in funds on the day the premiums are due.
- He recognised that the Company did give a second chance; by making a second application for payment a Policyholder cannot place responsibility on a Company to make repeated applications in the hope

that funds will become available. However he considered that the Company in this case could have made its position much clearer in its communications regarding its presentations for payment. The Company could have at the very least notified the policyholder (in its letter outlining its second unsuccessful request for payment) that no further requests would be made to his bank. The Company has accepted this recommendation.

- Regarding the intermediary's presentation for payment on a third occasion for house insurance he noted that the Company forwarded its unpaid notices and lapse of cover notice to this intermediary. The Company's argument that the companies making up the Group were separate legal entities and operate independently of each other was correct legally. However, he considered that the varying procedures within the group regarding direct debits, could not, but confuse a consumer as to any leeway being given.

While ultimately the onus was on the Policyholder to pay the premiums when due, having regard to the overall circumstances of this case, the differing applications for direct debits within the group companies and considering what was fair and reasonable, the Ombudsman decided that the Company pay the deceased's estate €25,000 in full and final settlement of the dispute.

Travel Insurance – cancellation costs of €4,000 repaid

The background to this case was that the Complainant booked a holiday to take place from February 2007 to April 2007. However, after the booking the Complainant was diagnosed with a serious illness and as a result was not able to travel on the proposed trip. The Complainant then tried to claim her cancellation costs of €4,000 from the Company.

The Company informed the Complainant that her trip would have lasted 61 days and as a result it would not be covered by the insurance policy. The insurance policy stated that: *"The duration of a trip must not exceed 60 days"*. The Complainant claimed that her trip was for 59 nights and with the varying schedule of flights her trip would not have exceeded the time frame of 60 days.

The Ombudsman noted that the insurance policy did not specifically provide a definition in its policy document as to what constituted a "day" for the purpose of cover. In arriving at a decision on the matter, the Ombudsman had regard to a dictionary definition of a 'day' i.e.: *"A period of 24 hours as a unit of time usually from midnight to midnight"*. Using this definition of a day and taking the times of departure and arrival to be exact, he found that the Complainant's intended trip would have only been for 59 full days. He directed the Company to pay the Complainant her cancellation costs.

Credit Card sent to wrong address results in €4,500 compensation for fraudulent transactions

The constant vigilance needed by both banks and customers against the possibility of fraud were illustrated in a case about a mistake in relation to an address. When the bank sent out the Complainant's new Credit Card and PIN it was sent to an old address and it was taken by a fraudster and used fraudulently. By the time the customer realised what had happened he had lost €12,000.

The Complainant claimed that the bank was responsible because he had notified the bank of his change of address in relation to his current account and he assumed that the bank would apply the change to his Credit Card account also, but it did not.

The Ombudsman decided that while the primary obligation was on the Complainant to see that his change of address was registered on all his accounts with the bank, nevertheless there was also a duty on the bank to give guidance to the customer to ensure that all account addresses were changed, including his Credit Card account. He noted that the current procedure for amending addresses adequately covers this matter. In his Decision the Ombudsman found that the Complainant, not the bank, was largely (but not entirely) to blame for what occurred and he directed that €4,500 of the €12,000 which had been stolen, should be paid to the Complainant to reflect this.

Misleading Investment Advice by Bank- €17,000 in compensation

A customer who approached his bank for investment advice invested €100,000 in a Bond as a result. Four years later the Bond was worth €74,000. He complained to the Ombudsman that he had been misled. He said he had wanted a low risk investment only.

The Bond was a Tracker Bond linked to the *EuroStx Index*. In the course of his investigations, the Ombudsman observed that the bank's own internal documentation noted that "*client wants little to no risk; 3-5 years*". The bank stated to the Ombudsman that this Bond was indeed a low risk investment. The Ombudsman was unable to agree. The Ombudsman found this Index Fund was not a low risk investment when it was sold to the Complainant and was satisfied from the documentation he had seen that the Complainant wished to invest his monies in products which offered little or no risk to the capital amount being invested. Notwithstanding this, a product was recommended to him and sold to him by the bank which exposed his money to a category of risk which was clearly higher than he wished to accept and in those circumstances the Ombudsman was satisfied that the complaint against the bank was justified.

In arriving at a quantum of compensation the Ombudsman took into account the fact that the customer had intended to invest his money in a Bond, therefore he must be deemed to have accepted some risk to his capital. Taking this into account, the Ombudsman awarded compensation of €17,000.

€8,000 award made as the Insurance Company did not seek the opinion of Specialist Consultant as required under a Total Permanent Disablement policy.

The Complainant was diagnosed with Cancer and an associated illness and made a claim for Total Permanent Disablement under an Emergency Care policy. The dispute concerned the refusal by the Insurance Company to pay a claim on the grounds that the Complainant did not satisfy the policy definition of Total Permanent Disablement. The Complainant also claimed that she had been mis-sold the policy by the Company representative.

The Complainant submitted medical evidence in support of her claim that she was totally and permanently disabled. Regarding the medical examination that had been arranged by the Insurance Company, the Complainant submitted that she had not been properly examined by the doctor (a GP). She also stated that she had informed the Company representative at the time of the sale of the policy that she wanted life/sickness cover should she get sick or die.

In response the Insurance Company disputed the claim of mis-selling stating that, according to its agent, the Complainant had contacted him about taking out the policy, and that she was happy to purchase the cover. With regard to the claim for benefit, the Company stated that the independent medical examiner's opinion was that the Complainant did not satisfy the criteria required for benefit to be payable under the policy.

After investigation a finding issued by the Ombudsman's Investigating Officer did not uphold the complaint of mis-selling; it did find that the Company had not sought the opinion of a Specialist Consultant as required under the policy, and that as a result it was not possible to adjudicate on whether the Complainant satisfied the policy definition of Total Permanent Disablement. The Finding stated that, whilst the medical evidence was inconclusive as to whether the policy definition was satisfied for a certain period of time, it was clear from the medical evidence that the Complainant had been seriously ill for this period. Accordingly taking all the circumstances of the case into account, a once-off payment of €8,000 should be made to the Complainant in recognition of her serious illness.

A review of the finding was requested of the Ombudsman by both parties to the dispute, the Complainant reaffirming the complaint of mis-selling, and that the award made was too low. The Insurance Company argued that the investigator's officer's finding to direct a payment purely in recognition of the Complainant's serious illness was beyond the powers conferred on the Ombudsman by legislation.

With regard to the claim of mis-selling, the Ombudsman found that as there was a conflict of evidence between the parties as to what was said at the time of the sale of the policy, it was necessary to have regard to the documentary evidence. The Ombudsman found that this evidence did not support the Complainant's submission regarding the suitability of the policy. The Ombudsman also pointed to the power to make a compensatory award under Section 57CI - (4)(d) of the Act and stated that the award of €8,000 was made having regard to all the circumstances of the case, including the Company's refusal of the claim without adhering to its own policy

requirements. He rejected the Company's submission and directed that the €8,000 be paid.

Incorrect information supplied to holder of Approved Retirement Funds - €28,000 of management charges refunded

The Background to this dispute was that in 1998 the Complainant invested in an Approved Retirement Pension Fund. It was the Complainant's case that the policy was mis-sold and that deductions had been made that had no legal basis. The Complainant claimed that he was given incorrect information and the Company had taken an abnormally long time to respond to his queries.

As regards the mis-selling the Ombudsman's decision was that while it is correct to say that part of an independent advisor's role is to explain the nature and extent of the policy, as the time for such explanation was at application stage i.e. in 1998, he could not investigate this aspect of the dispute as the matter occurred more than six years before the complaint was made and was therefore statute barred. He also pointed out that the Regulations which imposed a requirement on both insurers and insurance intermediaries to provide certain policy information in writing to a client, in relation to projected benefits, *commission and charges*, policy reviews, early encashment and taxation issues, were not in force in 1998 and do not have retrospective effect.

The Ombudsman noted that the Company's decision about when it will apply a Market Value Adjustment (MVA) and how large it will be, together with its decisions about bonuses, are usually matters that are entirely for the Company itself to determine and the policy document submitted in this case covered the situation where these determinations are made by the Company. On the question of management charges, the Company argued that a fund management charge of between 1.25% and 1.75% was standard and well-known within the industry. Expenses are indeed incurred in the administration and management of funds and while there was a policy provision specifically referring to investment management fees, it was a policy requirement that these fees had to be specifically mentioned on the policy schedule, which was not the position here. The Ombudsman also noted that the true position in this case was that the charges were not explicit charges but were reflected in the declared bonus rates. He was satisfied that the Company was correct in that such charges are well-known within the industry and that one

could not expect that such a policy would be immune from such charges without the policy expressly stating so. The Complainant's policies did not specifically say that there would be no charges applicable.

However, the Ombudsman felt that the position could have been made much clearer by the Company. In its correspondence with the Complainant it used various terms for the charges, none of which were specifically stated in the policy. The Company also admitted that it erroneously gave incorrect information to the Complainant.

Accordingly the Ombudsman took the view that Policyholders have a right to rely on information provided by Companies and if the information is incorrect then the Company must pay a penalty. Having regard to the Company's delays in communicating with the Complainant's queries, incorrect information provided on more than one occasion, the management charges issue and having regard to what was fair and reasonable in all the circumstances of the case, the Ombudsman's decision was that the Company were to refund to the Complainant 50% of the overall fund management charges deducted over the years, which amounted to €28,000.

Income Protection Policy and what constitutes farmers income – 'look back' carried out at Ombudsman's request

In 2004 the Insurance Company agreed to pay Income Protection benefit in respect of the Complainant's disability. The benefit payable under the terms of the policy was up to 67% of the Complainant's earnings in the twelve months prior to his disability, minus earnings after disability.

The Company's position was that if the Complainant did not suffer financial hardship, it offered to make payments "On Account" while waiting for the Complainant to supply her income details that would enable the Company to calculate her exact benefit amount. The Company specifically reserved the right to "claw back" any overpayments.

On receipt of income details, the Company noted that the Complainant's income reduction post-disability was less than was estimated. As a result the Company calculated that an overpayment was made and sought the return of same from the Complainant. The Complainant alleged mis-sale of the

policy, in particular that the policy did not make it clear how income was to be calculated.

The dispute here concerned what accounting figure represented the Complainant's income for the purpose of calculating income protection benefit. The Complainant's occupation was farming and therefore self employed. The Complainant argued that the profit/loss (described as '*actual profit*'), from her audited accounts, rather than taxable income (described as '*profit after income averaging*') should be the basis of the calculation of her income. The Company were given the opportunity by the Ombudsman to consider this method of calculation. The Company accepted that it was appropriate to use the '*actual profit*' formula. The result was that the amount said to be overpaid by the Company was substantially reduced.

The Ombudsman had concerns that perhaps other farming policyholder's income protection benefit could be adversely affected by the Company's previous method of calculation. He felt that as the Company had accepted the '*actual profit*' basis as the correct method of calculation, that the same method of calculation of benefit should equally apply to similar policyholders affected going back six years and should going forward apply to any farming policyholders' income benefit. He suggested a recalculation of all farming policyholders' income benefit going back six years. A direction by the Ombudsman to review other cases could not be given in view of the High Court judgment in the *Quinn Direct v Financial Services Ombudsman* appeal.

The Company did check its Income Protection claims portfolio and located only one additional case where the claimant was a farmer. This was a short duration claim with benefits paid in 2005 in respect of a short period of disability. The Company reviewed this claim to see if any adjustment to benefit was required using the '*actual profit*' basis. No adjustment was required as the claimant had not been underpaid.

This case highlights a Company's willingness to abide by the Ombudsman's suggested 'look-back' on old claims to ensure equity for all its policyholders and he complimented the Company accordingly.

Insurer forwarded an incomplete company file to Ombudsman and a recommended compensation award was doubled to €500

The Complainants each had a Capital Options policy with an Insurance Company since July 1998. The Company argued that it issued a cheque for Stg£500 to each of the Complainants in February 2002.

These cheques represented the Complainants' entitlements for loss of membership rights at demutualisation. The Company stated that it forwarded the cheques to the Complainants' individual addresses and insisted that both cheques were cashed, in March 2002 and May 2002 at the same bank. However, the Complainants contended that they never received these cheques and never received copies of these cheques despite their many requests. The Complainants argued that they had to make numerous telephone calls to the Company, wrote numerous letters and emails and still failed to obtain copies of these cheques from the Company.

The Complainants provided evidence to the Ombudsman's Investigating Officer that they had been corresponding with the Company with regard to the cheques since January 2005. At his request, the Complainants provided copies of their bank statements for the relevant timeframes (March and May 2002). The Company failed to provide any documentary evidence to the Ombudsman to support their assertions. Instead it pointed to a third party external company that had issued the cheques on behalf of the Company, but indicated that it had failed to retain copies of the cheques or any supporting statements of the cheques.

On 3 September 2007 the complaint was upheld in a finding issued by the Ombudsman's Investigating Officer. €250 in total was awarded to the Complainants (€125 each, as they each had a policy with the Company) in view of the poor customer service provided to the Complainants and the time spent by them trying to obtain copies of the cheques. It was also found that the Company should reissue the cheques to the Complainants (in €) as the Company's record-keeping was unsatisfactory and the evidence it provided to show that the cheques were issued was inadequate. On 6 September 2007 the Company then requested a review of the finding by the Ombudsman and included in its submissions copies of the cashed cheques.

In his Final Decision the Ombudsman

- Highlighted the fact that a full company file had been requested by his Office from the Company on 1 February 2007 and that the Complainants had been requesting the copies of the cashed cheques since early 2005.
- Pointed out that the cashed cheques were central to the complaint raised and that the Company had ample opportunity to retrieve them and submit them to the Ombudsman prior to the issue of the finding.
- Stated that it was clear that the Company had retrieved these in advance of the issue of the finding dated 3 September 2007 but did not submit same.
- Found that the actions of the Company were totally unacceptable.

He therefore directed that the customer service award should be increased to €500 (€250 awarded to each of the Complainants) and that the finding dated 3 September 2007 was to remain unchanged otherwise i.e. Stg£1,000 to be repaid also in €.

Confusion as to bank transactions by an elderly customer

An elderly customer who had lodged three cheques to his account totalling €1,115 was surprised to find when he received his next bank statement that although this amount was shown as a credit, his account had also been debited with this precise amount. He claimed that he had not withdrawn any such money.

In reply to the Ombudsman's enquiries the bank stated that it held a withdrawal slip signed by the Complainant for the amount in question and that furthermore the cash till had balanced for that day. The customer stated that he had signed a lodgement slip for the amount which he was lodging but had not withdrawn any money or signed any withdrawal slip. The Ombudsman noted that the bank had recently changed its system and no longer required customers to complete a lodgement slip when making lodgements to their accounts. The bank accepted that the Complainant may have mistakenly thought that the form he signed related to lodgement of cheques in the light of its change in practice.

The Ombudsman found this to be a relatively difficult case to resolve; there was a shortage of compelling evidence either way and it was clear that both the Complainant and the Bank genuinely were satisfied that their version of events was correct. He noted that there was no CCTV in operation at the branch at the time. The Ombudsman decided, on the balance of probabilities, that the Complainant had not made the withdrawal in question and that when the Complainant signed the slip he believed it was a lodgement slip for €1,115, and not a withdrawal slip for this amount. While he noted and accepted that the daily cash balanced for the day nevertheless the Ombudsman felt that the bank may have made a mistake and accordingly should refund the sum in question, €1,115, to the customer.

Dormant Bank Account of €25,000 is ownerless

A curious case involving a dormant account came to light when a firm of solicitors claimed entitlement to monies which had been lodged in a bank 20 years ago and had remained unclaimed since. The account in question now had a credit balance of approximately €25,000.

It had originally been lodged in the bank in the name of "Messrs. AB Solrs. Ref. Messrs. XY Solrs". A couple of years ago the bank notified AB of the existence of the account. AB said they knew nothing about it and made no claim in respect of it. Later, in an effort to establish ownership of the funds, the bank contacted XY and informed them of the existence of the monies in the account. XY promptly claimed entitlement to the monies. The bank, in the absence of proof of ownership satisfactory to it, refused to pay out the monies in the account. Messrs. XY complained to the Ombudsman about the bank's refusal.

In response to the Ombudsman's enquiries, the respondent bank set forth in some detail the steps taken by it in the last three or four years to ascertain the ownership and origin of these funds. In its efforts to establish title to these funds the bank contacted both solicitor firms, conducted a thorough review of its own internal records and went to the trouble of interviewing a retired employee who had handled the account of AB. The Ombudsman was satisfied that the respondent bank had amply demonstrated that it had taken all reasonable steps to determine the ownership of these funds. Messrs. AB made no claim as to ownership of the funds and the respondent bank wrote to Messrs. XY stating that "in the

absence of evidence from you that your firm is beneficially entitled to the funds, we cannot take the matter further”.

In summary then the position was that Messrs. XY had not established to the satisfaction of the bank any entitlement to the funds. Messrs. AB did not make any claim. The Ombudsman, pointing out that he had not been in a position to – and had not been invited to – determine the beneficial ownership of the funds, stated that his findings were expressly without prejudice to the Complainant’s entitlement to bring forward a claim in the future, supported by new evidence. As far as this complaint was concerned the Ombudsman was satisfied that the respondent bank had done everything possible to respond to the Complainant and had not failed in its duty in any respect. The complaint therefore was not upheld.

Forged or stolen cheques lodged to a bank account- complaint not upheld

A customer had four cheques totalling in value €5,460 lodged to her account by other sources. She then withdrew €5,000 on the strength of this lodgement.

Some days later the cheques were returned to her bank unpaid. It turned out they were stolen and/or forged cheques and the bank charged the amounts to her account. The Complainant claimed that the bank should be held liable for the amount because it was at fault in allowing her to withdraw €5,000 against the cheques and that the bank should not be allowed to retain the money and debit her account with the costs of the transactions.

However the Ombudsman held that, as a matter of banking law, if a customer was credited with, or drew down monies, in respect of uncleared effects then there was clear authority that the collecting bank is fully entitled to debit the account which had been credited with the apparent value of these cheques if they were subsequently found to have been forged and/or stolen. He also noted that her account details had been given by her on the internet to the sources that made the lodgement.

The Ombudsman held that the bank was in no way liable in this case and the complaint was not upheld.

Disposal of shares by stockbroker - conflict of interest complaint not upheld

A Complainant who had a portfolio of investments with a stockbroker complained that the stockbroker had disposed of shares in a particular company from the Complainant’s discretionary portfolio one week before takeover took place in which the stockbroker was acting for the takeover team.

The Complainant would have done much better in respect of these shares if they had not been sold and his complaint in effect was that his shares were sold in circumstances where a takeover followed shortly thereafter and another division of the stockbroker had been advising the takeover team.

Clearly the issue here was whether or not there had been a potential conflict of interest. In response the stockbroker emphasised that strict “Chinese walls” exist between the stockbroker’s corporate finance team on the one hand and the portfolio management team in the firm on the other. The stockbroker stated in evidence to the Ombudsman that under no circumstances would a trader in the firm ever know of deals in which the corporate finance team were advising until such matters became public.

Having reviewed the entire matter, the Ombudsman concluded that the stockbroker’s decision to sell the shares in question was based on its commercial judgement; was arrived at in good faith and was capable of being supported by objective factors. The Ombudsman was further satisfied that the portfolio managers in the stockbrokers had no idea that another department of the firm was acting for the takeover team. It was understandable that the Complainants should have been disappointed at the timing of the sale of their shareholding.

Nevertheless the issue that the Ombudsman had to determine was whether the evidence disclosed any conflict of interest or irregular activity on the part of the stockbroker. Having considered the matter carefully, the Ombudsman came to the conclusion that the evidence did not disclose any such breach of duty or any irregularity and accordingly the complaint was not upheld.

Motor Insurance Policy- Complainant failed to keep his vehicle in a road worthy condition.

The Complainant had a motor insurance policy with the Company from September 2006. In December 2006 the Complainant was involved in a Single Vehicle Accident on a country road. He submitted a claim to the Company for the damage sustained to his vehicle, citing the cause of the accident was due to bad road and bad weather conditions i.e. icy roads.

Upon investigating the claim the Company discovered that both of the Complainant's rear tyres were in bad condition and both tyre thread depths were well below the minimum legal requirements. The Company appointed an engineer, who after carrying out an inspection of the vehicle deemed the tyres to be the primary cause of the accident. The Company repudiated the claim in its entirety stating that the Complainant was in breach of the policy terms and conditions by failing to keep his vehicle 'maintained in an efficient and roadworthy condition'.

The Ombudsman found that the Company was acting in accordance of its terms and conditions in the repudiation of the claim and after considering the independent engineer's report was in agreement with the Company that the tyres thread depths were the primary cause that led to the accident.

Death Benefit Claim of €800,000 not upheld for non disclosure of prior medical condition

The background to this case was that the Insurance Company repudiated a death benefit claim. The deceased was the managing director of a product provider company for financial advisors and was a shareholder in the business. The deceased was insured under a Group Life Assurance Scheme set up for the staff of the business.

The Complainant was the deceased's company i.e. the policyholder. The Company's declination of the death benefit claim (for €800,000 plus) rested on the argument that the deceased's medical condition had not been revealed to the Insurance Company and that the requirements of the 'Statement of Attendance' (i.e. actively in work and not absent for

more than 10 days in past 3 months) as set out on the application form were not conclusively proven.

The Ombudsman's Investigating Officer's finding was that the Company acted within its rights in repudiating the claim. The finding paid particular regard to the general principle relative to non-disclosure.

The Complainant sought a review of the finding by the Ombudsman on the following grounds:

- The normal practice in the industry for Group Life Schemes is that the Insurer will offer a non medical / non declaration limit to facilitate their securing large business and to keep the costs at a minimum.
- It was argued that no underwriting was required for any benefit below the stated limits. The Complainant pointed to the information on the Company's web site in this regard.
- It was argued that this case qualified under the Company's conditions for a non selection limit as all employees were inclusive for a uniform level of benefit and all were capable of completing an 'actively at work' declaration.
- The Complainant argued that insurers are aware that that they get both good and bad risks, but on balance will write a profitable book of business and that the Company accepted the risk and issued a cover letter to the insured.
- The declaration of attendance had been completed in good faith by the proposers and that when the cover was proposed for, the Insurance Company were aware of the nature of his illness as it was common knowledge in the industry.

Ultimately the Ombudsman had to consider the issue of non-disclosure based on the unique nature of the group policy as opposed to how one would look at an individual policy.

Before coming to his final decision the Ombudsman paid particular regard to the following facts:

- The deceased was for a number of years, the Managing Director of the proposing company and the largest shareholder in the company. The company was a product provider company for Financial Advisors.

- The medical evidence indicated that prior to the proposal for cover the deceased had a terminal illness with a poor prognosis of a median of 2 years. The medical evidence submitted clearly showed the severity of the deceased's condition.
- A request for a quotation was received by the Insurance Company some months after the terminal prognosis.
- The Insurance Company had confirmed cover but the non medical limit was subject to an employer's declaration of attendance.
- The Insurance Company had advised at the time of proposal that the deceased's level of cover (i.e. 4 times salary) was over the non medical limit of €800,000 and a separate proposal form requiring medical information was forwarded. The proposal form was never completed.

With regard to whether the requirements of the statement of attendance were fulfilled, on the balance of the evidence, the Ombudsman considered that in a general sense, these requirements could reasonably have been satisfied. One would not have to be actually in the work-place all the time to carry out one's employment duties. The Ombudsman found that the evidence produced by the Complainant went *some* way to support this conclusion, but that this had to be balanced with all the facts outlined in the detailed medical records submitted.

Turning to the question of the necessity for disclosure of the deceased's medical condition, the Ombudsman had particular regard to the general law in this area and relevant case law. He noted that

- The Complainant's argument was that the Group Policy differed from an individual policy and excluded a requirement of full disclosure. The doctrine relative to disclosure in insurance contracts was dealt with in the case of *Aro Road and Land Vehicles Ltd v ICI* [1986] IR 403. In that case Henchy J. in the course of his judgement at page 408 stated as follows:

Generally speaking contracts of insurance are contracts uberrimae fidei, which means that utmost good faith, must be shown by the person seeking the insurance. Not alone must that person answer to the best of his knowledge any question put to him in a proposal form, but, even when there is no proposal form, he is bound to divulge all matters within his knowledge which a

reasonable and prudent insurer would consider material in deciding whether to underwrite the risk or to underwrite it on special terms. This is the general rule. Like most general legal rules, however, it is subject to exceptions. For instance, the contract itself may expressly or by necessary implication exclude the requirement of full disclosure. It is for the parties to make their own bargain – subject to any relevant statutory requirements – and if the insurer shows himself to be prepared to underwrite the risk without requiring full disclosure, he cannot later avoid the contract and repudiate liability on the ground of non-disclosure.

- What had to be decided by the Ombudsman was whether this specific case came within the exception referred to in that portion of the judgement as being an instance where the contract itself by necessary implication excludes the requirement of full disclosure. The topic was dealt with as a general principle in *MacGillivray and Parkington on Insurance Law*, (8th e.d., 1988). There it was considered whether the questions asked in a proposal form extended the duty beyond the general duty. At paragraph 646 it states:

It is more likely, however, that the questions asked will limit the duty of disclosure, in that, if questions are asked on particular subjects and the answers to them are warranted, it may be inferred that the insurer has waived his right to information, either on the same matters but outside the scope of the questions, or on matters kindred to the subject matter of the questions. Thus, if an insurer asks 'How many accidents have you had in the last three years?', it may well be implied that he does not want to know of accidents before that time, though these would still be material. If it were asked whether any of the proposer's parents, brothers or sisters had died of consumption or been afflicted with insanity, it might well be inferred that the insurer had waived the policy for non-disclosure of an aunt's death of consumption or an uncle's insanity. Whether or not such waiver is present depends on a true construction of the proposal form, the test being would a reasonable man reading the proposal form be justified in thinking that the insurer had restricted his right to receive all material information and consented to the omission of the particular information in issue?

- This was accepted as an accurate statement of the principle of limitation of the obligation for disclosure arising from the particular form of questions, in *Hilda Kelleher v Irish Life Assurance Co. Ltd (SC) 8 February*

1993, (unreported). In the *Kelleher* case the court held that the insurance company had significantly limited the disclosure required from the proposers and the non-disclosure by them did not entitle the company to repudiate liability.

- The declaration on the proposal form in the *Kelleher* case was:

"If any question contained in the proposal has not been fully, correctly, and truly answered, or if there is any misrepresentation or non-disclosure concerning the health, habits or occupation of the life assured or if any answer to any question in the proposal is misleading, the company shall be entitled to avoid the policy, and thereupon all premiums paid and all rights under the policy shall be forfeited to the company"

whereas in the case before the Ombudsman the declaration stated:

"If I fail to reveal all relevant information this contract could be void. Relevant information is information which would affect your decision to accept my application for insurance. I understand that if I am in any doubt as to whether any facts are relevant I should tell you. I will add any information, on extra paper, which is relevant but not covered by the questions on this form".

Applying the test - *would a reasonable man reading the proposal form be justified in thinking that the insurer had restricted his right to receive all material information and consented to the omission of the particular information in issue?*- the Ombudsman found that the proposal form declaration in this case did have a broader requirement than in the *Kelleher* case relative to the disclosure of all relevant information and went as far as to ask for any relevant information not covered by the questions on the application form.

The evidence submitted to the Ombudsman showed that the proposers for the insurance were aware of the serious nature of the deceased's illness. The Ombudsman also noted that it was the Complainant's contention in the initial submissions to his Office that *they placed the insurance without the knowledge of the seriousness of the deceased's condition*. However, in the review submissions the Complainant stated: *"When [we] proposed for this cover [the Insurance Company] were aware of the nature of his illness as it was common knowledge in the industry"*. The Ombudsman could not accordingly accept that the Insurance Company were given the full facts in the light of that statement.

The Ombudsman did not and would not accept that *'hearsay'* is a ground for presuming that any Insurance Company was aware of the full details of the deceased's condition and held that the Insurance Company should have been given the opportunity to assess same before the policy was issued. Furthermore the Ombudsman noted that the proposing company was itself involved in providing advice on financial and insurance products and would be well aware of the need for full disclosure.

All complaints received by the Ombudsman are unique and each is considered on its own merits having regard to the particular facts of the complaint. It was his final decision that the Insurance Company did not waive its requirement to full disclosure of *all relevant information* and that the serious nature of the deceased's medical condition was very relevant and should have been disclosed. The complaint was not upheld.

